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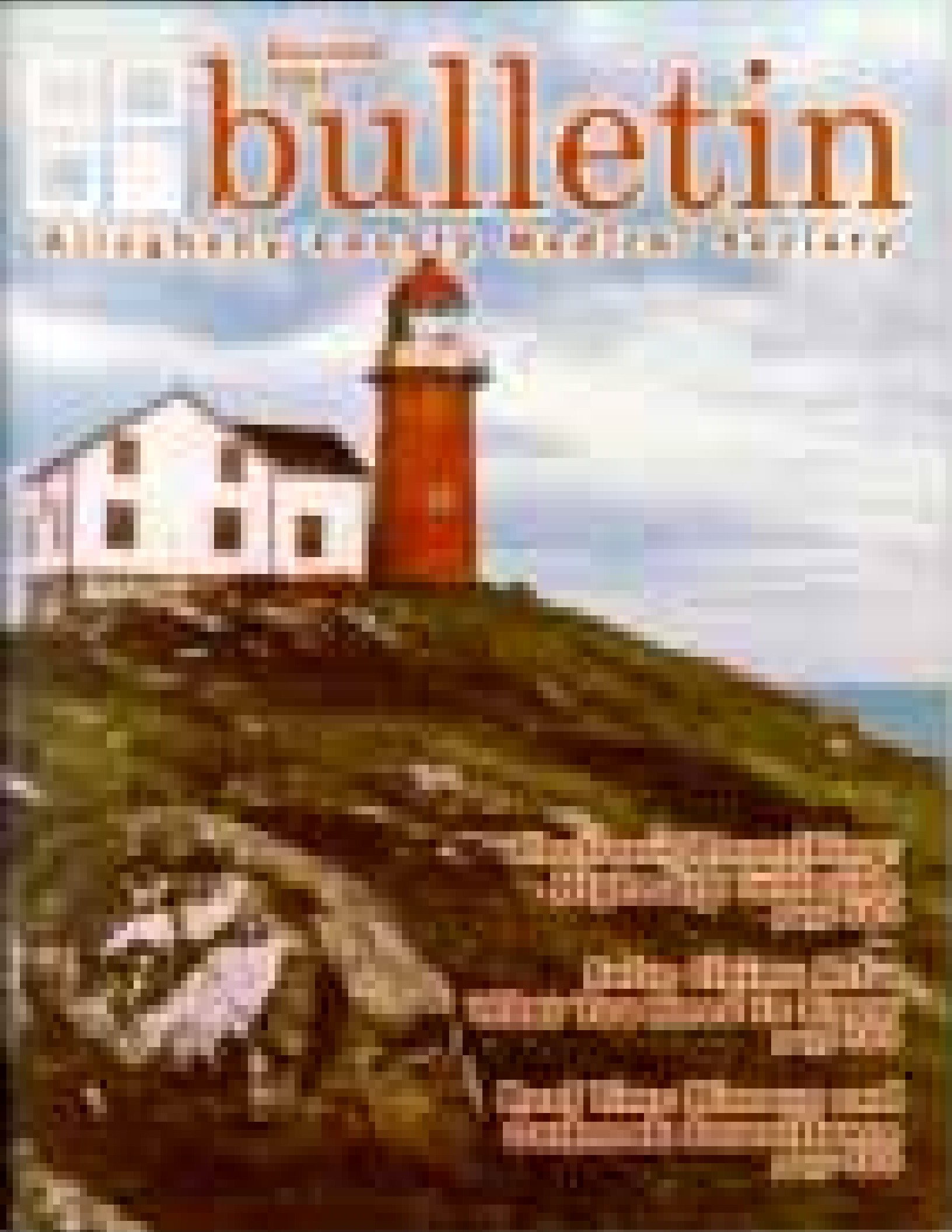

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December 2005 ¨ Vol. 94 No. 12

BULLETIN *of the Allegheny County Medical Society*

ARTICLES

COLUMNS

DEPARTMENTS

Cover Art:

Red Lighthouse
Ferryland, NF, Canada

by Kalyanmay Ghoshhajra, MD

Dr. Ghoshhajra is a diagnostic radiologist.

"It may be that those who do most, dream most."

—Stephen Leacock

ALLEGHENY COUNTY MEDICAL SOCIETY

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Let the Next Year Be Even Better

SAFDAR I. CHAUDHARY, MD

Allegheny County Medical Society has continued to embark upon various initiatives to improve the delivery of health care in our region. These efforts at various levels have been carried out by our membership quite eloquently. Working with other medical societies in the Commonwealth of Pennsylvania, the society has kept the issue of malpractice reform at the forefront of the county's legislators and citizens. Discussions with various stakeholders to keep medical care delivery affordable and efficient for patients have been the focus of the society's leadership. Preventive care initiatives have been undertaken on several fronts, most notably on curbing tobacco use and the obesity epidemic.

Significant energy was spent in streamlining the information flow to the membership, via both e-messages and facsimile. The society's website has been upgraded to meet the needs of the membership. Various committees working in synch with our executive leadership have focused on multiple tasks at hand, including membership enhancements and mentoring programs for medical students and other civic entities. Membership benefits are regularly updated to reflect changing needs. Various educational seminars were conducted in collaboration with other stakeholders. ACMS members volunteered for numerous natural disasters that struck our nation and others around the globe. Thanks to all those who put their efforts into meeting the challenges of health care on various fronts.

The *Bulletin* continues to strive towards the goal of meeting our membership needs. Many thanks to the tireless work of our editorial board and managing editor to gather information relevant to our members' needs and publish it in a timely manner. To add color to the *Bulletin's* cover, our readers graciously took the time to submit their photographic talent to be displayed for all of us to enjoy.

As this year unfolds to another, we continue to work towards having a diverse and enthusiastic group of associate and contributing editors who can meet the emerging challenges in medical journalism. Needless to say, your continued support in various manners, including healthy critique, is always welcome. As we enjoy the healing art of medicine in this beautiful world, let's make our next year even better than last.

In generosity and helping others,
be like a river
In compassion and grace,
be like the sun
In concealing others' faults,
be like the night
In anger and fury,
be like the dead
In modesty and humility,
be like the earth
In tolerance, be like the sea
Either appear as you are,
or be as you appear.

—Jalal al-Din Rumi

Dr. Chaudhary is a psychiatrist and medical editor of the Bulletin. *He can be reached at schaud2815@cs.com.*

A Call to Action

ADAM Z. TOBIAS

Traveling through China recently, I was surprised to find a clean, organized, modernizing country—much different from the third world country I had been expecting. At least in the more urban areas, the streets are well-paved, the drivers obey traffic laws and the large sidewalks are free of garbage. One area that severely lagged behind, however, was the smoking regulations. To be more specific, there weren't any. A 10-hour bus ride through the mountains on a bumpy dirt road with no guardrails and high cliffs can be harrowing enough; add 15 people smoking with the windows closed and now you have a recipe for nausea.

After returning to Pittsburgh, I met some friends for a drink at a local watering hole. Attempting to see my friends through the thick cloud of smoke in the bar, I was immediately reminded of my trip. It is almost hard to believe that here in Pittsburgh, in an area where the health care industry is easily the region's largest employer, we have progressed no further than China on this public health issue. Despite the success of countless other states and counties around the country in banning smoking from public places, we continue to fail in following their lead.

The dangers of secondhand smoke are difficult to dispute, despite what tobacco companies may have you believe. At least among health care providers, there is a clear consensus that secondhand smoke is bad for you. And yet, with the American health care system spiraling quickly downward, with a devastating medical liability crisis crushing our spirits, and with 48 million Americans uninsured, we have perhaps not focused on this issue enough.

Nonetheless, this one issue, the banning of smoking in public places such as bars and restaurants, could have a huge public health benefit on our citizens and especially on employees of these businesses who are continuously subjected to the smoke. Although some local restaurant owners fear that such a ban could hurt their business, areas that have enacted a similar law, New York City for example, have actually shown improvements in business after a small initial drop.

Our best hope for such a tremendous public health measure currently lies with the state legislature. At the time that I write this, two bills, one in the House and one in the Senate, are being considered. The first, S602, introduced by Senator Stewart Greenleaf of Montgomery County, calls for a uniform statewide policy prohibiting smoking in public places and workplaces. It is currently being considered in the Senate Public Health and Welfare Committee. The second, H1489, introduced by Representative Susan Cornell of Philadelphia, calls for a similar ban, though it unfortunately allows for a "separate ventilation" option which is less than favorable, given current data showing that such systems are ineffective at fully filtering out the bad effects of tobacco smoke. It is currently in the Health and Human Services Committee.

As health care providers, we have a tremendous voice in the community. Speaking with a united voice, we have the power to make a vital change to the public health of our citizens. I strongly urge you to

continued on page 572

contact your legislators and ask them to vote for these bills, with full support for S602, and support for H1489 with an amendment to remove the ventilation option from the bill's language.

In the unlikely event that bill has been voted on between the time of writing this article and its publication, I would still urge you to contact your legislators to either thank them or (gently) berate them.

If efforts to enact a public smoking ban are unsuccessful on the state level, an option also exists to do so on a county level. Such a measure would have to be voted on by the county board of health and then approved by the county council and County Executive Dan Onorato. After contacting your state legislators—while you have the phone in your hand—take another few minutes to get in touch with either a member of the board of health, the county council or Mr. Onorato. Four of the nine members of the board of health are currently physicians, so we should certainly be rallying our support behind them on this measure.

We are the guardians of the public health. Though we generally make decisions based on the benefit to our individual patients, we have a responsibility toward the community as a whole. We currently have a golden opportunity to make a genuine improvement in the health of those we serve. I urge you once again to take a few minutes out of your busy schedules to consider and act on this vital issue.

Please see the table on the facing page for a list of selected committees and contact information. The text of H1489 and S602, as well as a list of your legislators, can be found in full at www.legis.state.pa.us/index.cfm.

Adam Tobias is a fourth year medical student at the University of Pittsburgh School of Medicine. He can be reached at tobias.adam@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.

Senate Public Health and Welfare Committee (Majority)
Jake Corman, Chair
Jane Orie, Vice Chair
Edwin Erickson
Joseph Scarnati
Patricia Vance
Mary Jo White

Senate Public Health and Welfare Committee (Minority)
Vincent J. Hughes, Minority Chair
Jay Costa, Shirley Kitchen
LeAnna Washington

House Health and Human Services Committee (Majority)
George T. Kenney Jr., Chair
Katie True
Kerry A. Benninghoff
Beverly Mackereth
Fred McIlhattan
Susan E. Cornell
Michael E. Diven
John W. Fichter
Patrick Elvin Fleagle
Mauree A. Gingrich
Julie Harhart
Stephen R. Maitland
Douglas G. Reichley
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Curtis G. Sonney
Katharine M. Watson

House Health and Human Services Committee (Minority)
Frank L. Oliver, Chair
John Myers
Linda Bebko-Jones
Louise Williams Bishop
Jake Wheatley Jr.
Todd A. Eachus
James Harold
Thaddeus Kirkland
Nick Kotik
Marie A. Lederer
Kathy M. Manderino
Ronald G. Waters

Contact information for members of the county council can be found at: www.county.allegheny.pa.us/council/

Contact information the county board of health can be found at: www.achd.net/board/pubs/htm/main.htm

Contact County Executive Dan Onorato at executive@county.allegheny.pa.us or (412) 350-6500.

The text of H1489 and S602, as well as a list of your legislators can be found in full www.legis.state.pa.us/index.cfm.

Strengthening Relationships in the Health Care Arena

MARK A. GOODMAN, MD

When I began my tenure as president of ACMS, I wanted to focus on creating and fostering relationships with other organizations and hospital staffs. Looking back on the year, I believe that we have worked and continue to work on developing positive collaborations.

Pittsburgh United for Life-Saving Emergencies (PULSE), helped in part by the Laurel Foundation, has been offering automated external defibrillators (AEDs) free of charge to local businesses. Unfortunately, some companies have been declining the AEDs for fear of legal liability repercussions. Therefore, ACMS has been working with the Allegheny County Bar Association to encourage placement of AEDs in all local businesses, emphasizing that proper training will reduce the liability risk to companies.

In August I joined AMA Board Chair Duane Cady, MD, and PMS President William Lander, MD, for a press conference addressing the impending Medicare payment cuts and how it will affect physicians as well as patients' access to care. To continue providing quality medical care to our patients, we need to keep up with technology and continue to hire qualified health care staff. The new Medicare payments will not keep up with the cost of providing care, which will cause many physicians to decrease the number of Medicare patients they treat. We must continue to contact our legislators to replace this reimbursement system with one that more accurately reflects practice expenses.

Working with the Allegheny County Bar Association, American Institute of Architects-Pittsburgh Chapter, Homer S. Brown Law Association and UPMC, the society sponsored an event at Dowe's on Ninth to address diversity issues in the professional community. The event featured panel discussions by Dwayne Woodruff, ACBA Member and a candidate for the Allegheny County Court of Common Pleas; Chris Brown, host of *OnQ* on WQED; and Edward Barksdale Jr., MD, member of ACMS Board of Directors and co-director of the Intestinal Care Center at Children's Hospital of Pittsburgh. This event gave participants a chance to network with professionals and employers in the region and engage in conversation about how to attract and retain professionals from diverse backgrounds in health care, law, business and other fields. We will continue to work on diversity issues in the Pittsburgh region in the year to come.

We also continue to address the issue of obesity and healthy living through the Obesity Task Force. Under the direction of Dr. Terence Starz, the Obesity Task Force brings together leaders from organizations throughout our region to address this serious public health issue. For example, the task force has developed a Obesity and Healthy Living portal on the ACMS website to support health care professionals in developing educational programs and participating in public awareness and media events. In the past two years, we have provided more than 13,000 body mass index (BMI) charts to physician offices, increasing awareness about health, weight and lifestyles among adults, and encouraging communication between patients and physicians. Through PMS, the initiative has gone statewide, and we will continue to promote healthy living in the coming years.

The Medical Student Section continued to help and participate with ACMS on many projects. In October, the section brought in AMA President J. Edward Hill, MD, for a discussion on advocacy issues. He spoke on his desire to increase focus on such issues as public health, health disparities and coverage for the uninsured.

The Bylaws Committee worked on revising and renewing the society's bylaws. The most significant change made to the bylaws was the update of the membership categories to align with the Pennsylvania Medical Society's structure. The revised bylaws were presented and approved at the society's fall business meeting. I would like to thank the committee chair, Dr. Kris Gopal, for all his hard work on this project.

We are still facing a malpractice crisis in Pennsylvania, and I encourage everyone to continue writing to local, state and federal officials on this important issue. We gained one small victory with Governor Rendell continuing MCARE abatement; but until major tort reform is attained, we continue to look for alternative solutions such as meditation and arbitration.

Recently, we started work on an initiative to partner with the medical staff presidents of the area's hospitals to work on governance issues that affect physicians. The first meeting was held in early spring 2005 and another will be held early in 2006.

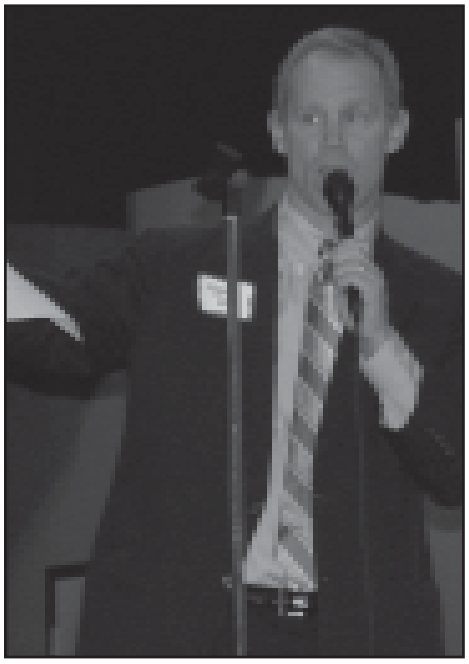
Finally, this year found the world faced with several disasters. Tsunami, hurricane and earthquake relief have been foremost on our minds. Several local physicians traveled to the hard-struck areas and provided medical care and other services. Locally, the society created a register of interested physicians who were willing to provide their services to displaced families of hurricanes Katrina and Rita who relocated to the Pittsburgh area. I thank all those who volunteered their time and expertise in the wake of these disasters.

I continue to encourage all physicians to become involved in organized medicine. Through our combined efforts, we are a strong force in advocating health care issues to the government and the public.

Dr. Goodman is an orthopedic surgeon and the president of the ACMS. He can be reached at goodman@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.

J. Edward Hill, MD, president of the American Medical Association, speaks to University of Pittsburgh medical students at a fall breakfast. Dr. Hill described the AMA's advocacy agenda and his desire for an increased focus on public health, health disparities and coverage for the uninsured.



State Representative Mike Turzai speaks to seniors at a Senior Health Fair and Flu Shot Clinic held in October at CCAC North. ACMS staffed a booth there with educational and informational materials.

Goetz named to ACMS post

Ms. Goetz

The medical society has selected Lisa M. Goetz to serve as its new communications director. Ms. Goetz previously worked as managing editor for academic publications such as the *Newman Studies Journal* and *Studies in History and Philosophy of Modern Physics*. Prior to that, she worked as the publications coordinator for the Department of Anesthesiology and Critical Care Medicine, Clinical Trials Program, at UPMC. Ms. Goetz gained association experience as director of communications for the Allegheny County Bar Association and as editor of the bar association's *Lawyers' Journal*. At Droz and Associates, she garnered agency experience in media and public relations; she also has taught courses in English and communications as an adjunct instructor for Duquesne University, Robert Morris University and the University of Pittsburgh. Ms. Goetz earned her BA in English (non-fiction writing) in 1990 and her MA in English literature in 1992, both from the University of Pittsburgh. She earned her PhD in English literature in 1997 from Duquesne University.

Medical students travel to Dallas

Several students from the American Medical Association-Medical Student Section (AMA-MSS) University of Pittsburgh School of Medicine Chapter attended the AMA meeting in Dallas in November. Students worked on internal legislative issues, including the realignment of the AMA mission statement and the response to Senate Bill 51. Involved in leadership roles at the meeting were Chapter Co-president Andrew Fisher; Co-president, Community Service Committee Chair and Region 6 Community Service Representative Anna-Binney McCague; and Alternate Delegate to the House of Delegates Deborah Brooks.

Fourth-year medical student Jaime Cavallo came back with top prize, the AMA-MSS National Student Research Award for Overall Excellence in Research and AMA-MSS National Student Research Award for Outstanding Research in Immunology/Microbiology. Her winning abstract was titled *The Expression and Function of Toll Like Receptor-4 in Enterocytes is Enhanced by Lipopolysaccharide in Vitro and During Systemic Endotoxemia*. (See photo, page 578, top right.)

The Pittsburgh Surgical Society recognized past presidents at its November meeting: (front, left to right) George Magovern Sr. (1987), Christopher Daly (1988), Kurt Stahlfeld (2002), Kenneth Lee (1999); (back, left to right) Marshall Webster (1991), Charles Copeland (1990), Lester Dunmire (1980) and Enrico Nicolo (2003). Not pictured are Michael Kavic (1998), Harry Sell (1997) and Eugene Wiener (1994).

The Pittsburgh Surgical Society recognized the following "Outstanding Medical Students" at its November meeting: Front left, Ernest Rudman, Drexel University at Allegheny General Hospital; front right, David Rittenhouse, Jefferson Medical College at Mercy Hospital; back left, Matthew Neal, University of Pittsburgh School of Medicine; and back right, John Rutkoski, Temple University at Western Pennsylvania Hosital.

Surgeons enjoy a "grand" evening

Members and guests of the Pittsburgh Surgical Society (PSS) met in November at the Grand Concourse at Station Square. Dr. Timothy Billiar presented the evening's talk, *Pittsburgh Surgery and the University*. Dr. Billiar is a member of the society and the George Vance Foster Professor and chair of the Department of Surgery at UPMC Presbyterian.

PSS annually honors outstanding senior medical students who have participated in surgical programs at local hospitals (photo, above right). This year, the Jefferson College of Medicine at Mercy Hospital has been added to a list that includes the University of Pittsburgh School of Medicine, Drexel University College of Medicine at Allegheny General and Temple University School of Medicine at West Penn Hospital.

President Daniel Gagne, MD, also recognized past presidents of PSS by presenting them with lapel pins (photo, above left).

Geriatrics society meets

Alfred L. Fisher, MD, PhD, associate professor of medicine of the Division of Geriatric Medicine at University of Pittsburgh School of Medicine, addressed members during the November meeting of the Pennsylvania Geriatrics Society-Western Division. His presentation, *What Can Research About Worms Tell Us About Geriatric Patients*, enlightened listeners on how biologic changes during aging are partly responsible for geriatric syndromes such as delirium and frailty and influence the unique responses of geriatric patients to illnesses and medications.

During the business meeting, guest speaker Cynthia Rosenberg, MD, addressed members on the new initiative to improve quality of care for Medicare beneficiaries with chronic illnesses. She informed members that Health Dialogue Services Corporation has been selected by the Department of Health and Human Services (HHS) to conduct a three-year pilot program in Pennsylvania that will help HHS evaluate various options for providing chronic care management services for fee-for-service Medicare beneficiaries on a broad scale. Dr. Rosenberg is medical director of the Pennsylvania Medicare Health Support Program and Health Dialog Inc.

Joint meeting held for two societies

The Pittsburgh Urological Association (PUA) hosted a meeting in November at the Allegheny County Medical Society, inviting members

(continued on page 578)

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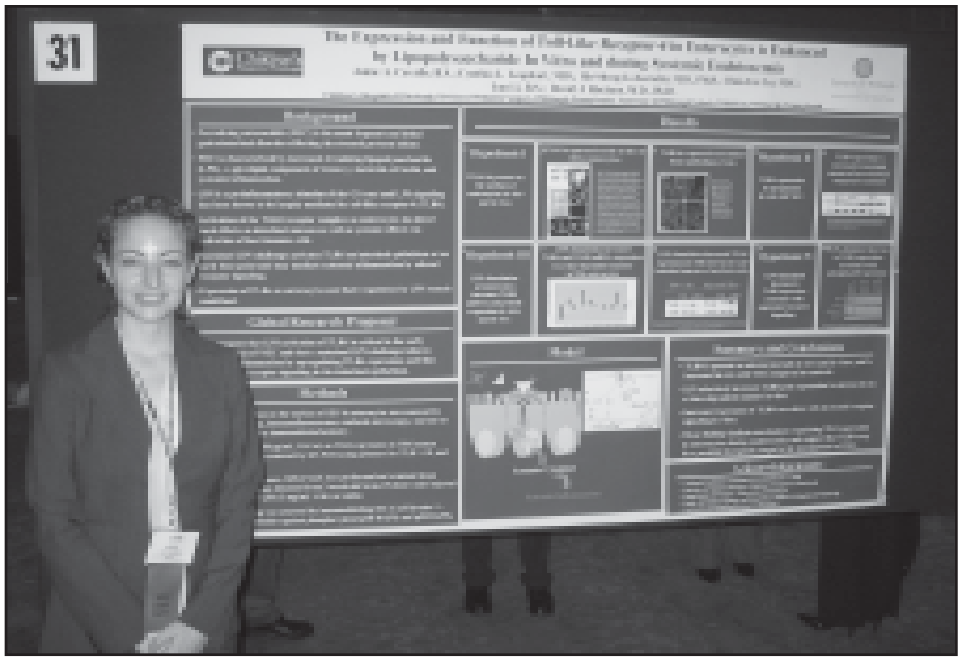
Pittsburgh Urological Association President Saleem Antoon Jr., MD, is pictured here with Anna Bamonte Torrence, guest speaker at the association's November meeting.



Pitt student Jaime Cavello is pictured here with her winning abstract in the competition for the National Student Research Award for Overall Excellence in Research and AMA-MSS National Student Research Award for Outstanding Research in Immunology/ Microbiology. She was with a contingent of students who traveled to Dallas in November.

of the Pittsburgh Obstetrical and Gynecological Society to join them.

Guest speaker Anna Bamonte Torrence, Esq., senior attorney at Houston Harbaugh, presented *Understanding and Preventing Malpractice Liability*. Ms. Torrance concentrates her practice in the area of health and litigation, specializing in representing physicians, medical groups and institutional providers on corporate organization, contract, managed care, employment and malpractice issues. Her presentation focused on in-depth and key issues concerning malpractice reform measures, including certificate of merit, expert reports, MCARE medical professional liability provisions, statute of limitations and punitive damages. In addition, she provided members with new information concerning MCARE insurance reforms. She said that recent Supreme Court data handouts from 2000-2003 indicated a decrease in filings in Allegheny County.

The next meeting of the PUA will be held on January 16, 2006. Members will be notified of meeting details when they become available. Contact Nadine Popovich at (412) 321-5030 or npopovich@acms.org for PUA membership information.

ACMS board receives financial gift

At the November 15 ACMS board meeting, Leticia Q. Jariwala, MD, presented $1,206 to ACMS and $1,200 to the ACMS Alliance on behalf of the South Hills and Western Branch of ACMS.

ACMS annual dinner set for Jan. 28

The Allegheny County Medical Society will install Terence W. Starz, MD, internal medicine, as its 2006 president at the society's annual dinner and installation of officers on January 28, 2006. The medical society will recognize its 50-year service awardees and present its annual awards at the annual dinner at the Duquesne Club beginning at 6 p.m. Entertainment will be provided by SkyView Jazz Trio, a local group performing swing, ballads and modern stylings. This event is open to all members at a cost of $85 per ticket. For more information, contact Dottie Hostovich at (412) 321-5030 or dhostovich@acms.org.

Geriatric meeting plans underway

Planning is underway for the 2006 Clinical Update in Geriatric Medicine conference, presented by the Pennsylvania Geriatrics Society-Western Division and the University of Pittsburgh Institute on Aging. The conference is scheduled for March 23-25, 2006, at the Marriott City Center in Pittsburgh. Featured guest faculty will include Thomas Finucane, MD, Johns Hopkins University of Medicine, Baltimore;

Barbara Phillips, MD, MSPH, University of Kentucky, Lexington; and Richard Stefanacci, DO, University of the Sciences in Philadelphia. In addition, 38 local faculty will present in-depth and focused lectures on a broad spectrum of key geriatric topics.

New to the conference is a half-day nursing home update, as well as an Alzheimer's disease update. A highlight of the program will be the dinner symposium featuring Drs. Finucane and Stefanacci, presenting *Are Medical Education and Practice Abetted by or Corrupted by Big Pharma?*

For more information on conference details and credit offerings, contact CCEHS at (412) 647-8232 or e-mail at CCEHS@upmc.edu. For information on becoming a member of the society, contact Nadine Popovich at (412) 321-5030 or npopovich@acms.org.

Associate editor appointed

The *Bulletin* Editorial Board has appointed D. Scott Miller, MD, as its newest associate editor. He will fill a position vacated by Basil M. Marryshow, MD, who is finishing up three two-year terms in service to the magazine.


Dr. Miller

Dr. Miller, a board certified internist, received his medical degree from Penn State Hershey, completed an internship at the University of Pittsburgh School of Medicine and a residency at UPMC Presbyterian. He is a member of the American College of Physicians.

The board also approved a second term as associate editor for Timothy G. Lesaca, MD.

Photo contest winners selected

The *Bulletin* is pleased to announce the winning entries in its 2005 Photo Contest. From among 45 entries, 11 photos were selected to grace the covers of the 2006 *Bulletins*, February through December; one Grand Prize winner will appear on the January cover.


At a recent meeting of the ACMS Editorial Board, Medical Editor Safdar I. Chaudhary, MD, presented Basil M. Marryshow, MD, with a plaque honoring his six years service as associate editor.

Dr. Katherine M. Flood's color photo, *River Boats, Ross Castle, Killarney, Ireland*, is grand prize winner this year. Other winners include Mr. Richard Altman (medical student) and doctors Melinda Campopiano, Barrylin J. Ferguson, Y. Erica Mak, Lester O. Prince, Terence W. Starz, Robert H. Trivus, Robert D. Tronzo and Robert S. Whitman.

Activities & Accolades


Dr. Pare

Amelia Pare, MD, plastic surgery, represented the Northeast delegation of the American Board of Plastic Surgeons in September for a discussion on the medical issues of children's deformities, Medicare and access to care with Pennsylvania's senators and representatives in Washington, D.C.


Dr. Reshmi

The state government of Karnataka, India, awarded Chandrappa S. Reshmi, MD, ophthalmology, a Rajyotsava Prashasti on November 1 in Bangalore. Dharam Singh, the chief minister of Karnataka, presented Dr. Reshmi with a gold medal, citation and Kashmiri shawl in recognition of his voluntary services in teaching ophthalmology to eye surgeons throughout India, as well as in appreciation of his community service in the state for more than 25 years. Dr. Reshmi is a native of Karnataka.


Dr. Starzl

Through the National Science Foundation, President George Bush recently announced that Thomas E. Starzl, MD, is one of eight recipients of the National Medal of Science. He is being recognized for his pioneering work in organ transplantation.


Dr. Rose

Ron Paglia profiled Carol E. Rose, MD, anesethesiology, for the October issue of *Hospital News.*

Representing the ACMS Speaker's Bureau, Robert Taraszewski, MD, internal medicine, spoke on the topic of nutrition to the Allegheny Chapter of Medical Assistants at its November meeting.


Dr. Turner

The local branch of the National Medical Association, Gateway Medical Society, recently named Morris Turner, MD, obstetrics and gynecology, Physician of the Year. Anita Srikameswaran of the *Pittsburgh Post-Gazette* interviewed Dr. Turner on this accomplishment. (*Editor's Note:* Ms. Srikameswaran's article is printed on page 610.)

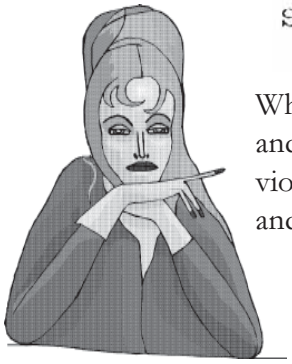
Send your Activities & Accolades items to the attention of Elizabeth Fulton at ACMS, 713 Ridge Ave., Pittsburgh, PA 15212 or e-mail efulton@acms.org. We also encourage you to send a recent photograph indicating whether or not it needs to be returned.

Dear Doctor

Rad M. Agrawal, MD, gastroenterology, discussed what hepatitis is and its symptoms and treatment. He explained that five different hepatitis viruses, lettered A-E, can attack the liver, the most common being A, B and C. The treatment would depend on the type of hepatitis and whether it is acute or chronic. Dr. Agrawal wrote that vaccinations are available for hepatitis A and B.

Anne Boland Docimo, MD, emergency medicine, discussed generic drugs. She wrote that generic drugs are cost-effective and have the same active ingredient as brand name drugs. Dr. Docimo explained that generics are produced several years after the brand name drugs have been on the market and only after the patent for the brand name version has expired.

The Dear Doctor column is published regularly in the Pittsburgh Post-Gazette's *Health Section. To contribute a Dear Doctor column, call Elizabeth Fulton at (412) 321-5030 or e-mail efulton@acms.org.*



Do you suspect or know someone who is a victim of domestic violence?

Where to Turn cards give important information and phone numbers for victims of domestic violence. The cards are the size of a business card and are discreet enough to carry in a wallet or purse.

Quantities of cards are available at no cost by contacting Allegheny County Medical Society at 412-321-5030.

Community Notes

New Year's Eve Party

The Triveni International Club is holding its Fourth Annual New Year's Eve Party at the Holiday Inn Pittsburgh Central/Green Tree, featuring live Indian music, dancing, entertainment and more. Call Ved Kaushik (724) 443-2462; R-D Kapoor (412) 967-9350; or Subash Ahuja (412) 963-6338 for more.

PRHI winter cardiac forum

The Pittsburgh Regional Healthcare Initiative's Winter 2006 Cardiac Forum is set for January 7 at UPMC Shadyside, with registration at 8:30 a.m. and the forum from 9-11 a.m. Blase A. Carabello, MD, keynote speaker, will present *Etiopathology of Mitral Regurgitation.* To register, call Karyl Troup-Leasure at (412) 586-6716 or e-mail ktroup@prhi.org.

HPI Governance Briefings

The Health Policy Institute will present *UPMC's Plan to Comply with Sarbanes-Oxley,* on January 13 from 8-9:30 a.m.The free briefing will be held at the Pittsburgh Athletic Association; CME credit is available. For more information or to register, contact Samuel A. Friede at (412) 624-6104 or friede@pitt.edu.

In Memoriam

Homa Dehgan, MD, age 71, passed away November 5. Dr. Dehgan, a pediatrician, graduated in medicine from Pahlavi University School of Medicine in Shiraz, Iran, in 1959. She served residencies at Bergen Regional Medical Center, Lincoln Medical Mental Health Center, St. Lukes Hospital and A.C. Logan Memorial Hospital. Dr. Dehgan served children in the Pittsburgh and Washington areas. She is survived by two children, Ali and Tania Alavi, and three grandchildren.

Pennsylvania Medical Society President **Lila Stein Kroser, MD,** age 72, passed away November 9. Dr. Kroser graduated in medicine from Woman's Medical College of Pennsylvania (now Drexel University College of Medicine) and served an internship at Philadelphia General Hospital. Until her retirement last year, Dr. Kroser, a family practitioner, had maintained a practice with her husband in Philadelphia since the 1950s. Dr. Kroser was clinical professor of family medicine at Drexel University and was a past president of the Philadelphia County Medical Society, the Pennsylvania Academy of Family Physicians and the Medical Women's International Association. She is survived by her husband Dr. Albert Kroser, daughters Dr. Joyann Kroser and Marla Lerner, son Jonathan and four grandchildren.

Robert J. Lanz Jr., MD, age 66, passed away November 1. Dr. Lanz, who was board certified in psychiatry, graduated from the University of Pittsburgh School of Medicine in 1965 and served an internship at St. Luke's Hospital and a residency at Western Psychiatric Institute and Clinic. He was a member of the Pittsburgh Psychiatric Society and the Pittsburgh Association for Psychoanalytic Thought. Dr. Lanz is survived by his wife Marylyn Moran Lanz, son Michael, daughters Amy Lanz Stepko and Julie Lanz, and two grandchildren.

CONTINUING EDUCATION

CARDIAC FORUM—January 7, 2006. Sponsor: Pittsburgh Regional Healthcare Initiative. UPMC Shadyside. For information, call (412) 586-6716 or e-mail ktroup@prhi.org.

CALL FOR WORKSHOP PRESENTERS: 15TH ANNUAL CASE MANAGEMENT CONFERENCE. —May 31-June 2, 2006. Seven Springs Mountain Resort. Sponsor: Western Psychiatric Institute & Clinic, et al. For information, contact Joanne Slappo (412) 605-1227 or slappojm@upmc.edu.

VIDEOCONFERENCE SERIES. Sponsor: Western Psychiatric Institute & Clinic, et al. CME available. For information, log on to www.wpic.pitt.edu/oerp.

ONGOING CONTINUING EDUCATION PROGRAMS & CONFERENCES. Sponsor: Western Psychiatric Institute & Clinic, et al. CME available. For information, call (412) 624-2523 or log on to www.wpic.pitt.edu/oerp.

ONGOING MENTAL ILLNESS & SUBSTANCE ABUSE (MISA) TRAINING SERIES. Sponsor: Western Psychiatric Institute & Clinic, et al. CME available. For information, call (412) 605-1227 or e-mail slappojm@msx.upmc.edu.

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.

DEC. 2005 & JAN. 2006 CALENDAR

December is the month for the following national awareness programs: Drunk and Drugged Driving and Aplastic Anemia. January is the month for Birth Defects Prevention, Glaucoma and Blood Donors.
(Source: U.S. Dept. of Health and Human Services).

December 26	Holiday/ACMS office closed
Jan 2	Holiday/ACMS office closed
Jan 5, 3:30 pm	Pittsburgh Ophthalmology Society
Jan 10, 10 am	ACMS Alliance
Jan 10, 6 pm	ACMS Board of Directors
Jan 11, 6:30 pm	Medical Assistants
Jan 16, 6 pm	Pittsburgh Urological Association at Mortons
Jan 17	Pennsylvania Geriatrics Society, Western Div.
Jan 17-18	PMS Board
Jan 18, 11:30 am	Emergency Medical Services
Jan 19, 12:30 pm	Pittsburgh Public Schools Administration
Jan 19, 12:30 pm	Pittsburgh Public Schools Speech Pathology
Jan 20, 7:30-11:30 am	Three Rivers Adoption Council

New Initiative Promotes Electronic Prescribing

CAREY T. VINSON, MD, MPM

Electronic prescribing enables a physician to transmit a prescription electronically to a patient's pharmacy of choice. This not only can be easier for the physician, pharmacy and patient than paper prescriptions, but it also can improve patient safety and reduce avoidable health care costs by decreasing prescription errors caused by illegible handwriting and communication errors. In addition, the process of checking for drug interactions, contraindications and allergies can be made automatically. Formulary restrictions, pharmacy benefits and the patient's out-of-pocket obligation can be determined prior to prescribing. Having access to this information at the point of care will make writing, transmitting and filling prescriptions quicker and easier and will also ensure that physicians can make informed decisions about alternative, lower-cost, therapeutically appropriate medications.

Electronic transmission offers benefits over written and oral prescription transmission in terms of accuracy, storage capacity, accessibility, security, productivity and minimizing the potential for adverse drug events. Electronic prescribing has the potential to allow drug therapy information to be stored "online," where it is readily available to patients' authorized health care providers. This can minimize the potential for medical misadventures caused when patients are treated by several different physicians, pharmacists or other health professionals.

To support the adoption of health information technology used at the point of care, Highmark Inc., an independent licensee of the Blue Cross and Blue Shield Association, has contributed an initial $26.5 million to The Pittsburgh Foundation. The foundation has created the Highmark eHealth Collaborative, a supporting organization that will use the funds for an electronic prescribing initiative. [*Note:* The collaborative is not a subsidiary or affiliate of Highmark Inc. and uses the name "Highmark" pursuant to a license agreement.]

The first major focus of the collaborative is on adoption and utilization of electronic prescription systems and electronic health records. It will provide funding to eligible physicians to help reduce the initial cost of acquiring and integrating into their practice electronic technology, such as a personal computer, PDA, electronic tablet or digital pen to generate and transmit electronically a prescription to a pharmacy. Physicians may acquire stand-alone, approved electronic prescribing systems or ambulatory electronic health records systems that include an approved electronic prescribing system. Eligibility criteria and restrictions will apply.

Prior to making the financial commitment, Highmark sought feedback through physician discussion groups and conversations with leaders in the medical community at large. The input and insights received were invaluable in aligning its goals with a practical solution that will help interested physicians adopt these new technologies.

Interested physicians can visit the Highmark eHealth Collaborative website at www.highmarkehealth.org to find complete details, including eligibility requirements

and the online application. Questions may be directed to the collaborative via its website.

I encourage physicians to take advantage of this unique opportunity to pursue funding for electronic prescription technology in their practices. In doing so, physicians will help reduce medication errors, eliminate time-consuming administrative work associated with handwritten scripts, better manage the requirements of multiple drug formularies and, most importantly, help ensure patient safety and satisfaction.

Dr. Vinson, a family practitioner, is medical director for quality and medical performance management at Highmark Blue Cross Blue Shield. He can be reached at carey.vinsonmd@highmark.com.

Collaborative Targets Electronic Prescribing

Highmark has contributed $26.5 million to The Pittsburgh Foundation, which will use the funds for an electronic prescribing (ePrescribing) initiative. The foundation created the Highmark eHealth Collaborative to encourage the adoption of health information technology used in patient care in order to improve patient safety and quality while increasing cost efficiency.

The first major project of the Highmark eHealth Collaborative is to help physicians reduce the initial cost of acquiring ePrescribing/eHealth Record technology for their practices.

To receive funding, physicians in western and central Pennsylvania must first fill out an online application on the collaborative's website at www.highmarkehealth.org. Physicians must be licensed to practice medicine in Pennsylvania and must be a licensed prescriber in order to qualify for funding.

The collaborative will pay up to 75 percent of the cost for a physician's office to acquire, install and implement the electronic technology system, up to a maximum of $7,000 per physician, with the physician's practice to pay the remaining balance.

(For more information about the Highmark eHealth Collaborative, visit www.highmarkehealth.org.)

Contact Phil Neubauer of Highmark Inc. (412) 544-4221or phil.neubauer@highmark.com.

Highmark eHealth Collaborative is not a subsidiary or affiliate of Highmark Inc. It is a supporting organization of The Pittsburgh Foundation funded by a major contribution from Highmark Inc. Use of the name "Highmark" is pursuant to a license agreement. Highmark Inc. is an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

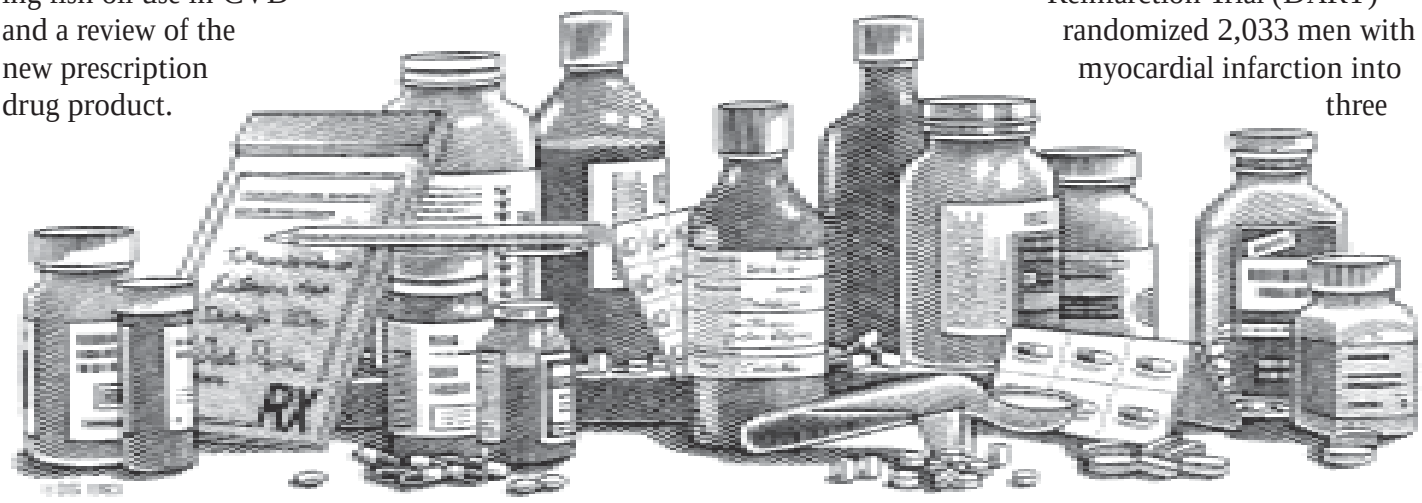
Omacor®— A New Prescription Product for Hypertriglyceridemia

SCOTT A. KACZMORSKI, PHARMD CANDIDATE

Advances in medicine have resulted in cardiovascular disease (CVD) falling from the number one cause of death in 2002.[1] Despite losing its top ranking, heart disease still affects approximately 70 million Americans with 27 million of those with CVD aged 65 or older. This figure is expected to increase as the U.S. population continues to age. The direct and indirect cost associated with CVD is estimated at $394 billion for 2005.[2] The mainstay of treatment for reducing CVD has been to control the major risk factors for disease such as hypertension, hyperlipidemia and diabetes. Recently, hypertriglyceridemia has been shown to increase the risk of CHD beyond that predicted by LDL cholesterol alone.[3] In 2005, the Food and Drug Administration (FDA) approved Omacor, a fish oil-based product for the treatment of hypertriglyceridemia. The following is a brief description of the evidence supporting fish oil use in CVD and a review of the new prescription drug product.

Fish oil (Omega-3 Fatty Acids) and cardiovascular disease

For many years now, researchers have hypothesized that fish oil may have a beneficial effect on the cardiovascular system. Many observational studies have shown that diets rich in omega-3 fatty acids (ω-3 FA) are associated with decreased risk of cardiovascular mortality, myocardial infarction and sudden death.[4] Marine fish oil (ω-3 FA) is found primarily in fatty fish (i.e. salmon, tuna, etc.) and is comprised of eicosapentaenoic acid [EPA] and docosahexaenoic acid [DHA]. Research has shown increasing evidence for several mechanisms of action such as anti-inflammatory, antithrombotic, antiarrhythmic and antiatherogenic effects of fish oil.[4] Several randomized control trials have added to the body of observational and epidemiological evidence supporting the use of fish oil in CVD. The Diet and Reinfarction Trial (DART) randomized 2,033 men with myocardial infarction into three



dietary groups (decreased fat, increased fatty fish or increased fiber). The study examined the effects of diet for the secondary prevention of myocardial infarction. The two-year incidence of reinfarction and death was not significantly affected in any treatment group. However, those randomized to a fatty fish diet had a 29% reduction ($p < 0.05$) in two-year, all-cause mortality compared with participants not advised to eat fatty fish.[5] The GISSI trial randomized 11,324 Italian men who were post myocardial infarction within the past three months into a placebo group and one group that received 850 mg of fish oil. The primary endpoints were death, nonfatal myocardial infarction and stroke. Those in the fish oil treatment group were found to have a 15% reduction in primary endpoints after 3.5 years (NNT = 48 for 3.5 years; $p = 0.008$).[4] Also, a systematic review by the Agency for Health Care Research and Quality (AHRQ) found fish oil to have favorable effects on cardiovascular and overall mortality.[4] Due to the body of supportive evidence for fish oil, the American Heart Association recommends the daily intake of one gram of ω-3 FA in patients with documented coronary heart disease (Figure 1).[6] The Adult Treatment Panel III (ATP III) recognizes that higher doses of DHA and EPA (3-12 g/day) have been shown to lower serum triglycerides (30–50 %) by reducing hepatic secretion of triglyceride-rich lipoproteins thus, they represent alternatives to fibrates and niacin for the treatment of hypertriglyceridemia. Doses of 1 to 2 grams of fish oil per day may also reduce the risk for major coronary events in persons with established CHD.[3]

Figure 1 - American Heart Association Recommendations for Ω-3 Fatty Acid Intake[6]

Population	*Recommendations*
Patients without documented CHD	Eat a variety of fatty fish at least twice a week. Include oils and foods rich in α-linolenic acid (flaxseed, canola, soybean oils or walnuts).
Patients with documented CHD	Consume approximately 1 g of EPA & DHA per day, preferably from oily fish. EPA & DHA supplements could be considered in consultation with the physician.
Patients needing triglyceride lowering	Two to four grams of EPA & DHA per day provided as capsules under a physician's care.

OMACOR® (omega-3-acid ethyl esters) Capsules

Indications/Use[7-8]

Omacor is indicated as an adjunct to diet to reduce very high triglyceride (≥500 mg/dL) levels in adult patients. Patients should be placed on an appropriate lipid-lowering diet before receiving Omacor and should continue the diet throughout treatment. The daily dose of Omacor is 4 grams per day, which can be taken as a single dose of four capsules or as two capsules twice daily. In clinical trials, Omacor was administered with meals.

Each 1-gram capsule of Omacor contains a combination of highly purified and concentrated (omega-3 acid ethyl esters) of EPA (~465 mg) and DHA (~375 mg). Although the mechanism of action is not completely understood, potential mechanisms include inhibition of acyl CoA:1,2-diacylglycerol acyltransferase and increased peroxisomal β-oxidation in the liver. Omacor may interfere with the liver's ability to synthesize triglycerides since EPA and DHA are alternative substrates for the enzymes that synthesize triglycerides. EPA and DHA also inhibit esterification of other fatty acids.

Clinical Studies[7-9]

The FDA approved Omacor based on the safety and efficacy of eight double blind, placebo-controlled trials (n=454). Patients with Type IIb (TGs between 177 and 750 mg/dL and LDL-C>160 mg/dL), Type IV (Same TGs between 177 and 750 mg/dL with LDL-C≤160 mg/dL) and Type V dyslipidemia (TGs ≥750 mg/dL) received Omacor 4 grams per day or placebo for 6 to 16 weeks. Pooled data from the eight studies showed decreases in triglycerides from baseline that ranged from 17.3 to 47.7 percent. An overall reduction of 28% was seen compared to an increase of 2.5% in the placebo group ($p<0.0001$). Omacor was effective in reducing triglycerides across the patient population however, a favorable effect on the overall lipid profile was observed only in the Type V population. Patients with Type IIb or IV dyslipidemia with

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increased levels of LDL-C at onset may experience increases in LDL-C and other atherogenic lipid biomarkers with the use of Omacor. These increases may negate the cardioprotective effect of triglyceride lowering.

The prescribing information for Omacor reports two of the eight trials used in the approval process. These trials studied the effects of Omacor in 84 adult patients with very high triglycerides randomized to either Omacor (4 g/d) or placebo. The studies were conducted over a 6 and 16-week duration and their results are summarized below in Table 1.

Adverse events/Drug interactions[7-8]

The most commonly reported adverse effects during clinical trials included dyspepsia, burping and taste changes (fishy taste). Omacor was well tolerated with discontinuation rates of 3.5% in patients treated with Omacor compared to 2.6% of patients treated with placebo. Clinically important drug-drug interactions via the cytochrome P450 system are not expected with Omacor. The use of Omacor concomitantly with anticoagulants has not been studied. Some studies do suggest that omega-3 fatty acids used concurrently with anticoagulants have caused prolonged bleeding times. Patients

Table 1 – Median Baseline and % Change from Baseline in Patients with Very High TG levels (≥ 500 mg/dL)

	TG		LDL-C		CHOL		HDL-C		VLDL-C		Non-HDL-C	
	BL	% Chg	BL	% Chg	BL	% Chg	BL	% Chg	BL	% Chg	BL	% Chg
Placebo	788	+6.7	108	-4.8	314	-1.7	24	0.0	175	-0.9	292	-3.6
Omacor	816	-44.9	89	+44.5	296	-9.7	22	+9.1	175	-41.7	271	-13.8

taking Omacor and an anticoagulant should be monitored periodically.

Contraindications/Precautions[7]

Omacor is contraindicated in patients who are hypersensitive to any component of the drug. It should also be used cautiously in patients with known sensitivity or allergy to fish. In some patients, elevated low-density lipoprotein (LDL-C) and alanine aminotransferase (ALT) levels were observed. LDL-C and ALT levels should be monitored periodically during Omacor therapy.

Cost[8]

Omacor is more expensive than OTC formulations of fish oil. The average wholesale price (AWP) is $1.18 per capsule ($4.72/day for usual dose). Comparatively, the AWP for generic gemfibrozil is $1.25 per 600 mg tablet ($2.50/day for usual dose) and $2.57 per 200 mg capsule of generic fenofibrate (Lofibra).

Place in therapy

Since heart disease affects nearly a quarter of the U.S. population, controlling risk factors is an important aspect of disease management. For the treatment of hypertriglyceridemia, the ATP- III guidelines recommend using either a fibrate or nicotinic acid as initial therapy.[3] Omega-3 fatty acids (such as Omacor) can be used as an effective alternative or adjunct to fibric acid derivatives and niacin especially when tolerability or adverse effects limit the use of such agents. Additional high quality trials are needed to confirm the cardioprotective effects of omega-3 FA for primary or secondary prevention of cardiovascular disease.

Mr. Kaczmorski is a PharmD candidate at the Duquesne University Mylan School of Pharmacy. For additional information on this topic, contact Tucker Freedy, PharmD, BCPS, director of the Drug Information Center at Allegheny General Hospital and adjunct clinical instructor at the school at (412) 359-4711.

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Ms. Shogan


Ms. Murty

The False Claims Act—
Implications for Health Care Providers

JACQUELINE O. SHOGAN, ESQ
AARTHI MURTY, ESQ

What is the False Claims Act? Federal fraud and abuse enforcement has escalated in recent years. One tool that the government is using with increasing frequency is the False Claims Act (FCA). The False Claims Act, 31 U.S.C. §3729 et seq., is an anti-fraud statute that prohibits the knowing submission of false or fraudulent claims to the federal government. Although the FCA addresses a wide range of conduct, liability under §3729(a)(1) is imposed when:

- a person presents, or causes to be presented, a claim for payment or approval;
- the claim is false or fraudulent; and
- the person's acts are undertaken "knowingly."

Persons who violate the FCA are liable for civil penalties of between $5,500 and $11,000 for each fraudulent claim submitted and treble damages.[1] Damages are generally defined as the amount the government actually paid, minus the amount it would have paid had the claims not been false. In addition, persons who violate the act are liable for the costs incurred in bringing the lawsuit.

An action under the FCA may be brought either by the attorney general or by a private individual on behalf of the government, which is commonly known as a qui tam action. *Qui tam* is the shortened version of the Latin phrase *Qui tam pro domino rege quam pro sipso*, which means "he who brings the action as well for the king as for himself." The private individual bringing the qui tam suit, known as the relator, must first serve the complaint on the government. The complaint remains under seal with the government for at least 60 days. During this time, the government may elect to intervene. If the government chooses to intervene, then the attorney general assumes control over the case and the relator is entitled to 15 to 25 percent of the recovery. The exact amount depends upon the extent to which the relator contributes to the prosecution of the case. If the government does not intervene in the action, the relator may proceed on his or her own and, if successful, recover 25 to 30 percent of the verdict. Similar factors are considered in determining the exact amount of the relator's reward as when the government does intervene. An employer is not allowed to retaliate against an employee in the event an employee becomes involved in the filing or investigation of an action under the FCA.

A relator's ability to bring a qui tam action is not unlimited. The primary restriction relates to the source of the relator's knowledge regarding the fraudulent conduct. The qui tam relator must be the "original source" of the information, which is defined as "an individual who has direct and independent knowledge of the information on which the allegations are based and [who] has voluntarily provided the information to the government before filing an action…which is based on the

information." §3730(e)(4)(B). Thus, the FCA encourages "whistleblowers" to bring claims against persons engaging in fraudulent conduct, but does not allow for private parties to reap the benefits of a governmental investigation made public unless they provided the information that resulted in the investigation.

Despite this limitation, the FCA's qui tam provisions have significantly increased the number of claims brought under the act and have resulted in the recovery of exceptionally large amounts for the government. In the past, cases brought under the FCA usually involved the military or defense industry. However, the focus has recently shifted to the health care industry. As reported in the December 2003, issue of the *Corporate Crime Reporter*, 56 of the highest 100 FCA settlements since 1991 have been with health care entities. Two of the top settlements ($731 million and $631 million, respectively) were with HCA, the Tennessee based health care corporation, with the relator's share in one of those cases reportedly being over $150 million. As of 2004, it was estimated that the total FCA amount recovered where there was an associated qui tam case was over seven billion dollars.

"Knowingly?" defined

When is a health care provider deemed to have submitted a false claim "...knowingly?" Since the time of its enactment, the FCA has required that the defendant commit the prohibited conduct "knowingly." Prior to the 1986 amendments to the act, a number of courts defined "knowingly" as "specific intent to defraud." Congress expressly rejected this definition in 1986 by ammending 31 U.S.C. §3729 to include the following definition of "knowingly":

- actual knowledge of the information;
- acting in deliberate ignorance of the truth or falsity of the information; or
- acting in reckless disregard of the truth or falsity of the information.

Congress clarified the knowledge standard in order to require that individuals and contractors receiving public funds make at least a limited inquiry as to their entitlement to the money they seek. The knowledge standard was intended to prevent "ostrich" situations, where an individual "buries his head in the sand" and fails to make any type of inquiry.

Although these definitions have been applied in varying ways by courts across the country, random errors in preparing or submitting claims are generally considered to be evidence of negligence rather than knowing or willful intent. However, courts have held that knowing or willful intent can be inferred from circumstantial evidence that includes repeated violations. For example, in *United States v. Brown*, 763 F.2d 984 (8th Cir. 1985), the defendant pharmacists were found liable under the FCA for submitting claims for the more expensive brand name drugs when only the generic drugs were dispensed. The court held that the requisite knowledge and willfulness could be inferred from the repetitious pattern of submitting the false claims. In contrast, a high rate of accuracy in the submission of claims undermines actions under the FCA for knowingly engaging in a pattern of erroneous claims. Thus, if the allegedly false claims constitute only a small percentage of the total number, a court is less likely to find intent.

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The justice department has made health care fraud and abuse one of its top priorities, and enforcement actions are expected to increase even further as more government dollars are spent within the health care industry.

Furthermore, if a provider has been put on notice of probable fraud and fails to investigate, courts have found the knowing submission of false claims. In *United States v. NHC Health Care Corp.*, 163 F.Supp.2d 1051 (W.D. Mo. 2001), defendant owners and operators of a nursing home were accused of submitting false claims for Medicare and Medicaid services that were never provided patients due to a staffing shortage. In refusing to dismiss the claims against the defendants, the court found that they "knew or should have known that if they did not have sufficient staff to properly care for their residents, then they should not have submitted bills to Medicare or Medicaid which represented that they provided such care." 163 F.Supp.2d at 1058. Thus, even though the government could not show that the defendants had knowingly submitted false claims, such intent could be inferred from their probable knowledge of the inability of their staff to provide sufficient care.

What does this mean for physicians?

Persons who submit Medicare or Medicaid claims to the government for reimbursement are subject to the penalties under the FCA if the claims are false or fraudulent and submitted with the requisite intent. Because penalties are imposed for each false claim that is submitted, liability under the FCA for Medicare or Medicaid providers can be great.

The justice department has made health care fraud and abuse one of its top priorities, and enforcement actions are expected to increase even further as more government dollars are spent within the health care industry. Although most of the money recouped in the past has been from large health care organizations, physicians also face significant risks. A physician may be liable not only if he or she submits claims for services not rendered ("mischarge" cases), but also if greater reimbursement than that to which he or she is entitled is sought ("overcharge" cases). In addition, an increasing number of cases are being based on allegations that the physician falsely certified compliance with applicable statutes, regulations or contractual requirements ("false certification" cases). This covers a wide range of conduct and can produce rather harsh results. For example, in *Peterson v. Weinberger*, 508 F.2d 45 (5th Cir. 1975), a defendant falsely characterized Medicare claims for physical therapy services as having been performed by or at the direction of a qualified physician. These claims would not otherwise have been reimbursable under Medicare. Damages were found to be the total amount paid by the government, rather than a difference in reimbursement rates, because the services as rendered did not qualify for payment. Physicians may also directly violate the FCA when they routinely waive co-pays. The Department of Health and Human Services, Office of Inspector General, has taken the position that routine waivers of deductibles and co-pays misstate the actual charges of the services. Thus, co-pays or deductibles should not be waived in the absence of individual findings of financial hardship or reasonable collection efforts.

Along with direct violations of the FCA, physicians need to worry about indirect violations. A recent case suggests physicians in Pennsylvania who are in violation of the federal Anti-kickback Statute or Stark Law can also be in violation of the FCA.[2] *United States v. Zimmer, Inc.*, 386 F.3d 235 (3d Cir. 2004), involved a whistleblower suit filed in U.S. District Court for the Eastern District of Pennsylvania by an orthopedic surgeon against Zimmer, a medical device manufacturer, under the FCA, Anti-kickback Statute, and Stark Law. The alleged kickbacks were "rewards," in cash or cash equivalents, that Zimmer paid to a health care system for purchasing its implants. These rewards, in turn, were allegedly shared with the prescribing doctors who made referrals to the health care system. The subsequent Medicare claims for full reimbursement by the health care system were allegedly fraudulent because they were not reduced by the amount of the rewards paid out. The district court had granted Zimmer's motion to dismiss since the health care system, not Zimmer, had submitted the claims for reimbursement. However, the U.S. Court of Appeals for the Third Circuit reversed, holding that a

party could be liable under the FCA if it assisted in the filing of a false claim, even if the actual presenter of the claim was unaware of the fraudulent conduct. In so holding, the court found that anti-kickback and Stark claims could form the basis of a FCA action, although it did not have to decide whether Zimmer's conduct rose to that level for purposes of the appeal.

Although the Zimmer case was an action against a medical device manufacturer, the same reasoning is applicable to any health care provider, including physicians. The lesson to be learned is one of constant vigilance. The importance of compliance programs cannot be emphasized enough. Physicians must continually monitor business arrangements and billing practices, and be attentive to changes in and interpretations of federal and state laws. Although the False Claims Act is just one way in which a physician's practices can be challenged by governmental authorities, it is one of the most powerful weapons within the government's arsenal since its whistleblower provisions provide a strong incentive for private parties to bring questionable practices to the government's attention.

Ms. Shogan is an attorney with the legal firm of Thorpe Reed & Armstrong, LLP. She can be reached at jshogan@thorpreed.com. Ms. Murty is a former employee of the firm.

REFERENCES

[1]Although the statute provides for penalties of not less than $5,000 and not more than $10,000 per claim, these amounts were increased to $5,500 and $11,000, respectively, for claims submitted on or after September 29, 1999, under 28 C.F.R. §85.3.

[2]The Anti-kickback Statute, 42 U.S.C. §1320a-7b(b), condemns any type of remuneration in exchange for a patient referral or referral of other business for which payment may be made by Medicare, Medicaid and other federal health programs, while the Stark Law, 42 U.S.C. §1395nn, prohibits a physician from referring patients who need certain designated health services to entities with which the physician has a financial relationship. The Anti-kickback Statute requires a knowing or willful violation, but there is no such requirement under the Stark Law.

Governor Ed Rendell's Message to the PMS House of Delegates

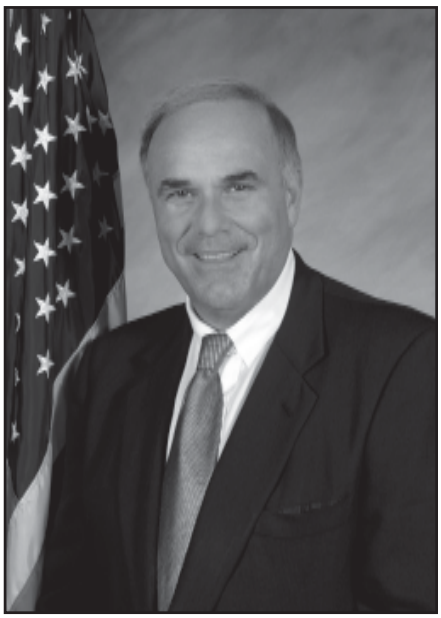
Sunday, October 16, 2005

Governor Ed Rendell addressed the Pennsylvania Medical Society House of Delegates in mid-October. His staff has graciously summarized that speech for publication here. Comments from the Pennsylvania Medical Society are included after the text of the speech on page 599.

Let me begin this morning by thanking Dr. Gurman for his brief but interesting introduction. I also want to thank Dr. Glunk. Dr. Glunk really is our liaison and spends a lot of time talking to Rosemarie Greco, who's head of our Office of Health Care Reform. They talk on a weekly basis which helps us focus on issues that are important to all of you and, in turn, helps direct your focus a little bit on issues that are important to us.

I, of course, want to congratulate Dr. Kroser for her induction as your new president; that's certainly worthy of applause. No job can be more daunting than to be president of a society of doctors, with the exception of being president of a society of lawyers. (*Editor's Note:* Dr. Kroser died suddenly on Nov. 9; see *In Memoriam*, page 581.)

This morning, I'd actually like to talk to you about what I think is one of the greatest challenges we face in Pennsylvania and that's medical malpractice. But before I do that, I want to take time to thank you for your efforts in working with us on two very, very important programs that the medical society has targeted, and that's childhood obesity and patient safety. Both are extremely important.



Governor Ed Rendell

Members of the society and members of our cabinet have been working together on a program to battle childhood obesity. Today in Pennsylvania, two out of 10 children qualify as obese, and two more out of 10 are at-risk of becoming obese. Our numbers are higher than the national average, which is 15 percent. And that's not surprising because six out of 10 Pennsylvania adults are considered to be overweight, and 25 percent are considered to be obese.

Overweight kids, as you know, are dramatically at increased risk for contracting diabetes. Type 2 Diabetes has traditionally been considered an adult disease, but we are seeing it much more frequently in adolescents. In fact, the threat of heart disease is showing up early in children. According to a study done by researchers at Children's Hospital of Pittsburgh, we are seeing this more and more in young children. Children with Type 2 Diabetes who are obese are showing early signs of cardiovascular disease similar to middle-aged adults. That is a stunning reality.

We know that we need to take a collaborative and comprehensive approach to dealing with this

problem, and I believe that we are. This approach is making Pennsylvania a national leader in childhood obesity prevention efforts. In 2003, Pennsylvania became the second state in the nation to develop a state plan to prevent obesity and chronic disease. In addition, we've formed Pennsylvania Advocates for Nutrition and Activity (PANA)—a statewide coalition seeking to improve the environment and make policy changes related to nutrition and physical activity and to assist us in implementing our statewide plan. In our pre-schools, we're focusing on this problem with a program called Color Me Healthy, that teaches children, teachers themselves and parents about the importance of health at the earliest of ages.

In 2004, Pennsylvania became one of three new states to be awarded a five-year grant from the CDC under its Steps to a Healthier US program. We're trying to reduce the burdens of asthma, diabetes and obesity by focusing on poor nutrition, physical inactivity and tobacco use. Right now, we're using these funds to target a pilot program in Fayette, Luzerne and Tioga counties.

We're also trying to make sure that parents and primary caregivers are more involved in the battle to combat childhood obesity. For the first time this year, parents in grades K-4 will get information about their child's body mass index (BMI) to help them better understand the growth development of their child. Parents and guardians will receive a letter from their child's school advising them of their child's BMI—whether they are underweight, healthy weight, at-risk of overweight, or overweight. The program is mandatory this year for grades K-4, will be mandatory next year for grades K-8, and will be mandatory in 2007-2008 school year for grades K-12. This program will present an opportunity for you as clinicians to get involved because the letter says that these findings should be discussed with the child's primary care physician. The departments of Health, Insurance and Public Welfare also have been working with the Pennsylvania Medical Society to develop a childhood obesity provider toolkit to help prepare both clinicians and parents to care for their pediatric patients.

This obesity challenge is just another reminder of why it's important to have health care. One of the things I am proud to say is that last year when states all over the country were facing the challenge of rising costs in Medicaid, we added 10,000 children to the rolls of our CHIP program. At the same time, we made sure that no adult lost Medicaid coverage; and that was in the face of 170,000 adults and family members joining the Medicaid program.

I also want to thank you for your work in trying to focus on patient safety. Patient safety affects so many things, including medical malpractice premiums. Rosemarie has told me about the efforts the society has made to focus on patient safety. Your decision to concentrate on eliminating hospital-acquired MRSA infections will help make patients safer in our hospitals, and that will be a significant step forward.

Within a week after becoming governor, I had to deal with the exploding crisis of medical malpractice. And let me make it clear that, regardless of all the controversy, I believe it was a crisis and I believe it had to be dealt with. So you will recall that, before I took office as governor, I had a press conference with then-Governor Mark Schweiker and outlined several steps that we wanted to take, including the MCARE abatement that has been such an important part of stabilizing the number of doctors here in Pennsylvania.

A lot has happened since December 2002, and I'd like to go over some of the things that convince me today that we have made substantial progress. Number one: We have been able to build upon Act 13. And many of you told me in November and December that Act 13 was just a small step and much more needed to be done. And I agreed with you. And we have built on Act 13 with a combination of legislation and initiatives by the Supreme Court Civil Rules Committee, initiatives that were instigated by myself, going to Chief Justice Cappy and talking about the things that needed to be done.

And there have been a whole host of further reforms: reforms that were designed to and succeeded in eliminating the number of frivolous lawsuits like the reform that requires a Certificate of Merit to be filed any time a medical malpractice lawsuit is filed in Pennsylvania; reforms in venue rules that have been so impactful in stopping venue shopping which has helped curb the total number of claims in Philadelphia, as well as across the state; reforms in setting up new and innovative programs like our mediation program; reforms in giving

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trial judges the much more easy task in remitting large, outlandish verdicts; and several more.

These reforms, again building upon Act 13, have been enormously successful in helping to abate what was a true and legitimate crisis. Let me give you some examples that lead me to that conclusion. Of course one of the indicators of the malpractice situation is the number of doctors practicing in Pennsylvania. Our MCARE Fund staff tells me that the number of physicians paying the MCARE surcharge has stayed constant during the three years that I have been governor, hovering right around the number of 34,000.

The affordability question. Let me talk about malpractice insurance affordability, starting with the MCARE abatement, that we did get through the legislature in 2003 and that did affect the physicians' MCARE payment in 2003, 2004 and 2005. And as all of you know, it eliminated 100 percent of the MCARE payment for physicians in the four most challenged specialties—neurosurgery, general surgery, obstetrics and orthopedics. For all other physicians it eliminated 50 percent. So far, over the last three years, the state has paid out $700 million in abating those MCARE payments. It came from an increase in the cigarette tax. And you will see commercials against me next year, talking about the number of taxes that I've raised and the dollars that are in the cigarette tax will be. They won't tell the people what the tax increase was for, but they'll be in the campaign commercials. I understood that when I did that, but I thought it was crucial to stabilize the situation, and the situation has been stabilized significantly. To give you sort of a frame of reference for how impactful that $700 million is: The combined annual budgets of the Insurance Department, the Health Department and the Department of Aging are $340 million. So that's more than the budgets of those three departments for two years, and that money has been passed onto physicians. Although I will say one of the most disappointing things is that members of my administration tell me they run into doctors all the time who don't realize that the state had anything to do with that MCARE abatement, which to me is phenomenal. But it is amazing to me that there are doctors practicing in Pennsylvania today who don't believe or don't know that the state government had anything to do with reducing their MCARE payments, and in some cases in the most challenged specialties, reducing their MCARE payments by $30,000 or $35,000. So the MCARE abatement has been very successful.

I got calls from many members of the society and many members of individual practice societies and groups about the insurance commissioner's decision to keep or move the primary coverage dollars. As most of you know, we responded to those calls and I was able to convince the insurance commissioner to keep the primary coverage level at $500,000 for now. So you will continue to pay the MCARE surcharge on $500,000 worth of coverage. Changing the levels now, I thought, would have been the worst time because we have started to make real definitive progress and changing that mix would have disturbed that progress, and we believe that the insurance commissioner made the right decision.

Let me get back to the question of affordability. The first condition of affordability comes from MCARE itself. Although this isn't definite in the sense it hasn't been fixed in stone, the MCARE people tell me that I am safe in reporting to you that next year the MCARE surcharge will be reduced from 39 percent to somewhere close to 30 percent — that is a 25 percent reduction. And although for the physicians getting 100 percent of their abatement picked up, it doesn't have any importance, it does for all of the other physicians. And that's a sure sign that we're beginning to turn the corner in this crisis.

Secondly, as most of you probably know by now, we've had great news in the area of primary coverage as well. This year, the state's three largest carriers—PMSLIC, Med Pro and the JUA—have kept their rates flat, something that hasn't happened for a long time in Pennsylvania. Let me put that in a frame of reference for you. In 2002, the year that I was elected governor, PMSLIC increased its rates by an average of 40 percent and then in 2003 increased its rates by 53 percent. To have PMSLIC and the other two major carriers keep their rates flat means that we have turned the corner and we are making substantial progress.

Let me talk about the question of availability because when I met with many groups when I was running for governor in 2002 and when I first became governor, availability was a crucial question as well. Well, the availability picture has brightened tremendously as well. In addition to the growth of a host of risk retention

groups, the good news is that PMSLIC has announced for the first time in a long time they are now writing new insurance for doctors. We haven't had news like that in Pennsylvania for awhile. They're going out and seeking new business. That again is a sure sign that we've begun to turn the corner.

Claims: Let's talk about the number of claims that have been filed. These statistics are even more impressive. According to recent data released by the Supreme Court, claims in medical malpractice cases are down statewide by 34 percent and down in Philadelphia (thanks to the venue rule) by 50 percent. These are 2004 figures, the last year we have full figures for.

But let's take a look at another example and that's the MCARE Fund payout. In 1999, the MCARE Fund paid claims of a little more than $300 million. In 2002, that went up to $348 million and climbed again in 2003 to $379 million. In 2004, the first year you would have seen the effects of any of the changes that were made, that number dropped to $320 million. But the news this year is even better. Commissioner Koken tells me that the MCARE payout this year will be $232 million, down from a high of $379 million. So the trend lines are going in the right direction. The programs are starting to kick in. It is my understanding that mediation in many parts of the state has taken hold and is becoming almost the norm, and mediation will certainly improve all of the numbers that I talked about.

We've made progress and we've turned the corner, but just as we were able to persuade the insurance commissioner not to change the mix between MCARE and private coverage because it wasn't the right time, I don't think the time has come for us to end the abatement. We will be seeking to extend the abatement for another two years. I think that is enormously important, and I hope that you will work with us to convince the legislature. There are some in the legislature that look at the figures I've just told you and say the problem is over. To say the problem is over is clearly premature. We've turned the corner; I believe turned the tide. I think we're on the way towards ending this problem, but we cannot upset the progress we've made. In my judgment, we must continue the abatement for the next two years and, at the same time, we must look at a way to pay out the unfunded liability that remains under MCARE. We cannot put that burden on our young doctors. That is a burden that the state has to work with all of you to find an answer to, and we are committed to doing that. Because—although the numbers of doctors practicing in the state, as I've said, have remained fairly stable in the last two and a half years or so—I am not unaware, coming from Philadelphia with all of its teaching hospitals of the fact that our young doctors graduating from some of the finest schools in the United States of America are not choosing in great numbers to practice in Pennsylvania. And we need to get rid of that unfunded liability so they will not have the burden in their earliest years of practice of helping to pay off something that they had no responsibility in creating.

I also want to ask the society to join us in being advocates for keeping not only doctors in Pennsylvania, but convincing young doctors coming out of school to stay in Pennsylvania. For too long, we all—with some degree of credence and understanding—bad mouthed the situation in Pennsylvania. We all said that with malpractice premiums going up at the rates that I just quoted for 2002 and 2003, this was a horrible place to practice medicine. I think the time has come to recognize that substantial progress has been made and to start talking to our younger doctors and our medical students and our interns about the fact that progress has been made. This is an area where you brought to us—in very loud and clear terms—a problem. We took action to help abate that problem. Now again, I'm not here to tell you that we've done everything that needs to be done or that the problem and the crisis is over. But those facts and statistics that I just quoted to you are as undeniable today that we have turned the corner and conditions are better than the facts and statistics you brought to me as governor-elect were undeniable back then that the problem was a true crisis and was out of hand and needed strong and firm and decisive action.

Like I said, what I did in creating the MCARE abatement and getting it through the legislature wasn't an act of political courage, it was a necessity. And government should respond to crisis and should respond to necessity and should respond quickly. The work that Rosemarie Greco has done working with all of you in creating the reforms—the legislative reforms and the reforms that have gone through the Supreme Court—have been substantial. We worked with Dr. Glunk and

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others to shape these reforms and to bring these ideas to fruition. So the time has come for us to start painting a picture that Pennsylvania *is* a good place to live and to work and *it is* a good place to practice medicine. We have the finest group of hospitals anywhere in the United States of America. We have wonderful health care organizations. We have great doctors. At the height of the crisis, I continued to say that. When there were groups out in Valley Forge holding up playing cards, much like the U.S. government did with Saddam Hussein and everybody else and, when I was the ace of spades, I continued to say that. Fortunately for all of you, I've been in politics in an executive position, so I'm used to all of that stuff. A lot of my legislators who'd come from safe districts who were the queen or the king were a little more taken aback by all of that. But I continued to say that and I believe that with all my heart. One of the things that makes the quality of life in Pennsylvania so great is the fabulous medical care that we have here. We've worked together, and you would have to be a fool not to understand what that level of medical care does for our economy—in Philadelphia, in Pittsburgh, throughout the Commonwealth of Pennsylvania. We are driven by our health care industry—by our hospitals, by our doctors, by our researchers, by our pharmaceutical companies. We have to understand how important all of that is to our economy.

So we will continue to work with you to identify problems. As I said, Dr. Glunk and others are constantly in touch with Rosemarie Greco and other people in our administration who will continue to make progress on a whole slew of problems. And we ought to make progress on patient safety, not just because it has an impact on medical malpractice premiums, but because it has an impact on human beings. And I am still enough of a romantic; I still believe there are good things in my business, though Lord knows that's tough these days. But I still believe that most of you became doctors, not because you wanted to make a lot of money, but you became doctors because you wanted to help people. The same reason I became a politician. I knew when I charted my course for my life that I would never be rich—I've never made anything that anybody would consider close to real money. And I've never missed it for a day. Because you know and I know that when we do our jobs well, when we do our jobs right, we can give people opportunities to live rich and full and happy lives. We can allow people to reach their full potential, and that's a gift to be able to do that and to be able to create that. That's a gift that many people in life never get to experience. So I believe that you care very deeply about what happens to patients and at the most heated times in this crisis, almost all of your representatives always said the right thing: "This isn't about doctors, it's about patients. It's about access to quality health care."

And I believe that you meant it. And that's what convinced me to help most of all because you believe and I believe that this was about our patients, about our people, about the underserved, about ordinary Pennsylvanians. And we have to keep the progress going; we've got to continue to work together. There are times that we will disagree, that's the nature of the business. But as long as the lines of communication are open, as long as we continue to dialogue with each other, I think we will continue to make progress; I ask for your help, first with the legislature to make sure that, although the tide is turning, we keep the abatement going. And we also need to start talking about some of the things that we've done. Even if you don't believe it went all the way.

Just a piece of advice: Every once in awhile people deserve a pat on the back when they've done stuff. And again, I'm less sensitive because I've been in the firing lines for 28 years. But some of the legislators who bit the bullet on a lot of these things...the Supreme Court, I think the chief justice did a great job of responding to this crisis. In the old Supreme Court, it would have taken three or four years to get any of the rules promulgated that were promulgated in three or four months this time. And we ought to let the people who've done a good job know that they've done a good job, know that we appreciate their efforts. And I think the best way for us, in government, to hear that is to hear you all talking about the fact that progress has been made, and Pennsylvania is a pretty decent place to practice medicine again.

Thank you all very, very much,

Governor Ed Rendell

Comments by the Pennsylvania Medical Society

The Pennsylvania Medical Society applauds and appreciates efforts that have been made by Governor Rendell's office on behalf of the current liability insurance crisis. It notes that the initial date is subject to different interpretation and does not yet indicate clear trends.

According to an *Associated Press* news story (March 21, 2005) of a report from the US Health Resources & Services Administration, malpractice payouts against Pennsylvania physicians jumped 13.5 percent in 2004 to $448 million, compared to $394.5 million in 2003. Other years include:

1991 .... $182.5 million	1998 .... $279.2 million
1992 .... $216.7 million	1999 .... $356.4 million
1993 .... $208.4 million	2000 .... $350.8 million
1994 .... $228 million	2001 .... $423.7 million
1995 .... $233.3 million	2002 .... $398.9 million
1996 .... $309.5 million	2003 .... $394.5 million
1997 .... $320.3 million	2004 .... $448 million

According to one study, the number of medical malpractice claims nationally is anticipated to drop one percent; however, the average size of malpractice claims will likely increase by 7.5 percent.[1]

Last April, the Pennsylvania Medical Society provided an analysis based on State Supreme Court Malpractice Data, as indicated in the table below.[2] This data does not indicate that malpractice claims are decreasing.

Pennsylvania Medical Society Analysis
State Supreme Court Malpractice Data

	2000	2001	2002*	2003	2004
State Findings	2,660	2,678	2,917	1,712	1,815
Philadelphia Findings	1,085	1,162	1,365	577	559

*In 2001, Act 13 passed and, as reported in the media, personal injury lawyers primarily in Philadelphia started filing claims at a high rate before new laws took effect.

Jury verdicts between January 2000 and July 2003

- Of the 14 jury verdicts greater than $10 million, nine were in Philadelphia.
- Of the 18 jury verdicts between $5 million and $10 million, 16 were in Philadelphia.
- Of the 87 jury verdicts between $1 million and $5 million, 48 were in Philadelphia.
- Defense verticts statewide totaled 73 percent.
- Defense verdicts in Phildelphia totaled 59.2 percent.

Jury verdicts between July 1, 2003, and Dec. 31, 2004

- Of the three jury verdicts greater than $10 million, all three were in Philadelphia.
- Of the seven jury verdicts between $5 million and $10 million, three were in Philadelphia.
- Of the 28 jury verdicts between $1 million and $5 million, 18 were in Philadelphia.
- Defense verdicts statewide totaled 78.4 percent.
- Defense verdicts in Phildelphia totaled 68 percent.

It is good news that claims are dropping and insurers should save money in litigation costs but, as payouts continue to grow, the country still needs to address issues such as reasonable limits on non-economic damage awards. The Pennsylvania legislature has not acted on non-economic damage awards and, to date, no insurer in Pennsylvania has decreased rates. There is still much work to be done.

For additional information, long on to www.pamedsoc.org and look for links to Liability Reform Action Center.

REFERENCE

[1]Study released on October 18, 2005, by Aon and the American Society for Healthcare Risk Management and reported by the *Wall Street Journal*.

[1]April 13, 2005, Analysis provided by the Pennsylvania Medical Society from public data available online at www.courts.state.pa.us/index/medical malpractice/intro.asp.

Pennsylvania Medical Society

For updates on medical liability, call the PMS Liability Reform Action Center at (800) 566-TORT (8678) or log on to www.pamedsoc.org\lrac.

You also can call the Allegheny County Medical Society at (412) 321-5030 and ask for tort reform updates or log on to www.acms.org.

FEATURE

Real Time Disease and Outbreak Surveillance (RODS): A 21st Century Innovation

MICHAEL M. WAGNER, MD, PHD

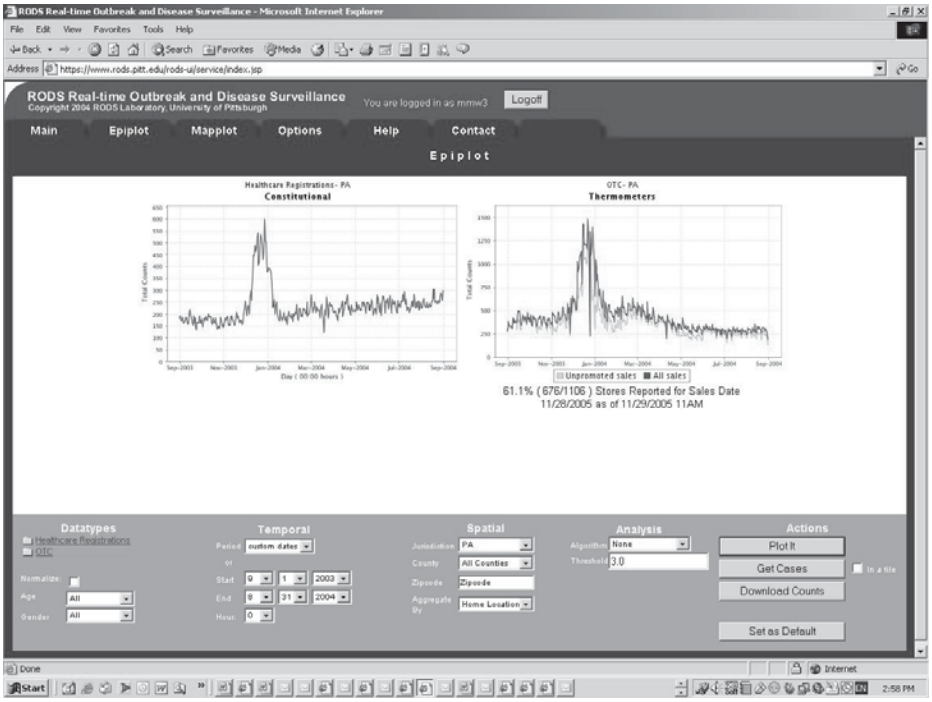
The RODS Laboratory is a collaboration between researchers at the University of Pittsburgh and the Auton Lab in Carnegie Mellon University's School of Computer Science. Drs. Wagner, Tsui and Espino founded the laboratory in 1999 to investigate methods for real-time detection and assessment of disease outbreaks. Current research interests of the faculty include algorithm development, assessment of novel types of surveillance data, and ral language processing detectability (visit www.rods.health.pitt.edu). The RODS system itself is open source software released under the GNU general public license (openrods.sourceforge.net).

Around the turn of the century (or more precisely August 1999), my colleagues and I at the University of Pittsburgh and the Carnegie Mellon Institute began to reinvent disease surveillance. At that time, hospitals did not use their clinical information systems or the Internet to transmit information to health departments. They filed reports of notifiable diseases using paper forms via the U.S. Postal Service—much as they had for the previous two centuries. Disease surveillance simply had not kept pace with information technology.

Six years later, we had established electronic connections between more than 130 of the 190 Pennsylvania hospitals and the Pennsylvania Department of Health. We had established large numbers of electronic connections among hospitals in Utah, Ohio, New Jersey, Houston, Dallas-Fort Worth and Taiwan and their health departments. We also created electronic connections between pharmacy and grocery corporations in the U.S. and their respective health departments, representing a large fraction of all such stores in the U.S. and health departments. We had built a system that not only maintains the connections, but examines the data automatically—24/7—for anomalies suggestive of disease outbreaks.

The name of this electronic disease surveillance system is RODS (real-time disease and outbreak surveillance). Within seconds of registration, a patient's chief complaint, gender, age and home zip code are available to the Pennsylvania Department of Health. Pharmacy and grocery chains transmit information about their sales of products such as thermometers on a daily or more frequent basis. Health departments can now see outbreaks and other population health events that were previously invisible, or at least only visible late or with the "retrospectoscope." During the 2003 influenza season, for example, health departments saw a prominent rise in visits to emergency departments for constitutional symptoms and in sales of thermometers well in advance of traditional methods of disease surveillance.

Although the technology we are using is only a small part of the secret to our success, it is an interesting story. The most important technology—the HL7 message router—is one that we didn't invent or even have to install. An HL7 message router is like a switchboard in a telephone exchange; it routes messages among different information systems in a hospital (e.g., from an ED registration system to a billing or laboratory information system). Most hospitals (in our experience, 84 percent) use HL7 message routers. The message router treats



RODS like any other data system in the hospital. The only difference is that the message is sent out over the Internet in encrypted form, rather than over the hospital's private network to another system in the hospital.

It is easy for a hospital to establish a connection to a health department using RODS. To establish a connection, a hospital simply configures its HL7 message router to transmit ED registration messages—stripped of personally identifiable information—to RODS.

RODS processes messages that it receives from hospitals by first decrypting them, then analyzing them using natural language processing. It displays daily counts of different symptom groups such as 'constitutional' on time graphs and maps on a standard web browser.

All of the technology used in RODS already existed in 1999 when we started our work. The Internet, web browsers, encryption and HL7 messaging had been developed for other purposes. We simply knitted it all together.

The real secret to our success was persuading hospitals and health departments to embark on this undertaking, which could benefit both immensely, but not until a critical mass of hospitals participated.

In the early days, it was a very tough sell. Hospitals had concerns that their ED utilization information would fall into the hands of their competitors. There were negative comments about the approach from distinguished leaders in public health. In general, there was lack of understanding of the potential of the technology and of the risks.

The turning point came in October 2001 when anthrax-tainted letters changed the perceived risk-benefit ratio. This development was followed by our successful deployment of RODS in Utah for the 2002 Olympic Games, which proved that hospitals could be connected very quickly by a tiny team at almost no cost.

The potential benefits of creating real-time electronic data exchange between public health and the health care system are enormous and the cost is low. The result will revolutionize disease surveillance and hospital infection control. It will make it possible for doctors to know the incidence of infectious disease in a community in real time, allowing them to know when it is appropriate to "look for zebras" and when it is not. Insurers will benefit as better information about the prevalence of disease in a community translates into more efficient treatment of patients with suspected infectious diseases.

We are not alone in our efforts to achieve this vision. Many other research groups and health departments are now constructing electronic disease surveillance systems that involve variants of the RODS approach. Some require hospital personnel to enter reportable diseases

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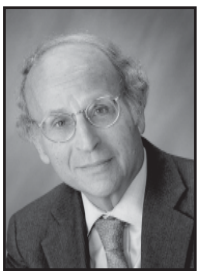
into web interfaces. The Commonwealth of Pennsylvania's electronic disease reporting system (PA NEDSS) is an example of such a system that has won national recognition. Other systems utilize daily electronic batch feeds of data. Although many of these efforts are complementary in that they provide additional data to health departments, they run the risk of asking hospitals to create duplicate data connections with a health department. They also increase the complexity of the relationship with hospitals as CEOs are being asked to consider participation in multiple projects whose interrelationships are often not communicated clearly. The most confusion at present is being created by the Centers for Disease's Biosense project, which is a latecomer and overlaps in data and function with RODS and other systems. Centers for Disease Control (CDC) is approaching hospitals in large cities to connect directly to CDC in Atlanta. Biosense sometimes approaches hospitals over the objections of state and local health departments. These approaches are sometimes made to hospitals in cities that have well-established plans and projects of their own underway. A recent example is Jefferson Hospital in Philadelphia.

There is also potential for confusion and redundant work in cities or states that are developing Regional Health Information Organizations (RHIOs). A RHIO looks a lot like RODS from a technical perspective. It establishes connections between health care organizations for the purpose of data exchange to improve clinical care. Ideally, disease surveillance systems and RHIOs will eventually become one. But during the transition, there will be instances in which hospitals are asked to participate in both types of projects. Ideally, hospitals will recognize that they have deep IT and medical knowledge and will exert leadership in bringing rationality to such discussions. Ideally, hospital IT departments will develop service-oriented architectures—such as that used by Amazon.com and increasing numbers of large corporations—to "externalize" data and functions so that they can interoperate with both health departments and other health care organizations to ultimately improve the health of the populations they serve.

What we and others have accomplished in the past six years is only the beginning of the transformation of disease surveillance. There remains much to do. The full capabilities of these new systems will be realized only when all data routinely collected by the health care system that can contribute to detection of infectious disease are available for disease surveillance. Outpatient data remains a challenge because of the number of outpatient practices and a lower level of automation. As in the past, technology will not be the rate-limiting factor. Improved disease surveillance systems must be willed into existence by leadership. The leadership must come not only from health departments but from the health care system.

Dr. Wagner is associate professor of medicine and intelligent systems and director of the RODS Laboratory at the University of Pittsburgh. For additional information, contact Steve DeFrancesco, director of information and technology and ASP project manager at the RODS Laboratory at (412) 383-8125 or sdefrancesco@cbmi.pitt.edu.



Preparing for Once-Unthinkable Dangers

ARTHUR S. LEVINE, MD

In this age of uncertainty, when peace and security can be instantaneously shattered without warning by acts of terrorism, medical professionals are increasingly faced with how to prepare for previously unthinkable dangers. Consequently, phrases like "biological threats to society" and "public health preparedness" have found their way into our lexicon at the University of Pittsburgh School of Medicine.

In the face of these risks, we are focusing on critical new research initiatives, incorporating special topics into our medical school curriculum and developing innovative ways to deploy essential information to the broader medical community.

On the forefront of our research efforts in the area of global public health and security is the Center for Vaccine Research in Biodefense and Emerging Infections (CVR), a major new initiative at the School of Medicine that will work to develop vaccines, drugs and diagnostics for viruses and other globally important infectious agents that not only occur naturally and can pose great health risks, particularly in developing countries, but also can be used as agents of bioterrorism. Primary consideration will go to studying biological agents with the potential to cause the greatest harm to masses of people, those that are most easily "weaponizable," and those currently receiving relatively little attention. The full CVR umbrella will span scientific activities ranging from basic immunology to the development of candidate vaccines for eventual human use. This program is both highly ambitious and on a fast track; we are currently engaged in an international search for an outstanding, visionary scientist with broad experience in vaccine development to direct this innovative, interdisciplinary endeavor.

(c) Jim Schafer

The Center for Vaccine Research in Biodefense and Emerging Infections will find its home in the university's newest research facility, Biomedical Science Tower 3 (BST3).

As part of a nationwide network of related initiatives, Pitt is one of 16 biomedical research institutions chosen to participate in the Mid-Atlantic Regional Center of Excellence for Biodefense and Emerging Infectious Diseases (MARCE)—one of 10 such centers established throughout the United States by the National Institute of Allergy and Infectious Diseases to carry out its strategy for biodefense research. Supporting the work of both the CVR and MARCE will be the university's new Regional Biocontainment Laboratory (RBL), one of 13 dedicated sites being set up across the country to safely conduct essential biodefense research into deadly infectious agents. The new lab will involve scientists who are already engaged in infectious disease research here as well as investigators who are yet to be recruited as part of our growing biodefense and vaccine development programs.

Even before the terrorist attacks of September 11, 2001, we had begun to integrate elements of

bioterrorism preparedness into our medical school curriculum. Since then, this evolving initiative has been cited by the Association of American Medical Colleges as a national model for other medical schools to follow. We address biological, chemical and radiological threats to society; emerging infectious diseases; food and water supply safety; terroristic hoaxes; antibiotic resistance; and similar issues that students wouldn't have encountered in any medical school until a few years ago. Moreover, we believe that incorporating level-appropriate content about these risks in various ways throughout the four-year curriculum is far more effective than focusing on them in one or two courses or seminars. Our program is not limited to specific types of attacks; rather, it is based on the principle of "prepare for all things." And while it is not intended to make our students biodefense experts, it is designed to prepare them to readily detect and identify any type of unusual or suspicious patterns of illness that might result from bioterroristic activity, to initiate the appropriate triage and treatment of patients, and to engage public health and safety authorities in the response. By making preparedness part of the normal fabric of studying medicine, we hope to continually reinforce its importance.

Our role in educating physicians extends far beyond medical school, however; Pitt's Center for Continuing Education in the Health Sciences has initiated a novel online tool, called Rapid Deployment Continuing Education©, that it developed in collaboration with the University's Center for Biomedical Informatics and Health Sciences Library System to quickly get timely and relevant information into the hands of health care providers. For example, in the aftermath of Hurricane Katrina, a module was released to address public health issues arising from environmental hazards among displaced New Orleans residents. As we faced shortages of influenza vaccine last year, information was developed to address guidelines for immunization. Updates will be issued as the epidemiology of influenza emerges, particularly in regard to avian flu. Similar modules with outbreak information and treatment recommendations have been developed for SARS, West Nile virus and hepatitis A, as well as for various quality improvement and mandatory training topics. The Rapid Deployment program has proven to be an effective way to minimize the time it takes to develop and disseminate materials, maintain essential quality and elicit valuable feedback from participants. Furthermore, this information is available to anyone, free of charge, at http://cme.health.pitt.edu.

Even before the terrorist attcks of September 11, 2001, we had begun to integrate elements of bioterrorism preparedness into our medical school curriculum.

We also stand shoulder-to-shoulder with our partner, the University of Pittsburgh Medical Center (UPMC), whose Center for Biosecurity is at the forefront in the high-profile and rapidly expanding field of bioterrorism preparedness, research and response. Based in Baltimore, the center resulted from the move of the Johns Hopkins Center for Civilian Biodefense Strategies to UPMC in 2003—home to some of the nation's leading bioterrorism preparedness experts, including Drs. D.A. Henderson and Tara O'Toole, who also serve on our faculty at the School of Medicine. In addition, UPMC has aggressively undertaken a wide range of initiatives concerning bioterrorism preparedness, primarily under the skillful direction of my colleague, Dr. Loren Roth.


Dr. Roth

Among these initiatives is one of the largest electronic physician tracking systems in the country, the UPMC MedCall Terrorism Response and Information Center, which provides immediate contact information for more than 11,000 UPMC physicians on a 24/7 basis.

As public health preparedness—in all of its forms—becomes more fully ingrained in our society, it, likewise, becomes a more essential part of our mission at the School of Medicine.

Dr. Levine is senior vice chancellor for the health sciences and dean of the School of Medicine at the University of Pittsburgh. He can be reached at alevine@hs.pitt.edu.

For the Birds: Pandemic Influenza Policy Falls Short

MICHAEL A. GAGLIA JR., MD
ADAM J. GORDON, MD, MPH

The specter of pandemic influenza and concordant fears of avian influenza have taken on national prominence of late. On November 1, President Bush called for $7.1 billion in funding to stockpile the H5N1 (avian flu) vaccine and anti-influenza medications and to fund cell culture technology that could accelerate future vaccine production. The president also called for lessening the burden of litigation upon vaccine manufacturers.[1]

The president's plan appears more than a year after the difficulties the nation experienced during the 2004 flu vaccine shortage, which was largely due to production problems experienced by Chiron Corp. In 2005, while the supply of flu vaccine has improved, distribution problems have persisted. Smaller physician practices have reported difficulties obtaining adequate vaccine, whereas larger chain pharmacies and grocery stores are selling the vaccine (with a healthy markup) to all comers.[2]

The flu vaccine's manufacturing and distribution problems raise questions about the timeliness of Bush's response to the threat of a flu pandemic. This plan displays a troubling lack of insight regarding trends in influenza vaccine supply, in that it does not specifically comment upon the decentralized and fragmented system in place for vaccine distribution. Such a system applies by default to both garden-variety flu vaccine and H5N1 vaccine.

Much of the recent media coverage has focused upon the stockpiling of antiviral medications and H5N1 vaccine, with the assumption that we only need to make more. But the vaccine shortage of the 2004-05 flu season also draws attention to a flawed system of distribution and demands that policy makers consider how to distribute a scarce medical resource fairly and efficiently.

Even if the president's plan were to achieve its stated goals, distribution of vaccine in the setting of a pandemic would be haphazard, decentralized and vulnerable to profiteering by manufacturers and providers alike. Furthermore, a largely unfunded mandate falls upon the states to purchase stockpiles of oseltamivir (Tamiflu). The plan only matches up to 25 percent of each state's purchase, which could lead to significant disparities from state to state in the setting of a pandemic.

The recent isolation of an oseltamivir-resistant H5N1 virus in Vietnam is also worrisome;[3] not only would such a virus render strategies for stockpiling antivirals futile, but widespread (and often inappropriate) use of neuraminidase inhibitors like oseltamivir may very well be driving the emergence of drug-resistant clones of virus.

The president's plan also calls for litigation relief without providing a mechanism for compensation of those who might be harmed by new and unproven vaccines. At best this is disingenuous when one takes into account that vaccine manufacturers are free to base their level of production largely upon considerations of profit and market-driven factors. Litigation relief may also encourage more non-practitioner administration of the flu vaccine, exacerbating the inequitable distribution of vaccine.

The president's plan unfortunately draws attention away from one key weakness: The present system for purchase and distribution of flu vaccine is largely unregulated and driven by the purchases and subsequent actions of providers independent of any overriding government authority. This may seem to place blame at the level of the Centers for Disease Control for a lack of coordination among states,

but this is a shortsighted criticism.

The more appropriate and worrisome question concerns the lack of any national system for distribution of vaccine during a shortage. This is a far more difficult question to answer because, during last year's shortage, each state's health department was free to act independently of the others if it so wished. Reallocation of vaccine between states was purely voluntary and marked by a relative lack of urgency, given the mild flu season.

The president's plan, viewed in the proper context of recent trends in flu vaccine supply and distribution, is incomplete given what we know about the near-inevitability of the next influenza pandemic. It is not difficult to imagine a situation of "every state for itself" during a season of high morbidity and mortality. Such a situation would be further complicated by the lack of control and, for that matter, enforceable authority of each state's health department over the immunization practices of large and small providers.

It is thus imperative for lawmakers not only to consider supply and market considerations, but also to make hard decisions about the national distribution of flu vaccine before the next pandemic.

Dr. Gaglia is a fellow in general academic medicine and pediatrics at the University of Pittsburgh. He can be reached at gagliajrma@upmc.edu. Dr. Gordon, a contributing editor for the ACMS Bulletin *and assistant professor of Medicine at Pitt. He can be reached a gordon@acms.org or 412-688-6477.*

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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Lessons from a Pittsburgh Physician Evacuating Katrina

MOISÉS A. ARRIAGA, MD

Timing is Everything. Seven weeks before Katrina, we moved from a great home and a busy otologic surgery practice in Pittsburgh to be close to family in my wife's and my childhood home city of New Orleans. With the hurricane bearing down, we joined nearly 800,000 people evacuating a doomed city—we had not yet finished unpacking from the Pittsburgh move.

Persistence pays dividends

Convincing elderly parents to ignore their experience and listen to their children and the media is a challenge. For those who have never lived in a hurricane region, the period from 1969 to 2005 in New Orleans included dozens of recommendations to evacuate without tangible evidence of hurricane damage afterwards. "Local wisdom" that the news was again crying wolf was hard to overcome. Eventually we prevailed and both families safely evacuated.

Location and luck can be indistinguishable

The infamous 17th Street canal levee failed a few blocks from our newly purchased New Orleans home. For days we were told that the house was submerged under 10 feet of water. It really is amazing how fortunate you can feel to learn you've only lost one third of your house to wind damage and not flooding.

Disasters clarify priorities

Television coverage showed thousands fighting for such basic necessities as food, water, shelter and safety. For those who escaped before the storm, the reaction is an almost instinctive roll call of family, friends and co-workers. Is everyone safe? Is there an emergency need? Perhaps the greatest comfort comes in telephone calls and e-mails from friends and acquaintances just checking on your safety in the days afterward.

The after-disaster story can be boring to outsiders

Living through such an odyssey prompts you to blurt out detailed stories of survival—as if telling the stories allows an escape of stress from the event. Please forgive us evacuees as we sometimes go on and on answering simple social questions with more detail than you wanted. On the other hand, New Orleaneans see the media coverage fading while the need is greater than ever. A sub-Category 3 levee system is not a sexy topic. Despite the recent catastrophe, plans for necessary repairs and upgrades have still not been approved. More shocking are the blame games and political jockeying: local versus federal, Democrat versus Republican, and even claims that the floods represent a sort of theistic justice. Blame abounds while solutions are scarce. Real people like your family and neighbors are today struggling to rebuild their lives and a modern American city—it's never been done before!

Camaraderie of the displaced

To Katrina survivors, news coverage of the aftermath is addicting and all-encompassing. National media tidbits of New Orleans news are devoured and analyzed in my family with a fervor I've never seen on any topic. Like Pittsburgh, New Orleans is a city of neighborhoods. Meeting a New Orleanean survivor immediately brings a familiar series of questions: Was everyone OK? Where was your home? How did you do with the flooding? Have you been back? Are you moving back?

Medical/social systems are fragile

The impact of Katrina on medical delivery systems in New Orleans are vivid examples of the

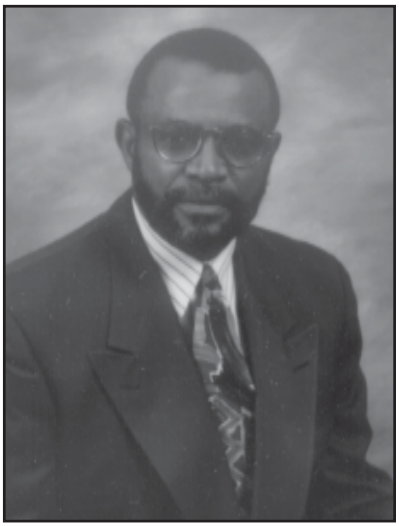
large-scale reorganization facing the region. Charity Hospital and University Hospital are closed and essentially condemned. Three of the four other major hospitals in New Orleans are closed indefinitely, and three suburban hospitals remain open facing serious questions about their ability to remain viable. If you're a major investor do you open the hospitals before people move back and rebuild New Orleans? Do the sub-Category 3 levees slow you from investing in New Orleans? If you're a patient, do you return to the city before a first-rate health care delivery system is operative? Sure it's a *Catch 22*, but is any city really immune from major disasters—flood, earthquake, tornado or terrorism? We need to figure out how to solve major crisis response and rebuilding for everyone's sake.

Pittsburgh is a caring home

Within one hour of the media reporting the catastrophic New Orleans levee failure, I received a call from my practice partner in Pittsburgh offering for me to return. While the media has covered the wide-ranging local hurricane relief efforts, as a recipient, the empathetic response of Pittsburgh friends and colleagues has been overwhelming, including offers of lodging, supplies and real caring. Since my return, I've learned of dozens of calls from patients inquiring about my family's safety. Even now, as I'm back at work, my patients won't permit me to ask about their health until they're certain things are fine with their doctor—what kindness!

While we'll remain actively involved in rebuilding our childhood home city from afar, my family and I are lucky and proud to return to our adult home city, Pittsburgh.

Dr. Arriaga is an otologist/neurotologist. He can be reached at (412) 359-6690 or tec8lote@aol.com.



Morris Turner, MD

Morris Turner, MD: Physician, Educator, Humanitarian

ANITA SRIKAMESWARAN

When Morris Turner was born 57 years ago on a remote southern Georgia farm to sharecropper parents, his untrained aunt acted as midwife.

After that humble start, he graduated from a three-room schoolhouse, got a scholarship to Morehouse College in Atlanta, was recruited as part of a fledgling minority program to the University of Pittsburgh School of Medicine, and completed his specialty training in obstetrics and gynecology at Magee-Womens Hospital.

Last month, Dr. Turner was honored at a banquet hosted by Gateway Medical Society, which has named him *Physician of the Year*. The society is the local branch of the National Medical Association, which promotes the interests of black patients and physicians.

"He is just the composite of what we'd like to see: a compassionate, caring physician who also believes in his community and wants to give back," said society president Dr. Jan Madison.

Dr. Turner still has an essay he wrote as a ninth-grader about how to become a doctor. Growing up in a segregated society showed him the unmet need for medical care in the black community.

"I used to see [sick people] carried to the doctor, usually by the person who owned the farm that they lived on," he said. "Regardless of how sick they were, they had to wait until after the white people were seen."

"If I were a doctor, I could fix this," he thought.

A love of learning led him to complete three grade levels in a year. The school he attended had three rooms and a potbellied stove for winter heating. His mother thought him too young to go to college when he was first offered a scholarship at age 14.

"I guess I must have cried for about a month afterward," Dr. Turner recalled, laughing. "Just to show how immature I was."

He later got a scholarship to Morehouse, attending at a time when Martin Luther King Jr. and other luminaries were launching the civil rights movement.

Pitt representatives went to Morehouse to recruit minority students for medical school. A group, including Dr. Turner, went to Pittsburgh for a tour around Christmas 1968. The young man from the South had no real idea of where the city was, but it certainly left an impression.

"It was the coldest I had ever been in my life," Dr. Turner said. "I didn't know how people survived this sort of thing."

He graduated from Pitt's medical school in 1973 and continued ob-gyn training at Magee. He joined the prac-

"We need more minority students who have the committment to come out and serve their community, but these days, medical students can incur more than $100,000 in debt just to get through school."

tice of the late Dr. Robert Kisner, one of the first African Americans to complete Magee's residency program.

Their shared goal was to serve the black community, but "I learned soon after I got into practice that there are lots of people out here who need help," Dr. Turner said. Now he works in East Liberty, Wilkinsburg and Monroeville, and his mission is still the same: Deliver high-quality health care and illness prevention education, especially to underserved communities.

After three decades in obstetrics, he is delivering the grandchildren of some of the first babies he delivered. "In the 1980s, there was this explosion of teenage pregnancies," Dr. Turner said. "Now those kids are also teenagers who are having babies."

For a long time, "I didn't see anybody coming through the system who was willing to come out and do what I had done," Dr. Turner said. "We need more minority students who have the committment to come out and serve their community, but these days, medical students can incur more than $100,000 in debt just to get through school," he noted. "They are not hardly looking to come to a poor community," he said. "They can't afford it to work and pay back loans and make a life for themselves."

Ms. Srikameswaran is a reporter for the Pittsburgh Post-Gazette. She can be reached at anitas@post-gazette.com or (412) 263-3858.

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