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“This nation will remain the land of the free only so long as it is the home of the brave.”
—Elmer Davis

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Cover Art:
Web of Life
by Todd M. Hertzberg, MD

Dr. Hertzberg is a diagnostic radiologist.
For patients with kidney disease, quality of care can help you maintain quality of life. UPMC and Dialysis Clinic, Inc. (DCI) have formed a unique partnership to provide clinical excellence and state-of-the-art treatment options to our patients in Western Pennsylvania. This partnership is designed so patients may experience fewer complications and hospitalizations while undergoing dialysis treatment. Our union brings together UPMC’s expansive network of specialized physicians and researchers with DCI’s 40-year history of providing exceptional dialysis services. With convenient locations and treatment options like at-home dialysis, we are dedicated to making a difference in the lives of those living with kidney disease.

For more information or for a referral to a UPMC/DCI dialysis center, call 412-647-3700.
In keeping with the chaos of our current era, I decided to write an incoherent editorial full of arbitrary, largely useless observations.

The U.S. Treasury Department wants to dictate the salary structure of all financial institutions receiving bailout money, and some people find this surprising. To this I say: Welcome to our world. The government has been essentially dictating what a physician's time is worth for years. When you sell your soul to the devil, be prepared to dance to his music.

Curiously, our outrage over publicly supported institutions paying millions to their employees, particularly ones who underperform (to say the least), doesn't seem to extend to athletic coaches who make obscene salaries at state-funded schools, whether they win or lose. Or to teams like the Pittsburgh Pirates. The hapless Bucs only exist because taxpayers shelled out a king's ransom to build them a stadium, yet they feel justified paying Jack Wilson $7 million last year to drive in 22 runs and hit one homer. Salaries for public school teachers have been steadily rising for decades as student performance plummets. In urban areas like Detroit, less than 25 percent of public school graduates are prepared for higher education, despite astronomical increases in per-pupil expenditures. The head of the autoworkers' union makes a nice living too, as his membership plummets and his industry is on the verge of extinction.

Paying through the nose and getting nothing but smelly failure in return goes beyond AIG, Bear Stearns and other Wall Street miscreants. In fact, handsomely rewarding underachievement seems to be the new American way of doing business. Katie Couric makes $15 million a year to host the lowest rated network news program in history. Keith Olbermann at MSNBC earns about $8 million to host a cable show that only his immediate family watches. (Well, they may at least watch it occasionally.) The Detroit Lions paid its star cornerback $5 million in 2008 to defend one pass (yes, one pass in 16 winless games). He wasn't even injured. Actors the likes of Angelina Jolie, George Clooney, Bruce Willis, Brad Pitt and John Travolta still command eight-figure guarantees, even though their movies rarely break even, let alone earn a profit for investors. Some (Jolie and Clooney, for example) have never had a bonafide blockbuster hit, yet are still treated as royal cash cows. Others, like Willis and Travolta, have had hits but have also produced major catastrophes that far outweigh their few money-making turns. At least Buick finally wised up and quit paying Tiger Woods $20 million a year (!) when it figured out that the golf legend's endorsement didn't sell cars. (Hmmm, I wonder why the U.S. auto industry is broke?)

To shift gears: One word I don't want in my obituary is “grisly.” I read a newspaper article last year about how North Carolina passed a law requiring anyone operating an amusement park ride in that state to be over age 18. The law was in response to “several grisly deaths” on such rides in recent years. It got me thinking: What constitutes a grisly death? Whatever it is, I want no part of it.

As I write this, Easter season is approaching. One aspect of the passion of Christ that always puzzled me as a Roman Catholic: According to John’s gospel, when the Romans went to arrest Jesus in Gethsemane, Peter grabbed his sword and hacked off the ear of the chief servant of the High Priest. Jesus told Peter to put away his weapon, then promptly picked up the bloody ear and...
reached it as his captors watched. Now, if I were a Roman soldier sent to arrest a guy and then witnessed my “perp” replace a severed body part as it were made of Velcro, I might have second thoughts about my mission. Arresting Gods, space aliens, people from the future or whoever else can stick on severed ears is not in a Centurion’s job description.

In those ED drug commercials, why do advertisers think it’s romantic to see two naked, saggy middle-aged people publicly soaking in antique claw-footed bathtubs? Then again, if a man can sustain his manhood, so to speak, while sitting waist-deep in ice cold bath water in the middle of a cornfield, he must be taking some powerful drugs. Or frozen stiff.

We have lost the art of creatively insulting people. For some superb examples of how to berate your fellow man without stooping to standard four-letter epithets, I suggest Shakespeare’s Richard III; the first act consists largely of Queen Margaret and others spewing venom at Richard. The next time someone pulls out of a parking space and dents your fender, rather than the usual proctologic aphorism, assail the miscreant thusly: “Watch where you are going, you foul infection of a man, you elvish-marked abortive rooting hog! You are but the knavish slander of your mother’s heavy womb, the loathed issue of your father’s cruel loins sealed at your nativity as a cremenly slave of hell!” That will at least give the person something to ponder as he beats you with a tire iron.

Speaking of English kings, the early Saxon royalty used nicknames to differentiate monarchs historically (Edward the Martyr versus Edward the Confessor). After the Norman conquest of 1066, that tradition slowly gave way to the French method of simply assigning Roman numerals. William the Conqueror eventually became William I, Richard the Lion-hearted became Richard I, and so on. That was good, because not every king had a good moniker, like “the Conqueror” or “the Lion-hearted.” The worst had to be Ethelred the Unready. Not only was the poor sap cursed with the name Ethelred, but he later was called “the Unready.” Couldn’t historians cut him a break and just call him “the Barely Adequate?” “The Fecally Incontinent” would have sounded better. In general, nicknames are a double-edged sword; that’s why I am glad I never had one. For every “Bear Bryant,” there is a “Bum Phillips” or “Foge Fazio.” It’s great to be Tiger Woods, but how about “Soupy Sales?” And if you remember who Soupy Sales was, start paying closer attention to those ED commercials, because you are getting up there in years.

Finally, while I am blathering about language, when did the word “drifter” get such a negative meaning? At one time, it conjured images of a free, unfettered soul. There was even a singing group called The Drifters. Now, the word drifter is associated with some unwashed psychopath whose sole accomplishment in life was earning a Boy Scout merit badge in Shallow Grave Digging. Such are the times we live in, I guess.

Dr. Vertosick is a semi-retired neurosurgeon practicing in Washington County and associate editor of the ACMS Bulletin. He can be reached at vertosick@acms.org.

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.
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**Allegheny County Medical Society**
Elizabeth Fulton, 412.321.5030
Your colleagues who serve as leaders for both the Allegheny County Medical Society (ACMS) and the Pennsylvania Medical Society (PMS) want you to have a productive, happy life because our whole community benefits from your personal well-being and efficient practice of medicine. In the April Bulletin I listed membership benefits available through PMS, and this month I bring you benefits available through the ACMS, including:

- Endorsed Vendor Program
- Educational Opportunities
- Printing Services & Professional Announcements
- Communication Opportunities
- Philanthropy
- Opportunities for residents, part-time physicians and spouses

**Endorsed Vendor Program**

The ACMS Endorsed Vendor Program helps meet your everyday professional needs by obtaining competitive pricing and the best service available from businesses you rely on to operate your office efficiently.

You can purchase medical supplies at discounted rates through Allegheny Medcare. For years, Malachy Whalen & Co. has provided our members with great life insurance rates. USI Affinity has provided quality group health insurance for you and your employees. Liberty Mutual discounts auto, home and life insurance for the ones you love. Medical Waste Recovery provides competitive rates for disposing of medical waste. PNC Merchant Services will assist you in developing a line of credit to reduce your transaction fees, check scanners for the office and online services, all without setting foot in a bank (see p. 203). Business Records Management will help you with all your document storage needs. I.C. System will help with bill collection so your staff can focus on patient care. Staples Technology Solutions offers member pricing for a variety of office supplies and services.

Please see the full-page ad on page 200 for contact information on the vendors who participate. For more information on the Endorsed Vendor Program, contact ACMS staff member Jim Ireland at (412) 321-5030.

**Educational opportunities**

The Allegheny County Medical Society provides seminars for coding electronic medical records, legal affairs, HIPAA training, Red Flag and OSHA compliance. Physicians who choose employment may want to consider our contract review service with Attorney Michael Cassidy of Tucker Arensburg PC. Find out more about current educational opportunities by visiting www.acms.org.

**Printing services & professional announcements**

ACMS members enjoy special rates on professional announcements and printing services. ACMS professional announcement service allows you to maximize the impact of your mailing by targeting physicians by specialty and geographic location. Contact ACMS staff member Susan Brown at (412) 321-5030 or sbrown@acms.org.

To obtain colorful BMI charts and Where to Turn domestic violence cards for your office, contact ACMS staff member Elizabeth Fulton at efulton@acms.org or (412) 321-5030.

**Communication opportunities**

Your monthly membership magazine, the Bulletin, is a great place to make your voice heard by penning a letter for the “From the Mailbag,” column or writing a continued on page 202
“Perspective” on a topic of concern; or you might simply suggest a topic you’d like to see covered in an upcoming issue of the Bulletin. E-mail bulletin@acms, or contact Linda Smith at (412) 321-5030 or lsmith@acms.org.

You can connect with the public through the society’s partnership with the Pittsburgh Post-Gazette by writing a “Dear Doctor” column. If you feel strongly about a topic, we’d love to list your name on our Speakers’ Bureau list. Contact Elizabeth Fulton for details (see p. 201).

Philanthropy

The ACMS Foundation traditionally supports programs that provide practical solutions to very real problems in our community. Since 1960, it has generously given more than $2 million in grants and scholarships to medical and nursing students and community health service organizations. Annually, the foundation awards two $2,000 scholarships to third- and fourth-year students from Allegheny, Armstrong, Beaver, Butler, Washington or Westmoreland counties who are enrolled full-time in a Pennsylvania medical school. The Pennsylvania Medical Society Foundation administers the scholarship program. For more information on philanthropic opportunities, contact Susan Brown (see p. 201).

Part-time physicians

We welcome the opportunity to include more part-time physicians in our activities. Part-time physicians may also benefit from the medical society’s services, from health care to advocacy to media relations to philanthropy. As physicians we understand that there must be a balance between home and work life.

Residents

We consider the Allegheny County Medical Society as a home for all residents through mentoring, assistance with financial management seminars, contract review and advocacy with Resident and Medical Student Advocacy Day in both Washington, D.C., and Harrisburg. The medical society’s website (www.acms.org) provides information on activities and events available to all members.

Spouses

The ACMS Alliance is an organization of physician spouses and supporters that meets throughout the year for a variety of business and social activities. In partnership with the ACMS Foundation, the alliance helps provide scholarships to nursing and allied health students at the Community College of Allegheny County. For information on how to join the ACMS Alliance, contact ACMS staff member Dorothy H. Ostovitch at (412) 321-5030 or visit www.acms.org. A warm welcome awaits.

The Allegheny County medical society welcomes feedback—positive or negative—in respect to its currently offered or potential future services. Please call (412) 321-5030 or visit www.acms.org.

Dr. Paré is a plastic surgeon and 2009 treasurer of ACMS. She can be reached at pare@acms.org.

Community Partnerships

The ACMS has frequently partnered or interacted with numerous community groups; some partnerships are ongoing:

- Allegheny County Bar Association
- Allegheny County Health Department
- Brother’s Brother
- Carnegie Mellon University
- Carnegie Science Center
- Center for Hearing and Deaf Services
- Committee on Quality End-of-Life Care
- Community College of Allegheny County
- Consumer Health Coalition
- Duquesne University School of Health-Related Sciences
- Duquesne University School of Pharmacy
- Gateway Health Plan
- Gateway Medical Society
- Governor’s Office of Health Care Reform
- Health Policy Institute
- Hospital Council of Western Pennsylvania
- Hospital and Health Systems Association of Pennsylvania
- Pennsylvania Academy of Family Physicians
- Pennsylvania Chapter of the American College of Physicians
- Pennsylvania Society of Physician’s Assistants
- Pittsburgh Business Group on Health
- Pittsburgh Regional Health Initiative
- Rx Council of Western Pennsylvania
- SMC Business Council
- Three Rivers Adoption Council
- Three Rivers Area Labor Management Council
- Tristate Association of Physicians of Indian Origin
- University of Pittsburgh Graduate School of Public Health
- University of Pittsburgh School of Medicine
- University of Pittsburgh School of Pharmacy
- VHA Pennsylvania
- YMCA Camp Kon-O-Kwee/Spencer
ACMS Member Benefit: Reduce Your Credit Card Processing Fees

The Allegheny County Medical Society has established a new business partnership with PNC Merchant Services¹ for processing your Visa, MasterCard & Discover Network transactions. PNC Merchant Services provides solutions that will help your practice provide patients with several payment options, and it gives you the ability to manage your receivables cash flow more efficiently and effectively.

As an ACMS member you will receive special, discounted payment processing rates! Take advantage of all of the PNC Merchant Services benefits available to our members:

- PNC Merchant Services will beat your current payment processing costs or you will receive a $300 Visa Gift Card;²
- One rate, statement and funding for all Visa, MasterCard and Discover Network transactions;
- Next-day funding is available with a PNC checking account;³
- PNC Merchant Services will collect your fees at the end of the month versus everyday;
- Customer help desk and support available 24 hours-a-day/7 days-per-week;
- PNC Merchant Services also offers a gift card program to help increase traffic, repeat customers and cash flow for your practice.

Transitioning your payment processing to PNC Merchant Services is easy. If you own your processing equipment, PNC Merchant Services will reprogram your terminal free of charge or you can lease or purchase the latest and most secure equipment at reduced rates. PNC Merchant Services has a full array of equipment and peripherals designed to meet your practice needs for point-of-sale or online sales.

ACMS members interested in enrolling in the PNC merchant services program should visit the medical society’s website at www.acms.org and click on “Reduce Your Credit Card Processing Fees.” Complete the information form you find there and a PNC Merchant Services representative will contact you. If you do not have access to the web, contact the medical society at (412) 321-5030 and request an information form.

The Allegheny County Medical Society is very pleased to have PNC Merchant Services assume the role of our endorsed payment processor. We encourage you to take advantage of its services. If you have any questions, please contact a PNC Merchant Services representative at (888) 562-2300.

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³Next-day funding on Visa, MasterCard and Discover Network payment processing transactions valid only when processing is provided by PNC Merchant Services and funds are deposited into a PNC Bank business checking account.

Member Benefit

One Voice

Not everyone has time to attend medical society meetings and “get involved.” Your membership dues, however, make it possible for ACMS to be the regional voice for physicians in a challenging medical climate.

The physician voice IS heard. Your dues make this possible.

ALLEGHENY COUNTY MEDICAL SOCIETY

Leadership and Advocacy for Patients and Physicians

Member Benefit

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You’re entitled to receive the medical society’s corporate rate on automobile rentals at Enterprise rent-a-car, for everything from compact cars to luxury cars, trucks and passenger vans.

Simply call any Enterprise rent-a-car office and ask for details. Use Allegheny County Medical Society Customer I.D. #40A7256.

Allegheny County Medical Society Leadership and Advocacy for Patients and Physicians

May 2009 : Bulletin  203
I never thought I would say this, but I’m thrilled to be working 10+ hour days again, six days a week. After a five-month hiatus from the hospitals and clinics of the UPMC system, I’m doing my acting (“practice”) internship at UPMC Shadyside and loving every minute of it. Yes, I’m a fourth-year, post-match medical student, and I should be so burned out by now that I shouldn’t want to do anything but sit on a beach in Florida soaking up the sun before I start my residency in July. I mean, don’t get me wrong—Florida does sound pretty good right now—but this is my last opportunity before I start my first “real” job to ask all the dumb questions I have festering in my mind, to get my MI and pneumonia workups down pat, to efficiently see patients, write helpful notes and give concise, accurate patient presentations with insightful and comprehensive assessments and plans.

You see, I want to hit the ground running when I start my internal medicine residency next month at Allegheny General. So many people have told me that the intern year is the most difficult and trying of all in the course of a physician’s training and career. Yet, despite the long hours and sleepless nights on call, the steady tempo of continuous pager beeps and the never-ending, hospital-wide walk rounds featuring scores of painfully-detailed medical student patient presentations (“Mr. Jones is a 49-year-old man who was hit by a truck two days ago and has a broken leg... family history is negative for gonorrhea, rhabdomyolysis, cervical cancer... review of systems is negative for excessive flatulence, acne vulgaris and jock itch, but positive for leg pain and swelling...”) I look forward to the other side of what people tell me about the intern year: that it is the time when I’ll stop feeling like a mere out-of-place student with a poorly defined role and instead feel like my patients’ primary doctor.

I’m presently enjoying my acting internship for exactly this reason: I’ve worked hard to earn the trust of my senior resident and attending; in return, I’ve received the right to create and execute my very own plans for my patients’ care. I make the calls and speak with my patients’ families and primary care physicians; I speak with their medical consultants whose services I myself have requested; I decide on the criteria that must be met before they are discharged; I write their scripts, make sure their pain is adequately treated and check their INR at the interval I feel is necessary to assure their warfarin is being correctly dosed. I do everything an attending would do for his or her patients. Sure, I make mistakes (all of which are caught by my senior resident before being put into action), but I also make correct decisions, and from these correct decisions I gain valuable confidence. My desire to be an expert history-taker, physical-examiner and an up-to-date, evidence-based plan-maker has skyrocketed. To me, nothing has been as satisfying as knowing that I’ve made the right decisions that ended up curing my patient’s pneumonia or finding that the recurrent fevers and chills are due to a bacte-
emias produced by an occult case of bacterial endocarditis.

As it has finally become a reality to me that one day in the not-too-distant future I will be solely responsible for caring for many seriously ill people, I have found a new appreciation for the passionate attendings and residents with whom I work. I have been privileged to be around these doctors who truly love what they do and who strive daily to provide the best care that they can. They religiously read the results of the most recent clinical trials; they always listen to their patients’ needs and treat them according to their wishes; and they call meetings between the pharmacy staff, nurses and unit managers when trends on the floors become evident to them. They go out of their way to tell medical students about the neat Austin Flint murmur the man in Room 567 has, and they praise their team for the things they do well and offer to help them with their weaknesses.

At times I’ve felt that I was less enthusiastic about medicine than my classmates and others in the medical field, such as these passionate residents and attendings. I’ve found that many people who work in healthcare have had very specific and emotionally powerful life experiences that have gotten them into medicine. I never really had one of these experiences, but I always enjoyed the satisfaction that comes from helping other human beings, whether from returning the wallet that someone left behind on the bus or from caring for them as their doctor. I ask that all of you reading this article look within yourselves and rediscover why you got into medicine. For me, the daily opportunity to experience the joy that comes from knowing I have helped another person has convinced me that my choice to go to medical school was the right one.

Next year I want to be an approachable resource to the medical students on my team, a valued team-player to my peers and a dependable, attentive physician to my patients. These past few weeks I’ve spent as an acting intern have re-ignited my eagerness to become a physician, and the experience has led me to happily welcome the future responsibilities that come with the honored title of Doctor.

Mr. Greytak is a fourth-year medical student at the University of Pittsburgh School of Medicine. Mr. Greytak becomes Dr. Greytak when he graduates on May 18! He can be reached at greytak.ryan@medstudent.pitt.edu.

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.

Got Something to Say? If you’re an ACMS member and would like to write a student or resident column, call Linda Smith at (412) 321-5030, x105 or e-mail lsmith@acms.org.

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Geriatrics Clinical Update

Approximately 340 individuals from the tri-state area participated in the 17th Annual Clinical Update in Geriatric Medicine at Pittsburgh’s Omni William Penn Hotel on March 19-21.

Thomas Finucane, M.D., was the prominent guest speaker for the dinner symposium, outlining choices faced by patients, caregivers and physicians in What Is So Hard About Dying? Dr. Finucane is professor of medicine in the division of gerontology and geriatric medicine at Johns Hopkins University School of Medicine.

Geriatrics professionals from many disciplines, including physicians, nurses, pharmacists, physician assistants, social workers, long-term and managed care providers, and health care administrators participated in key plenary sessions and two symposia on hospitalized care of the elderly and common geriatric problems. Course work included 40 presentations and panels featuring national and local instructors, as well as the latest information and indepth updates on geriatrics care.

Drs. Judith Black, Shuja Hassen and Neil Resnick served as directors for this annual conference, jointly sponsored by the Pennsylvania Geriatrics Society–Western Division, University of Pittsburgh Institute on Aging and University of Pittsburgh School of Medicine. Center for Continuing Education in the Health Sciences. Previously awarded the American Geriatrics Society Achievement Award for Excellence in a CME program, the event continues to grow and draws prominent international and national lecturers, as well as nationally renowned local faculty.

At Thursday’s dinner meeting, the Pennsylvania Geriatrics Society-Western Division presented its 2009 David C. Martin Awards to six medical students, all of whom attend the University of Pittsburgh School of Medicine.

Recipients included: Neilly Buckalew, Brain morphology differences in older adults with disabling chronic pain; Cathy Cheng, Psychological burden related to urge urinary incontinence predicts and its change correlates with therapeutic response to biofeedback in older women; Jason Sanders, Dehydroepiandrosterone sulfate (DHEAS) in the oldest old and factors associated with nine-year DHEAS decline; Emily Spangler, Ankle arm index and walking endurance in community-dwelling older adults; Sarah Sullivan, Vertebral fractures and misclassifications of osteoporosis in men with prostate cancer; and Laura Viccaro, Does timed up & go add to gait speed in predicting health, function and falls in older adults?

Students each received a certificate of excellence and a $1,500 honorarium to attend the American
Geriatrics Society national conference where they presented their work, networked with leaders in geriatrics and became part of the AFAR ongoing network. It is the hope of the society that students came away with a greater appreciation of the challenges and rewards of geriatrics and will ultimately pursue a career in this expanding field. This year’s conference was held in Chicago from April 29 to May 3.

Since its inception, the geriatrics society has awarded more than $43,000 to medical students who are interested in the field of geriatric medicine. The award is named for David C. Martin, M.D., who established the first geriatric fellowship in Pittsburgh.

Mark your calendar now for the 2010 Clinical Update in Geriatric Medicine to be held March 25-27, 2010, once again at the Omni William Penn. Geriatrics society members will receive a discount when registering for the conference.

To inquire about becoming a member, contact Nadine Popovich at (412) 321-5035, ext. 110, or at npopovich@acms.org. You can also apply for membership online at the geriatrics society website at www.acms.org/pagswd.

**Surgeons’ meeting**

Members of the Pittsburgh Surgical Society and Southwestern Pennsylvania Chapter of the American College of Surgeons met at the LeM ont on March 31 to hear Ricardo Ferrada, M.D., who spoke on Penetrating Precordial Trauma, based on his experiences in the trauma unit where casualties of illegal drug trafficking are treated. Dr. Ferrada is professor in the department of surgery and chief of the burn unit and acute surgery and critical care at the Univeristario del Valle, Cali, Columbia, South America. While in Pittsburgh, Dr. Ferrada visited with his daughter, a fellow in the trauma department, and son-in-law, a resident in the UPMC Presbyterian Department of Surgery.

Plans continue for the merger of the Pittsburgh Surgical Society and the Southwestern PA Chapter of the American College of Surgeons. Watch for information regarding the fall meeting.

continued on page 209

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Obstetrics/gynecology society

The Pittsburgh Obstetrical and Gynecological Society met on April 6. Dr. Rifaat Bassaly, society president, introduced Dr. Michael Nhabes of BioSante Pharmaceuticals Inc. (Lincolnshire, Illinois). Dr. Nhabes presented information on clinical trials for the treatment of hypoactive sexual desire disorder, describing issues related to the FDA’s denial of the Procter & Gamble patch and how indications for the trials taking place in Pittsburgh for the BioSante product have been established. He said there are many reasons for lack of sexual desire, but he believes that gynecologists (not psychiatrists) should be the primary identifiers of the disorder. For more information on the Pittsburgh trials, contact Dianne Meister at (412-321-4030) or dmeister@acms.org.

Dr. James Garver, the society’s incoming president, will meet with the council to plan upcoming meetings. The council is considering changing its meeting format and would appreciate comments from members on a survey to be mailed in the near future.

ACMS call for nominations

The medical society’s Nominating Committee is seeking candidates for the 2010 ACMS Board of Directors and other elected offices, including delegates to the Pennsylvania Medical Society. The Nominating Committee is also looking for individuals interested in serving on the ACM S Communications, Membership or Ocupational Medicine committees.

The need for physician leadership is critical during this time of change in the medical profession. Please respond by Friday, June 19. Nomination forms are available for download at www.acms.org, or simply complete and return the form below. For more information, call John Krah at (412) 321-5030.

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**2010 Nomination Response Form**

**I am interested in being considered as a candidate for the ACMS:**

- **Board of Directors**
  - Represents the membership on timely issues impacting physicians and patients, managed care, patient protection, legislative issues, etc.
  - Meets six evenings per year, special meetings as needed;
  - Makes policy decisions in the best interest of the medical profession;
  - Acts as the formal interface between ACMS and other organizations.

- **Delegation to the Pennsylvania Medical Society**
  - Represents the physicians of Allegheny County in voting on a wide variety of topics impacting physicians, patients and the practice of medicine;
  - Meets twice annually prior to each House of Delegates’ meeting that is held over a weekend in October;
  - Presents resolutions to the House of Delegates received from the ACMS Board of Directors or membership.

Your Name __________________________ Your Phone # __________________

I would like to recommend the following colleague as a candidate for (circle one):

Name __________________________ Phone ____________ Board Member / Delegate
Name __________________________ Phone ____________ Board Member / Delegate

Please FAX to 412-321-5323 by Friday, June 19.
Nancy Nieland-Fisher, M.D., age 69, passed away on March 28. Dr. Nieland-Fisher (dermatology) graduated in medicine from West Virginia University in 1967 and completed both an internship and residency at West Virginia University Hospital. She also served as a research fellow in dermatology at Johns Hopkins Hospital and as a dermatology and rheumatology trainee and clinical associate in medicine at the University of Tennessee Electron Microscope Research Laboratory in Memphis. In 1995, Dr. Nieland-Fisher was the second woman to preside over the Allegheny County Medical Society. She is survived by her husband Richard; son Nathaniel; daughters Ariel, Brita, Jennie, Nate and Sarah; and two grandchildren.

Medical society leadership
Dr. Nancy Nieland-Fisher was a warm and caring physician. She was dedicated to her patients, family and the medical profession. Nancy was a gentle and soft-spoken individual, but had a resolute focus on medical issues and spoke vigorously for patients and for the ability of physicians to care for their patients. During her tenure as president of the ACM S in 1995, I distinctly remember her challenging and questioning Senator Arlen Specter on several points of national policy during a medical society meeting. Not normally at a loss for words, the senator took the points she made and later followed up with ACM S.

Beyond her services as an officer, Nancy served on the ACM S Board of Directors and as delegate to the Pennsylvania Medical Society. She spoke frequently to community groups and in interviews for radio and print.

It is indeed unfortunate that Alzheimer’s disease took her from her family and her practice far too early in life. Her untimely passing took this kind, caring and gentle person from all of us. Our deepest sympathy is extended to her husband Richard “Dick” Fisher and to her children, Ariel, Brita, Jennie, Nate and Sarah.

—John Krah
ACM S Executive Director

A Tribute to Dr. Fisher

The Pittsburgh dermatologic community was profoundly saddened to learn of the death of Dr. Nancy Nieland-Fisher on Saturday, March 28. Dr. Nieland-Fisher was an icon in dermatology in this area for more than three decades, known for her clinical skills, both diagnostic and therapeutic. Dr. Nieland-Fisher’s enthusiasm for clinical dermatology never diminished during her long professional career.

In the early 1970s when Dr. Nieland-Fisher entered practice in Pittsburgh, there were only about 15 dermatologists in all of Allegheny County. The University of Pittsburgh did not have a department of dermatology. At that time, dermatology was still a division of the department of medicine, and in those days dermatology did not have the recognition and prestige it now enjoys. Besides establishing her private practice, Dr. Nieland-Fisher became the director of outpatient dermatology at Falk Clinic. She was keenly aware of the cutaneous manifestations of systemic disease, and she had a particular interest in connective tissue diseases, especially lupus erythematosus. Her diagnostic acumen and resident teaching enhanced her reputation. I believe she was instrumental in helping to lay the groundwork for what would evolve into a department of dermatology, thus giving dermatology new credibility at UPMC.

Dr. Nieland-Fisher’s patients included people of all ages, but she had a particular love for seeing infants and young children as patients with whom she effortlessly established rapport, and she was able to put many anxious parents at ease. Never did she refuse to see patients, no matter how long it made her days. When Dr. Nieland-Fisher retired, her patients were saddened and expressed fond memories of her. Now, her professional colleagues mourn her passing.

—John McSorley, MD, clinical professor of dermatology, University of Pittsburgh
The Pittsburgh Tribune-Review featured Edward D. Snell, M.D., family medicine, as a Newsmaker in April. Dr. Snell, head physician for the Pittsburgh Pirates, recently was chosen as president of the Major League Baseball Team Physicians Association.

The International Society of Arthroscopy, Knee Surgery and Orthopaedic Sports Medicine recently named Freddie Fu, M.D., orthopedic surgery, as its president. Dr. Fu will serve a two-year term.

Medicine is like a labyrinth – a maze of pathways, each beckoning exploration to uncover new information that could benefit our health. Yet in spite of this complexity, medicine’s greatest achievements have been the simplest – the products of intense focus.

At West Penn Allegheny Health System, we choose to place all of our resources – indeed our entire focus – exactly where they belong: at home, in western Pennsylvania, on improving the health of our patients.

The West Penn Allegheny Health System – one purpose, one mission.
Golf outing
Our Own Home will hold its fourth annual golf outing (scramble) at Grandview Golf Course on September 11. Set to begin with a 1 p.m. shotgun start, the event will award more than $1,000 in cash prizes. The entry fee is $500 for a foursome and $130 for an individual, including light lunch, sit-down dinner, skill prizes, refreshment cart and a chance at a hole-in-one car by P&W Foreign Cars; dinner is $40 for non-golfers. Sponsorships are available. Call (412) 367-4461 or e-mail rexkay@aol.com.

Our Own Home is a Western Pennsylvania-based nonprofit organization that builds housing for people with mental illnesses and provides individual on-site psychosocial structured programming conducive to recovery. For more information, visit www.ourownhome.org.

Physician assistant program
The Duquesne University Physician Assistant Program is seeking physicians to serve as clinical preceptors for physician assistant students. Becoming a Duquesne University physician assistant student clinical educator is a vital investment in the future of the local health care system. Health care industry organizations and medical associations consistently predict that the demand for primary care providers will outpace the numbers entering the health care workforce in the coming years. Physicians can be an integral part of the solution to this dilemma by preparing medical students and physician assistants for practice. Some of the benefits of being a clinical preceptor include:

- professional appointment at a prestigious academic institution;
- access to faculty resources and campus services;
- a sense of giving back to the profession and local medical workforce;
- satisfaction in being a role model for students;
- Category II CME credit for teaching PA students; and
- ability to assess students’ abilities and identify those whom you may want to hire in the future.

If you or a colleague is interested in learning more about this exciting opportunity, contact Dana Motika, clinical coordinator, at (412) 396-4244, or Bridget Calhoun, program director, at (412) 396-5917.

Research: children of bipolar parents
Researchers at the Western Psychiatric Institute and Clinic of UPMC are looking for individuals with bipolar disorder who are the parents of a child between the ages of 12 and 18 who does not have bipolar disorder. Participation involves an initial assessment interview with parent and child and attendance at 10 to 12 free weekly counseling sessions for up to three months. Interviews with parents and children also are conducted to evaluate mood symptoms. Families will be compensated for participation. For more information, call Kelly Monk at (412) 246-5796.

April 11, 2009
Dr. Levine’s article, “Confronting the Albatross of Medical Student Debt” (Bulletin, March 2009, p. 134), does not cover the real issue of why medical students have so much debt. Medical schools themselves are a huge problem. When I graduated a few years ago, we used to (and still do) call medical schools a “money-making scam.” Salaries of the administration and board of directors at medical schools are outrageous! The profit a medical school makes is outrageous! The cost of taking exams is also outrageous! If you want to lower medical student debt, address these issues first. There is no need to have the federal government foot the bill for medical school education. I would love to see a bill that would force schools to match the same amount of money that a student must take in federal student loans. I assure you, the cost of tuition would go down rapidly!

Sundeep Ram, DO

Dr. Levine’s response
As someone who has long advocated large-scale, tuition-free or loan-forgiveness programs to help students finance their medical education and who has diligently dedicated increasing amounts of discretionary institutional funding to provide scholarship support in recent years, I’m bemused by the suggestion that medical student debt is an artificial problem. According to The Handbook of Academic Medicine, published in 2008 by the Association of American Medical Colleges, “Student tuition and fees are an oft-cited source of funding for higher education institutions. In the medical school arena, tuition and fees
have always been a small but relatively stable component of revenues, about 3 to 4 percent, since the 1960s.” If medical schools could balance their budgets without tapping into such a narrow revenue stream and thereby alleviate the debt burden on the same people they exist to serve, believe me, they would. Arthur S. Levine, MD

April 11, 2009

I enjoyed reading the editorial about the “uninsured” by Michael Chapman (“The Uninsured: A dangerously glib label on a much more complicated package,” Bulletin, March 2009, p. 102). Some facts need to be cleared up though; he stated the nation has 47 million “uninsured.” Ten million are illegal immigrants and 20 million people are those between the ages of 25 and 55 who can afford insurance, but choose to buy other things like cars or DVD players. To “solve” the insurance crisis, our patients must be responsible for themselves. In India, more people have money and insurance compared to the 1980s, yet there is an explosion of diabetes because they are not responsible when it comes to their diet. We could give every person in America $1 billion of insurance coverage, but what good would it do if patients continue to eat 4,000 calories a day? Sundeep Ram, DO

Dr. Chapman’s response: Thank you for your response, Dr. Ram. Those are excellent points which I think highlight the need to (a) unpack the concept of the “uninsured” and see whether this is a population label that is truly meaningful (I would argue that it is not); and (b) question the notion that providing the product known as “health insurance” to everyone is really the panacea many see it as.

You also raise what I consider to be the central question facing this nation’s health care policy makers: How do we incentivize folks to behave more responsibly, take better care of their health and make wise use of limited resources? I don’t have a simple answer for that, but increasing the influence of third-party payers doesn’t seem the right way to achieve this. To draw an analogy, increasing the ease of obtaining auto insurance is hardly the solution to reckless driving. Best Regards, MC

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**Membership Benefit**

Parking permits for the 2009 Steeler and Pitt football seasons  
*Permits not required for Pirate games*

Parking permits are available to **ACMS members only** on the following basis:

1. Separate season-long permits for Steeler games and Pitt Panther games will be available at the following rates:
   - Steelers: $195 (includes exhibition and post-season)
   - Pitt Panthers: $45
2. Permits will be awarded by lottery.
3. Limit one permit per team per member
4. One parking spot per permit
5. Payment in full must be received by noon, Monday, June 1, 2009.
6. Drawing for the 64 spaces will be held the afternoon of June 1. Members drawn will be notified by mail and permits mailed.
7. Payments from members whose names are not drawn will be returned promptly.
8. Season permits will be mailed as a package with one pass per game included. **No duplicates will be issued.**
9. Permits are non-refundable.
10. Lot attendant will collect passes at each game.

**PAYMENT MUST BE RECEIVED BY JUNE 1, 2009, AT NOON!**

Please call the medical society at 412-321-5030  
or visit www.acms.org for more information or to obtain a form.
Eighth International Conference on Bipolar Disorder—June 25-27, David L. Lawrence Convention Center. Sponsor: Western Psychiatric Institute and Clinic & University of Pittsburgh School of Medicine. E-mail bipolarconference@upmc.edu or call (412) 802-6917. Visit www.8thbipolar.org for more.

23rd Combined Skin Pathology Course—July 24-29, Hyatt Regency International Airport Hotel. Sponsor: Medical Education Resources. E-mail Tami Good at tami@mer.org. Or contact Course Director Alan Silverman, M.D., at 412-682-3083 or asilverman@ameripath.com.

Regional Mental Health Training Series—April-June 2009. Sponsor: Western Psychiatric Institute and Clinic. Call Nancy Mundy at (412) 802-6900 or visit www.wpic.pitt.edu/oerp for more information.


This listing includes local events that are coming up soon; a more complete list is available on the medical society’s website at www.acms.org or by calling (412) 321-5030.

May 18, 6 pm .............. ACMS Editorial Board
May 20, 11:30 am .......... Emergency Medical Services
May 21, 5:30 pm ........... ACMS Finance Committee
May 25 ......................... HOLIDAY: ACMS office closed
May 27, 5:30 pm ........... Pittsburgh Pathology Society
June 9, 6 pm .................. ACMS Board of Directors
June 12, 10 am ............. Three Rivers Adoption Council
June 17, 10 am .............. Governor’s OHCR
Chronic Care Commission

Memorial Day, May 25
“A nation that does not honor its heros, will not long endure.”
President Abraham Lincoln

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MANSOOR ALAM, MD

“...take one blood pressure medication and my baby aspirin” said the 87-year-old woman sitting in front of me.” When I was finished taking her medication history, she had a total of seven medications: a beta-blocker, aspirin, Excedrin PM to help her sleep, “regular” Excedrin to help with any morning aches and pains and to help with the sleepiness from the Excedrin PM given the night before, ferrous sulfate three times daily, a stool softener to help with her horrendous constipation and an over the counter H2 blocker to help with the gastrointestinal upset from the iron.

The importance of taking a thorough medication history is evident in the vignette above. Many patients do not include over the counter (OTC) products, dietary supplements and herbal preparations in the list of medication they are taking. Asking purposeful questions to elicit this information is necessary when discussing therapy with any patient. In the geriatric patient population, it is especially important to have an accurate medication list when prescribing, as this group often has more disease states to treat, drug metabolism and clearance changes, as well as risk factors for medication non-compliance and adherence.

When discussing medication prescribing and utilization in the elderly, phrases such as “inappropriate prescribing,” “do not use” and “that medication is on the X, Y, Z list,” come to mind. In recent decades, multidisciplinary teams have created various guides to help clinicians with prescribing medications in elderly patients, a group often excluded in large clinical trials. Many of these lists are helpful, some are not easily accessible or memorable, and others are not user friendly. From a medical decision-making perspective, it is again vital to have an updated and accurate medication list to determine if a medication is appropriate for a patient. In this article, we will focus on the use of the over the counter product, Excedrin, in the elderly.

Excedrin is the product highlighted here, although many over the counter medications contain similar ingredients, and should be considered with the same cautious eye. Are the Excedrin products containing diphenhydramine and caffeine appropriately utilized or necessary in these patients?
Patient cases from the physician’s desk

After a long day I was about to finish my last patient, who had come for her annual physical exam. She was an 83-year-old woman with minimal medical issues, the foremost being urge urinary incontinence. I noted a negative physical exam and bare medication list, consisting only of tolterodine. I then sat down for a quick review of systems.

“Oh yes, I used to go bathroom about five to six times before I was started on tolterodine, now I go only once or some times twice.” I thought that sounded positive. Then she proceeded to say: “I fell down three times while going to the bathroom a few nights ago.” When I asked her how the fall occurred, she did not remember exact details but stated she had some bruising the next morning.

Unusual or not? She is a healthy and functionally independent woman without a history of falls. Moreover she was not taking any other suspect meds. After considering all etiologies for the fall, I was perplexed. Just to be complete in my questionnaire, I asked if she takes any other OTC medications, and she replied, “I always take Excedrin PM as it helps me sleep well.” At last I could connect the dots.

As I entered the exam room, a vibrant 75-year-old woman greeted me; she was a new patient to the practice. After getting to know her, completing the physician exam and review of systems, I examined her medication list. Excedrin Extra Strength: two tablets at 9 a.m., one tablet at noon and one at 3 p.m., and two tablets at 6 p.m. struck me. I could only imagine the pill-burden and side effects associated with this regimen. The patient used this for migraine prevention and had been on this schedule for three years, nearly migraine free. She denied any complaints with the regimen, only that she felt slightly anxious at times and did require a hypnotic at bedtime. She was currently not under the care of a neurologist, and the decision was made to slowly titrate her dosing regimen down.

I could have missed these scenarios if I was not taught about taking a thorough medication history during my training. It is also not unusual for patients to think that OTC medications are not “drugs.”

Diphenhydramine hydrochloride

Diphenhydramine hydrochloride is a widely used first generation antihistamine, available for over the counter use in the United States. Antihistamines are used for a myriad of symptoms including rhinorrhea, sneezing, insomnia and pruritus, and are peppered throughout cough and cold products available for patient use. Other first generation antihistamines include brompheniramine, chlorpheniramine, dimenhydrinate, diphenhydramine, hydroxyzine and doxylamine. Second generation antihistamines include loratadine, fexofenadine, desloratadine and cetirizine. Important differences between the two classes are that first generations block both histaminic and muscarinic receptors and cross the blood brain barrier, whereas the second generations primarily block histaminic receptors with less crossing of the blood brain barrier. Blocking muscarinic receptors leads to additional, often unwanted, anticholinergic side effects.

A common method to recall cholinergic, and therefore anti-cholinergic, effects is the pneumonic SLUDG. Cholinergic effects cause increases in salivation, lacrimation, urination, defecation and gastrointestinal motility. Anticholinergic effects are remembered by anti-SLUDG. Antihistamines are also known to cause dizziness, sedation and hypotension in geriatric patients. While first generation antihistamines are thought to be more

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<th>Excedrin Products and Ingredients³</th>
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<tr>
<td><strong>Acetaminophen</strong></td>
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<tr>
<td>Back and Body</td>
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<tr>
<td>Extra Strength</td>
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<td>Tension Headache</td>
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*buffered with calcium carbonate

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reputation is everything

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highly anticholinergic, the individual patient and his or her concomitant medications should be considered. Baseline cognitive and medical comorbidities as well as additive anticholinergic effects of medications, may precipitate more obvious reactions to any antihistamine.

Diphenhydramine has known dose-related in vitro anticholinergic activity. When studied in 426 hospitalized medical patients 70 years or older, diphenhydramine-exposed patients versus non-exposed patients were associated with having increased risk of any delirium symptoms (RR 1.7, 95% CI 1.3-2.3), inattention (RR 3.0; 95% CI 1.5-5.9), altered consciousness (RR 3.1; 95% CI 1.6-6.1), and longer median length of stay (7 vs 6 days; P = 0.009). Considering diphenhydramine’s widespread use and risk for significant morbidity, use should be ascertained when taking a medication history, and prescribing should be highly reserved when caring for geriatric patients.

Caffeine

Several Excedrin products contain caffeine. Many patients are unaware of this active ingredient when making their purchase. Although caffeine has a role in headache and migraine management, it may also interfere with the sleep/wake cycle of its consumers. Although large, well-designed studies in the elderly are lacking in the literature, in order to see the outcomes of this medication, clinically, the effects are evident. Caffeine has a weak diuretic effect and may worsen urinary incontinence. It also can cause increased excitation, insomnia and, hence, decreased daytime recovery sleep in the middle-aged patients if taken close to bedtime. The effect of caffeine in the elderly should be considered when scoring neuropsychological assessments. In test patients, recent consumption of caffeine-containing products showed a linear decrease in performance with increasing age. Contrarily, studies have called for further research in the association of caffeine’s potential neuroprotective functions in cognition and Alzheimer’s Disease. Clearly, caffeine comes in many forms, not just from OTC medications, and prescribers should be aware of its presence when providing recommendations.

Highlighted here are a few of the specific ingredients in Excedrin; however, practitioners need to exhibit cautious skepticism when recommending OTC products in the geriatric population.

Dr. Heather Sakely is a clinical pharmacist in geriatrics and family medicine at UPMC St. Margaret; she can be reached at sakelyh@upmc.edu. Dr. Mansoor Alam is completing his fellowship in geriatric medicine at UPMC St. Margaret; he can be reached at alamm@upmc.edu.

REFERENCES
2. JAGS 2007; 55(6): S373-S382
4. www.excedrin.com
**Compliance with Red Flag Rules: Identity Theft Protection Program Requirement**

**PAUL J. WELK, PT, ESQ**

On December 4, 2003, the president signed the Fair and Accurate Credit Transactions Act of 2003 (FACTA). FACTA directed a number of federal agencies to issue joint regulations regarding the detection, prevention and mitigation of identity theft and to issue guidance regarding policies and procedures for users of consumer reports in certain circumstances. On November 9, 2007, the Federal Trade Commission (FTC), in conjunction with other federal agencies and pursuant to FACTA, published the Red Flag rules (rules). Among other things, the rules define what a creditor must do to implement an identity theft protection program. The FTC has delayed the compliance date for the rules on multiple occasions, most recently indicating that it would delay enforcement until August 1, 2009.

Before addressing the rules themselves, it is important to briefly review the applicability of the rules to health care settings. Many readers may recall that the American Medical Association (AMA) argued that health care providers (providers) are not covered by the rules because providers do not fit into the definition of a “creditor.” Furthermore, the AMA argued that, even if providers are deemed to be creditors, they are already required to comply with the Health Insurance Portability and Accountability Act (HIPAA) and therefore should not be subject to the additional requirements of the rules. Despite the AMA’s arguments, in a letter to the AMA dated February 4, 2009, the FTC stated that the “plain language and purpose of the rule dictate that health care professionals are covered by the rule when they regularly defer payment for goods and services.”

Given the FTC’s position that the rules apply to providers, it is important for all providers to have an understanding of the rules and their compliance obligations. An analysis of the rules and the requirements of an identity theft protection program are best addressed through the summary and analysis below.

- **Step One:** Is the provider a creditor? A creditor under the rules includes any person who regularly extends, renews or continues credit. Under this definition, if a provider permits a patient to pay for health care services after those services were furnished or through some type of deferral or installment payment, the provider is a creditor.

- **Step Two:** Does the provider offer covered accounts? The rules define “covered account” to mean an account that a creditor offers or maintains which is primarily for personal, family or household purposes that permits multiple payments, and; any other account (including a business account) that a creditor offers or maintains for which there is a reasonably
foreseeable risk of identity theft. A provider who permits multiple payments to be made on an account, for example by allowing the existence of an unpaid co-payment or deductible, would be a creditor offering covered accounts under the rules.

- **Step Three:** Implementing a written identity theft protection program. If a provider is a creditor and offers covered accounts, the provider is subject to the rules and must implement a written identity theft protection program (program). The specific nature of the program is dependent upon the size and complexity of the provider. In addressing the nature of a specific provider’s program, the above referenced FTC letter states that “a small medical practice with a well-known, limited patient base might have a lower risk of identity theft and thus might adopt a more limited program than a clinic in a larger metropolitan setting that sees a high volume of patients.” The rules provide the following guidance to practices in implementing and developing a program:

(a) **Identify** the red flags applicable to the specific provider and incorporate these red flags into the program. Examples of red flags that may be applicable to the provider include a patient submitting a driver’s license or an insurance card that appears to be altered or forged or a patient’s signature that is an obvious forgery.

(b) **Develop** reasonable strategies for detecting the red flags applicable to the provider. This can be done by taking steps such as verifying the patient’s identification upon registration. A provider should periodically review the types of accounts that it offers to identify those accounts that qualify as covered accounts under the rules.

(c) **Respond** appropriately to a red flag that is detected. The rules require providers to develop responses for suspected incidents of identity theft and to mitigate the damages when it occurs. Examples of appropriate responses include contacting a patient believed to be affected by identity theft, ceasing collection efforts on an open account subject to a red flag and notifying applicable third-party payors of potential identity theft.

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Apologies to Mother Earth

Basil Albert Marryshow, MD

I stand here before you for beast and for man
To beg your forgiveness as surely you can
For each day that we've taken your bounties in hand
Enjoying your fruits though not tending the land
And ruling your vast kingdom without following your plan

We've not been responsible stewards of this planet
Without even the courage or the will to amend it
Once verdant forests and fields laid barren in haste
Teeming rivers and lakes made lifeless by waste
And we deny the capacity to understand it

Nations vie with each other for your dwindling resources
Issue ultimatums and marshal their forces
To take them with might and consider it is right
To enter one's backyard and engage in a fight.
What do we do then when they've run their courses?

The right to life or death is not our call
We are not that advanced a species after all
Animals are hunted and we still call it fun
To poison and maim them and force them to run
Or subdue them in camouflage and from an ocean trawl

Our sins are all there but we choose to ignore them
For selfish greedy minds will just not abhor them
We can't see the last chance for this the end game
"Technology will solve our problems", we so loudly proclaim
But nuclear, coal and oil, in time we'll deplore them

My world, you are choking and gasping for air
While megatons of noxious chemicals defile your atmosphere
On a daily basis, winning the battle for life as we know it
Upsetting your delicate balance-and how well you show it
Still we relentlessly continue with nary a care.

What can we say to our planet, limping so sadly?
From the excesses of man behaving so badly
We see you weep in Katrinas and Ivans and Ellens
We hear you sneeze in Vesuvius, Etna and St. Helens
Spewing ashes, destruction and rage in all directions so madly

We see your melting polar caps and the forlorn polar bears
Each day realizing our most urgent of fears
We see the dying bees and the monster frogs
And Amazon River barges half sunken with logs
And loudly you scream in protest, but no one hears

You will survive these insults, I know that you will
You will keep on spinning and time will stand still
To give you space, in an eon or two
To recover yourself and start life anew
With simpler creatures, from the quiet and chill

Plankton, amoeba and beasts yet unfurled
Would surely be friendlier to this beautiful world
And you will remember in your own special way
The utter folly of mankind who had nothing to say
But plundered and raped you at the expense of us all

Shall we compose a requiem for when you will die?
And affix the blame where it surely must lie
And not point a finger and claim "it's not me"
For we're all your keepers and keepers should be
More diligent and careful and concerned when you sigh

So I stand here before you for beast and for man
To beg your forgiveness as surely you can
Please let us go quickly though damnation we've earned
For our thoughtlessness and disregard of signs yet unlearned
Please spare us your wrath if it fits in your plan
This I beg of you.

Thanks to Dr. Marryshow for again sharing his creativity with our readers. Dr. Marryshow is a retired orthopaedic surgeon, who served for many years on the Bulletin's Editorial Board. We welcome submissions of poetry, cartoons and short prose. Please e-mail bulletin@acms.org.
(d) Identify an individual to oversee, administer and update the program. This individual is responsible for reviewing and updating the program based upon developments such as actual incidents of identity theft, changes in identity theft prevention mechanisms or other similar events. The practice’s governing body (for example, its board of directors) should take formal action to adopt the program. The program’s administrator should report at least annually to the practice’s governing body in writing regarding the provider’s compliance with the program.

(e) Train the provider’s staff regarding the program. The required level of training for each employee is dependent upon the employee’s specific job duties. The level of training may range from a general overview to a specific and detailed training session for those employees handling covered accounts.

(f) Review third-party service provider arrangements. The practice’s service providers must develop and implement appropriate policies and procedures to detect, prevent and mitigate identity theft. For example, a practice would be required to ensure that a third-party billing service has such policies and procedures in place and has a mechanism to report potential or apparent identity theft to the practice.

In addition to the identity theft provisions of the rules, they also place certain obligations on practices that use or request consumer credit reports, for example, as a part of a pre-employment process or relative to a patient account. Basically, the rules require the practice to implement policies and procedures to enable the practice to form a reasonable belief that a consumer credit report relates to the consumer about whom it was requested. Practices that furnish information to credit reporting agencies have additional duties relating to furnishing an accurate address to the agencies. These requirements apply in those cases where the practice receives notice of an address discrepancy from a credit reporting agency.

Finally, while the rules also place additional obligations on credit and debit card issuers, these obligations are unlikely to apply to most practices and therefore not addressed in this article.

In summary, effective August 1, 2009, a creditor that offers covered accounts must implement a written identity theft protection program designed to detect, prevent and mitigate identity theft. Although the above analysis may at first appear onerous, in many cases a practice will likely be memorializing the informal policies and procedures it currently has in place while at the same time promoting sound business practices and satisfying its compliance obligations under the rules.

Mr. Welk is an attorney with Tucker Arensberg P.C., where he frequently advises health care providers in the areas of corporate and health care law; he can be reached at pwelk@tuckerlaw.com.

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**Reportable Diseases 2009: Q1**

**Allegheny County Health Department**

**Selected Reportable Diseases**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Jan-Mar 2009</th>
<th>2008</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campylobacteriosis</td>
<td>17</td>
<td>101</td>
<td>76</td>
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<tr>
<td>Cryptosporidiosis</td>
<td>2</td>
<td>21</td>
<td>17</td>
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<tr>
<td>E. coli 0157:H7</td>
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<td>7</td>
<td>11</td>
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<tr>
<td>Giardiasis</td>
<td>14</td>
<td>96</td>
<td>47</td>
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<tr>
<td>Guillain–Barre Syndrome</td>
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<td>9</td>
<td>4</td>
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<tr>
<td>Hepatitis A</td>
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<td>9</td>
<td>19</td>
</tr>
<tr>
<td>Hepatitis B (acute)</td>
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<td>24</td>
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<tr>
<td>Hepatitis C (confirmed)</td>
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<tr>
<td>Legionellosis</td>
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<td>Shigellosis</td>
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<td>AIDS</td>
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<tr>
<td>Carbon Monoxide Poisoning</td>
<td>5</td>
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</tr>
</tbody>
</table>

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.
The current bear market has caused many of us to re-evaluate our financial plans. While some have responded by panic selling, others have made only modest changes or maintained their current portfolios. Now that the damage has been done, should you change your financial plan?

Before doing anything, realize that, while the current value of your portfolio has dropped, your ownership of the underlying assets has not. Although stocks may fall further and declines can last for decades, most markets recover in less time. To participate in the strong and unpredictable rallies that usually end bear markets, you need to remain fully invested. The reason most long-term investors only receive about half of the long-term market return is that they fail to understand that “time in the market” is far more important than “timing the market.”

Even if you need to liquidate part of your portfolio for living expenses, you can start by selling your fixed income (bond) investments. Calculating how long you can live on your investment income and fixed income investments before you need to sell equities (stocks) will tell you how many years your portfolio can wait for equity prices to recover. The limitation of this approach is that selling fixed income investments gradually increases your equity allocation and risk over time.

While waiting for the markets to recover, you will also continue to receive dividend income from your equity investments. During the great depression, dividends fell by 75 percent in 1934 compared to the pre-crash amount, but stabilized for the next five years at 50 percent of the pre-crash amount. You do get “paid” to continue holding equity.

With these perspectives in mind, you may want to revisit your asset allocation: the division of assets between equity and fixed income. A good “rule of thumb” is to hold your age in fixed income and the remainder in equity. Gradually reducing your equity as you approach retirement decreases the risk of experiencing a bear market when your investment horizon is short, but provides enough growth to keep up with future inflation. Keep in mind that portfolios with a minimum equity position of 20 percent have higher returns and less volatility than an all-bond portfolio.
Young investors in the accumulation phase with many years until retirement are best served by continuing to buy equities according to their planned asset allocation model. For older investors approaching or already in the distribution phase where they may need to liquidate their assets, there are three possible approaches.

The first option is to “stay the course” and maintain your asset allocation by purchasing equity. Although during the great depression the Dow did not permanently pass through its 1929 high until 1954, investors recovered their losses sooner if they reinvested in equities after 1929. This approach is useful if higher future inflation causes fixed income investments to decline in value as interest rates rise. The risk of this strategy is that the markets may not recover in your investing lifetime. To quote John Maynard Keynes, “The market can stay irrational longer than you can stay solvent.”

The second option is to reduce your equity allocation by five to 10 percent every few months until you reach your comfort level or “sleeping” point. You actually default to this option if you do not rebalance and the market reduces your equity allocation for you. Although this strategy provides downside protection if equities fail to rebound, you lose the opportunity to recoup your losses if the market eventually recovers.

The final option is to sell your equities and purchase money market funds or short term bonds. Although this may allow you to sleep better in the short term, you lock in your losses and the opportunity loss will be even greater if the market bounces back. Selling low may not be the best remedy for not having sold high!

Which approach you take should depend on your time frame, need and ability to accept the downside risk that the markets may not recover for years. The conventional wisdom is to batten down the hatches and stay the course, but you may have to modify your plan if you can’t sleep at night or your investment goals have changed.

Dr. Weinstein co-authored a Retirement Planning chapter in J.K. Lasser’s Expert Financial Planning and currently teaches an annual Financial Planning course at the American Academy of Ophthalmology. Dr. Weinstein also serves as associate editor of the ACM Bulletin. He can be reached at garyweinsteinmd@aol.com.
The Need for Regional Demonstrations in Containing Costs and Improving Quality

Karen Wolk Feinstein, PhD

The tenets of President Obama’s health care reform program are clear: universal health coverage, modernizing the health care system, and promoting wellness and prevention. But the success of his health care agenda depends on restraining the runaway growth of health care costs and, most of all, eliminating waste—the 40 percent of all health care spending that doesn’t help patients and in some instances actually hurts them.

Hospital cost is the largest component (35 percent) of our national health care bill, and those who suffer from serious chronic illnesses (e.g., congestive heart failure, pneumonia, depression, chronic obstructive pulmonary disease, diabetes and asthma) are the most frequently hospitalized, are at highest risk of repeated hospitalization and account for three-quarters of total health care costs. With good reason, therefore, the president’s FY2010 budget stresses cost containment through the prevention of recurring, avoidable hospital admissions.

The simple, effective path to cost containment is improving patients’ health status, helping them to participate fully at home and at work, and keeping them out of the hospital. In fact, these priorities enable us to understand where and how costs can be removed and quality improved. But we need to know more about what works and what protects quality of care, while restraining cost. That’s why regional demonstrations like those conducted by the Pittsburgh Regional Health Initiative (PRHI) are so important.

With support from the Jewish Healthcare Foundation, the Fine Foundation and Staunton Farms Foundation, PRHI has just launched its latest regional demonstration, Integrating Treatment in Primary Care (ITPC), a project with national implications for improving patient care and reducing unnecessary hospitalizations among those who are at highest risk. Five community health centers will participate: UPMC C St. Margaret New Kensington Family Health Center, two practices from Southwestern Pennsylvania Human Services and two practices from Cornerstone Care.

ITPC will focus on a particularly important aspect of preventing hospitalizations. Readmission rates are highest among chronically ill patients who also suffer from depression or substance use problems. One-third of patients with chronic illnesses readmitted to area hospitals within 30 days of initial discharge also suffer from depression or alcohol and drug abuse issues. Four of five patients readmitted within 90 days of discharge are similarly afflicted. These behavioral problems cause longer hospitalizations, more frequent emergency room visits, increased use of medical services and much higher health care costs.

Southwestern Pennsylvania is a good target for a demonstration in this area of health care. The Pittsburgh area has the third-highest rate of hospitalization among Medicare beneficiaries with serious chronic illnesses.
Steve Taminecz (front facing), a lean implementation specialist at PRHI, helps workers from UPMC St. Margaret New Kensington Family Health Center and Southwestern Pennsylvania Human Services define their shared vision for collaborative care.

Tina Hahn (center, standing), project manager, and Karen Wolk Feinstein (right, standing), president and CEO of PRHI, help workers at Southwestern Pennsylvania Human Services develop a process map of the current state of patient care.

attributable to preventable hospitalizations connected to chronic diseases total $4 billion. Worst of all is the toll on patients: for those who are admitted to hospitals for chronic disease-related illnesses, 30-day readmission rates range from 15 percent to 30 percent; 12-month readmission rates are 30 percent to 50 percent.

Hospital readmissions can result from breakdowns in patient care during hospitalization, during the discharge process, after a patient leaves the hospital or all of the above. Such issues, of course, are magnified if a patient is depressed or struggling with a substance use problem. In these cases, patients are less likely to fill a prescription, take medications according to instructions or schedule follow-up visits with their doctor; those propensities add up to more hospital readmissions.

Staff at each of the participating community health centers recently received joint training in three evidence-based methods: the Chronic Care Model for managing the care of patients with chronic disease; Improving Mood and Promoting Access to Treatment (IMPACT) for depression; and Screening, Brief Intervention and Referral to Treatment (SBIRT) for unhealthy substance use.

Rather than three practitioners working separately, an entire care team led by the primary care physician will collaborate on a patient’s treatment plan. The project will also test the inclusion of a pharmacist and a behavioral health care manager as part of the primary care team. Since not all interventions and services are reimbursed today by public and private payors, unreimbursed services will be paid for as part of the demonstration project with the explicit purpose of making the case for permanent reimbursement policy changes.

In the short run, these interventions will cost more money. But the theory is that standardizing (and paying for) specific, coordinated patient interventions in the primary care setting will improve affected patients’ mental and physical health, and will eliminate the need for thousands of hospital admissions and readmissions in Western Pennsylvania. This is what must be tested and demonstrated.

The unique importance of regional projects like ITPC is in testing the feasibility of new concepts, including real-life effects on patients and providers, before the nation leaps to widespread policy change. By supporting and conducting regional demonstrations and making policy changes based on what’s learned from such projects, the federal government (especially Medicare) can move forward expeditiously on a long-term, cost-containment strategy that improves patient outcomes.

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Dr. Wolk Feinstein is president of the Jewish Healthcare Foundation of Pittsburgh and founding co-chair of the Pittsburgh Regional Health Initiative. She can be reached at info@prhi.org.
In recent years, there have been reports in medical literature and in the general press identifying a trend among some physicians. These articles assert that there are increasing numbers of physicians working in areas that may be considered another physician-specialty’s “turf.”

Authors writing about specialty areas in one publication comment that Medicine may always have experienced some low level of “disruption of territorial boundaries” among physicians—sometimes resulting in improved overall care and sometimes motivated by more expedient goals and resulting in a redistribution of compensation rather than in added patient benefits.1

Now, however, changes in boundaries between specialties are becoming more common. In addition, physicians today are more frequently experimenting with adding auxiliary services to try to increase revenues. In some cases, these auxiliary services represent services that have typically been in the territory of another specialty (such as when family physicians offer microdermabrasion). In other instances, the auxiliary services are quasi-medical (such as when dermatologists expand their offices to include therapeutic massage services).

Often a physician's decision to offer extra services has been motivated by the desire to increase practice revenue, especially in geographic areas or in time periods when revenues have been slowing or falling. Medical practice consultants have encouraged physicians to expand their practices. For example, an article in Medical Economics magazine on “boosting the bottom line” of a physician practice advises that:

At a time of stagnant or diminishing reimbursement rates, adding an ancillary service might just be the stimulus your practice needs.
stimulus your practice needs... Patients pay out-of-pocket for Botox injections and other cosmetic procedures, as well as for non-traditional services such as acupuncture and massage therapy. And why send patients elsewhere for labs, X-rays and nutritional counseling when you can provide these in your office and reap the financial benefits?2

There are a number of examples of physicians taking on new and different duties that they may traditionally not have done—either by virtue of their chosen specialties or just by virtue of their being physicians. In advertisements and medical literature, you can find instances of:

- family physicians who are offering nerve conduction studies, stress testing, colonoscopies, microdermabrasion, injections for varicose veins, tattoo removal or laser hair removal;
- obstetrician/gynecologists who are offering microdermabrasion, laser hair removal and other cosmetic procedures such as Botox and Restylane injections;
- dermatologists who are opening “medi-spas” and offering services such as massages, manicures and pedicures; and
- internists who are taking X-rays in their offices and reading them on site.

There is nothing inherently wrong with learning and offering a new procedure. Nevertheless, this activity generally brings increased liability risk. The increased risk can be acceptable or unacceptable based on individual circumstances. The liability risks linked to the new service are likely to be manageable if you research the ramifications of making available a new service; receive proper training in how to give the new service; understand and comply with laws and regulations and administrative constraints associated with offering the service; and train office staff members to appropriately and competently participate in treatment. On the other hand, if you hastily or imprudently introduce a new service, the liability risk may be adverse.

If you are considering expanding into a new area of practice, especially one that is outside the usual scope of practice, continued on page 230
your clinical field, or if you have already taken steps to do so, the following tips may assist you in limiting your malpractice risks:

- Get appropriate training so that you can competently perform the procedure you want to offer. “Some of the worst damage we’ve seen was inflicted by untrained physicians who thought they knew how to use a cosmetic laser,” says the director of the Maryland Laser, Skin and Vein Institute in an article about risks of laser hair removal. What’s true for cosmetic laser procedures is true for any new procedure you want to perform. Obtain sufficient training before you begin doing new work. Consider training programs that allow for proctoring while you gain experience, if this type of program is available. In addition, if you decide to train a staff person in your office to help with or perform a procedure, make sure you develop and follow a plan for this training that ensures the person is properly trained and has suitable back-up and supervision when treating patients.

- Make sure you are doing enough procedures to keep your skills sharp. After you begin offering the new service and as you build your patient base, analyze the situation periodically to determine whether or not the volume of business is high enough for you to maintain competency in performing the procedure.

- Meet appropriate standards of care. Check to see what standards and guidelines exist for the procedure or service you are offering. Also, check to see if another specialty group besides your own has promulgated guidelines. For instance, internists who read X-rays will be held to the same standard of care as radiologists and should understand and follow pertinent guidelines from the American College of Radiology.

- Have a plan for coping with side effects and poor outcomes. Even if you have received excellent training and have well-honed skills, you will have varying results in procedures you perform. Occasionally, despite your best efforts, a patient may experience side effects or have a substandard outcome. Have plans in place—including referral plans—for what to do to assure that patients get the best possible care in adverse circumstances. When possible, give written instructions to patients outlining signs and symptoms that may indicate a side effect or complication. If a patient reports a problem, agree to see the patient promptly instead of simply offering phone advice. If referral to another specialist is required to deal with a problem, maintain contact with the patient and offer support until the problem is resolved. Such actions indicate an attitude of caring about the patient and concern about resolution of the problem.

- Consider how to situate new equipment in your office. The new service you want to add will likely require you to purchase or lease equipment. Health care consultants advise considering where new equipment will be physically situated in the office. “If (an) ancillary service requires machinery and other equipment, make sure your office can accommodate the new gear,” one consultant advises. “If you don’t have sufficient square footage, you’re going to have to spend money on page 179 of the April Bulletin, Donna Kell’s telephone number was printed incorrectly; the correct number is (412) 381-5160. The editorial staff apologizes for this error.
to add and outfit space so that you can deliver the new service safely and conveniently.2

- Appropriately maintain and sterilize equipment. Patient safety and quality of outcome are related to proper equipment maintenance and calibration. You have the responsibility to provide safe patient treatment equipment, and you can face liability if faulty equipment causes patient injury. Performing routine preventive maintenance will help to keep medical devices and equipment at an optimum level of operation and will reduce the risk of malfunction. Have procedures in place for maintenance, calibration and cleaning of all patient care and diagnostic equipment. Equipment should be maintained, at a minimum, in accordance with the manufacturer’s recommendations, and all maintenance and repairs should be documented. In addition, you have a responsibility to minimize exposure of patients to contaminants. You should follow manufacturers’ guidelines for equipment and instrument sterilization. Consider developing and maintaining a log to document sterilization of instruments and equipment used in office procedures. Documenting the sterilization process will aid in defending against allegations of negligence if a patient asserts that he or she became infected after undergoing a procedure in the office.

- Check with your liability insurance carrier to be sure you are carrying an appropriate level of malpractice insurance to cover the new procedure. Sometimes opting to offer a new procedure may require you to move to a different level of professional liability coverage. Discuss your plans for adding an extra service with your insurance underwriter to be sure you have the coverage you need.

This material is intended to provide information on risk management issues and is not legal advice. Ms. Davis is a project manager in risk management for PM SLIC Insurance Company. She can be reached at kdavis@pmslic.com.

REFERENCES
3 In the wrong hands, hair removal can cause burns, scars, pigment changes. The Washington Post. May 7, 2002, F-05.

Poison Pen

Plant and mushroom exposures — Should we be concerned?

Most plant and mushroom exposures are relatively innocuous events. The Pittsburgh Poison Center has never documented a fatality due to the ingestion of a plant, and deaths due to mushroom poisoning are extremely rare. However, folklore often creates panic and unnecessary therapeutic intervention (e.g., emesis, gastric lavage) following the ingestion of a botanical or an unidentified mushroom.

In 2008 the Pittsburgh Poison Center managed 1,447 patients who were exposed to botanicals and 100 who ingested mushrooms. In the majority of those exposures, removal of the plant or mushroom debris from the oral cavity was adequate intervention. A minimal number of plants such as the dieffenbachia, caladium, philodendron and pothos may cause minor oral or gastrointestinal irritation, and dilution with a beverage usually suffices. The ingestion of “red berries” is treated the same way. While uncommon, if someone develops toxicity, symptomatic therapy (which rarely necessitates a visit to the emergency department) is implemented. In a recent study (J Emerg Med 2007;33:381-383), we reported our experience in the management of 322 pediatric patients who ingested “backyard” mushrooms. Only 9.6 percent had minor symptoms associated with the exposure; the majority were asymptomatic and required no therapy. The most common nuisance plant is poison ivy, which produces its classical dermatitis and must run its course. For ocular, dermal and oral exposure to peppers such as the jalapeño, we have yet to find a good remedy, other than simple decontamination and time. Most of the annual plants which adorn home gardens are relatively nontoxic.

However, a limited number of nature’s plants and mushrooms are highly toxic. There are hepaticotoxic mushrooms in western Pennsylvania and, if a suspected ingestion occurs, the Pittsburgh Poison Center can facilitate the identification of the mushroom and provide contemporary treatment advice. Water hemlock and poison hemlock are very poisonous and require immediate attention, but these exposures are rare. Jimson weed and related plants, which are abused for their hallucinogenic properties, can produce profound anticholinergic toxicity.

If you or your patients require Poison Help in managing a plant or mushroom exposure, contact the Pittsburgh Poison Center at (800) 222-1222. The center’s professional staff provides 24/7 emergency poison information and medical toxicology consultation.

Information for this column was provided by Edward P. Krenzelok, PharmD, F-AACT, DABAT, who serves as director of the Pittsburgh Poison Center at the University of Pittsburgh Medical Center. He can be reached at krenzelok@upmc.edu.
A Report from Haiti

Daniel R. Lattanzi, MD

I have been working in Haiti for the past 12 years. During this time, various physicians and health care providers together established a health clinic and a maternity center. Recently a team of physicians, Drs. Dayle Griffin, Margaret Larkins-Pettigrew, Anthony Sico and I, visited the health center. Although we had many goals, our primary focus was to establish a working relationship with local birth attendants and maternity center staff.

Built two years ago, the maternity center provides birthing rooms and eight post partum beds for the patients. Three trained midwives staff the center. Many infant and maternal deaths still occur because of the practices of the traditional birth attendant. Though the birth attendants have limited training, they provide the majority of the delivery services in the home. Some were placing goat dung on the umbilical cord stump of newborn infants, which eventually led to neonatal tetanus. Others were using witchcraft during the delivery that limited the attention paid to the mother. Women were dying from post partum hemorrhage and severe pre-eclampsia; 30 percent of the pregnant women tested positive for malaria.

A prenatal program was made available that provided pregnant women with vitamins, chloroquine and mosquito nets to prevent anemia and malaria. To further improve newborn and maternal care, improved coordination and cooperation were necessary between traditional birth attendants and trained midwives. At a meeting called to improve care for all women, the program presented was Fanm Pa dwe Pedi Lavi N an Bay Lavi, which translates: “No women should lose her life while giving life.” Thirty birth attendants were present along with our birthing center staff. Dr. Larkins-Pettigrew presented a program focusing on safe delivery and prevention of complications related to delivery. Birthing packs were made available to the birth attendants at the meeting and their multiple benefits were discussed; these packs included triple dye for the umbilical cord, plastic sheets for the protection of the mother during delivery, sterile scalpels, baby hats, perineal cleansers and suction bulbs.

After a lunch of rice and beans, Dr. Griffin discussed proper care of the newborn, emphasizing maintaining proper newborn temperature and infant resuscitation.

Continued on page 235
As medical professionals and members of the health care community, we have the privilege of sharing our knowledge and our concern for others to help people in need. This is especially true in these hard economic times when we need to focus on the basics of delivering care.

Operation Walk is a group of volunteers who share the “wish to walk” around the world and in our own backyard. Here in the United States, physicians cure patients with arthritic hips and knees and return them to a very active lifestyle through sometimes magical, always life-altering, joint replacement surgery. However, in many developing countries, this opportunity simply does not exist.

Operation Walk was founded in 1994 by Dr. Lawrence Dorr, who practices medicine in Los Angeles. Now, 15 years later, Operation Walk has nine different sites across the country and Canada with Pittsburgh joining as the newest team. Operation Walk Pittsburgh is a not-for-profit volunteer medical service program that provides free surgical treatment to patients with disabling arthritis in developing countries. Operation Walk also educates in-country orthopaedic surgeons, nurses, physical therapists and other health care professionals on the treatments, processes and surgical techniques for diseases of the hip and knee.

The Operation Walk Pittsburgh team will travel annually to countries all over the world to provide these life-transforming surgeries. In August, the Pittsburgh team—consisting of Drs. Anthony DiGioia, Michael Weiss and Anton Plakseychuk (all surgeons), Drs. Saryu Desai and Anna Uskova (anesthesiologists), and internist Bob Bernstein, M D—will make its first trip to Antigua, Guatemala. The team hopes to provide 60 to 70 patients with new joint replacements during its one-week stay there. In November the group will participate in Operation Walk Pittsburgh giving several families in the region something to truly be thankful for at Thanksgiving. The Pittsburgh Operation Walk team is the only chapter in the country undertaking a local aspect of this work to provide surgeries for patients in need within our own neighborhoods and the tri-state area.

Our goal is to provide hip and knee replacement surgery that will truly be a transformational experience for people in desperate need, but 100 percent of the trip

continued on page 235
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Dr. Sico discussed proper techniques for laceration repair. Pig legs were brought in from the market as models for suturing practice. A lively discussion regarding pregnancy-related problems ensued. The final result was the establishment of a comfortable environment for the traditional birth attendant at the birthing center. The midwives are committed to supporting the birth attendants as all present improved their skills at delivery.

Our team looks forward to our next visit to Haiti to provide additional services and information for the staff.

Dr. DiGioia is an orthopaedic surgeon in the Pittsburgh Area who heads the Operation Walk Pittsburgh team. He can be reached at tony@pfcsusa.org. Ms. Harmon can be reached at jharmon@mail.magee.edu or (412) 641-8645.

Dr. Lattanzi is an obstetrician/gynecologist. He can be reached at danlinda15@aol.com. The ACM awarded Dr. Lattanzi its Physician Volunteer Award in 2003. For more information on the award or on his work in Haiti dating back to 1996, see Bulletin, April 2004, page 191, “Daniel Lattanzi, M.D.: 2003 ACM Physician Volunteer.” To view online, visit www.acms.org click on “Bulletin Information” and select “Past Issues.”

expenses, supplies and staff must be provided by the Operation Walk Pittsburgh team. Our partner organization, the AMD3 Foundation, supports Operation Walk Pittsburgh efforts by raising funds from dedicated individual donors and sponsoring corporations.

We hope that you will join us in our commitment to grant the “Wish to Walk” for patients everywhere and become a supporter of Operation Walk Pittsburgh. Our team will be expanding in the coming years and will need medical professionals with the expertise and dedication to truly make a difference. You can contribute your time, medical supplies and monetary support to make possible the missions here in the Pittsburgh region and around the world. For more on helping to grant the Wish to Walk, visit www.operationwalkpgh.org.

Dr. Lattanzi is an obstetrician/gynecologist. He can be reached at danlinda15@aol.com. The ACM awarded Dr. Lattanzi its Physician Volunteer Award in 2003. For more information on the award or on his work in Haiti dating back to 1996, see Bulletin, April 2004, page 191, “Daniel Lattanzi, M.D.: 2003 ACM Physician Volunteer.” To view online, visit www.acms.org click on “Bulletin Information” and select “Past Issues.”

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The Allegheny County Medical Society Board of Directors met on February 17, 2009. Board Chair Adam Gordon, M.D., called the meeting to order at 6:10 p.m.

Board members began this meeting by providing their names, specialty and hospital affiliation, and by identifying what they believe to be the highest priority for the medical society in 2009. Dr. Gordon proceeded by outlining the responsibilities of the ACM S Board of Directors and providing them with pertinent reference materials.

New Business
The board approved the appointment of Daniel Pituch, M.D., and Deval Paranjpe, M.D., to the ACM S Board of Directors for 2009, as recommended by the executive committee, as well as the second year of a three-year term for the Bulletin’s medical editor, Dr. Scott Miller.

Next, ACM S President Douglas Clough, M.D., briefly reviewed the medical society’s strategic plan and business plan, noting that it was a work in progress for the executive committee and board of directors. The board approved the plan with revisions; the revised plan will be circulated to board members.

The board then discussed this year’s ACM S Gala held in January. Board members noted their approval of the new format that emphasized fundraising for the ACM S Foundation, and it voted to create a gala committee to plan the 2010 event with the primary charge of increasing both the number of auction items and attendance. Members of the new ACM S Gala Committee include: John Delaney Jr., M.D. (chair); Rose Delaney, Dr.PH.; Doris Cope, M.D.; Adriana Selvaggio, M.D.; Deval Paranjpe, M.D.; and Brian Miller, M.D. Other members may be added as needed.

In a final action, the board approved the position statement: “Ethical Responsibilities in Change in Affiliation of Medical Practices or Separation of Employment.” (See sidebar on page 237.)

Reports
James Ireland, ACM S assistant executive director, reported that renewal statement reminders have been mailed. The medical society is initiating a direct mail campaign from each member of the board of directors and is implementing a trial membership campaign with Pennsylvania Medical Society. Medical staff visits by the officers will be scheduled for the spring.

ACMS Executive Director John Krah noted the following:
- Auditors are completing the 2009 audit.
- Committee on Quality End of Life (CQEL) will be recognizing the 15th year for the ACM S-ACBA Living Will. (The form is being updated to reflect the new law governing living wills in Pennsylvania.)
- USI Affinity, the medical society’s endorsed insurance program, recently noted a 98 percent retention rate in January medical program renewals.
- Liberty Mutual, auto and homeowners insurance programs, now has 60 policies in force.
- PNC Merchant Services program has been initiated and is experiencing office enrollment.
- The ACM S Medical Supply Program is on track and growing, showing increasing returns.
- Red Bag Waste Management, a program in collaboration with the Hospital Council of Western Pennsylvania, is now operational and will be offered to membership.

Chandan Khandai, M.S.I., who serves as the board’s medical student representative, reported that medical students at the University of Pittsburgh School of Medicine will focus on community organization projects, health insurance and educating membership. The board’s resident representative, Brian Miller, M.D., reported that many young physicians are unfamiliar with the medical society and it is difficult to keep resident physicians informed on activities. He suggested that a one-page e-mail of “hot topics” would be a quick and handy reference on the actions of the society.

The Primary Care Work Group, under the leadership of Drs. Lawrence John and Anthony Spinola, will update the group’s work in an article in an upcoming issue of the ACM S Bulletin. The group will be meeting with State Representative Dan Frankel, chair of the Allegheny County Democratic Delegation, on February 19. Efforts are underway to host a Primary Care Summit this fall with a nationally-known speaker; preliminary discussions have been held with Highmark and UPMC Health Plan to sponsor this program. Interviews have been provided to KQV Radio, the Pittsburgh Business Times and the Pittsburgh Post-Gazette.
Tribune Review. Other articles have appeared in Newsweek, Time and USA Today explaining the challenges of the primary care physician. (Editor’s Note: See article on page 184 of the April Bulletin for the Primary Care Working Group update.)

Reporting for the PMS Trustees, Paul Dishart, M.D., noted that PMS has been working with the governor’s office to address M care. The Pennsylvania budget has a projected $2 billion deficit. The Pennsylvania Medical Society has filed a legal action against the state to preserve the M care fund from being used for the general budget deficit.

Dr. Clough noted that the ACM S committees have been finalized and that he appreciates the board’s enthusiasm for the society’s upcoming activities. He looks forward to a challenging year.

This is a summary report. A full report is available by calling the ACM S office at (412) 321-5030. Board meetings are open to members. If you wish to attend, contact the society to receive a schedule and meeting agenda. The next regular Board of Directors meeting is Tuesday, June 9, 2009.

Ethical Responsibilities in Change in Affiliation of Medical Practices or Separation of Employment

Continuity of patient care and choice of physician are of utmost importance when there is a change in ownership or affiliation of medical practice with a hospital or in separation of physicians from employment.

Physicians have an ethical obligation to notify patients of changes in practice with sufficient notice to provide a smooth transition of care. The same considerations should be observed by institutions owning practices when a change occurs.

The AMA Council on Ethical and Judicial Affairs provides this guidance:

- The patients of a physician who leaves a group practice should be notified that the physician is leaving the group. Patients of the physician should also be informed of the physician’s new address and offered the opportunity to have their medical records forwarded to the departing physician at his or her new practice location.
- In most cases, when physicians make such a change in their practice, patients are notified and offered the choice to follow their physician or to see other physicians in the original practice, and the transitions are made smoothly.
- Competitive business interests should recognize the special and personal relationship that exists between a treating physician and patients and make every reasonable effort to assure that such transitions are handled in a timely and responsible manner to assure that patients’ interests and the ability to choose their physicians is of primary importance.

The Allegheny County Medical Society supports this policy and encourages all employing entities to ensure that patient access to their physician of choice is addressed in a courteous manner consistent with the above principles with any change of employment.

Thank You for your membership in the Allegheny County Medical Society

The ACMS Membership Committee thanks you for your support. Your membership strengthens the society and helps protect our patients.

Please do your part by encouraging your colleagues to become members of the ACMS. Membership applications are available online at www.acms.org.

Questions or Comments? Call the membership department at 412-321-5030, ext. 110 or e-mail membership@acms.org.
Help Wanted
IF YOU ARE an Internist, Family Practitioner or Emergency Medicine physician interested in new opportunities in this area, there are Primary Care opportunities north and south of Pittsburgh, and an Emergency Medicine opening in metropolitan Pittsburgh. These excellent opportunities are with a local independent group practice, a hospital-owned group practice, and the other is a hospital employed position. Contact Daniel Stern & Associates for all the job details. We have served the Pittsburgh area for over 40 continuous years, are members of the National Association of Physician Recruiters (NAPR) and abide by their Code of Ethics. We never divulge your information or send out your CV without your permission. For full details please contact Carla Anderson, Daniel Stern & Associates, 412-244-6434; fax 412-244-6430; or e-mail canderson@danielstern.com.

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