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We’ve done our homework
so you can spend more time doing what you do best.
As life expectancy at birth continues to improve, it poses interesting challenges of uncharted expectations and defining new norms. According to the National Vital Statistics Reports, life expectancy at birth for all races was 49.24 years from 1900 to 1902. This steadily improved to 68.07 years in 1949-51 and, for year 2000, it is 76.9 years. This certainly leads to new ethical issues with policy impacts for all. In the area of health care, its impact has been enormous, prompting difficult questions about healthcare delivery. Do we treat our elderly with state-of-the-art healthcare technology and scientific knowledge, or do we use these precious healthcare resources for education and prevention for our children and adolescents who are vulnerable to obesity and exposed to drugs, nicotine and alcohol? What is the right pathway and who makes that determination?

Extending life by all means has been the norm in the medical domain. How do we define the quality of extended life? Even when confronted with terminal life issues, we run into interesting dynamics with families and friends. What would this patient have wanted to do? Do we have advanced directives? Even when we do have advanced directives, how do we attend to conflicting family wishes? Occasionally these dilemmas of continuing life-saving measures for elderly and others in vegetative states end up in courtrooms. It becomes even more interesting when the government steps in to dictate ethical determinations, as witnessed recently in a Florida case of a woman who was in a state of coma and receiving tube feeding. This case captured national headlines as the State of Florida intervened and ordered that life-sustaining measures could not be discontinued. That is all nice and well as long as we figure out a way to pay for the medical costs and other liabilities.

With ever-expanding and certainly expensive treatment options, where do we draw the line? When and by whom does the decision get made that a bypass for grandpa at age 81 is not cost effective and will not improve his quality of life? Another hip or knee replacement at 78 may just be limited in its outcomes for improving the quality of life. What is quality of life, after all? And who defines it: the person himself, family, friends, physician, a trial attorney or our government? After we make the decision about the procedure and resulting quality of life, who will pay for it? Is either party making such a decision personally responsible for making such payments, just the way we do for other matters in our lives?

No one stops us from buying a luxurious home as long as we can pay the bills. Other decisions are just as difficult, such as extending the ability to walk by another 35 percent with 30 percent less pain in ambulation, for an elderly patient who resides in a nursing home. Or treating a leg ulcer with antibiotics off and on for more than six months for a Geri-chair bound grandma. Keep in mind the cost of these antibiotics continues to rise as first-line antibiotics are not as cheap and successive prescriptions may even be more expensive.

At a recent ACMS Board meeting, Kenneth Melani, MD, CEO of Highmark, provided very interesting data about cost drivers. As ever-increasing healthcare costs continue to impact our day-to-day practice of medicine, more attention is being
paid to what, after all, is driving these costs so rapidly. Dr. Melani indicated that one of the fastest growing components of healthcare costs is caring for our elderly. It sparked a discussion among those in attendance as to what quality of life really means and how we pay for such costs. In addition, Dr. Melani challenged the physician leadership with some basic public health issues of the increasing prevalence of obesity and high rate of nicotine addiction in our region.

Needless to say, the overt and hidden cost of medico-legal practices remains a challenge in many states, the Commonwealth of Pennsylvania being at the forefront of the malpractice crisis. In spite of an abundance of evidence otherwise, it was amusing to read a rebuttal, “Caps Aren’t the Cure,” in response to a January 9 Post-Gazette editorial, “Half a Prescription,” by State Rep. Frank LaGrotta. Mr. LaGrotta’s editorial offered some solutions, but maintained that astronomical jury awards for pain and suffering and the trial lawyers’ quest to pocket these awards are just fine and have nothing to do with Pennsylvania’s healthcare crisis. What physicians in Pennsylvania have been alerting our citizens to is a serious matter and has proven to be an effective measure in other states. Curbing our biggest bleeder of healthcare resources is essential. I was hoping that Mr. LaGrotta would also recommend that trial lawyers should limit their own fees and give more to the “victims” of pain and injury, and perhaps contribute less to legislators and more to prevention education efforts for teens in crisis.

It seems that this healthcare crisis genie is out and no longer considered just a physician’s delusional thinking and self-serving matter. These and other healthcare issues have become fodder for national debate. The upcoming U.S. presidential election seems to have focused on affordable healthcare for our citizens, among other matters of concern. Malpractice caps are being viewed as a critical matter, driving the healthcare cost astronomically. Caring for our elderly is another matter, however; with the voting power and concern by our elderly on how to cover the increasing costs of health care, it will pose an interesting challenge for those seeking election. How we come to terms with quality, cost containment and affordability for all, nevertheless, will be a task for politicians with courage, determination and vision.

In the meantime, I can’t help but think about many simple preventions for obesity, nicotine addictions, drug abuse and dependence. Prevention and behavioral health interventions cost much less to individuals and our society by attending to the root causes of behaviors rather than when they become a medical liability.

Human behaviors and attitudes do respond to concerted efforts by communities when we work together with the spirit of volunteerism and less selfish motives, when money is important but not critical, when we think of others and less of ourselves, when we strive to be humble and less arrogant, when we can make decisions benefiting our children and less for ourselves. Well, this debate is just on its way; do feel free to give your thoughts for the future of healthcare and any solutions; but of course these need to be affordable ones.

Dr. Chaudhary is a psychiatrist and medical editor of the Bulletin. He can be reached at schaud2815@cs.com or (412) 427-6828.
Untutored as I am in the nuances of high finance and the world economy, the wisdom of certain recent events is indeed mystifying. My utter lack of knowledge in this regard and my consequent anxiety about the future of this republic is taking its toll and causing me some very worrisome days and sleepless nights.

I am referring specifically to what I perceive as our blatant fiscal irresponsibility as a nation and our callous disregard for the comfort and health of our own citizens now and in the future. I have my suspicions, but I am not sure of all the factors that seem to be propelling our inexorable slide into the canyons of financial disaster. One reason is possibly extreme folly. Another is sleight of hand and mirrors.

I was quite astonished to learn that the much anticipated and loudly heralded Medicare Prescription Drug Modernization Act will cost the taxpayers a minimum of $400 billion. For what? This convoluted mess that requires an advanced degree in accounting to unravel will not substantially add to the comfort of our senior citizens nor afford many of us much relief from the crushing costs of prescription drugs. After token coverage for some, eligible citizens will still have to pay exorbitant prices from their own pockets until they have virtually mortgaged their souls to qualify for the next round. It appears that the major beneficiaries of this shrewdly crafted bill will be the pharmaceutical companies and the HMOs. This is no accident.

Deep down, this bill offends one’s sense of fair play and feeds one’s frustrations on many fronts. Undeniably, Americans pay unconscionably high prices for their medications. We pay two or three times more for medications manufactured in this country than Canadians, Mexicans and Europeans do for the same brands. Logic dictates that we should pay less because of reduced shipping costs and the absence of import duties.

To rub salt in the wounds of all Americans, it is not comforting to know that the federal government funds about 42 percent of all private U.S. healthcare research and development (R&D) expenditures with our tax dollars, including a significant portion of the R&D costs for new drugs. With that in mind, one would naturally expect that the drug companies, with the active coercion of a willing Congress, would have been passing out medications on the sidewalks or, at least, would have been selling them to us at 50 percent less than they sell similar products abroad. No such luck.

Illustrating their utter contempt for a pliant electorate, our government has threatened severe penalties for anyone as bold as to travel beyond our borders for, or to reimport, necessary and life-sustaining prescription medications. Only the U.S. government is allowed to shop around abroad for cheaper medications for its own use. Closing all avenues of escape and with the deftness of a savage beast purposefully moving in for the kill, this bill also prohibits participants from purchasing supplemental insurance to pay for those items not covered by Medicare such as co-payment. I cannot imagine many actions as predatory and unconscionable as that.

So that they can maintain exorbitant profits at the expense of the elderly, many of whom are on fixed incomes and who regularly face the choice between medicines and food, the pharmaceutical companies have reigned fear on the foreign pharmacies for selling medications back to Americans, even at a profit, and have
threatened severe reprisals including the withholding of future shipments if the practice continues.

It is quite curious and still quite baffling how Congress suddenly developed the backbone to pass such legislation, notwithstanding an inordinate amount of arm-twisting from other quarters. They counted rather heavily on the mistaken notion that the senior citizens of this land would be eternally grateful for every small morsel thrown their way. This legislation was intentionally couched in such cryptic and stilted language as to render it relatively undecipherable. After the smoke cleared, however, there was little question that we had become, once again, the unwitting pawns in a high-stakes charade exquisitely choreographed for the enrichment of a select few.

It seems, too, that much of the success of the passage of this bill was due to the considerable weight of the American Association of Retired Persons (AARP), whose benefit in this is quite obscure. I feel that they illegally supported this bill in my name without my consent. I have about a dozen friends who, like me, are members of the AARP and not one can recall either being consulted or giving permission to that organization to act on their behalf. One wonders whether a poll or survey was ever taken to assess the mood of the membership.

For reasons that I cannot quite understand, the idea of guaranteeing a basic level of medical care to all citizens is not being very well considered. In terms of humanity and humaneness, that leaves us well behind the pack of progressive nations that put the welfare of its citizens ahead of the lure of wealth and power.

The concept of universal health coverage had been bandied about for many years, but there was always the reluctance on the part of Congress to provide us with this comfortable and essential perquisite under the pretext that it was too costly. With an eye on re-election, however, they grudgingly appropriated $400 billion for the partial prescription plan to start in 2006. Yet a massive tax cut of several hundred billion dollars was rushed through with all deliberate speed—to start immediately. Faster yet, and with the token resistance of a jelly-fish, we urgently passed bills donating $480 billion for reparations of Iraq, lesser amounts for Afghanistan, and for the privilege of teaching our “superior” ways to their citizens—starting immediately. And without batting an eye, we are proposing to spend incalculable trillions of dollars to revisit the moon and possibly to embark on a fool’s errand to Mars. Meanwhile, the toll of human suffering here mounts and valuable medical research is curtailed, suspended or abandoned for lack of funds.

We spend borrowed money without reserve and we satisfy IOUs with abandon as though there were no reckoning down the line. We show little urgency in controlling the rapidly increasing trade deficits which, last year alone, reached over $114 billion with China, $75 billion with Japan, $12 billion with South Korea, $50 billion with Great Britain, $40 billion with Mexico, and $50 billion with Canada to name just a few of the lucky winners. All this reflects adversely on the quality of life we now enjoy and will, undoubtedly, impact disastrously on our well-being in succeeding years.

If the will were there, that same zeal for spending could easily be channeled into providing universal medical coverage for everyone within our borders. If we factor in our present spending for Medicare and Medicaid, and eliminate the exorbitant profits that the private insurance companies now siphon off from the pool of health care dollars, we may well find that the difference is naught or not that great. We may even save money. But the jackpot questions still loom large: Where is all this “monopoly” money coming from? Who will eventually pay for all these expensive adventures? How long can a country, even seemingly as prosperous as ours, survive such massive continued on page 63
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egression of capital before collapsing? These are rhetorical questions, of course, as we already know the answers.

A few years ago, a mellifluous senator from Illinois, Everett Dirksen, lamented our profligate ways, albeit tongue-in-cheek, when he observed that our national budget exceeded our revenues by a few billion dollars. In response to the usual untenable arguments in favor of deficit spending, he was known to remark, “$1 billion here and $1 billion there and pretty soon we’re talking about real money.” Well, old Everett is probably doing somersaults in his grave now, at whirlwind speeds, when poked with the absurdity of those words. He never could have imagined the dizzying heights to which our appetites have risen.

I have my suspicions still, but I cannot entirely explain all these events on stupidity alone. And I do not subscribe to the theory that deficits don’t matter, although it seems to be a prevailing sentiment that pervades all levels of our society. In my mind, there has to be an overwhelming degree of insensitivity with liberal helpings of greed to motivate one to mortgage our future and that of our children and our children’s children without the least bit of concern or moral anguish for this terrible legacy. This insouciant attitude toward national insolvency is truly maddening.

It becomes quite troubling too, when one stops to ponder the fact that the cost of our abdication of decency will be borne almost entirely by the middle income working men and women for many generations to come. Virtually none of these privations will affect the favored legions and their progeny who will be able to squirrel away countless millions of their ill-gotten gains for insulation against harsh winters ahead.

Dr. Marryshow is an orthopaedic surgeon. He can be reached at docshow@comcast.net.

The opinion expressed in this column is that of the writer and does not necessarily reflect the opinion of the Editorial Board, the BULLETIN, or the Allegheny County Medical Society.

Smoking during pregnancy is responsible for 20%-30% of all LBW infants.

According to research presented in Pediatrics (June 2003)...
The American Academy of Otolaryngology—Head and Neck Surgery Foundation awarded Charles D. Bluestone, MD, otolaryngology, and Barry E. Hirsch, MD, otolaryngology, Distinguished Service Awards at its 107th Annual Meeting in September. The foundation also recognized David E. Eibling, MD, otolaryngology, with a Presidential Citation Award.

Dr. Eibling presented Is it a normal larynx? The spectrum of normal in videostroboscopy at the academy’s annual meeting in September and gave the keynote address at the Society of Military Otolaryngologists in September, both in Orlando.

Jonas T. Johnson, MD, otolaryngology, assumed the position of editor of The Laryngoscope in October.

Eugene N. Myers, MD, professor and Eye and Ear Foundation chair for the Department of Otolaryngology at the University of Pittsburgh School of Medicine, was recently appointed as medical affairs advisor to the International Association of Laryngectomees (IAL).

Robert L. Ferris, MD, otolaryngology, presented Expression pattern of chemokine Receptor 6 (CCR6) and CCR7 in squamous cell carcinoma of the head and neck (SCCHN) identifies a novel metastatic phenotype at the Presidential Session of the International Society of Biological Therapeutics meeting in Washington, D.C., on November 1.

David L. Mandell, MD, pediatric otolaryngology, presented the lecture Laryngomalacia induced by exercise in a pediatric patient at the SENTAC 31st Annual Meeting, October 30-November 2, in New Orleans.

Luis Fabregas from the Pittsburgh Tribune-Review interviewed G. Alan Yeasted, MD, internal medicine, for an article on aneurysms, published January 4.

Edward M. Barksdale Jr., MD, pediatric surgery, was featured in the December 30 edition of the Pittsburgh Post-Gazette as one of its “Dozen Making a Difference.” Dr. Barksdale is a founding board member of Every Child Inc., an agency that helps medically fragile children in unstable or stressful home environments in part by supporting their families.

Safdar I. Chaudhary, MD, psychiatry, was featured in the December 30 edition of the Pittsburgh Post-Gazette as one of its “Dozen Making a Difference.”

With the support of the Muslim Community Center of Greater Pittsburgh and his assistant, M. Rashad Hasanm, Dr. Chaudhary created the Coalition for Human Dignity to work toward preventing drug and alcohol use among local youth.

Gary Goldberg, MD, physical medicine and rehabilitation, recently was appointed director of the Brain Injury Rehabilitation Program at Mercy Rehabilitation Center of Mercy Hospital of Pittsburgh. He is president-elect of the American Association of Electrodiagnostic Medicine.

Children’s Hospital of Pittsburgh recently presented Angelo S. Runco, MD, pediatrics, with the 2003 Howard A. Mermelstein Award for excellence in pediatrics. Dr. Runco received the Lifetime Achievement in Pediatrics at the Western Pennsylvania Hospital in 2002.

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**The Bulletin** | February 2004
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**In Memoriam**

Theodore R. Gelet, MD, age 66, passed away on January 9. Dr. Gelet, a cardiologist, graduated from George Washington University Medical School in 1964 and served both an internship and residency at Mercy Hospital in Pittsburgh, where he later served as director of the cardiac care unit. He also served for a period of time as family physician for Steelers owner Art Rooney Sr. before retiring from his solo practice in 1998. He is survived by wife Eileen, son Christopher, two daughters, Pam Gelet and Jennifer Gelet Sheehan, and three grandchildren.

Robert W. Hilberg, MD, age 61, passed away on December 24. Dr. Hilberg, who specialized in hematology/oncology, received his medical degree from the University of Pittsburgh Medical School in 1967 and served both an internship and residency at Mercy Hospital in Pittsburgh. He also served two years in the U.S. Navy as chief of hematology-oncology at the Great Lakes Naval Hospital and most recently worked as medical director of Family Hospice and Palliative Care in Mt. Lebanon. He is survived by wife Linda, and two daughters, Dina Hilberg and Julie Hilberg-Hunt.

**From the Mailbag**

January 22, 2004

Dear Dr. Chaudhary:

I read with intense interest your article “Rise and Fall of the Years,” published in the last issue (January 2004) of the Allegheny County Medical Society Bulletin. It was a good year for the Bulletin, giving to its readers all the information needed to understand the multiple problems that our medical profession faces in these crucial times, especially the malpractice situation. With its new format, the Bulletin is accomplishing its goals in the medical community. Just retired and away from Pittsburgh, I enjoy the Bulletin pages every month. I congratulate you for the outstanding job you are doing conducting this important medical journal.

Cesar A. Ruiz, MD

Ex-director GI Laboratory

(Old St. Francis Hospital)

**Speaker’s Bureau**

Richard Bowers, MD, ophthalmology, spoke about glaucoma to a senior group at Baptist Homes, Mt. Lebanon, in November.

Lydia Saris-Mechenbier, MD, internal medicine, spoke to a group of 6th, 7th and 8th grade students at a career day activity at Washington Polytechnical Academy, Lawrenceville, in January.

G. Alan Yeasted, MD, internal medicine, spoke about diabetes to a senior group at Baptist Homes, Mt. Lebanon, in January.

**Dear Doctor**

J. Howard DeHoff, MD, internal medicine, wrote on how to get the best from doctor’s appointments. He recommends patients choose their physician carefully, prepare for the visit by making notes, make eye contact with the physician and take a list of current medications, both prescription and over-the-counter.

Alice F. Rocke, MD, general surgery, wrote about lymphedema of the legs. She explained that the condition is manageable with the help of a certified lymphedema therapist who can design a program to help prevent the lymph fluid from accumulating and get the sufferer back to daily life.

*The Dear Doctor column is published regularly in the Pittsburgh Post-Gazette’s Health Section.*
Surgical society holds meeting
The Pittsburgh Surgical Society held a meeting on January 19, when it presented its “Most Interesting Cases for 2003.” The following physicians presented their prize-winning case studies: Drs. Selma Cetin, Children’s Hospital of Pittsburgh; T. Clark Gamblin, University of Pittsburgh Medical Center; Patrick Gatmaitan, Conemaugh Memorial Medical Center; Mark Hennon, West Penn Allegheny Health System, Allegheny General; and John Robinson, Mercy Hospital of Pittsburgh.

The surgical society also presented its annual $500 scholarships to the following senior medical students who are interested in surgery: Joseph Golob, University of Pittsburgh School of Medicine and Stacy Milan, Temple University School of Medicine (West Penn Hospital campus). Haig Dudukgian, Drexel University School of Medicine (Allegheny General campus), who was unable to attend, is also a scholarship recipient.

Ophthalmologists host program
The Pittsburgh Ophthalmology Society hosted a program for its members on January 10, featuring Michael Parshall and Sandra McGraw, JD, of the Healthcare Group from Plymouth Meeting, Pa., who spoke on office management specific to ophthalmology. Members and office managers also attended the program that provided members with 5.5 CME credits.

Urologists add March meeting
Due to the cancellation of its December program, the Pittsburgh Urological Association will host a meeting at the medical society headquarters on March 15, with registration at 6:00 p.m., dinner at 6:45 and the program at 7:15.

Roger R. Dmochowski, MD, professor of urology, Vanderbilt University, will serve as invited guest lecturer, speaking on The Future Direction of Overactive Bladder Therapy. Dr. Dmochowski, who also serves on the editorial boards of the World Journal of Urology, Journal of Pelvic Medicine and American Urology Association’s Office of Education (CD-ROM series), has authored or co-authored 16 book chapters and more than 80 journal articles and has presented at numerous national and international society meetings. Dr. Dmochowski has received numerous awards, including the Zimskind Award of the Urodynamics Society. To register for the program, contact Nadine Popovich at (412) 321-5030 or npopovich@acms.org.

Ophthalmologists to meet in March
The Pittsburgh Ophthalmology Society will hold its 40th annual meeting, March 19-20, at the Hilton Hotel; the Allied program will run concurrently on March 19. The Friday evening banquet will be held at Pittsburgh’s Grand Hall at the Priory. Douglas Koch, MD, will serve as the Thorpe Lecturer; other speakers will include Dr. Donald Budenz, Robert Cionni and William Mieler. Dr. Michael Azar, who is the president of the Pennsylvania academy, will update the society on state activities, and Geoffrey Anders of the Healthcare Group will present Planning Your Exit Strategy. Registration fee for the annual meeting is $350; for more information, contact Dianne Meister at (412) 321-5030 or dmeister@acms.org.
Geriatric medicine update set
The Pennsylvania/West Virginia Geriatrics Society, in conjunction with the University of Pittsburgh School of Medicine’s Center for Continuing Education in the Health Sciences, will hold a clinical update in geriatric medicine on April 1-3 at the Pittsburgh Hilton Hotel and Towers.

The burgeoning number of older adults challenges healthcare providers to make cost-effective medical decisions while still providing high quality care. This year’s conference will address not only a broad spectrum of geriatric conditions, but also provide information on long-term care regulations and reimbursement issues. The following nationally known speakers will serve as guest faculty: Drs. Patricia Bomba, Helen Fernandez, Thomas Pinucane, Peter Hollman, Reena Karani, Lew Lipsitz, Kenneth Shay (DMD), and Susan Tolle.

The conference will provide an in-depth update of geriatric care using a variety of formats including lectures, breakout workshops, long-term care session and evidence-based medicine. The conference will also feature a two-hour symposium, That Was the Year That Was, that seeks to organize, evaluate and prioritize the literature published over the past year, focusing on the health of older adults, with the goal of identifying areas where new strong evidence has been uncovered that should affect geriatric practices. New data on geriatric disease and syndromes, systems of care of older adults and mental health in the late life will be covered. Also scheduled is an interactive dinner presentation on Oregon’s approach to end-of-life care.

The American Geriatrics Society has endorsed this conference, and credits earned from this activity may be counted toward the AGS Geriatrics Recognition Award. In addition, a maximum of 18.25 Category 1 credits toward the AMA physician’s recognition award is available. Other healthcare professionals are awarded 1.825 continuing education units (CEUs), which are equivalent to 18.25 hours of instruction. For more information on conference details and credit offerings, contact Amy Lederer at (412) 647-8216 or email at ccehs@upmc.edu. Registration is available at www.upmc.edu/CCEHS/cme/formal_courses.asp.

In conjunction with this conference, the Pennsylvania/West Virginia Geriatrics Society will hold its annual spring business meeting on April 2 at 12:15 p.m. For information regarding the meeting or membership, contact Nadine Popovich at (412) 321-5030 or npopovich@acms.org.

The Allegheny County Medical Society held its inauguration dinner in January when it installed officers for 2004 and presented its annual awards. Pictured here, outgoing President G. Alan Yeasted, MD, passes the gavel to 2004 President Edward Teeple Jr., MD.

Geriatrics society supports scholars
The Pennsylvania/West Virginia Geriatrics Society is pleased to announce its collaboration with the American Federation of Aging Research (AFAR) through its support of the RPS/AFAR Medical Student Geriatric Scholars Program. The society will award each of two area students with a scholarship of $4,000 to participate in 2004.

The scholars program encourages and supports medical student interest in geriatrics with the ultimate aim of preparing future leaders in geriatric medicine. Since its inception in 1994, 700 medical students representing 80 medical schools have participated in the program, which includes an 8-12 week opportunity in clinical geriatrics and aging research. Scholars will train at one of four National Training Centers. In addition, the University of Pittsburgh, which is recognized as a John A. Hartford Foundation Center of Excellence in Geriatrics Initiative, may also serve as a training center for the medical student geriatric scholars. Selection for the scholars program will begin this month. Detailed information, including recipients of the grant, will be announced in April. For more information regarding the program, visit AFAR’s website at www.afar.org/medstu.html.

Leadership training part 2 on March calendar
Three Peas, HeretoFore, Not in a Pod, the second session of the Developing Exceptional Leadership Teams in the LTC Series developed by the University of Pittsburgh Institute on Aging, continued on page 68
will be held March 31 from 1-5 p.m. at the Hilton Hotel and Towers. One of the most challenging problems facing LTC leadership is being able to work effectively together; participants will be trained to better understand the art of negotiation and collaboration in making difficult policy decisions. They will also work together to address one of the three key transitions of care areas: ethical issues in long-term care, delirium management and change in level of care. For more information, including credit offerings, call (412) 647-8232.

Morton promoted to key position
The medical society has promoted Christina E. Morton to the position of communications director. Morton, who graduated from Duquesne University with a B.A. in communications, joined the ACMS staff in May 2000 as communications assistant and last year served as communications manager. She will be managing all communications services, including community and media relations, promotion and advertising. She also will serve as staff liaison for both the Communications and Child Health Committees.

Associate editors appointed
The Bulletin’s Editorial Board has appointed three new associate editors to fill open positions, including Janet A. Chollet, MD, obstetrics/gynecology; Timothy G. Lesaca, MD, psychiatry; and Adam Z. Tobias, a second-year medical student at the University of Pittsburgh.

Dr. Chollet, who is board certified in obstetrics and gynecology, has been in private practice here in Pittsburgh since April 2000. She was written articles for the American Journal of Obstetrics and Gynecology and locally for the Pittsburgh Post-Gazette. Dr. Chollet also has been involved with television script-writing for the popular show, E.R.

Dr. Lesaca, who is a psychiatrist at Sewickley Valley Hospital, has written for a number of publications, including Psychiatric Times, The West Virginia Medical Journal, Journal of Clinical Psychopharmacology and the American Journal of Psychiatry. He currently serves as a reviewer for General Hospital Psychiatry, the Journal of Nervous and Mental Disorders and Psychiatric Services.

Mr. Tobias has served as contributing editor for the ACMS Bulletin for the past year and has contributed a number of student columns (Getting There: The Musings of a Medical Student). He will continue to coordinate the column.

Medical students attend meeting
A contingent of 13 medical students from the University of Pittsburgh School of Medicine attended the
American Medical Association's interim meeting in Honolulu in December where they voted on new AMA policies that affect student debt, the anti-trust lawsuit against the National Residents Matching Program (NRMP), contraception and adoption by same-sex parents. The group included Jeff Bassett, Dan Brown, Drew Chronister, Bianca Durando, Matt Feng, Margaret Gibson, Megan Groh, Stamatis Kantartzis, Jonathan Keith, Alison Lewis, Avi Manchandia, Adam Tobias and Alik Widge. Ms. Gibson and Mr. Chronister served as delegate and alternate-delegate to the AMA's House of Delegates.

Patient education materials made available
The ACMS has prepared patient education materials on the professional liability crisis in Pennsylvania for physicians to place in their waiting rooms, hand out to patients and share with colleagues. A sample of the front and back of one of the handouts is pictured on page 88. Call (412) 321-5030 to request a supply for your office.

Correction to January Bulletin item
Please note that Lester O. Prince, MD, was mistakenly listed as a plastic surgeon on the Table of Contents page of the January Bulletin. Dr. Prince, whose grand-prize-winning photo graced the cover of that issue, specializes in physical medicine and rehabilitation.

Favorite websites to be listed
If you have websites that serve you well in your daily work, please share them with your fellow ACMS members by sending them to lsmith@acms.org for publication in a future Bulletin article. We would also be interested in hearing about ways you use the Internet technology to make your work as a physician easier. If you have questions, please call Linda Smith, Bulletin managing editor, at (412) 321-5030.

Medical 'biz in the 'Burgh
U.S. District Judge Robert Cindrich plans to resign from the federal bench continued on page 70

What Every Physician MUST Know about....

ASSET PROTECTION PLANNING

Please join us for a complimentary breakfast with two distinguished and compelling speakers, each a foremost authority on domestic and international asset protection techniques.

Mr. Ralph Minto, Jr., CPA, J.D.,
Founder, Ralph Minto, Jr. & Associates

Mr. Al Behar
Senior Vice President and Senior Trust Consultant
Wachovia Trust Co., N.A.

Saturday, April 24, 2004
8:00 AM to 10:00 AM
ACMS Meeting Room
713 Ridge Avenue, Pittsburgh, PA 15212-6098
RSVP 412-201-5525
to become chief legal counsel to the University of Pittsburgh Medical Center starting Feb. 1. Cindrich, who has served as a UPMC director since 1996 and represented it as outside counsel before his 1994 judicial appointment, will replace George Huber, who was named UPMC’s senior vice president for corporate relations and regional programming last fall after serving 28 years as general counsel to UPMC or its predecessor institutions. UPMC Chairman G. Nicholas Beckwith said that UPMC’s decision to hire Cindrich was unrelated to December’s filing of two lawsuits against Magee-Womens Hospital.

[1/6/04 Pittsburgh Post-Gazette]

Pennsylvania physicians will have to stay in the state for a year in return for help in paying their MCARE assessment. A physician who accepts a rebate for 2003’s assessment must stay in Pa. through the end of this year or be required to repay the rebate, while acceptance of a rebate for 2004’s MCARE assessment requires a doctor to stay in Pennsylvania through the end of 2005. A physician will not qualify for the rebate if his or her license has been revoked in any state in the last 10 years, or if he or she has settled or lost three or more medical liability claims each worth at least $500,000 in the last five years.

[1/8/04 Associated Press]

A shortage of blood donated to the Greater Alleghenies Region of Red Cross Blood Services is being felt at some area hospitals and probably will not ease up for some time. Latrobe Area Hospital’s blood supply is perilously close to depletion, and the hospital’s blood bank supervisor said that one major accident could wipe out the surplus the hospital has been dipping into for routine treatments. From Jan. 1 until Jan. 8, the hospital had used 47 units of red blood cells, while the regional Red Cross has provided the hospital with only 38 units during that time period, forcing LAH to dip into its surplus set aside for emergencies.

[1/9/04 Pittsburgh Tribune-Review]
The Pennsylvania Supreme Court’s chief justice wants local court officials across the state to report the number of medical malpractice claims filed in the past four years and monitor new cases as they come in. The request came in the form of a letter on behalf of Chief Justice Ralph J. Cappy, and in response to a reform proposal Gov. Ed Rendell made last year, that was sent to president judges in the state’s 60 judicial districts by state court administrator Zygmont A. Pines. The letter also seeks detail about how many medical malpractice cases the courts are transferring from one jurisdiction to another, but it does not ask for information about the size of malpractice verdicts.

[1/13/04 Associated Press]

Magee-Womens Hospital’s CEO is stepping down. Irma E. Goertzen plans to retire March 1, ending 15 years at the helm that saw the institution vastly expand research activities, programs and facilities and undergo a controversial merger with the University of Pittsburgh Medical Center. A national search is planned for her successor, while Goertzen will remain CEO of Magee-Womens Health Corp., parent of Magee-Womens Research Institute, Magee-Womens Health Foundation and Magee-Womancare International.

[1/14/04 Pittsburgh Post-Gazette]

The increased Pennsylvania tax on tobacco products is expected to further reduce smoking and help physicians pay malpractice insurance. The budget agreement between Gov. Ed Rendell and the state assembly in December contained a 35-cent increase in the cigarette tax between now and the end of 2004, 25 cents of which is earmarked for abatement of physicians’ MCARE premiums. According to Rendell’s Office of Health Care Reform, a secondary goal of the cigarette tax hike is to further encourage smokers to quit. The anti-smoking advocacy group, Tobacco Free Kids, projects that Pa.’s cigarette tax, the 12th highest in the nation, will discourage 51,000 people from taking up the habit and reduce teen smoking by six percent.

[1/12/04 Lebanon Daily]

 PITTSBURGH FOOT AND HAND CENTER, P.C. SPECIALIZED ORTHOPAEDICS FOR THE FOOT AND HAND

Michael W. Bowman, MD, and staff are pleased to announce the opening and relocation of his practice under our new name: Pittsburgh Foot and Hand Center, P.C. We are committed to providing the same quality orthopaedic care for the foot and hand that you have come to expect. Two convenient locations are available to serve your patients:

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We appreciate the opportunity to continue to care for your patients.

HPI Lecture Series
As part of its ongoing lecture series in Health Policy and Management, the Health Policy Institute will sponsor a lecture on March 17 at the University of Pittsburgh Graduate School of Public Health from 4-5:30 p.m. Sara Rosenbaum, JD, Hirsch Professor of Health Law and Policy at the George Washington University, will present Civil Rights and Health Disparities. CLE credit is available. Lectures are free and open to the public; there is no registration. For more information, call (412) 624-6104 or visit www.pitt.edu/~hpi. This website features summaries of past lectures.

HPI Governance Briefings
As part of its ongoing governance briefings, the Health Policy Institute will sponsor a program on March 5 at the University of Pittsburgh Graduate School of Public Health from noon-1:30 p.m. Bruce Gordon, senior vice president, Moody’s Investors Service, will present How Bond Rating Agencies Look at Institutional Credit Factors. CLE credit is available. Registration is required for these sessions, which are available at no charge to those interested in governance of healthcare organizations. For additional information or to register, call (412) 624-6104 or visit www.pitt.edu/~hpi.

Influenza Website
The University of Pittsburgh’s Center for Continuing Education has updated its web module on influenza to address this year’s outbreak and vaccine supply. The module is available at http://cme.health.pitt.edu and is free of charge. The activity was developed with resources from UPMC, the University of Pittsburgh and a grant from the National Library of Medicine; there is no commercial support. First-time users will need to enter some basic registration information. If you have questions, contact Barbara Barnes, MD, MS, associate dean, CME, University of Pittsburgh School of Medicine, at (412) 647-8212 or barnesbe@upmc.edu.

Science & Engineering Fair
The Pittsburgh Regional Science & Engineering Fair (PRSEF) is looking for individuals to serve as judges at its annual event, slated for April 2 at Heinz Field. Celebrating 65 years in April, the fair attracts students from all over the region. Judges are needed for all categories, especially behavioral science, biology, chemistry and medicine, to not only select the awardees, but interact with the students and share their own love of engineering and science. Judges must work at the April 2 fair from 9 a.m.-2 p.m.; they also will be invited VIP guests at the PRSEF Award Program on April 3, where more than 1,500 parents, students, teachers, judges, sponsors and volunteers are expected to attend. Last year’s PRSEF attracted 680 students from 80 schools in 12 counties, and more than $300,000 in cash and scholarships were awarded. Call (412) 237-1534 to volunteer or to register online at www.pittsburghsciencefair.org.

Bioterrorism survey
ACMS physician members will soon be receiving an important survey from Princeton University’s Program on Science and Global Security on how state and local governments are preparing for future bioterrorism threats and emerging infectious diseases. Since physician collaboration and cooperation with public health agencies is critical to the success of any future public health response, part of this study will include surveying physicians on their knowledge and beliefs about their state and local health agencies. All surveys will be confidential and will be released only as summaries in which no individual’s answers can be identified. Information about the study will be available at www.princeton.edu/~globsec, and you can call the survey’s author, Dr. Laura H. Kahn, at (609) 258-6763 with any questions or e-mail lkahn@princeton.edu. The survey should take no longer than ten minutes to complete. Final results will be posted on the above website.
Continuing Education


Ongoing Continuing Education Programs & Conferences. Sponsor: Western Psychiatric Institute & Clinic, et al. CME available. For information, call (412) 624-2523 or log on to www.wpic.pitt.edu/oerp.

Ongoing Mental Illness & Substance Abuse (MISA) Training Series. Sponsor: Western Psychiatric Institute & Clinic, et al. CME available. For information, call (412) 605-1227 or e-mail slappojm@msx.upmc.edu.

Looking Back: Things learned enroute to the doctors' lounge

Bulletin, Vol. 68, No. 5, March 10, 1979

A classic case of malpractice: Claudius I (Emperor of Rome, 10 B.C.-54 A.D.) choked to death on a feather. His physician, Xenophon, shoved the feather down Claudius’ throat in an effort to induce vomiting after his wife served him poisonous mushrooms.

Progress: Seeking a cure for morphine addiction, a German chemist name Dressler, in 1898, added acetic acid to morphine and came up with a “cure” 15 times more addictive than the original substance—heroin.

—Marshall M. Johnson, Jr., MD

Thanks to Barbara E. Swan, M.D., who researched and contributed the Looking Back column.

February 2004

The Bulletin ◆ 73
Unfractionated heparin (UFH) has been commercially available since the 1940s. Although we have decades of experience with the drug, it is still one of the leading drugs most frequently associated with medication errors. These errors may significantly affect the therapeutic response of UFH therapy, increase the rate of adverse drug events (ADEs) and negatively impact the overall cost of care.

**Medication errors**

A medication error, as defined by the National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP), is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer.¹

Results of the Institute of Medicine’s 1999 report suggest that medical errors account for 44,000 to 98,000 deaths per year.² The estimated total cost of medical errors in the United States is 17 to 29 billion dollars per year. Drugs are the most common cause of medical errors in hospitals occurring in 3.7% of inpatients.² The most common types of medication errors leading to patient deaths, according to information submitted to the Federal Drug Administration (FDA) Adverse Event Reporting System during 1993 to 1998, involved improper dosing of the intended drug and the administration of an incorrect drug.¹

**Challenges with intravenous UFH therapy**

For many years, intravenous UFH has been a key therapeutic agent in the treatment of thrombotic conditions, including deep vein thrombosis, pulmonary embolism and acute coronary syndromes.⁴ Although frequently prescribed, UFH remains a difficult drug to manage from a medical, nursing and pharmacy as well as laboratory perspective. Due to its variable pharmacokinetic profile, a course of intravenous UFH therapy is often associated with multiple dosage adjustments and frequent laboratory monitoring.⁴ Weight-based dosing protocols have been used in...
an attempt to refine UFH dosing and monitoring; however, the adoption of numerous protocols within a single institution merely adds to the dosing and monitoring confusion. In addition to these challenges, the use of abbreviations, dosage and rate calculations, multiple solution concentrations and intravenous delivery pumps further increases the risk for medication errors.

High-alert medications
The Institute of Safe Medication Practices (ISMP) has classified UFH as a high-alert medication which is defined as a drug widely used in the healthcare setting having a high risk of patient injury when administered incorrectly. A nursing and pharmacy survey conducted by the ISMP revealed that over 80% of the participants also considered UFH a high-alert medication and had special precautions in place for its use within their respective institutions.

MedMARxSM is an Internet-accessible, anonymous medication error database that is part of the United States Pharmacopeia (USP) medication error program. In review of the errors submitted to this database during 2001, four of the five most frequently reported products were “high-alert” medications as classified by the ISMP (insulins, heparin, potassium chloride and morphine). The top five reported products accounted for 14.3% of all product selections in the database. According to further analysis, UFH was one of 12 products involved in 14 reported patient fatalities, ranked third for its involvement in patient harm, and was the most frequently reported drug for errors resulting from an improper dose or quantity. In a focus review of emergency department medication errors, UFH was consistently associated with prescribing and dosing errors.

Analysis of UFH medication errors: 2003
In October 2003, we performed a preliminary sample analysis of 2,390 reported UFH errors submitted to the MedMARxSM database during January through June of that year. Since participants may alter records after submission, the data presented here may be subject to change. As indicated in Table I, the four error types most frequently associated with the use of UFH included an improper dose or quantity, dose omission, incorrect prescribing and an unauthorized drug (medication not authorized by a legitimate prescriber was dispensed and/or administered). Consistent with previously reported data, the greatest percent of UFH errors included an improper dose or quantity. This type of UFH error was also most frequently associated with negative outcomes or patient harm.

As part of a medication error program, it is important to identify at what staff-level an error was initiated in addition to isolating where the breakdown occurred in the medication use process. This information is not to be collected for punitive purposes but to detect meaningful trends that will lead to targeted educational and process improvement interventions. As depicted in Figure 1, 42% of the UFH errors reviewed in this sample occurred during medication administration. These errors may include the administration of an improper dose, administration of a drug by the incorrect route, infusion of an incorrect solution, incorrect programming of an infusion pump and the misinterpretation of dosing charts. An equivalent proportion of errors occurred due to incorrect medication documentation and prescribing, 19% and 18%, respectively. (Figure 1)

Approximately 50% of the UFH errors were initiated at the nursing staff level potentially defined as nurse practitioners, licensed practical and registered nurses, and therapists.
tered nurses, home care nurses and nonspecific nursing personnel. This group was followed by physicians, then pharmacy, 15.5% and 12.6%, respectively. (Table 2)

**Reducing intravenous UFH errors**

Numerous recommendations and process improvement programs have been developed in an attempt to reduce the frequency and severity of UFH errors. Most of these programs have incorporated elements that target dosing and administration, since the majority of the reported UFH errors are concentrated in these areas.

One simple intervention is to ensure the availability of UFH dosing charts or computer programs on all nursing units which list or calculate the appropriate infusion rates for various doses. Since dosage adjustments occur frequently with UFH therapy, these charts can greatly reduce errors related to the miscalculation of infusion rates. Limiting the number of UFH dosing protocols within an institution can reduce prescribing and administration errors. Multiple protocol variations can further complicate an already error-prone process for all healthcare professionals involved. However, a limited number of institution-approved, weight-based UFH nomograms can enhance appropriate dosing and monitoring as well as reduce adverse events. The implementation of pre-printed UFH physician orders can promote institution-approved dosing nomograms and prompt appropriate aPTT and platelet monitoring. From a documentation perspective, patient-specific anticoagulation flow sheets can quickly assist the prescriber in evaluating UFH therapy as well as provide other staff members with a central place to document UFH treatment details such as physician orders, doses administered, flow rate changes, laboratory values and adverse events.

The use of pre-mixed UFH solutions has become a standard in the majority of institutions. Although this has reduced errors associated solution preparation, it does not obviously eliminate errors related to UFH bolus doses. Since UFH is available in multiple concentrations, it is important to limit random floor stock and, when applicable, establish a patient profile interface with automated dispensing cabinets. This type of technology enables pharmacy to assist in the medication use process.

Medication errors with IV infusions are generally associated with significant potential for harm. Adverse drug events linked to IV infusion devices are most commonly a result of incorrect programming. *Smart pumps* represent the next generation of infusion devices that, according to the ISMP, are setting a new standard of safety for IV medication administration. The smart pump is expected to reduce medication errors through innovative technology that incorporates institution specific comprehensive drug libraries, usual concentrations, dosing units (i.e., mcg/kg/min, units/hr) and dose limits. These new infusion devices perform a “test of reasonableness” to ensure that the information programmed into the pump by the user coincides with pre-established institutional guidelines prior to infusion initiation.

Medication errors account for numerous deaths each year and place an additional economic burden on our healthcare system. The medication use process for intravenous UFH is very complex, leading to multiple error
Medication errors account for numerous deaths each year and place an additional economic burden on our healthcare system.

opportunities for all individuals involved with this treatment modality. Ongoing analysis of UFH errors within an institution promotes the initiation of essential process improvement interventions that aim to simplify and standardize therapy, improve communication, enhance educational initiatives and utilize new error-reducing technologies when feasible.

References


5 http://www.ismp.org/msaarticles/HighAlertMedicationsPrint.htm

6 http://www.ismp.org/msaarticles/survey3print.htm


8 http://www.qualityhealthcare.org/QHCT/Topics/PatientSafety/MedicationSystems/Changes.htm

9 http://www.ismp.org/msaarticles/smartprint.htm

Dr. Rihn is associate professor of clinical pharmacy, Duquesne University School of Pharmacy, and chief clinical officer, University Pharmacotherapy Associates. He can be reached at (412) 380-7907. Dr. Nicolai is clinical pharmacy specialist with University Pharmacotherapy Associates.

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Each autumn, the Office of Inspector General (OIG) of the Department of Health and Human Services provides a detailed warning to the healthcare community of what to expect in the coming year’s investigation and enforcement efforts. Emerging from a tumultuous year which saw the departure of many senior staffers, capped by the resignation of embattled Inspector General Janet Rehnquist, the OIG has signaled that there will be no respite from the snooping of the Medicare police in 2004.

As in prior years, there’s a little something in the IG’s bag for everyone. Selected highlights from the 2004 Work Plan include:

**Hospitals**
- The OIG plans to increase its oversight of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in the wake of allegations from Rep. Pete Stark and other critics that JCAHO’s auditing process has grown too lenient.
- Recent controversies surrounding manipulation of hospital charges continue to draw the OIG’s attention to inpatient outlier issues.
- In the area of imaging and other diagnostic testing in emergency departments, OIG intends to determine whether the testing services were medically necessary and whether the tests were interpreted contemporaneously with the beneficiary’s treatment. A potential impact is that the common practice of sending studies done at night for interpretation by radiologists and other subspecialists the next day may be in jeopardy, and the use of teleradiology may need to increase.

**Home health services**
- Access to and quality of home health services following the implementation of the prospective payment system (PPS) will be reviewed. The OIG notes that, since the PPS effective date of October 2000, the average number of visits per episode of care has fallen dramatically, which suggests that Department of Health and Human Services (HHA) may be reluctant to accept beneficiaries who need extensive services.
- OIG will also review patient choice issues and the impact of arrangements between HHA and health systems or other providers which may tend to restrict such choice.
Nursing homes
- OIG will continue to monitor the effect of PPS on access to skilled nursing facilities. The Work Plan notes that some patients with certain medical conditions or service needs experienced delays, and some discharge planners attributed these delays to the prospective payment system.
- Part B payments services in skilled nursing facilities will be examined to determine the extent of unbundling, payment for inappropriate services, and aberrant billing patterns occurred, and to identify any duplicate Part B payments and services. The IG will also review medically unnecessary or excessive billing for imaging and laboratory services.

Medicare physicians and other health professionals
Physicians and individual practitioners can anticipate OIG to focus on perennial issues and a number of fresh controversies:
- Coding of evaluation and management services (again), including improper use of modifier –25 to bill for procedures performed the same day as an evaluation and management visit.
- Use of modifiers with national correct coding initiative edits which have finally been made public on the Centers for Medicare and Medicaid Services (CMS) website.
- Place-of-service errors, especially questionable claims for services in hospital outpatient departments or ambulatory surgical centers.
- “Long distance” physician claims where the practice setting and the beneficiary’s home were separated by a significant distance. Such claims often fail the “smell test.” OIG notes that patients with ongoing illnesses requiring skilled care are unlikely to travel long distances from home.
- Billing for medically unnecessary diagnostic tests, particularly nerve conduction studies which have increased by 37 percent in one year.
- Services and supplies incident to physicians’ services, another constant on the Work Plan year after year. Such services need to be personally supervised by physicians, be of a nature commonly performed in the office setting and be performed by staffers only after physician evaluation of the patient. This method of payment has expanded over the years far beyond the program’s original intent.
- Independent diagnostic testing facilities (IDTFs), fixed-location or mobile entities that provide certain testing services independent of a hospital or a physician’s office. OIG will determine whether (1) IDTFs provided services for which they had prior approval, (2) the designated level of physician supervision was provided, and (3) the nonphysician personnel who performed the diagnostic tests were properly licensed.

Medicaid drug reimbursement
Record settlements with TAP Pharmaceuticals, AstraZeneca and other drug-maker controversies continue to focus OIG’s attention on this costly segment of the Medicare and Medicaid programs, including:
- Prices paid by Medicare versus prices paid by other purchasers,
- Physician acquisition costs,
- Computation of and manipulation of Average Manufacturer Price, Average Wholesale Price and Best Price,
- New versions of existing drugs,
- Medicaid drug rebates, and
- Overprescribing of OxyContin and other psychotropic drugs, including Hydrocodone, Xanax, Diazepam and Soma.

Ongoing OIG activities
- OIG will continue its Compliance Program Guidance to the healthcare industry, and anticipates updating its hospital guidance, which was the first in its series of compliance guidance documents during 2004.
- Several new Anti-Kickback Safe Harbors are expected to be released in 2004.
- OIG will continue to issue fraud alerts, advisory bulleting and advisory opinions; monitor and enforce EMTALA patient...
Committed to Pennsylvania Physicians

PMSLIC was established twenty-five years ago by physicians for physicians. Our concern for health-care professionals practicing in Pennsylvania extends beyond writing policies. Our defense of good medicine is vigorous. Risk management activities are tightly integrated with underwriting standards. We lobby persistently for meaningful medical liability reform. While malpractice carriers falter and fail, PMSLIC is taking actions today to maintain a stable source of professional liability insurance for Pennsylvania physicians for the future.

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Forewarned is forearmed

The items above are just a sampling of the investigations and other activities OIG plans for 2004. All healthcare providers should stay current with the investigation priorities of government and take steps to achieve and remain in compliance before federal agents appear at their doors with badges and search warrants. The full text of the Work Plan can be downloaded at http://www.oig.hhs.gov/publications/docs/workplan/2004/2-CMS%20FY04.pdf. It may not be reassuring bedtime reading, but it will be worth your while.

Mr. Maruca is a partner with the Pittsburgh office of the law firm of Fox Rothschild O’Brien & Frankel, LLP, which serves as counsel to the Allegheny County Medical Society. He can be reached at (412) 394-5575 or wmaruca@foxrothschild.com.
In today’s healthcare environment, it is becoming increasingly difficult to manage finances because of rising costs and declining reimbursement for services. What can be done about it? There are many pieces to the financial management puzzle. A critical first step is preparing a budget. Unfortunately many medical practices do not prepare annual budgets.

“Top 10 Reasons” Why Most Practices Do Not Have a Budget
1. There is always enough money in the bank.
2. Don’t want to follow one; want flexibility.
3. Never did it before; predecessors never did it.
4. Huge distraction that serves no real purpose.
5. Always precedes layoffs, pay cuts and general belt tightening.
6. Only for irresponsible people who don’t make a lot of money.
7. Never saw one put to good use in or outside of medical school.
8. No clue how to do it correctly.
9. Can’t trust the numbers in a budget; someone is pulling them out of thin air.
10. Won’t help patients, make staff happier or cut down on hassle factor.

Top 10 Responses
Response #1: Can’t Get Too Much of a Good Thing
Many medical practices do not even consider managing finances until there is no money in the bank to make payroll or pay the monthly bills. Some practices are more fortunate in this regard and do not have significant cash flow issues. However, there is usually room for improvement. Discovering problem areas early and implementing solutions can result in even more cash in the bank. Who doesn’t want extra money that could be used to purchase that new piece of equipment, renovate the waiting room or boost morale by giving bonuses this year?

Response #2: Not Set in Stone
A budget is simply a guideline or an expectation of financial performance. It is not meant to be a rigid document that must be followed to the letter. In fact, actual results will rarely, if ever, exactly match budgeted results. Timing of receipts and disbursements are often difficult to predict and unexpected items also come up. These and other extenuating circumstances may impact actual results. Use the budget as a tool to compare actual financial results against budgeted amounts. Investigate the reasons for significant variances that will allow you to make informed decisions regarding finances for the remainder of the budget year.

Response #3: Think Outside the Box
How many times have you heard, “We’ve always done it that way”? This mentality is not productive. The only way to progress or make improvements is to think outside the box. The budget process alone will get you thinking about healthcare market trends and how your
practice will thrive in that environment. It could prove insightful and perhaps even conjure up revenue-generating or money-saving ideas.

Response #4: A Multitude of Uses

In truth, the budget process does require time and effort. However, there are many good reasons for doing it. A budget is a critical first step in understanding your practice’s finances. It also is useful in making business decisions such as adding new staff, purchasing equipment or switching supply vendors. Measuring actual financial results against budget may help identify operational issues. This allows you to be proactive in implementing solutions before things get out of hand.

Response #5: Stretching the Dollar

Developing a budget is not necessarily about cutting costs and tightening the belt. It should be viewed as a mechanism for determining the impact of anticipated changes in your practice’s revenue and expenses. For example, there may be circumstances that will affect revenue sources in the coming year. What impact will decreased reimbursement from payors have on the practice? Should other service lines be considered as revenue sources? What impact will the addition of a physician assistant have?

A budget also makes it possible to identify unnecessary spending that can be better utilized for other things. Perhaps the money saved by eliminating a publication that sits on the shelf can be put to better use by sending a staff member to a training seminar. There is no doubt that a budget can be used to determine where expenses can be shaved, but it is also useful in shifting funds to get more bang for the buck.

Response #6: Control Your Financial Destiny

A budget is a tool to help prioritize spending and manage money—no matter how much or how little. Just as in personal finances, those who manage income and expenses are typically more financially stable. Often practices do not discover financial difficulties until the end of the year when reviewing financial statements and realizing losses have been incurred. Take control of your practice’s financial destiny by developing a realistic budget and periodically monitoring performance—before it’s too late!

Response #7: Would You Build a House Without a Hammer?

A budget is a basic tool that every business, including medical practices, should have in order to successfully manage finances. Just as it would be difficult to build a house without a hammer, it would also be difficult to effectively measure a practice’s financial performance without a budget. Budgets are useful in determining the feasibility of expanding service capabilities and adding extraordinary items. For example, a practice may be considering hiring an additional physician. By plugging in estimated revenue and expenses associated with that, a budget will show the impact to the practice’s bottom line. When doing this type of analysis, it is important to keep in mind all of the variables. Will the physician be bringing an established patient base or starting from scratch? Will additional staff be needed? Can the current office space accommodate another physician? What will the additional malpractice insurance expense be? What impact will another physician have on supplies and other

continued on page 84

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February 2004

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operating expenses? How will the physician’s compensation be structured? All of these factors contribute to the bottom line and should be evaluated prior to moving forward.

Response #8: Where to Start?

Generally, there are four steps to the budget process. First, gather information on anticipated changes in the market and in your practice operations. Develop assumptions based on this information combined with historical practice data. Second, utilize the information gathered during the planning process to develop and create an annual budget. The annual budget should be broken down further into a monthly format. Next, measure performance by comparing actual monthly financial results against budget and investigating significant variances. And finally, once the causes of variances are discovered, implement solutions wherever possible to keep the variances from growing.

In the event you are still scratching your head, keep in mind that there are useful budget tools available in the market to assist you in creating a budget.

Response #9: Fact or Fiction?

As previously mentioned, actual results rarely match budgeted amounts exactly; however, a budget should be developed using actual historical and market information. The number should not be “pulled out of thin air” and should reflect a reasonable depiction of the expected revenue and expenses for the budget period.

Response #10: Put a Smile On!

A medical practice that is financially stable will make everyone happier. Staff morale will typically be better because employees are not constantly worried about penny-pinching and staff cuts. Patients will be happier because the office is generally more organized and staff is more attentive. Overall, the hassle factor is much lower because the staff and physicians can focus on patient care rather than worrying if there is enough money in the bank to pay the bills.

Bottom line: No more excuses. Develop your 2004 budget now. It is the foundation on which to begin solving the financial management puzzle medical practices face today and in the future.

Ms. Haas is a financial analyst with PMSCO Healthcare Consulting. She can be reached at ahaas@consultpmsco.com. PMSCO is a subsidiary of the Pennsylvania Medical Society.
## Reportable Diseases

### Allegheny County Health Department

#### Selected Reportable Diseases

<table>
<thead>
<tr>
<th>Disease</th>
<th>Sept-Dec 2003</th>
<th>Jan-Dec 2003</th>
<th>Jan-Dec 2002</th>
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<tr>
<td>Campylobacteriosis</td>
<td>53</td>
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<tr>
<td>Cryptosporidiosis</td>
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<td>3</td>
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<tr>
<td>E. coli 0157:H7</td>
<td>3</td>
<td>12</td>
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<td>Encephalitis:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>West Nile</td>
<td>0</td>
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<tr>
<td>Other</td>
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<td>Giardiasis</td>
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<tr>
<td>Guillain-Barre Syndrome</td>
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<td>Carbon Monoxide Poisoning</td>
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*Not Available*

Disease reports may be filed weekdays during regular business hours from 8:30 a.m. to 4:30 p.m. by calling (412) 578-8060. At all other times, please call the Health Department’s 24-hour telephone line (412) 687-2243.

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**# Successful Physician Compensation Plans Require More Than a Check Up**

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February 2004

The Bulletin ◆ 85
Update: New Programs Designed to Improve End-of-Life Care

The February 10, 2001, issue of the Bulletin featured an in-depth look at the medical community’s efforts to improve care of the dying, both nationally and locally. Each year since then the Bulletin has provided annual updates on the movement’s progress locally (February 9, 2002, February 2003). We hope this year’s update will prove useful as well. Please call (412) 321-5030 if we can assist you in connecting with local programs or locating additional information on this important topic.

Institute to Enhance Palliative Care

As the result of a unique collaboration between the University of Pittsburgh and a local hospice concern, Family Hospice and Palliative Care, the university has established The Institute to Enhance Palliative Care. The institute represents a community of scholars and health professionals who have joined together to improve care for the seriously ill and dying. Combining the community-based, patient- and family-centered philosophy of Family Hospice with Pitt’s extensive research and educational resources, the institute aims to be a regional and national resource such as now exists at only a select group of academic institutions.

Its mission is education, research and advocacy on behalf of the dying and their families. A primary goal is to improve the training of all types of healthcare providers to ensure they have sufficient skills to serve the growing elderly population and seriously ill and dying patients. The institute will work with other community groups such as the Take Charge Partnership of Western Pennsylvania and the End-of-Life Providers Task Force to help build and support community initiatives in end-of-life care. For additional information, contact David Barnard, director of The Institute to Enhance Palliative Care, at barnard@pitt.edu or contact the institute’s administrative coordinator, Nicole Fowler, at fowlernr@msx.upmc.edu.

Advanced Illness Coordinated Care Program

Highmark Blue Cross Blue Shield—in cooperation with the Center for Advanced Illness Coordinated Care (CAICC) in Albany, New York, and the Heritage Valley Health System (HVHS)—has launched a pilot program focusing on patients with advanced illness and a life expectancy of 18 months or less. The program, that keeps the physician-patient relationship at the center of care, incorporates six structured conversations about the many psychosocial issues that emerge during advanced illness and end-of-life care. A specially trained social worker helps the physician provide education and guidance to patients and families in understanding their illness and treatment options. Educating patients about their disease and the alternatives available as the disease progresses helps reduce barriers to palliative and hospice care and supports the patients’ decisions through all stages of care. “The initiative adds a ‘pre-hospice’ component to the routine medical care process and reduces barriers to end-of-life care,” says Judith Black, MD, medical director of Highmark’s Senior Products Division. In other areas where the AICC model has been implemented, positive outcomes have been demonstrated for seriously ill people, particularly in the areas of advance directives, referrals to hospice and place of death. With funding provided by the Jewish Healthcare and Highmark Foundations, 100 patients will participate in the project, which will conclude in May 2004. The University of Pittsburgh, Section of Palliative and Medical Ethics, in conjunction with CAICC, will assess program outcomes. For more information, contact Marian Kemp at (412) 544-2086.

New option for hospice patients

Family Hospice and Palliative Care opened the doors to its new Quality of Life Center in 2003, providing hospice patients and their families with an additional option for daily care and life enhancement.
The first of its kind in western Pennsylvania, the Quality of Life Center is a day respite center for families and caregivers as well as an activity and life-enhancement center for the patients. Visual and audio stimulation are provided, along with counseling, support, meals and snacks. There are activities such as movies, discussions, presentations and craft projects. Art, music, pet and massage therapists work on a pre-arranged schedule to provide comfort and peace of mind for the center’s guests. Some clinical services are also available, such as blood pressure checks and vital signs.

The center is located in the historic Civil War mansion—Anderson Manor—located in the Manchester neighborhood. With further renovations in the planning stages, the second floor will become a hospice residence, an alternative for patients and families when the level of care can no longer be managed in their own home setting. For more information or referrals, call Ellen Douglas (412) 231-7034.

Opportunities to learn more

In partnership with the Allegheny County Medical Society, Duquesne University Department of Physician Assistants and the School of Law will present a program featuring end-of-life topics at the 2nd annual Steel City Symposium on March 27 in Bayer Hall on the Duquesne campus. The goal of the symposium is to provide physicians, physician assistants and attorneys with important information on end-of-life issues, from both the medical and legal perspectives. Six hours of CME/CLE are available for this activity.

Deborah Opacic, EdD, PA-C, will be a featured speaker at the Steel City Symposium, focusing on clinical issues, managing symptoms and improving the quality of life for end-of-life patients.

Registration information is available by calling (412) 396-5914; the registration deadline is March 15. Cost for the symposium is $50; physician assistants pay $35 and students $10; Duquesne students attend for free. A continental breakfast will be provided.

Susan Tolle, MD, director of the Center for Ethics in Health Care at the Oregon Health Sciences University, will be a featured speaker at the clinical update in geriatric medicine, April 1-3, co-sponsored by the Pennsylvania/West Virginia Geriatrics Society and the University of Pittsburgh School of Medicine’s Center for Continuing Education in the Health Sciences. Dr. Tolle will be speaking on the Physician Order for Life-Sustaining Treatment (POLST) and its use in long-term care. The POLST has been used very successfully in Oregon, and the state of West Virginia has now adopted its use. She will talk about Oregon’s approach to end-of-life care (EOL) and how to create system changes to improve it. Dr. Tolle also will meet with a group of Pittsburgh leaders to discuss how the Oregon experience could be duplicated here in western Pennsylvania. For more information on the geriatric clinical update, call Nadine Popovich at (412) 321-5030.

Paul Malley, president of Aging with Dignity, an organization whose mission is to help individuals and their families plan for the care they wish to receive in the continued on page 88
event of serious illness, met recently with key community leaders in Pittsburgh, including physicians and representatives of organizations that advocate for the aging. Aging with Dignity distributes Five Wishes, the nation’s most popular advance healthcare directive. Mr. Malley said employers across the country are recognizing the benefit of providing information to employees to assist them in dealing with issues that confront their personal lives.

** Websites of Interest **
- www.ohsu.edu/ethics/polst (Oregon Health and Science University)
- www.epeconline.net (Education for Physicians on End-of-Life Care)
- www.agingwithdignity.org (Aging With Dignity)
- www.lastacts.org (Last Acts Campaign to Improve End-of-Life Care)
- www.abcd-caring.org (Americans for Better Care of the Dying)

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- PA personal injury lawyers practice with a 70% error rate. Seven out of ten medical liability claims are dropped, dismissed, withdrawn or found in favor of the defendant.
- America’s litigation system costs more than $200 billion annually, driving up what consumers pay for health care.
- Personal injury lawyers often pocket up to 40% of injury awards, in addition to their costs in medical malpractice cases.
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The Problem?
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- Reasonable limits on non-economic damage awards
- Reasonable limits on attorneys’ contingency fees

Locate and contact your state legislators at www.acms.org

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Got something on your mind?

As a member of the ACMS, there are many ways to express your thoughts:

✓ Call the 24/7 Physician Hotline at (412) 321-5035, ext. 131 and let us know what you’re happy with (or unhappy with), or tell us how we can better serve you as a member. Tell us what’s on your mind. We’ll take note and, if appropriate, publish it in an upcoming issue of the Bulletin.

✓ Write a Letter to the Editor of the Bulletin. Did you agree or disagree with something you read in the Bulletin? Express yourself and share your opinion with our readers. If you have even more to say than a few paragraphs, write a “Perspective” (500-900 words) and e-mail it to lsmith@acms.org or FAX it to Linda Smith at (412) 321-5323.

✓ Become an associate editor of the Bulletin and contribute editorials on a regular basis, as well as helping to shape the direction of the medical society’s membership magazine. Send your letter of interest in becoming an associate editor, along with one or two writing samples to Dr. Safdar Chaudhary, Medical Editor, ACMS, 713 Ridge Avenue, Pittsburgh, PA 15212.

✓ Log on to www.acms.org/express and submit your ideas for the Bulletin. We’d be happy to research your ideas for features and special reports, or to add your favorite website to our list to be shared with our readers.

Please let us know what you’re thinking!

Linda L. Smith, Bulletin Managing Editor

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A Place to Turn

The answer to your question may be just a phone call away. Your medical society can almost always give you an answer or direct you to exactly where you can get it.

Problem Solved.

So get back to your patients. They’re the reason you became a doctor in the first place.
Between dealing with patients and insurance companies and the looming medical liability crisis, worker safety standards regulated by the Occupational Safety and Health Administration (OSHA), may be lower on physicians’ priority lists. But if offices aren’t in compliance when an inspector visits, physicians could end up with penalties and thousands of dollars in fines brought against them.

According to Ed Selker, assistant area director of the Pittsburgh OSHA office, there are a few reasons an office may be targeted for inspection:

- **An employee has filed a complaint.** OSHA is obligated to look into any complaint an employee may have filed.

- **There has been a rash of citations in the area.** If many citations have been issued in a specific area, OSHA will use a computerized device that will randomly choose hospitals, nursing homes and larger offices and clinics with more than 15 employees to inspect for problems.

- **A fatality or serious injury has occurred.** If an employee dies or becomes seriously injured on the job, OSHA will investigate and inspect the office for violations.

“OSHA compliance officers are courteous, professional and accommodating,” Selker notes. They understand physicians’ offices can be busy and will work with the office within reason.

The inspectors will want to see the office’s bloodborne pathogen program and talk with the staff person in charge of the program. They will want to talk to employees about the working conditions. The inspector will want to make sure the employees are trained in the program. If an office deals with hazardous chemicals, the inspector will also want to see the hazard communication program.

The best way to deal with any inspection is to always be prepared for an inspection. Problems with bloodborne pathogen regulations is the number one reason why medical offices are cited by OSHA, followed by hazard communication.

Basic requirements for the bloodborne pathogens standard include having an annually updated written exposure control plan; using universal precautions, safer engineered needles and appropriate personal protective equipment such as gloves, face and eye protection and gowns; providing free hepatitis B vaccine to exposed employees; providing medical follow-up to employees who...
may have been exposed to a bloodborne disease; using labels or a color-coding system for sharps and waste disposal, contaminated laundry and specimens; properly containing all regulated waste; and providing bloodborne pathogen training for employees.

Basic requirements for the hazard communication standard include having a written hazard communication program; having a list of hazardous chemicals used or stored in the office; keeping a Material Safety Data Sheet for each of those chemicals (can be obtained from the manufacturer); and providing hazardous chemical training to employees.

Medical offices with an X-ray machine may also want to consider safety concerns with ionizing radiation. The ionizing radiation standard requires a survey of the types of radiation used in the facility; restricted areas to limit employee exposure; personal radiation monitors to be worn by employees working in restricted areas; and rooms and equipment labeled with caution signs.

As well as inspecting items that are medical office specific, the inspector will also look for general safety violations such as blocked exits, bad wiring or walking surfaces which could cause falls. Most violations that are found in any workplace are obvious and could easily be prevented, according to Selker. “It comes down to common sense,” he says.

One easily corrected item that may be overlooked by many offices is the OSHA poster (or state equivalent), which must be displayed where employees can see it. The poster explains workers’ rights to a safe workplace and how to file a complaint.

To get more information on regulations or to obtain brochures or posters, log on to www.osha.gov or call OSHA at (412) 395-4903. OSHA also operates a free consultation service. Call (800) 382-1241 for more information.

References:
Imagine traveling halfway around the world to start your career in a country where you know no one. Quzi M. Ahmed, MD, FACS, born in a part of India that is now Bangladesh, remembers vividly how he felt when he flew to the United States to further his medical education in his quest to become an ophthalmologist. “I was depressed. I was homesick. I wrote a letter on the plane saying I’m so sick I don’t know whether I can continue going,” he says.

Dr. Ahmed’s decision to come to America was firm, though. He wanted to pursue ophthalmology because it would allow him to be independent and not be an employed physician. “I thought I should go to a country where I could work and learn,” he says.

Now 74, Dr. Ahmed was born into a modest family with eight siblings. His father was a headmaster at a school and his mother, a homemaker, died of uterine cancer at the young age of 38 while he was still in high school. “It made an impression on my mind that I should be in a profession where I am needed,” he says.

After graduating from the University of Calcutta, he decided to pursue medical school. Money was tight and he worked half a year after finishing his undergraduate work to support himself through medical school. He attended Calcutta Medical College during World War II and read his roommate’s books at night to save money.

It was a time of much political upheaval when the university’s hospital served as a military hospital. Dr. Ahmed decided upon graduation from medical school that he wanted to go to a country without so much discrimination, dictatorship and turmoil. When his hopes to train further in London were dashed due to the expense, he spotted an advertisement on a medical school bulletin board that offered $60 a month for a general internship in New England Hospital in Massachusetts. He applied and was accepted. Getting there, however, created another impediment because he didn’t have the money to make the trip. His uncle assisted him by raising money from business people in optometry with the promise that, if he did not come back to the country, he would return their money.

As he boarded the plane to America he was relieved to see a classmate. When the classmate changed planes in Turkey, however, a sense of anxiety and dread welled up in him. “I thought, ‘What if I’m not accepted in a way where I perform well? Then what happens to me?’” he says. He got so anxious that he told the flight attendant he wanted to stop over in London because he was too ill to continue. He wrote a desperate letter to his father and got so anxious in London that he wasn’t sure where he was. “Everything seemed strange,” he says. He contacted a friend and stayed in London for two days before he felt well enough to continue his trek across the Atlantic to Boston. Anxiety overtook him again as he stood alone on the ground at Logan Airport, his first time in a strange new world. “I was wondering where I should go. I was alone,” he recalls. When the cab driver dropped him off at the hospital, he saw two young women from Pakistan...
Quazi Ahmed:
Realizing a Dream

and another from India and emotions again improved.

Dr. Ahmed’s residency at New England Hospital in
general medicine served as the springboard to life in the
United States, but he had a long journey ahead to fulfill
his dream of being an ophthalmologist. Residencies in
ophthalmology were hard to come by. He was promised
one at Sinai Hospital in Baltimore if he served another in
pathology, but upon completing that residency, was told
another candidate has taken his spot in the ophthalmol-
ogy training. Disaster struck again when the bank in
which he had saved all his money went bankrupt. “It was
a rough world for me,” says Dr. Ahmed.

He decided to take another residency in order to save
money to pursue ophthalmology training in London and
was offered $400 a month for a general practice residency
in Pottsville, Pennsylvania. He sent for his wife, a nurse,
whom he had not seen in two years. He had to jump
through another hoop when he learned that his visa was
soon to expire. The chief of medicine at Pottsville took a
liking to him and urged immigration to grant him a five-
year extension. The doctor also helped Dr. Ahmed to gain
acceptance into a three-year residency program in ophthal-
mology at Montefiore Hospital in Pittsburgh under the
direction of well known ophthalmologist, Harvey E.
Thorpe, MD. He followed that program with a fellow-
ship there in the late 1960s, learning such innovative skills
as laser surgery.

Dr. Ahmed joined a practice with Abraham Steinberg,
MD, upon the completion of his training and has witnessed many
changes over his 30 years in that
practice. He cites less invasive
procedures and quicker recovery
times for patients as one of the key
advances, but says the problems
associated with managed care are
not an example of progress. Dr.
Ahmed sub-specialized in retina
and laser surgery using lasers to
improve conditions such as macu-
lar degeneration and retinal tears.

Today, Dr. Ahmed practices
part time as a preceptor to second-
and third-year ophthalmology
residents at the Pittsburgh Veterans Administration
Hospital and works part time under contract with Davis
Eye Group. In his leisure time, Dr. Ahmed enjoys spend-
ing time with his wife, daughter and grandson.

Fellow ophthalmologist, Ronald Berkman, MD, who
has known Dr. Ahmed since he was a resident, says his
colleague was a very driven man, always driven to get an
answer when he did an examination. Shamsher Bakth,
MD, a cardiologist who has known him for 25 years also
spoke quite highly of him. “Dr. Ahmed is very articulate
and active in community work and as a physician.”

As a Muslim living in America, Dr. Ahmed has been
active in helping those of his native land by forming the
Pakistani Student Association in 1968 and the Bangladesi
American Association of Western Pennsylvania, as well as
being a founding member of the Muslim Community
Center of Greater Pittsburgh. Although he is interested in
supporting the culture and customs of his native land, he
believes strongly in the freedoms that everyone has in the
United States. “We try to incorporate it to include others
in the community. We want to be part of American
society,” he says.

Dr. Ahmed says he tried to return to Bangladesh in
1968, but found the political climate oppressive. “I was
told I couldn’t speak my mind or I would be put into jail.
Freedom of speech, freedom of religion…these are things
that no human being should be deprived of,” he says.

Ms. Petzel is a freelance writer in the Pittsburgh area.
The topics of insurance carve-outs and malpractice reform might not seem to be closely related, but several experiences in the past few months have stimulated some interesting connections. I spent the morning of September 6, a pleasant sunny Saturday, with other medical colleagues at the Allegheny County Medical Society building in Pittsburgh, one of the participating sites in a statewide Pennsylvania Medical Society (PMS) Leadership meeting that focused on the campaign to achieve tort reform.

There were several informative presentations and discussions, noting that the growth in court awards and the rapid increase in malpractice premiums have resulted in a deteriorating financial environment for many medical specialties in Pennsylvania. A manpower report was presented with data suggesting that these fiscal changes coincided with a decreased availability of these specialists due to departures from the state, retirement or fewer physicians moving to Pennsylvania. To conclude, Judge Joan Orie Melvin, who had been endorsed by the PA Medical Society’s Political Action Committee for the recent State Supreme Court race, provided a civics lesson that described the power of this court relative to the elected legislators and demonstrated her appreciation of the problems facing medicine in the commonwealth.

Although increases in malpractice premiums have not affected psychiatrists to the same degree as some other specialists, we strongly support the PMS in this action because we agree that it is in the best interest of patients in the commonwealth.

Of more direct concern for the practice of psychiatry, however, has been the negative impact of commercial managed care organizations on the care of mentally ill patients. While managed care constraints also have a direct impact on the balance sheets of practitioners and institutions, there is also concern that the morale of psychiatrists and their satisfaction with practice are adversely affected by the increasing amount of time spent completing forms, making phone calls and writing letters in an effort to be allowed to deliver appropriate care to their patients.

One potential consequence that many of us encounter anecdotally is the difficulty faced by some patients seeking psychiatric care in the community. The inaccuracies of the managed care provider panels have been noted repeatedly, but of more concern is the possibility that a significant number of psychiatrists have grown tired of the continued harassment by managed care and have opted out of these panels. We have asked the PMS to provide us with manpower data for psychiatry in Pennsylvania similar to that provided for the groups most threatened by the malpractice crisis.

Finally, I recently addressed a group responsible for...
the oversight of a mental health care delivery system who wanted to hear about issues of importance to Pennsylvania’s psychiatrists. My comments led to a spirited discussion about insurance carve-outs, an arcane topic of unclear significance for many individuals in the community. As psychiatrists know well, there are two distinct but related factors that cause patients with mental illness to be treated differently from patients with other medical disorders: Patients must use different means to access psychiatric care, and the utilization of care is subject to discriminatory constraints. They are the “behavioral health carve-out” and discriminatory insurance coverage.

The American Psychiatric Association (APA) adopted a policy calling for an end to both of these practices in March 2002 and called for us to repeatedly emphasize this at every opportunity. We frequently express our concern about the barriers associated with the insurance coverage for psychiatric disorders, but less often speak out against the “carve-out” that facilitates these discriminatory practices. We must continue to speak out against this division at every opportunity, especially when our audience contains community leaders and employers. The separation of funding and delivery of psychiatric services perpetuates stigma and has allowed the massive and disproportionate reduction in the resources provided for the treatment of mental illness. It would never have been permitted for cardiovascular or endocrine diseases. Why is it permitted to continue for those patients with mental illness?

Dr. Haskett is president of the Pennsylvania Psychiatric Society. He can be reached at (412) 586-9207 or haskettrf@upmc.edu. This article first appeared in the October 2003 issue of the Pennsylvania Psychiatrist and is reprinted with permission of the Pennsylvania Psychiatric Society.
The Allegheny County Medical Society Board of Directors met on November 18, 2003. Board Chair Gerald Pifer, MD, called the meeting to order at 6:10 p.m.

Dr. Pifer stated that, at the House of Delegates, the Pennsylvania Medical Society (PMS) Board of Trustees expanded to include representatives from specialty groups. Three ACMS members were elected as specialty representatives, Ralph Schmetz, MD, PMS Trustee, Primary Care Physicians; Bruce A. MacLeod, MD, PMS Trustee, Hospital Based Physicians; and Adam J. Gordon, MD, PMS Trustee, Young Physicians Section.

Dorothy Hostovich reported the ACMS Alliance will have a raffle benefiting the Allied Health Associate Degree Scholarships of CCAC at the annual dinner and requested member support. ACMS Foundation agreed to match an amount up to $4,000.

Safdar Chaudhary, MD, medical editor, ACMS Bulletin, reported on three open associate editor positions. Dr. Chaudhary continues to seek funds for the Bulletin, including the possibility of tobacco settlement funds for professional education.

Megan Groh, medical student, thanked ACMS for its leadership and mentoring of students who attended the House of Delegates. She thanked the society for its support in sponsoring students to attend American Medical Association (AMA) conventions, requesting continued financial support. The board approved $500 to the student delegation for travel expenses to the interim session of the AMA House of Delegates. Avi Manchandia, who was elected chapter vice president, reported the Tar Wars anti-smoking campaign for elementary schools is underway. Medical students visit schools and provide information to fourth- and fifth-grade students on the effects of smoking, statistics and hazards.

Alan Axelson, MD, reported the Pittsburgh Regional Healthcare Initiative (PRHI) currently is focusing on patient safety and substance abuse. It is trying to increase awareness of substance abuse via doctors’ offices by physicians asking questions and looking for warning signs. Dr. Axelson noted Paul O’Neill, who was named CEO of PRHI, is determined to see its programs make a difference in Pittsburgh.

Dr. Pifer provided a brief history of the Allegheny County Jail Health Advisory Board. Through county funding and physicians and healthcare workers donating time and efforts, the advisory board provides prescriptions and health care for inmates at a manageable cost. With the election of Dan Onorato as Allegheny County chief executive, the board is uncertain if it will continue to function or if its focus will be redirected.

Terence Starz, MD, reported on the Health Policy Institute (HPI). A board orientation meeting for those who have oversight responsibilities is being offered to update current issues in governance. HPI is interested in facilitating community efforts to address public health issues. It reviewed the policy issue of technology use in clinical practice.

Guy Stofman, MD, chief of plastic surgery at Mercy Hospital, expressed his personal concerns on the professional liability insurance crisis, providing a view of his practice situation and imploring the board and society to take an aggressive posture on this issue at the November 22 meeting with Senator Arlen Specter.

Dr. Pifer then introduced Victor Tucci, MD, emergency and bioterrorism coordinator, Allegheny County Health Department (ACHD). The health department received a grant from the U.S. Department of Health and Human Services to start a Medical Reserve Corps in Western Pennsylvania. Dr. Tucci wants to recruit doctors, nurses, pharmacists and healthcare professionals to provide health care in case of an emergency. Volunteers will be provided a state identification card credentialing them as emergency responders and will be protected against liability under the Good Samaritan Act. He asked the medical society for assistance in recruiting physicians for the program. ACMS offered to seek recruits at the appropriate time by advertising in the Bulletin and sending notices by fax.
and e-mail to the membership.

Edward Teeple Jr., MD, reported the general meeting of the House of Delegates focused on tort reform and reimbursement issues. PMS installed Dr. Desai as its 154th president.

The board reviewed a letter from Thomas M. Golden, president, Pennsylvania Bar Association, to Dr. Desai, president, PMS (October 29, 2003), requesting a cease to the public ad campaign “...Stop Lawsuit Abuse.” Dr. Desai reported his response to Mr. Golden noting the personal injury lawyers ad campaign against physicians. The board noted that, in a response, it would be wise to mention that this is an opportunity to work together to fix the problems.

Dr. Desai gave a synopsis on the PMS position on the Professional Liability Reform Campaign. Act 13 was an omnibus bill, containing improvements but not addressing the MCARE Fund. The governor is proposing a 25 cent per pack cigarette tax plus money from the auto fund, providing $20-$25 million to the abatement. He is also trying to draw money from Medicaid to go through hospital funding to provide some relief. Payment would go to hospitals and hospitals would pay into MCARE. PMS wants 100 percent MCARE abatement for all physicians to provide short-term relief, as well as long-term reform through caps on attorney’s contingency fees and non-economic damages.

The board reviewed proposals for an end-of-life symposium by Christopher Hughes, MD, 11th District Trustee, Washington County Medical Society (October 15, 2003). Dr. Hughes would like to offer the program, previously presented in Washington County, in Allegheny County. The board agreed to support both programs through advertising in the Bulletin, and faxing and e-mailing medical society members.

Accepted as informational was a letter from Laura H. Kahn, MD, MPH, MPP, FACP, Research Scientist, Princeton University, Program on Science and Global Security (Oct. 20, 2003), regarding an assessment survey on how state and local governments are preparing against bioterrorism and infectious disease threats. The board approved releasing a membership mailing list to Dr. Kahn for the survey.

The board also reviewed a letter from John H. Feist, MD (Oct. 3, 2003), regarding medical screening scams. Portable screening units offer tests to the public, without indicating if a medical professional is in attendance. The society will write a letter to the Department of Health asking it to make proper inquiries into the units for public safety.

The board reviewed a letter from Nabil Fahmy, MD, FACG, FACP (Oct. 20, 2003), regarding expert testimony outside the individual’s field of expertise. The board will seek permission to reprint the article for physician information. The topic was referred to the Executive Committee for further discussion.

John Krah, executive director, noted he and some of the officers are meeting with the medical staffs at both Children’s Hospital and Allegheny Valley to seek funds for the PMS tort reform campaign.

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The Pennsylvania Insurance Department has set a cap on large surpluses maintained by the state’s four nonprofit Blue Cross companies. The new regulation directs the Blue Cross firms to obtain department approval of their surpluses and defines an excessive surplus as 3.25 times more than the mandatory minimum surplus required by state law. Companies with excess surplus will be required to submit a plan to “fairly and equitably” redistribute that money to ratepayers and people with little or no health insurance. Independence Blue Cross’s $800 million surplus falls below its defined level of excess, while Highmark Blue Cross & Blue Shield’s surplus appears to fall within the new guidelines at about three times the state minimum.

[1/17/04 Philadelphia Inquirer]

A second physician has filed suit against Magee-Womens Hospital and the UPMC Health System, accusing the hospital of falsifying hundreds of thousands of pap smear reports and practicing poor quality control. Dr. Kenneth S. McCarty Jr., a board-certified pathologist, said that the inadequate controls resulted in misidentification of patients and mislabeling of specimens, and that doctors who voiced concern about quality problems in the department faced intimidation and threats. In December, former Magee pathologist Silver filed a similar suit, and two local women filed for class-action status regarding the Magee lab’s handling of Pap smears, prompting a state health department investigation which is underway.

[1/23/04 Pittsburgh Post-Gazette]
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