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Dr. Klein specializes in orthopaedic surgery.

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The polar vortex: Divide and conquer

Deval (Reshma) Paranjpe, MD, FACS, MBA

As I write this, the United States are on fire. Peaceful protests were happening in the name of justice for George Floyd, an African American whose pleas for mercy and eventual depraved killing under the knee of a Minneapolis police officer with a history of multiple brutality complaints were viewed by our stunned nation via damning video evidence. The peaceful protests gave way to rioting, looting and burning of local businesses; police and civilian cars were burned; policemen were killed, civilians injured and one photojournalist lost an eye to a rubber bullet in the chaos.

While liberals and conservatives assailed each other on social media and moderates clamored for peace, a strange phenomenon was quickly noted and publicized by officials across the nation this weekend, including in our own city of Pittsburgh. Our police chief stated unequivocally that it was not the peaceful Pittsburgh protesters who were instigating the violence; four white men dressed as anarchists started the mayhem and destroyed a police SUV and curiously spray-painted both anarchist and communist symbols (the latter completely going against the theme of anarchy). Undisciplined young people who came to the protest for the excitement joined in and accelerated the chaos; the real protesters left. The mayors of St. Paul and Minneapolis and the governor of Minnesota all stated that the instigators in Minneapolis were from out of state and had ties to white supremacist groups. Similar things were heard in cities all over the country – radical elements, often not from the area, were deliberately sabotaging the protests by acts of violence and rioting. Who are these people – anarchists, white supremacists, antiFa, or some unholy alliance of these strange bedfellows, all bent on destruction of our civil society? At this point, as I write this, we don’t know.

The net result of all of this, aside from the loss of life, injury and destruction of property? The story of George Floyd is being lost in the scuffle. The protests started out with the goal of demanding justice for Floyd in the form of more severe murder charges for the police officer who killed him, charges against the other three officers, ceasing of police brutality toward African Americans and, most importantly, a sea-change away from racism in America. Instead, the radicals succeeded in hijacking and drowning the protesters’ message and incited more division, fear, and anger on both sides. Only the radicals accomplished their mission this weekend; it is almost as if George Floyd were murdered twice. The nation’s attention has been diverted toward the nonstop images of riots, looting and arson. Instead, the nation’s attention should be focused on the very real and critical problem of racism in America; an opportunity for national dialogue and meaningful change has nearly been lost. Hopefully, the days ahead will be different. Don’t let that opportunity be lost on the personal level; check in with your African American patients, co-workers and colleagues, many of whom are inwardly hurting deeply in ways the those of us who are not African American cannot begin to fathom - unless we ask, and learn. Ask how they are doing; acknowledge their trauma. Educate yourself, and do whatever you can in your own sphere of influence to combat overt and covert racism.

This situation is emblematic of the divide-and-conquer strategy that is being used in every sphere in our country and our world. Issues and parties have become so polarized that people leave no room for civilized discussion and debate that could actually lead to a constructive and responsible solution. Talking heads on TV shout over each other. Political candidates shout over each other. The public is divided, and when a moderate voice speaks up, each side is quick to demonize that voice as belonging to the other side. The moderate voice is drowned
out and crushed. And when the time comes to make a choice, or to honestly appraise the failings of each side, a distraction inevitably to divert attention from the issues being discussed and further polarize people along a completely different issue. This distraction is equivalent to the riots. How many distractions have we had? One could argue that Russian interference in our elections, Chinese mendacity adversely impacting our public health readiness for the coronavirus, impeachment hearings, rabble-rousing tweets from 45 – all of it qualifies.

We the people are so distracted by the daily crises and polarizations that we ignore the forest for the trees. We ignore the moderate voice of reason and consider it a minion of the Other Side. The idea of arguing passionately with each other and then going out for a beer together sadly just doesn’t seem to exist anymore. Does the news media stoke this polarization for the sake of ratings? Absolutely. But do we, who should know better, buy into it? Sadly, too many of us do.

Now think of other issues besides politics. Think about the anti-5G activists who are burning down 5G towers and wearing tinfoil-lined hats and whose diatribes have led to the development of radio-frequency identification (RFID) blocking clothing lines (I kid you not). The radical elements of the movement delegitimize it in the eyes of the general public and the governments; when you think anti-5G, you think nutjob. A polarity is created; either you are anti-5G and therefore automatically a nutjob, or you are not against 5G at all and therefore sane. But what if there were a moderate voice with a legitimate complaint or question? For example, Joel Moskowitz, PhD, from UC Berkeley published an opinion piece in Scientific American (We Have No Reason to Believe 5G is Safe; October 17, 2019) citing that 240 leading experts in nonionizing radiation considered radio-frequency radiation (RFR) as a human carcinogen and called for stronger limits on electromagnetic fields (EMF) in the International EMF Scientist Appeal. He also pointed out that the U.S. Food and Drug Administration (FDA) (without a formal risk review or review of recent research to the contrary) reaffirmed the Federal Communication Commission’s (FCC) 1996 EMF exposure limits, and that 5G radiation would use millimeter waves which would, in theory, carry increased carcinogenic risk for humans as well as risks for plant and animal life. This debate may exist respectfully in the scientific community, but the evening news would lump Dr. Moskowitz in with the tinfoil hat crew and subject him to ridicule. The tower-burning radicals have silenced the moderates through distraction; you are now either pro-5G or a nutjob, with no room for discussion. This should not be the case. We should be able to have a conversation.

Now think of the bane of many of our existences, the anti-vaxxers. Their fiery rhetoric inspires our own fiery rhetoric to the point where dialogue often does not exist. A recent study of pro- and anti-vaccine Facebook pages done by GWU data scientist showed a startling truth: vaccine advocates are losing the battle for the hearts and minds of the undecided. While anti-vaccine pages may have less followers, they outnumber pro-vaccine pages and are actively engaging in dialogue with neutral pages with huge followings. In other words, they are dominating the conversation with the undecided. They are listening to questions and answering them in a myriad of different ways, casting diverse doubts and spreading viral misinformation. Pro-vaccine advocates on the other hand do not actively proselytize, and when they do there is only one message with less engagement, less listening, and less likelihood to entertain and convert doubters. Now imagine if a non-physician raised a legitimate question about the efficacy or safety of a vaccine or the trials involved to bring it to market. Imagine if a non-physician supported getting all the recommended vaccines but argued against receiving multiple vaccines on the same day. Would you consider the possibility that perhaps multiple vaccines on the same day are given for purposes of compliance and convenience and not scientific necessity? Would you engage, or instantly dismiss them as an anti-vaxxer nutjob and shout them down? Your answer and how you engage with the patient may determine whether the child in question is vaccinated, and may perhaps change or sway other minds in that parent’s community. Actively listening to and engaging the moderate voices and addressing their concerns is apparently the key to winning the war; our willingness to listen before opining gives us credibility in their eyes.

Lastly, think of our biggest current problem – COVID-19. Physicians have found ourselves in a strange place. Many of us have lost faith in the CDC’s credibility as an impartial scientific institution and consider it to have been hijacked for political purposes.

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given the issuing and retracting of questionable advice re: masks and viral transmission. Some of us are livid ever since they advised us to work wearing bandannas in the absence of actual PPE. There seems to be a power struggle in the CDC leading to the retractions, which gives some hope. On the other hand, the WHO’s credibility is considerably damaged. The problems began when it bowed to political and financial pressure from China to exclude Taiwan from data and response sharing in the COVID crisis, despite excellent containment measures in Taiwan. The problems deepened when the WHO advised that only symptomatic people, caretakers of COVID patients and healthcare workers should wear masks in March. We now know that asymptomatic transmission occurs regularly, and yet this recommendation has not been changed as of the day I write this. One could argue that politically and economically motivated misinformation from these bodies has hurt the moderate masses by leading to tactical errors in public health management and hijacked the mission of preventing spread. Leaving aside issues of testing and contact tracing, how many lives might have been saved if cloth mask wearing and social distancing had been encouraged from the start as it had been in Asian countries? Could we have avoided a long shutdown?

If you can’t believe the CDC or the WHO, who and what can you believe in? Your own medical training, your research and critical thinking skills, and your common sense.

Who can and will the general public turn to if not the CDC or WHO? YOU, that’s who.

At this time, it is crucial that physicians display leadership within our own spheres by staying up to date and informed on every development possible from discoveries about pathophysiology, treatment, potential preventive therapy as it arises, and vaccine progress. We also need to educate ourselves about hoaxes so that we can address them. We also need to encourage universal mask wear so that our economy can stay open without spikes and further lockdowns.

Although it may be hard to hold a long conversation while wearing an N95, remember: Don’t feed into the polarization. Resist the temptation to think in black and white. Our knowledge about this virus is continually evolving, and it’s OK to acknowledge that. Ask questions and be an active listener and then address concerns. People are angry because they are afraid, and because tremendous interpersonal conflicts have arisen within families where different members have different levels of knowledge, capacity for understanding consequences, and/or risk tolerance. Lastly, recognize, acknowledge, notice and name your own fears and anxiety about COVID-19. Is fear and emotional exhaustion perhaps making you bury your head in the sand and let down your own guard because you too are “tired of being afraid?”

Remember, the virus hasn’t changed, there is no vaccine yet, our county going “green” does not mean the pandemic is over, and our patients are depending on us for good advice.

Good luck and stay safe, my friends.

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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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Assessing risk

ANDREA G. WITLIN, DO, PHD

As physicians, we continually appraise risk in all aspects of our practices and during our admonitions to our patients. There is the standard litany of surgical risks that we parrot to our patients – infection, bleeding and injury to local structures (standard “line” for almost any surgical procedure). The cure rate or alternatively the recurrence (or death) risk associated with various cancer therapies is always included and demanded by our patients. Yet, over time, those perfunctory statistics and hackneyed pronouncements become mundane and their meaning blurs even for us.

At the same time, we tacitly accept many risks in our daily lives – driving (including driving post-call, driving after a few drinks at a restaurant), overeating (or poor dietary choices), smoking, flying and travel in general. For the most part, we do not even consider these as risks as they are pervasive in our lives and in society writ large. We learn as we age that our personal perception of our risk changes. We tend to view risks to our children or parents through a different lens entirely.

Initially, when I became “the patient,” those “standard” risks we recounted blithely to our patients took on a different meaning. I recognized it as cruel payback when I was first told the “standard” – infection, bleeding – but when the risk of pulmonary embolism or death was added to the list, I swallowed hard and winced. I wondered, is this what my patients really thought when I nonchalantly spoke those words?

What appears to be a small risk to a practitioner when they may never have had a patient of theirs experience such a complication fades … but that risk remains front and center for their patient, nevertheless. A seemingly innocuous readmission for an infectious complication, a prolonged hospitalization, C diff that resolves are just part of the process for the physician, but … for the patient? Physicians no longer make house calls. Most procedures are outpatient or short stay … the “real issues” associated with disease or surgery are never seen. By post-op or post-hospital visits, most issues have resolved and are forgotten. Really? By whom?

As a nation, we are all faced with a new unknown and incalculable risk from COVID-19. Economic risks are pitted against life and death (and everywhere in between). Red and blue are pitted against one another. The risks and viewpoints differ starkly depending upon which news outlet one watches (or reads). Our doctors and other healthcare providers are no less divided or concerned.

I’ve now had four video visits. They all start with – “Are you staying safe?” I have to give my providers credit for this introduction. But I’m not sure that they understand my trepidations. How can they? They can parrot the same risk factors that we hear in the news – older age, diabetes, heart disease, obesity. They can note the confluence of cases in nursing homes, jails, or meat packing plants. Racial disparities also skew risk. But, does any of that really make me feel better or safer? I try to press my docs for statistics on other patients with primary immunodeficiency or those with autoimmune diseases on immunosuppressive therapy. In reality, we all know that I am an N of one and none of that means anything. There are no peer review articles, no books written. No treatments, no vaccines. Only anecdote and urban legend.

How long can I stay under house arrest? How long until I feel safe? When does the risk of delaying routine follow-up tests, visits and procedures overwhelm my COVID risk? How long can I live in a bubble? I almost felt better whenever society was quarantined writ large. Now I feel that I am part of a forgotten group.

I have too many “free” hours to let my mind wander. I re-evaluate previous risks and behaviors. Have our recommended surveillance protocols

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been overrated? Were they really necessary? Skin cancer screening, colonoscopies, mammography and PSA testing, to name a few.

Who is safe to be around? What does it look like to be an asymptomatic carrier or spreader?

When we view the intense cleaning and sanitizing regimens of today – what does that say about the risks we took in the past? Would we have less incidence of flu had we all worn masks during flu season? What about incidence of food-borne illness – are all those salad bars so necessary or appealing?

I think what’s so different is the nature of COVID itself. Its (risk) is so different than everything else. In a way, it’s like the hidden risks at a restaurant – kind of like Russian roulette. But the disease manifestations are so unpredictable and all-encompassing. I’m a bit skittish of getting the flu, but I never assumed that if I did succumb to it that I would die from it. I figured that I would be miserable for a while and then take a bit longer than most to get back to baseline. I never worried that I would likely end up on a vent … for an indeterminable time and without family around (or that a family member would be in the same position without me being there to advocate for them). And although I’ve weathered some pretty daunting life-threatening complications, I had confidence that for the most part, I would be treated with the established protocols du jour that in time would work. Not so for COVID. I’d like to think that things are a little better now than at the beginning of this pandemic … but how much better, I don’t know. I can’t say that I was ever really fearful of dying of a complication of my many co-morbidities, but the thoughts that this is something totally out of my control and that my risk of mortality is high, and of death without family around, are really daunting.

I’ve always been a data-driven person, so I like to think that better statistics of the risk assessment would be helpful. Like many, I’d like to see better and more widespread testing. For starters, I’d like to know which of my providers and their assistants have been tested, what are the positivity rates at the facilities that I frequent, what has been the local experience treating COVID patients similar to me. I’d like to think that learning those numbers would be liberating. But I’m not sure.

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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.
Within a few generations of the Emancipation Proclamation, the social and political environment of the South became inhospitable for African Americans. In the three years known as the Great Migration, 1916 to 1919, over half a million African Americans fled the South seeking higher wages and a less hostile environment. During the great Depression in the 1920s, when sharecroppers were turned away from their farms and the Ku Klux Klan was on the rise as a home grown terrorist organization, more than a million African Americans left the South in an attempt to escape the rigid race-based social hierarchy, poverty, lack of educational opportunities and racial violence. With mob violence, lynching and intimidation to “keep them in their place,” many had no choice but to migrate to join relatives in Chicago, Detroit, Pittsburgh, New York, Portland and Los Angeles (Davis, R. 2003. The History of Jim Crow: Escaping Jim Crow).

The first historic disaster that affected African Americans in the United States was The Great Mississippi Flood of 1927. Incessant rain in the early summer of 1927 caused the Mississippi River to swell, weakening the levee system in Mississippi and New Orleans. The levee system was breached, causing large amounts of water to flood into the low-lying communities inhabited by African Americans (Slivka, J. 2005, Sept 12. Another Flood that Stunned America. U.S. News and World Report, P 26). The flood covered an area about the size of New England affecting seven states in its flood zone. History records 250 people killed and more than 700,000 displaced. Accurate records of African American births and deaths were never kept, so the true number of people killed or washed out to sea will never be known.

In 1927, government disaster protocols in New Orleans were filled with racial overtones. Evacuation opportunities and relief supplies went to whites first. Many of the rescue boats hauled whites only. African Americans were so low a priority during the rescue attempts that in some instances, animals (mules) were rescued before them. Some African Americans still living on plantations as laborers were held at gunpoint to prevent them from evacuating, fearing they wouldn’t come back (Barry JM. 1997. Rising tide: The Great Mississippi Flood of 1927 and how it changed America. New York: Simon & Schuster). To save the city of New Orleans, city leaders blew up the levee with 39 tons of dynamite in the marshland village of Caernarvon (no longer exists) 13 miles out of town, diverting the water at 250,000 cubic feet per second through the African American population residing in that marshland.

The second equally devastating event for African Americans was the Vanport Flood in 1948. Racial segregation and discrimination was not limited to the South. In Portland, Ore., non-white populations were excluded from social and economic equality. Very few African Americans lived in Oregon until the 1940s. The major employer was the Defense Industry. An Executive Order from President Franklin Delano Roosevelt prohibited discrimination in the defense industry. The president reassured the public that a job would be available for anyone who wanted it. That brought nearly 200,000 people to Portland, 15% of whom were African Americans. Whites resented this and

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would not house African American workers. The government made two housing projects for African Americans: Vanport and Guilds Lake. E. K. MacColl’s "The Growth of a City: Power and Politics in Portland," 1980, wrote that the Vanport housing project was built in a low-lying reclaimed swamp. African Americans crowded into the shanty town development because they had little choice where to stay. On May 31, 1948, at 4:17 pm, the rising river water broke the dike and Vanport was quickly submerged in 15 feet of water. Women and children drowned in that flood because the men were still at work. To avoid blame and the local spotlight, the total of dead was listed as 15 people, not acknowledging that the vast majority of the dead were washed downstream into the Pacific Ocean. No lessons were learned, and no preparation was done based on the Mississippi flood years before. Race was a major factor. Whites would not house the African American refugees. The African Americans that lived in areas other than the Vanport housing project tried to help as much as they could. Eventually, an abandoned shipyard island was used for dorms for those who chose to stay.

On Aug. 29, 2005, the most devastating hurricane to hit the United States, Katrina, made landfall in Southern Louisiana. The negative image of the inner city and its residents produced stereotypes about these communities and media coverage that constructs these residents as being irresponsible for their own well-being. In “Blaming Victims and Survivors: An Analysis of Post-Katrina Print News Coverage," M. Davis and T. French wrote that the news media coverage shifted blame onto victims and survivors of Hurricane Katrina, focused the conversation on race and class distinctions by describing survivors as poor and black, and conflated lawlessness to construct victims as threats and looters. Although the mandatory evacuation for Katrina was given 19 hours before the projected landfall, leaving little time for millions of people without financial resources and lack of access to transportation to evacuate, the media coverage painted victims as irresponsible by suggesting they had detailed knowledge of the threat and did not react. Hurricane Katrina highlighted the failure in the government on a local and national level in its inability to protect inner cities from disasters.

The U.S. Senate Committee on Homeland Security and Government Affairs in a post-Hurricane Katrina report, "A Nation Still Unprepared," offered seven foundational recommendations and 81 building block recommendations for disaster preparation, none of which dealt specifically with inner-city preparedness. The House of Representatives’ Select Bipartisan Committee’s Report on the response to Hurricane Katrina in 2006 entitled “A Failure of Initiative” does an excellent job of outlining the local, state and federal failures, but does not offer any recommendations for improvements to future inner-city preparedness. The U.S. Census indicates has access to the web is still working (i.e., EMP attacks); the electric power is still on; and that you are among the 78% that see, hear, pay and quickly respond to directions. Those assumptions don’t align with the reality of at least half of the American population. The lack of inclusive planning by jurisdictions may be inadvertently violating civil rights of the socially vulnerable populations. When making plans for catastrophic events today, it is often assumed that everyone has access to a computer. The Centers for Disease Control and Prevention’s (CDC) "Get Informed" section of the "Individuals and Families Planning" of the Pandemic Flu website directs the reader to reliable, accurate and timely information to a website. Making a website the place for important information assumes that the world wide web is still working (i.e., EMP attacks); the electric power is still on; and that you are among the 78% that see, hear, pay and quickly respond to directions. Those assumptions don’t align with the reality of at least half of the American population. The lack of inclusive planning by jurisdictions may be inadvertently violating civil rights of the socially vulnerable populations.

When we think about disasters and the inner city, the common image is one of social breakdown. Disaster research studies demonstrate that this
negative image of the inner city often is held commonly by police, fire departments, the American Red Cross and the military. JD Goltz, in the International Journal of Mass Emergencies and Disasters 1992 article “Initial Behavioral Response to a Rapid Onset Disaster," says that at least in the immediate aftermath of disasters, inner-city communities show resilience and unity, strengthening of social ties, self-help, heightened initiative, altruism and prosocial behaviors. In short, when things are at their worst, disaster-stricken communities tend to rise to the occasion.

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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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The epidemic epicenter ...

Pittsburgh

THADDEUS OSIAL, MD

Besides the astoundingly rapid progress made in describing the nature of SARS-CoV-2 (COVID-19) and the advances in describing the virus and approaches to treatment, another result of the recent pandemic has been resurgent interest in previous epidemics and pandemics, and most notably the Spanish Influenza of 1918-19. The estimated world-wide death toll of that H1N1 illness was probably 50 million, and possibly as high as 100 million. The world population in 1918 was only 28 percent of today’s population, thus a comparable toll today would be 175 to 350 million. It has been estimated that one-third of the world’s population may have been clinically infected during the pandemic, with mortality rates among the infected of more than 2.5%. Up to 50% of deaths were in people 20-40 years of age (see https://www.ncbi.nlm.nih.gov/books/NBK22148/ for a comprehensive review).

Recently, as I was perusing history of medical websites, I came upon the University of Michigan’s (UM) History of Medicine site (http://chm.med.umich.edu/). I discovered that my undergraduate alma mater, with faculty member Dr. Howard Markel, has developed an extensive resource for the study of that devastating pandemic. As a University of Pittsburgh Medical School graduate, it was not lost on me that the UM and the University of Pittsburgh have strong links in the study of epidemic illness. One only has to look at the work of Dr. Jonas Salk (Pitt researcher but former UM postdoctoral fellow) and his former department chairman, and later director of the Poliomyelitis Vaccine Evaluation Center at the University of Michigan School of Public Health, Dr. Thomas Francis. Together, they announced the successful conclusion of the national polio vaccination trial on April 12, 1955, at Rackham Hall at UM.

It was in reviewing these sites that I learned the well-documented fact that Pittsburgh had the highest death rate of any major city in the United States during the Spanish flu, followed closely by Philadelphia. Pittsburgh was in fact the U.S. epicenter. The average death rate for Eastern cities was 555 per 100,000 people. By contrast, Pittsburgh’s death rate was 807 per 100,000 people, deadlier than that of Philadelphia (748) or Boston (710). The flu killed at least one of every 100 residents: 4,500 deaths. At its peak, in October 1918, daily death rates were in the range of 170, and new cases 1000/day. In parts of the city, 95% of residents were affected by the flu.

It should not be surprising, then, that Nancy Bristow begins her 2012 book “American Pandemic: The Lost Worlds of the 1918 Influenza Epidemic” with the story of her great grandfather’s becoming an orphan during the Spanish flu, in Pittsburgh. It began her quest to understand history of that time and provides great insight into that period. I have used it as another reference.

I also came across a useful article, “Pittsburgh in the Great Epidemic of 1918” by Kenneth A. White, in the Western Pennsylvania Historical Magazine from 1985. It provides extensive details of the efforts of the general community, as well as the medical community to address the social upheaval (and I have borrowed freely from it): https://journals.psu.edu/wph/article/view/3959/3776.

Themes familiar to us today were seen in that prior era. Its very name, Spanish flu, was a misnomer, as early cases were described in Midwest Army camps in early 1918, and then may have spread to various European cities prior to the outbreak in Boston in the fall of 1918. Soldiers traveling to Europe for WWI engagement may have led to the spread; it may have been American flu. “Social distancing” and the use of face masks were advocated by some. Early on, there was public outrage over the closing of public venues. As is quoted by White, the Pittsburgh Leader commented on the Pennsylvania state health commissioners closing of theaters and public
places, stating “...the only thing that will result from it will be that many people will be deprived of what are their rights under ordinary circumstances and no great good will be accomplished.”

Sports events were canceled. Public safety measures were instituted. Police received orders to “arrest all persons expectorating on the sidewalks, in the street cars, incline cars, railroad cars of any other places” with fines of a hefty $100 or a month in jail. As the epidemic widened, schools were closed or, if remaining open, would send home children with a cough or sneezing. The fear of closing of liquor stores led to a rush to stock up. In a recent Time magazine article, Nancy Bristow described the “Anti-Mask League” which swept the country, noting its wide acceptance in San Francisco. Pittsburgers were active participants.

In an interesting example of social distancing, Western Pennsylvania Institution for the Blind (as it was known) was a closed small community which enacted protective sequestration early on of everyone. There were no visitors, and students did not leave. As a result, no cases of influenza appeared in the school during the period it was closed to the outside world.

The medical community stepped up, where possible. There were shortages of physicians due to the War in Europe, leaving some communities with few or no doctors. As a result, the University of Pittsburgh medical students manned the hospital wards as interns. The nursing community stepped up to provide care to the over-taxed healthcare facilities. Hospitals throughout Allegheny County worked together to address the patient needs – Magee, West Penn, Mercy Homeopathic, St. Francis, South Side and St. Joseph’s, to name a few. Local facilities such as the Concordia Club, Kingsley House, and organizations such as the Moose Club and Hunting and Fishing Club provided tents and supplies for overloaded facilities. Sadly, a desperate need was filled when the sisters at St. Vincent’s Hill and St. Mary’s Lyceum offered their buildings as temporary orphanages. The Irene Kaufmann Settlement shouldered responsibility for all nursing service in the Hill District.

Treatments of the day were limited primarily to supportive care with a variety of recommendations including salt-water gargling and purgatives. Among the more interesting recommendations was quinine. (Hydroxychloroquine not being available!)


To give some idea of the nearly 150 headlines (which could be just as well from our recent papers), I note for example:

- In early fall of 1918, the Pittsburgh Sun’s headlines read: “Situation here does not alarm.”
- By October, the Gazette-Times noted: “Lists of Grip Victims Shows Big Increase,” and within days: “Rapid Spread of Influenza in Pittsburgh,” and soon: “Influenza Sweeping Nation; Pittsburgh under Quarantine.”
- The fallout spread; The Sun Times noted: “Pittsburgh For the First Time Sees All Sports Events Suspended,” and “Churches And Bars Closed,” but then again “Whisky Praised as Influenza Medicine.”
- There were calls for help as noted in the Pittsburgh Times: “Red Cross Needs 300 Nurses To Fight Spanish Influenza,” and “Officials Plan Hospitals for Grip Patients.”
- But not everyone followed the rules, said the Pittsburgh Sun: “Fight Begins on Influenza Ban Violators.”
- And not everyone agreed with recommendations over time, as the Sun reported: "Fight on Lifting Influenza Ban is Expected."
- But finally: The Sun reported: “Influenza Hold on Pittsburgh is Weakening,” and about five weeks into the epidemic, the Pittsburgh Gazette Times reported: “Influenza Ban To Be Lifted Next Saturday.”

Little did they know then that another wave would hit the following year, and in fact, Bristow’s ancestors died in a later wave of the disease in 1920. The severity of the 1918 pandemic led to finger pointing, including to certain ethnic and religious groups. As Bristow noted, “Forgotten was the failure of public health leaders to mobilize the nation in advance of the approaching scourge. Ignored was the inability of modern medicine to protect Americans from influenza, pneumonia and death.” Implementation of nonpharmaceutical interventions was eventually instituted in most cities, but the time of activation, duration and choice or combination of these nonpharmaceutical interventions appear to have been key factors in their success or failure. In Pittsburgh, some of the blame may be related to a decision to keep schools open initially. Pittsburgh waited three weeks after implementing other closure orders to

Continued on Page 182
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Membership benefits ($1792 value)

<table>
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<tr>
<th>Benefit Description</th>
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| ACMS Bulletin                                            | • Free annual subscription, 12 monthly issues.  
| • $60 value                                             | $60 value |
| Physician Wellness Program                                | • Confidential assistance  
| • $800 value                                             | $800 value |
| Insurance Programs: term, whole, long-term care, and disability | • Personal coverage  
| • Group discounts not available on the public market     | $800 value |
| Liberty Mutual Auto & Homeowners Insurance               | • Up to 20% savings  
| • $782 value                                             | $782 value |
| Educational Programming                                  | • State-mandated training programs for license renewal  
| • $150 value                                             | $150 value |
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<tr>
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extend those closures to schools as well. The Pittsburgh Sun noted in late October, well into the epidemic, that “City Schools Not Closed by Grip Epidemic” and “Children Best in Schools, Says Burns” (Dr. Burns was Director of School Hygiene). Others speculate that Pittsburgh’s “bad air” at the time was an important factor.

I am struck by today’s relative ignorance in the population, and the medical community, of this devastating event. (I personally remember during my medical training in the 1970s hearing from patients who told of siblings and parents who had died from “the 1918 flu,” but I neither appreciated nor explored the issue.) This well explains the relative astonishment that such an event could occur today (at least to others besides Bill Gates). But as Bristow explains, our universal blindness to this disaster: “To remember the pandemic would have required Americans to accept a narrative of vulnerability and weakness that contradicted their fundamental understanding of themselves and their country’s history ... The return to pandemic conditions was a terrible surprise, a shocking descent into a past from which Americans hoped they had escaped.” A prophetic statement made almost a decade ago.

It is a cliché to note that those who forget history are apt to repeat the mistakes. We may be once again proving that statement. Also, I wish I’d known this story back in the 1970s when I might have been more insightful in reviewing the “Family and Social History” of patients from that era.

Dr. Osial is a practicing rheumatologist with Margolis Rheumatology Associates, UPMC. He attended the University of Pittsburgh School of Medicine, where he also completed his internal medicine and rheumatology training. He can be reached at osialta@upmc.edu.

References
2. Nancy Bristow; American Pandemic: The Lost Worlds of the 1918 Influenza Epidemic 2012
4. White, Kenneth A; Pittsburgh in the Great Epidemic of 1918” The Western Pennsylvania Historical Magazine (Volume 68, Number 3, July 1985)

Society News

ACS – SWPA Chapter Most Interesting Cases presented

On June 1, the Southwestern Pennsylvania (SWPA) Chapter of the American College of Surgeons (ACS) met virtually to consider interesting case presentations by surgical residents from area training programs. Twelve cases were submitted, and the top six were selected for discussion at the event.

Kristin Krupa, MD, began the evening with a presentation of “A Case of a Large Bowel Obstruction Caused by a Gallstone.” Other presentations included “Delivering good news: a case of successful combined cesarean section and bowel resection for small bowel obstruction in the third trimester,” presented by Katherine Hrebinko, MD; “Pneumopericardium in an otherwise healthy 24 year old male,” presented by Kevin Train, MD; “Improvement of Liver Function Tests After Splenectomy in Patient with Schistosomiasis: A Case Review,” presented by Peter Zak, MD; and “Complete Mesh Migration into the Small Bowel Following Parastomal Hernia Repair,” presented by Waseem Lufti, MD.

Hillary Simon, DO, was voted Most Interesting Case for her presentation on “A Bullet within the Pericardial Sac: To Remove or Not To Remove?”

Congratulations to Dr. Simon and to all our presenters, and special thanks to Chapter President Alan Murdock, MD, for moderating the evening’s event.
June 2020

Dear Colleague:

The Allegheny County Medical Society is seeking candidates for the 2021 ACMS Board of Directors, Delegates to the Pennsylvania Medical Society and Peer Review Board; we invite your nominations. All members are asked to participate. We especially encourage our resident and young physicians to get involved. The future of medicine depends on you.

If you are interested in participating in ACMS leadership, or if you would like to recommend a colleague, please e-mail nominations@acms.org or fax this memo back to 412-321-5323.

Questions, please call ACMS at 412-321-5030 and speak with our Chief Executive Officer, Jeremy Bonfini.

Sincerely,

William K. Johnjulio, MD
President

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I am interested in being a candidate for the ACMS:

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<tr>
<th>BOARD OF DIRECTORS</th>
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<th>PEER REVIEW BOARD</th>
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<tr>
<td>Three-Year Term</td>
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<td>patients and the practice of medicine.</td>
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<td>Society.</td>
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<td>physician or physicians.</td>
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<td>□ Meets four times per year, special</td>
<td>attending the House of Delegates in</td>
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<td>meetings as needed.</td>
<td>October in Hershey, PA.</td>
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Circle: YES  Circle: YES  Circle: YES

Name ____________________________________  Email ____________________________________

[Please Print]  Phone ________________________________

I would like to recommend __________________________________________________________ for

_________ Board of Directors  ___________ Delegate.  ___________ Peer Review

Please enclose a copy of your CV. Fax the completed form to 412-321-5323 by Monday, July 20, 2020.

Thank you.
Atherosclerotic cardiovascular disease (ASCVD) is a major health problem and the leading cause of mortality and morbidity worldwide.\textsuperscript{1,2} An elevated level of low-density lipoprotein cholesterol (LDL-C) is directly associated with development of ASCVD. LDL-C lowering with hydroxy-3-methylglutaryl coenzyme A (HMG-CoA) reductase inhibitors or statins has been shown to inhibit the progression of coronary atherosclerosis and reduce cardiovascular morbidity and mortality.\textsuperscript{1,2,3} Statins are generally well tolerated, however one of the major reasons for the lack of adherence to high- or moderate-intensity statin therapy as recommended in the guidelines is the concern for adverse events. The most common adverse events with statins are muscle-related adverse events, which range from myalgia to rhabdomyolysis, followed by asymptomatic elevation in hepatic enzymes and more recently with high-dose statins concern for developing type 2 diabetes.\textsuperscript{1,2,3} Despite their proven efficacy and wide availability, because of their dose-dependent side effect profile, a considerable proportion of patients with elevated cholesterol fail to achieve guideline-recommended targets. When the degree of LDL-C lowering attained by maximally tolerated doses of statins is insufficient, we now look to several non-statin medications for additional effect. Ezetemibe and proprotein convertase subtilisin/kexin type-9 (PCSK-9) inhibitors (evolocumab, alirocumab) have both been proven to decrease LDL-C levels and associated atherosclerotic cardiovascular disease morbidity and mortality.\textsuperscript{1,2,3} However, PCSK-9 inhibitors may be limited somewhat due to their subcutaneous administration and cost.

Therefore, the FDA approval of a new oral non-statin medication is a welcome addition to the treatment armamentarium to help reduce LDL-C and ASCVD risk. Bempedoic acid (Nexletol\textsuperscript{TM}) oral tablet was approved by the FDA on Feb. 21, 2020.\textsuperscript{4,5} It has been shown to upregulate LDL receptors, decrease LDL-C and reduce atherosclerotic plaque formation in hypercholesterolemic patients.

**What it is:**\textsuperscript{4,5} Bempedoic acid is a novel cholesterol-lowering drug. Administration of bempedoic acid in combination with maximally tolerated statins, with or without other lipid modifying agents, decreases LDL-C, non-high density lipoprotein cholesterol (non-HDL-C), apolipoprotein B (apo B) and total cholesterol (TC) in patients with hyperlipidemia.

**How it works:**\textsuperscript{4,5} Bempedoic acid is an ATP-citrate lyase (ACL) inhibitor that lowers LDL-C by inhibition of cholesterol synthesis in the liver. ACL is an enzyme upstream of HMG-CoA reductase in the cholesterol biosynthesis pathway. Bempedoic acid and its active metabolite (ESP15228) are prodrugs which require coenzyme activation by very long-chain acyl-CoA synthetase 1 (ACSVL1) to ETC-1002-CoA and ESP15228-CoA, respectively. ACSVL1 is expressed primarily in the liver. Inhibition of ACL by ETC-1002-CoA results in decreased cholesterol synthesis in the liver and lowers LDL-C in blood via upregulation of low-density lipoprotein receptors. Because bempedoic acid is a prodrug activated by an enzyme expressed primarily in the liver, this allows it to avoid the potential myotoxicity associated with statin therapy.

**Dosage:**\textsuperscript{4,5} It is FDA approved for the treatment of established ASCVD in heterozygous familial hypercholesterolemia as an adjunct to diet and maximally tolerated statin therapy, in adult patients who require additional lowering of LDL-C. The recommended dosage of bempedoic acid, in combination with maximally tolerated statin therapy, is 180 mg administered orally once daily. It can be taken with or without food. Monitor lipid levels within 8 to 12 weeks of therapy initiation.
Table 1. Summary of Phase 3 Clinical Trials of Bempedoic Acid

<table>
<thead>
<tr>
<th>Study</th>
<th>Patient Population</th>
<th>Background Therapy</th>
<th>Study Duration</th>
<th>Endpoints</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLEAR Harmony</td>
<td>ASCVD +/- or HeFH; on max tolerated statin (LDL-C ≥ 70 mg/dL)</td>
<td>Maximally tolerated statin therapy</td>
<td>52 week</td>
<td>Primary: long term safety</td>
<td>No diff in any ADE or serious ADE (14.5% v 14%) Mean difference LDL-C -18.1% v placebo</td>
</tr>
<tr>
<td>n = 2230</td>
<td></td>
<td></td>
<td></td>
<td>Secondary: 12-wk LDL-C</td>
<td></td>
</tr>
<tr>
<td>CLEAR Wisdom</td>
<td>ASCVD +/- or HeFH; on max tolerated statin (LDL-C ≥ 70 mg/dL)</td>
<td>Maximally tolerated statin therapy</td>
<td>52 week</td>
<td>Primary: % change from baseline 12-wk LDL-C</td>
<td>Significant reduction in mean difference LDL-C at 12-wk – 17.4% Significant decrease in other lipids + biomarkers (non-HDL-C, tol chol, apoB, hsCRP)</td>
</tr>
<tr>
<td>n = 779</td>
<td></td>
<td></td>
<td></td>
<td>Secondary: changes in levels of lipids, lipoproteins, biomarkers</td>
<td></td>
</tr>
<tr>
<td>CLEAR Serenity</td>
<td>High risk ASCVD + HeFH w/ statin intolerance + inadequately controlled LDL-C</td>
<td>Continued stable lipid lowering therapy including low-dose statin</td>
<td>24 week</td>
<td>Primary: % change from baseline 12-wk LDL-C</td>
<td>Significant reduction in mean difference LDL-C at 12-wk – 21.4% Significant decrease in other lipids + biomarkers (non-HDL-C, tol chol, apoB, hsCRP) BA well tolerated no incr in muscle related ADE</td>
</tr>
<tr>
<td>n = 345</td>
<td></td>
<td></td>
<td></td>
<td>Secondary: changes in levels of lipids, lipoproteins, biomarkers</td>
<td></td>
</tr>
<tr>
<td>CLEAR Tranquility</td>
<td>High risk ASCVD w/ statin intolerance + inadequately controlled LDL-C ≥ 100 mg/dL</td>
<td>Add-on to ezetimibe 10 mg ± low dose statin</td>
<td>12 week</td>
<td>Primary: % change from baseline 12-wk LDL-C</td>
<td>BA + ezetimibe significantly reduced LDL-C at 12-wk – 28.5% v placebo Significant decrease in other lipids + biomarkers (non-HDL-C, tol chol, apoB, hsCRP). Similar ADE between groups</td>
</tr>
<tr>
<td>n = 269</td>
<td></td>
<td></td>
<td></td>
<td>Secondary: changes in levels of lipids, lipoproteins, biomarkers</td>
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</table>
Contraindications: There are no contraindications listed in the manufacturer’s labeling.

Adverse events: During clinical trials, adverse reactions led to discontinuation of treatment in 11% of bempedoic acid-treated patients and 8% of placebo-treated patients. The most common reasons for bempedoic acid treatment discontinuation were muscle spasms (0.5% versus 0.3% placebo), diarrhea (0.4% versus 0.1% placebo) and pain in extremity (0.3% versus 0.0% placebo). Adverse reactions (≥ 2% and greater than placebo) were upper respiratory tract infection, muscle spasms, hyperuricemia, back pain, abdominal pain or discomfort, bronchitis, pain in extremity, anemia and elevated liver enzymes. Also tendon rupture occurred in 0.5% of bempedoic acid-treated patients versus 0% of placebo-treated patients and gout occurred in 1.5% and 0.4% of patients respectively.

Drug interactions: Bempedoic acid may increase simvastatin or pravastatin concentrations and may increase the risk of simvastatin- or pravastatin-related myopathy. Avoid concomitant use of bempedoic acid with simvastatin doses greater than 20 mg or pravastatin doses greater than 40 mg. There is no impact on dosing of other statins (atorvastatin, rosuvastatin).

Use in specific patient populations: No dosage adjustment is necessary in patients with mild or moderate renal or hepatic impairment. There is limited experience in patients with severe renal impairment (eGFR < 30 mL/min/1.73 m²) and it has not been studied in patients with end-stage renal disease receiving dialysis. Patients with severe hepatic impairment (Child-Pugh C) have not been studied.

Pregnancy: There are no available data on bempedoic acid use in pregnant women to evaluate for a drug associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes. Discontinuing use when pregnant is recognized unless the benefits of therapy outweigh the potential risks to the fetus.

Lactation: There is no information regarding the presence of bempedoic acid in human or animal milk, the effects of the drug on the breastfed infant, or the effects of the drug on milk production. Because of the potential for serious adverse reactions in a breastfed infant, based on the mechanism of action, advise patients that breastfeeding is not recommended during treatment with bempedoic acid.

Clinical efficacy: The safety and efficacy of bempedoic acid was evaluated in the industry-sponsored Cholesterol Lowering via Bempedoic Acid, an ACL-inhibiting Regimen (CLEAR) program, consisting of 4 key randomized, double-blind, placebo-controlled studies in > 3600 patients. The primary goal of CLEAR Harmony was to evaluate the long-term safety of bempedoic acid. CLEAR Harmony enrolled 2,230 patients with HeFH or ASCVD receiving maximally tolerated statins and with LDL-C levels ≥ 70 mg/dL. At week 12, bempedoic acid reduced the mean LDL-C by 19.2 mg/dL (representing a difference vs. placebo in mean change from baseline of 18.1%). The incidence of adverse events and serious adverse events was not significantly different between the groups; although rates of discontinuation due to adverse events was greater in the bempedoic acid group (10.9% vs. 7.1% respectively).

CLEAR Tranquility and CLEAR Serenity each enrolled approximately 300 high CV risk patients with statin-intolerance and inadequately controlled LDL-C levels. Bempedoic acid lowered LDL-C levels by 21% to 29% at week 12 without increasing risk of muscle symptoms compared with placebo. CLEAR Tranquility evaluated the efficacy of bempedoic acid as an add-on to ezetimibe 10 mg. In the CLEAR Wisdom clinical trial, 779 patients with ASCVD and HeFH on maximally tolerated statins and an LDL-C ≥100 mg/dL, bempedoic acid significantly reduced LDL-C (mean difference 17.4% vs. placebo) at 12 weeks as well.

A global cardiovascular outcomes trial, known as the CLEAR Outcomes trial, is assessing bempedoic acid in more than 14,000 statin-intolerant patients with hypercholesterolemia and high-risk CVD. The primary endpoint is time to first occurrence of cardiovascular death, nonfatal myocardial infarction, nonfatal stroke, or coronary revascularization over an estimated time period of approximately 3.5 years. Bempedoic acid’s effect on cardiovascular morbidity and mortality has not yet been determined.

How supplied: Bempedoic acid (Nexlotol™) is supplied as a 180 mg oral tablet. Additionally, the FDA recently approved a fixed dose combination product, bempedoic acid 180 mg and ezetimibe 10 mg (Nexlizet™), the first non-statin combination drug approved. Nexlizet™ is not available yet, but anticipated to be available in July 2020. Both drugs are manufactured by Esperion.
Cost: Nexletol™ 180 mg oral tablet is estimated to cost ~$13 per tablet or ~$390/month supply (Average Wholesale Price (AWP) price is provided as reference price only).

Conclusion: Bempedoic acid (Nexletol™) is a novel oral non-statin medication – the first ATP-citrate lyase inhibitor blocking an earlier step of cholesterol synthesis in the liver than statins. It is approved for patients with familial hypercholesterolemia or CV disease who need additional LDL lowering despite maximally tolerated statins and ezetimibe. A high intensity statin is still the recommended gold standard for ASCVD or familial hypercholesterolemia. Ezetimibe should be added first since it has been shown to reduce CV events in some high-risk patients also on a statin. Adding a PCSK9 inhibitor also has been shown to reduce CV events in high-risk patients on a statin and lower LDL but requires a subcutaneous injection and is costly. Bempedoic acid should be used in patients who cannot achieve guideline-recommended LDL-C levels despite maximally tolerated statin plus ezetimibe therapy or in patients with true statin intolerance. Additional data is needed to further evaluate the effect of bempedoic acid on cardiovascular morbidity and mortality.

For any questions concerning this article, please contact Tucker Freedy, PharmD, BCPS, at the Allegheny Health Network, Allegheny General Hospital, Center for Pharmaceutical Care, Pittsburgh, Pa., (412) 359-3192, or email tucker.freedy@ahn.org.

References
5. Nexletol (bempedoic acid) [prescribing information]. Ann Arbor, MI: Esperion Therapeutics Inc; February 2020.
Although physician offices were always classified as essential businesses under the Pennsylvania Emergency Closure Rules, and could always have remained open, many physician practices nevertheless opted to close the practices, reduce hours, or remain only open for emergency patients. Now that Pennsylvania is reopening to all businesses in stages, we thought it would be valuable to have a source of curated information specifically applicable to the reopening of physicians’ offices, similar to the COVID-19 Private Practice Checklist published by ACMS on March 19, 2020.

We believe the risk issues can be separated into four basic categories:

1. Patient management
2. Facility management
3. Staff protection
4. Patient consent forms and waivers

**Patient management**

The scheduling, management and testing of patients returning to the practice, and prioritizing their treatment based upon the severity of their medical conditions, will be one of the most challenging aspects of reopening the practice, if only because of your lack of actual control over patients’ conduct. Communicating to patients how the practice is being reopened and patient management also will involve the issues of preparing the facility and protecting your workforce, each of which will be discussed separately. All practices should take the following steps:

1. Screen patients, and visitors if you are going to allow visitors to accompany the patients (which is another judgment issue), for symptoms of acute respiratory illness or other potential COVID implications.
2. Administer or require testing and screening where possible.
3. Work with your primary hospital to determine what action plans the hospital has implemented and might be willing to share or coordinate.
4. Ensure proper inventory and availability of PPE.
5. Require patients to use PPE and train staff to train patients in the proper use of the PPE.
6. Coordinate with the organization and management of your facilities.

**Facility management**

One of resources included from the CDC is a lengthy document including planning resources by setting. The material for physicians’ offices includes a medical office planner, templates, timelines, resource allocation guidelines, etc., for the use of the office. You must make arrangements for:

1. Appropriate cleaning and disinfecting of the office as required and communication of that to patients in order to demonstrate not only your compliance but your expectation of the patient’s compliance.
2. Redesigning your patient intake process to minimize contact (reduce handling of patient sign-in sheets and writing instruments, sterilization of the writing instruments, social distancing for check-in).
3. Select waiting room and exam room furniture to facilitate cleaning. For example, if the current waiting room furniture is cloth and very difficult to clean, perhaps you either want to cover the furniture, rent plastic chairs, or make some other arrangements.
4. Encourage the use of the telehealth if your practice resources are set up to accommodate that.
5. Limit visitors.
6. Allow telephone check-in and instruct patients to wait in their cars until they are called to the office, minimize the number of patients (visitors) in reception or examine rooms and provide a means of exit that doesn’t require the patients to return through the reception room, if possible.

**Staff protection**

In the resources section is the CDC Interim Guidance on Risk Assessment for Healthcare Personnel who might be exposed to patients, i.e., Criteria for
Return to Work. Protecting your staff from patients is equally as important as protecting patients from potentially infected staff. Therefore, the planning should include many of the same precautions:

1. Testing and screening both for daily practice and especially for return to work if a staff member has tested positive.
2. Appropriate training and PPE resources for staff.
3. Implementing social distancing for staff if possible, with respect to the concentration of the staff in the office, allowing staff to work remotely, either from home or from another offsite location, for services that do not require direct patient contact.
4. Rotating staff by groups so that one group is not exposed to the other group if possible.
5. Reducing the density of all individuals in the office by extending office hours and booking fewer patients per hour.

**Patient consent forms, waivers**

Many physicians have asked whether it would be appropriate, and perhaps even advisable, to require patients to sign waivers and releases with respect to potential infection from their offices. We have advised that this is both inadvisable and probably ineffective. Instead, we suggest a patient notice or advisory communicating all of the affirmative steps you have taken to protect both the patients and your staff ending with a conclusion or warning that, despite all of your efforts, everyone should be aware, because of your statements and because of all the publicity and public announcements regarding potential COVID infections, that it is impossible to guarantee the safety of any individual who has chosen to go out into the public, to accept services from your office, or any other commercial office or any of their other social contacts, but that you will do your best. Asking the patient to sign a waiver as a condition to further

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- Ryan Siney - Cybersecurity, Compliance
- Paul Welk - Mergers & Acquisitions
- Jerry Russo - Investigations
- Danielle Dietrich - HIPAA, Collections & Litigation
- Rebecca Moran - Mergers & Acquisitions and Physician Contracts

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*Continued on Page 190*
treatment also would suggest that you would refuse to treat the patients if they did not sign the waiver; this might not only invalidate the waiver but it might be tantamount to patient abandonment in the midst of necessary medical treatment, which is an ethical violation.

**Conclusion**

We have attached below a list of what we think are the most appropriate resources regarding these issues, but please contact us if you have further questions.

**Resources**

- Planning Resources by Setting: Physicians’ Offices: https://www.cdc.gov/cpr/readiness/healthcare/physicians.htm

Mr. Cassidy is a shareholder at Tucker Arensberg and is chair of the firm’s Healthcare Practice Group; he also serves as legal counsel to ACMS. He can be reached at (412) 594-5515 or mcassidy@tuckerlaw.com.
## REPORTABLE DISEASES 2020: Q1

### Allegheny County Health Department

### Selected Reportable Diseases/Conditions

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<tr>
<th>Selected Reportable Disease/Condition*</th>
<th>January to March**</th>
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* Case classifications reflect definitions utilized by CDC Morbidity and Mortality Weekly Report.

** These counts do not reflect official case counts, as current year numbers are not yet finalized. Inaccuracies in working case counts may be due to reporting/investigation lag.

**NOTE:** Disease reports may be filed electronically via PA-NEDSS. To register for PA-NEDSS, go to [https://www.nedss.state.pa.us/NEDSS](https://www.nedss.state.pa.us/NEDSS). To report outbreaks or diseases reportable within 24 hours, please call the Health Department’s 24-hour telephone line at 412-687-2243. For more complete surveillance information, see ACHD’s 10-year summary of reportable diseases: [https://www.alleghenycounty.us/Health-Department/Resources/Data-and-Reporting/Infectious-Disease-Epidemiology/Epidemiology-Reports-and-Resources.aspx](https://www.alleghenycounty.us/Health-Department/Resources/Data-and-Reporting/Infectious-Disease-Epidemiology/Epidemiology-Reports-and-Resources.aspx).
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Ballroom of the Rivers Casino, Pittsburgh

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