BULLETIN

Founded 1872

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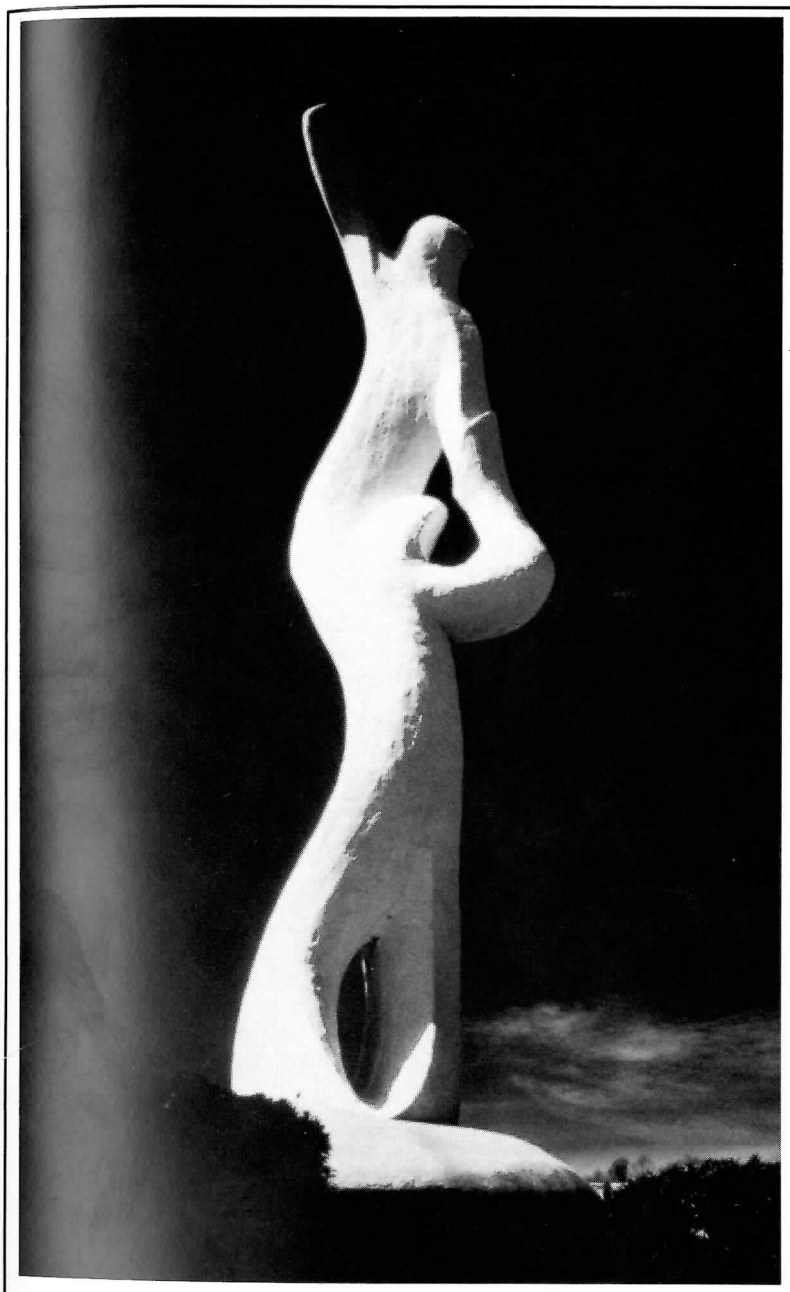

"Space Apollo"

This sculpture on the campus of Alderson Broaddus College, Philippe, West Virginia was created in 1968 by Mark Warner whose idea came from Sir Issac Newton's "I stand on the shoulders of Giants." Warner named the statue "Apollo" in appreciation of the space program.

Alderson Broaddus is well known for its outstanding physician's assistant program and its graduates from that program are much sought after.

Mary Jane Jenkins

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BULLETIN

Mahoning County Medical Society
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The Bulletin is published nine times a year, monthly with the exception of May, July and August by the Mahoning County Medical Society, 5104 Market Street, Youngstown, Ohio 44512. Phone (216) 788-4700.

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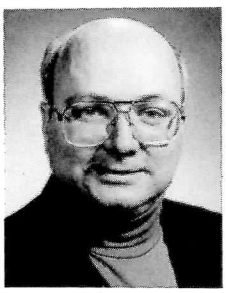
Directions



James A. Lambert, MD

The annual meeting of the Ohio State Medical Association was held on the weekend of May 4th in Cleveland. At the annual meeting resolutions are introduced and acted upon which determine policy for the Ohio State Medical Association in that given area. The following are several resolutions that are of interest.

Tanning Parlors

The policy of OSMA is to continue to support educational campaigns regarding the hazards of tanning parlors as well as develop local ordinances to protect patients and the general public from improper and dangerous exposure to the ultra-violet radiation.

One of the problems relates to the character of the light delivered. There can be considerable variation in the intensity of the light which is not measured on any regular basis in most of the tanning parlors. The bulbs themselves can vary greatly in the intensity depending on the life of the bulb. These potential hazards are not appreciated by most patients or non-dermatologists.

Insurance Payments

There is currently a state law which provides penalties for late payment of claims by third party payers. OSMA is therefore encouraging the director of the Ohio Department of Insurance to actively enforce the prompt payment provisions of the Ohio Revised Code. This is an area where individual physicians may seek assistance through the county medical society or OSMA if they feel there is a problem regarding late payment by insurance companies.

Hospital Trustees

The current recommendations of the Joint Commission for Accreditation of Health Care Organizations recommends that the hospital medical staff have presence and voice at the meetings of the hospital board of trustees. The resolution adopted by the House of Delegates urges the JCAHO to require that there be at least one medical staff representative on the hospital's board of trustees who is elected by the medical staff, in practice at that hospital and has a vote.

The relationship of the board of trustees to the members of the medical staff appeared to be an area of considerable concern to many of the members of the House of Delegates from around the state. This illustrated one attempt to partially resolve this situation.

Another area of conflict between the hospital trustees and medical staff was targeted regarding the election and selection of medical staff and departmental officers. The resolution urged the AMA Board of Trustee members on the JCAHO to change the accreditation standards to require that all medical staff by-laws and hospital governing documents recognize the inherent authority of the medical staff to elect the medical staff officers and that the elections not be subject to affirmation or concurrence by the board of trustees. The original resolution included the election of clinical department chairman, but this was recognized as a violation of the board of trustees power to hire and fire salaried department chairman. This portion was dropped from the final resolution.

Pre-Existing Conditions

A major problem that is becoming more prevalent regards the determination of pre-existing conditions. A family may be covered by a new insurance carrier because of a change in jobs or change of carrier by the employer. If a family member has a significant medical condition, they may be denied coverage on the basis of pre-existing illness. This puts the family at a considerable disadvantage in regard to their medical/financial well-being.

The resolution requested the Ohio Department of Insurance to provide health care coverage to all applicants regardless of pre-existing conditions.

This area is of obvious concern to both the insurance carriers, the physicians and the patients. The insurance carriers do not want to be at risk for significant medical liability for new patient cover-

age. However, with the mobile society we now have and the changes that can occur in job situations and in insurance carriers, this problem needs resolution.

Post-Natal Care

Third party payers have often required that either the mother or newborn infant must go home before the other is ready. This leads to considerable hardship, especially if the mother is breast-feeding.

The resolution calls for development of appropriate options for the care of newborn infants who may be ready for discharge prior to discharge of the mother when the mother's medical condition warrants continued hospitalization.

National Practitioner Data Bank

The National Practitioner Data Bank was supposed to be implemented in April. However, this has been delayed because of technical problems and the beginning date is now proposed for late summer or early fall. One of the problems noted in the law regards the amount of time available to respond to any adverse determinations.

The resolution asks the AMA to request the Department of Health and Human Services to instruct the National Practitioner Data Bank to institute physician notification of adverse data bank entries by certified mail with return receipt requested.

This would assure the involved physician the appropriate notification and time for appeal.

Abortion

Clearly the House of Delegates did not wish to take a stand either way on the policy on abortion. The AMA had previously taken a stance indicating that any decision should be done individually between the physician and the patient. The OSMA resolution followed this same format. The resolution further directed that no action which might be construed as either promoting or opposing legislation relating to the legality of abortions be taken.

Although the intent of the resolution was to form a cosetely neutral position, many interpret this as a stance that favors the pro choice segment.

Living Wills

This resolution called for the adoption of policies regarding the right of patients to refuse medical treatment. There are 11 specific points addressed in the resolution, which is No. 70-90 for those who wish to read the entire resolution. The final result, however, encourages physicians to inform their patients of the importance of clearly communicating their wishes and preferences in advance so as to guide the treatment decisions when the patient is no longer able to make health care decisions for himself.

These are samplings of some of the policies that the OSMA will be pursuing in the coming year. The full text of these resolutions are available through the medical society office for those interested in reading them in their entirety. This sampling is presented in an effort to encourage the local physician community to present concerns to the medical society that might be presented as resolutions at the next annual meeting. Drs. Lakhani and Gordon both presented resolutions that were accepted by the House of Delegates and are now being forwarded to the AMA for additional consideration and action. Organized medicine on a local, state and national level are attempting to reflect the will and concerns of the practicing physicians. However, this can only be adequately performed when input is available from the active practitioners. I encourage all of you to come forward with your concerns so that we might work together in improving the medical practice environment. □

Curbing Lab Costs?

Denise L. Bobovnyik, MD

When I pay my accountant I realize that he probably has not done all the work himself. He has several assistants who do the tedious work for x$/hr. He then reviews the work, adding final touches and charges (X + y)$/hr for the total work. Office temporary services charge (x + y)$/hr, with the worker getting x dollars and the contracting company getting y dollars. Attorneys do the same.

Why then, can't a physician contract with a lab for x$, receive the results, review them, interpret their meaning in light of medications and patient condition and charge (x + y)$?

Medicare says "No." This service is included in the office visit. However there is no modifier to separate an office visit with lab interpretation versus office visit without lab interpretation, so how are we being compensated for this duty? Easy. Do the labs in your office.

This worked well until 1988 with the establishment of CLIA, Clinical Laboratory Improvement Amendment. At this time it was realized that POL's (Physician Office Laboratories) were not regulated by any consistent standards. Reports were made of non-qualified persons (ancillary staff, physician spouses) performing in-office tests without proper training. Also, decrease in Medicare reimbursement fueled the rise in in-office testing. Couple this with the availability of a least 4 products which can be easily used for single and/or panel blood chemistries and the potential for POL's to become a major expenditure for Medicare is apparent.

There have been complaints of Medicare fraud, "unbundling" (coding panel labs separately to obtain higher reimbursement) and jeopardizing health care due to inaccurate results. Also at this time the hearing on Pap smears and cytology errors was in progress. The need for some type of regulations is evident, however I can't help but feel that Medicare had created its own monster.

Trying to force physicians not to charge for lab testing has backfired. There are now more physicians doing office labs *because* of the policy than there would have been had the previous system been modified. Patients like the convenience of immediate results. Had Medicare thought about this it would have been better to allow physicians to charge for labs with the requirements that physicians contract only with Medicare approved labs. This is only logical if patient interest (i.e. accurate lab tests) are the concern, not limiting Medicare spending, which I believe is the real issue behind the initial regulation.

We now have more administrative costs, more lag time in payment, delays in a system already overburdened and antagonism between the physicians and Medicare. And after nearly two years there are still no official regulations on physician office labs. This is yet another case where Medicare has outsmarted itself. □

Mesenteric Embolism, Surgery vs. Medicine

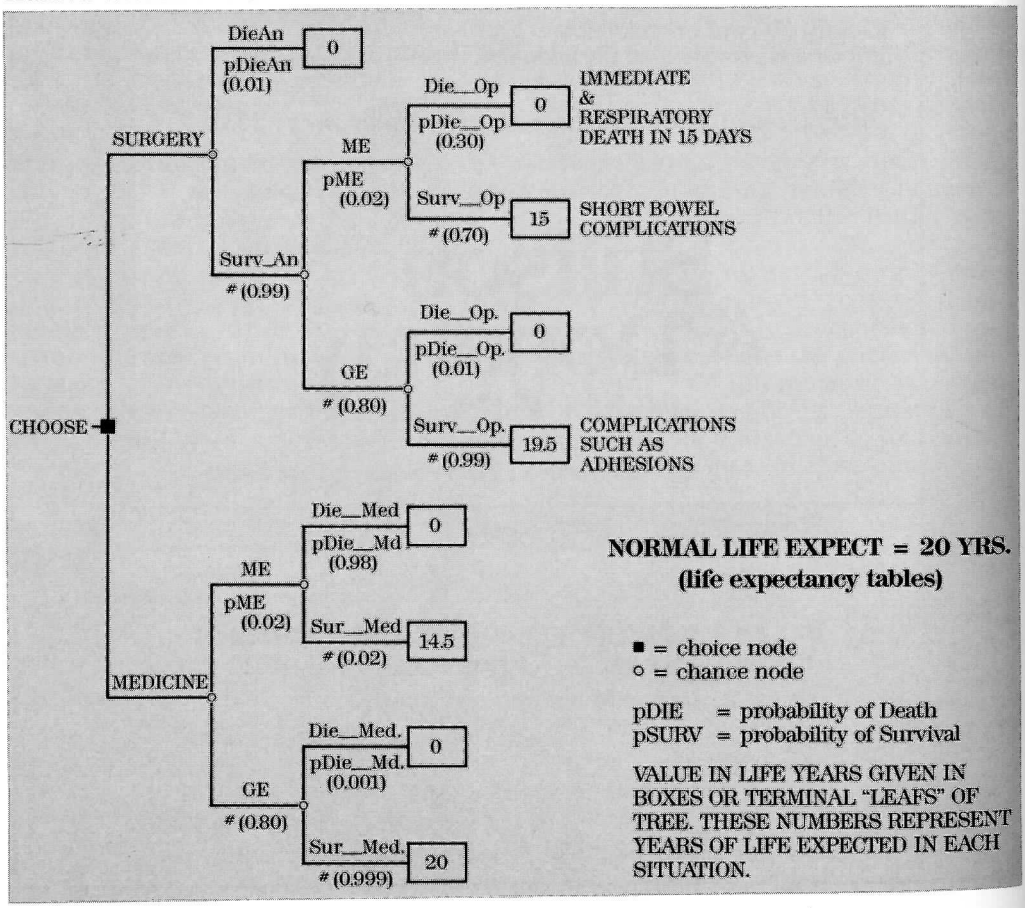
A 50 year old white unemployed steel worker is brought to a local hospital emergency room with severe diffuse abdominal pain of sudden onset. There is a past history of rheumatic heart disease and long standing atrial fibrillation controlled on digoxin. The resident on duty notifies the senior emergency room physician that this pattern of findings suggests the possibility of acute mesenteric vascular insufficiency. However, he stresses that he can not rule out a severe acute gastroenteritis and he asks his supervisor if this patient's management should be conservative and medical, or should immediate surgery be considered.

All who read this column are aware that the use of the term "possibly" is fraught with ambiguity. At best it indicates a prior probability of about 20 to 30%[1]. The above decision must first be framed within the context of an identified time period. Outcomes and complications in this case would be best evaluated by comparing the course of events over the postoperative period of two weeks (14 days).

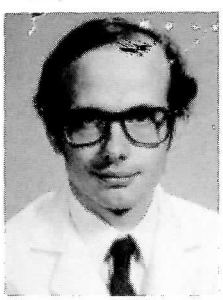
The problem may be divided into four major elements and the variables and values listed below are derived from the medical literature using a unique local data base that resides within our Youngstown community, as well as the experience of senior physicians:

ELEMENT #1: STARTING POINT
50 Year White Male
Atrial Fibrillation
Acute Abdominal Pain

ELEMENT #2: CHOICE OF MANAGEMENT
Surgery
Medicine



Leonard P. Caccamo, MD, FACP



Kimbroe Carter, MD

Mesenteric Embolism, Surgery vs. Medicine (Continued)

ELEMENT #3: PROBABILITIES OF THE CLINICAL STATE AND SUBSEQUENT CLINICAL EVENTS

Mesenteric Embolism (ME) = 0.20 (resident's estimate)
Gastroenteritis (GE) = (1-.0.20) = 0.80
Prob anesthetic death = pDie__An = 0.01
Prob death with Surgical Rx & ME = pDie__Op = 0.30
Prob death with Surgical Rx of GE = pDie__Op. = 0.01
Prob death ME & Med Rx = pDie__Med = 0.98
Prob death GE & Med Rx = pDie__Med. = 0.001

ELEMENT #4: OUTCOME VARIABLES & UTILITIES

Normal Life Expectancy (50 yr male) = 20 yrs
Other Outcomes = expressed in Life Years (see tree)

The Youngstown Medical Decision Making Society recently structured this problem and Figure 1 illustrates the decision tree that best describes the expected alternative strategies and reasonable outcomes. This process helps to precisely identify what information is required from the medical literature. There are three reasons why the medical literature is often viewed as irrelevant: (1) the exceptions that may be important are often not easily found; (2) the observer is often unaware of the breadth, depth, and relationships of a particular problem; and (3) the physician, under serious time constraints, does not know where to begin his quest or, more importantly, how to narrow his search. All of us see what we look for and fail to recognize what we do not know. Once we have identified what information we need the clinical librarians in the Jeghers Medical Index are quickly able to search and retrieve pertinent articles that will provide the appropriate quantitative probabilities and utility values for each of the clinical outcomes. When discovered, such values can be plugged into a computer driven decision tree. The "best" strategy of action is then calculated by averaging out and folding back the tree. The process begins at the leaves of the tree (outcomes) using the "foldback" approach. Next month we shall illustrate how foldback calculations are made. The final results are illustrated in Figure 2 below. EU stands for the EXPECTED UTILITY in LIFE YEARS. Although a computer makes calculations less time consuming the problem can be structured on paper and the results calculated with the use of a hand calculator using the concept of foldback. Those of you familiar with foldback should manually attempt to derive the figures provided for the expected utility for surgery and medicine. The tree in Figure 1 provides all the information you will need.

FOLDBACK DATA AT DECISION NODE
EU [SURGERY] = 17.37
EU [MEDICINE] = 16.04

The result as shown in the box, is a close call that favors surgical treatment at the root or decision node ■ (solid square). Next month we will explore a "WHAT IF" strategy using ONE WAY SENSITIVITY ANALYSIS and pose the following questions:

1. What if the physician's prior probability (prevalence) estimate is varied?
2. What if the surgeon's skill (probability of an operative death) is varied?
3. What if the anesthesiologist's skill (probability of anesthetic death) is varied?

The answers obtained will be generated on a personal computer utilizing the Tufts Decision Maker program Version 6.0 written in Turbo Pascal. During a recent library fair at St. Elizabeth Hospital Medical Center this very model was demonstrated to area physicians and regional librarians. This computer program is licenced to a member of our local decision making group by the Division of Informatics New England Medical Center, Pratt Medical Group. Literally many hours of hand calculations can be saved and results rapidly produced with the aid of this instrument and computer graphics.

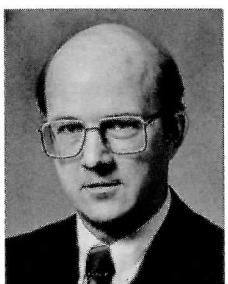
1. Cutler P. Problem Solving in Clinical Medicine Williams & Wilkins 1979 (page 32). □

Durable Power Of Attorney For Health Care

Medical science has often made it possible to prolong the life of the terminally ill, to resuscitate the aged individual whose heart or lungs have failed him, to sustain a patient on life support systems long past the point when, in another generation, he might have expired. Traditionally, in a hospital an assumption is made that, when a patient enters the hospital's walls, that patient desires complete treatment and therefore such treatment is extended. Thus, when a person has expired he will usually be resuscitated and maintained, be it through CPR, shock treatment, ventilation or drug therapy. This assumption is not always correct, however. Indeed, the worst fear of many has come to be having one's body kept alive while the mind is absent or substantially diminished - to live without living - while the assets and the spirit of family survivors waste away. Thus, with the new technologies have arisen difficult moral, ethical and legal questions when dealing with the comatose, dying or terminally ill.

Traditionally, decisions relating to treatment were made between the patient's physician and family. There was no legal mechanism for the health care treatment wishes of the unconscious patient to come into play. Last September, however, legislation went into effect in Ohio that established for the first time a Durable Power of Attorney for Health Care. The bill is surely overly complex, but does make some progress toward the resolution of a difficult problem for patients and physicians alike: where the patient is in a vegetative state or is terminal with no possibility of recovery, how far should the health care provider go in preserving life - particularly where prolongation is contrary to the wishes of the patient and/or family?

With a generic Power of Attorney, a representative, called the "attorney-in-fact", is given the authority to take legally binding actions on behalf of the principal. With a Durable Power of Attorney for Health Care, the principal is now able to delegate health care decisions to the attorney-in-fact.



Nils P. Johnson Jr., J.D. Attorney Johnson is a partner in the Canfield law firm of Johnson and Johnson. He is a contributor to several publications, including Ohio Magazine.

Eligibility

Under the statute, Ohio Revised Code Section 1337.12, *an attorney-in-fact can be any competent adult* who is not the treating physician, his agent or emloyee, or an agent or employee of the health care facility providing services for the principal.

Qualification Of Witnesses

A Durable Power of Attorney must be witnessed by at least two individuals who are adults and who are not related to the principal by blood, marriage, or adoption and who will not "benefit in any way from the death of the principal." Each witness must attest that he knows the principal personally, that the principal signed in his presence, and that in his opinion the principal appears to be of sound mind and is not under duress or undue influence.

Thus, while it is clear a beneficiary under the principal's will is ineligible to be a witness, it is possible one also could maintain that someone who *potentially* stood to gain (such as a subordinate at work who might enjoy a promotion on the principal's death) would also not qualify. Clearly, the physician does not want to be placed in the position of having to make such determinations. Fortunately, the statute also provides that the instrument, in the alternative, may be acknowledged before a notary public. Therefore, *to give the physician greater comfort, it is recommended that the Health Care power-of-attorney be both witnessed and notarized.*

Duration/Revocation

The Power of Attorney is effective for seven years after the date of its execution, although some practitioners provide in the instrument that this period is to be extended "where provided by law" in the event the period should be lengthened subsequently by statute. *The Durable Power of Attorney may be revoked at any time* by a principal merely by stating that fact or by destroying the document or by communicating by any means his intent of revocation. *Where revocation has been*

communicated to a physician, the physician is obliged to "make the notification a part of the health care records of the principal." {Ohio Revised Code 1337.14}

Only Effective On Incapacity

It is to be noted that the Power of Attorney *only becomes effective when the principal has lost the capacity to make health care decisions for himself.* Thus, there is a focus in the statute upon the personal desires of the principal regarding the artificial prolongation of his life. In other words, the attorney-in-fact must act consistently with the desires of the principal where they are known or must act in the best interest of the principal where they are not. {Ohio Revised Code 1337.13}

Should Use With "Living Will"

This creates an additional difficulty for the physician where he is ignorant of the personal philosophy of his patient. Therefore, *it is good practice for the attorney drafting the instrument to accompany it with a so-called "living will"* which is merely a signed and acknowledged expression by the principal of his intention, for example, not to be resuscitated. Although a living will is not binding in Ohio, as a practical matter, its presence at the time a health care decision need be made by an attorney-in-fact, must give comfort to the treating physician that he is complying with requirement of the statute that health decisions be made, when possible, based upon the intention of the patient. The living will can be incorporated in the power-of-attorney.

Attorney's Access To Health Data

In this regard, in order to make a judgment and to give informed consent to remove the life prolonging equipment and services, the attorney-in-fact is given by statute the same right as the patient to receive information about proposed health care and to review the patient's health care records.

Powers Of Attorney-In-Fact

Assuming, then, that the Durable Power of Attorney for Health Care has been properly drafted, witnessed, and notarized and the patient's desire not to have his life artificially prolonged is known, what is the authority of the attorney-in-fact and the responsibility, not to say *liability,* of the physician? First, *an attorney-in-fact has no right to withdraw health care that is necessary to maintain the life of the principal unless the principal is in a terminal condition.* Furthermore, even though the principal may be in a terminal condition, *the attorney-in-fact does not have the right to withdraw health care that is necessary to provide "comfort care."*

An attorney-in-fact under a Durable Power of Attorney may not cause health care to be withdrawn unless all the following apply:

1.) In the opinion of the principal's physician *and at least one other physician,* providing nutrition or hydration would not provide comfort to the principal.

2.) In the opinion of the attending physician *and at least one other physician,* either the death is imminent (whether or not nutrition or hydration is provided and whether or not withdrawing nutrition or hydration is not likely to result in death of the principal by malnutrition or dehydration) or, if nutrition and hydration are provided, they could not be assimilated or would shorten the life of the principal.

3.) *The attending physician and the other physician are to note their opinions on the hospital records.* Where the principal has previously consented to a health care procedure, the attorney-in-fact may not withdraw his informed consent to such procedure unless the physical condition of the principal has decreased the benefit of such treatment to him and the health care is no longer significantly effective in achieving the purposes for which the principal consented to its use originally.

Pregnancy

Informed consent to health care, where the principal is pregnant, may not be refused or withdrawn by the attorney-in-fact unless the treating physician *and at least one other physi-*

cian determine to a reasonable degree of medical certainty that the fetus would not be born alive, or, (the statute also paradoxically provides), "unless the pregnancy or the health care would pose a substantial risk to the life of the principal."

Civil And Criminal Immunities

The statute attempts to give immunity from criminal and civil prosecution to the treating physician who relies upon a Durable Power of Attorney for Health Care. No civil or criminal consequence will flow where the attorney-in-fact's informed decision is relied upon by the physician in a good faith belief that the attorney-in-fact is authorized to make the decision and the physician in good faith believes that the attorney-in-fact's decision is consistent with the desires of the principal, or where those desires are unknown, the decision is consistent with the best interest of the principal and the physician has attempted to communicate with the principal, has failed to do so, *and has made a note of that attempt in the health care records.*

Pitfalls For The Physician

Although the immunities section of the statute provides some comfort for the physician, there remain areas of concern. As already remarked, there is the affirmative requirement that certain actions of the physician be noted on the record of treatment. Also as mentioned, certain actions and decisions must be taken in concert with a second physician. Additionally, the physician must in good faith believe that the power-of-attorney is properly drawn. The doctor, too, must see to it that the attorney-in-fact has sufficient information to make an informed decision. Importantly, the doctor must, also, believe the course proposed by the attorney-in-fact is consistent with the desires of the patient. Finally, as provided by O.R.C. 1337.13, liability may still arise where there has been negligent care deviating from accepted standards of care, and this caused or contributed to the patient's terminal condition, injury, or death.

Health Care Power May Not Be Required

No physician or health care facility may require that any patient execute a Durable Power-of-Attorney for Health Care.

May Not Prevent Transfer Of Patient

The new law closes by stating that neither the doctor, nor the hospital that refuse to comply with the instructions of the attorney-in-fact to withhold or withdraw health care necessary to keep the principal alive, shall prevent the transfer of the principal/patient to the care *of another physician or another facility* that would permit withdrawal of life support. In plain language, if one hospital refuses to "pull the plug", a patient can now be transferred to one that will agree to do so. This section is sure to generate controversy, for it creates the possibility of so-called "wrongful life" lawsuits where a hospital refuses the transfer, and the family thereafter refuses to pay subsequent medical costs.

Summary

The new Durable Power of Attorney for Health Care for the first time in Ohio provides a means for delegating health decisions to third parties. The physician must become familiar with the new statute to avoid potential liabilities. It is best for such a power-of-attorney to contain an expression of the treatment wishes of the principal and to be both properly witnessed and notarized. Although they may not require a patient to sign such a form, hospitals or physicians may request that standardized forms be used with which they are comfortable, provided a statutory notice provision is incorporated. (The State medical association has these available.)

Although, undoubtedly there will be problems with interpreting the new statute, surely it provides a useful tool in enabling a person to have his health care treatment wishes fulfilled or, at a minimum, allowing him to transfer the right to make important decisions to a trusted family member or friend. □

Communicable Disease Reporting

One of the most difficult problems for local departments of health is the accurate monitoring of communicable diseases in the community. It is estimated that local health departments in Ohio receive only 20-25 percent of the actual number of reportable communicable diseases. This underreporting makes it very difficult to answer your questions or address your needs as well as those of the community when we are asked to respond statistically to a given communicable disease.

There are many reasons for timely and accurate reporting of such diseases, not the least of which is it is the law. Chapter 3701-3 of the Ohio Revised Code provides the mechanism for what is to be reported, how it is to be reported, who is responsible for reporting and when. The following is a brief synopsis:

3701-3-03. Method of reporting.

(A) Reports of cases of notifiable diseases listed as Class A and Class B in rule 3701-3-02, of the Administrative Code shall be made on forms prescribed and furnished by the director; provided, in lieu of the written reports from physicians required in the Rule, health commissioners may accept from physicians within their health districts verbal reports by telephone or otherwise, within the same time limitations as required for written reports.

(B) Reports of situations when an epidemic of any disease listed as Class C in rule 3701-3-02, of the Administrative Code is suspected shall be made by telephone or other rapid means of communication.

(C) In reporting cases of notifiable diseases, such reports shall conform to the nomenclature of the international statistical classification of diseases, injuries, and causes of death.

3701-3-04. Who shall report.

Reports of notifiable diseases required by law and those listed as Class A and Class B of rule 3701-3-02, of the Administrative Code shall be reported to the board of health by the physician in attendance. A person in charge of a hospital, dispensary, clinic, or other institution providing care or treatment, having knowledge of such a case, shall report it unless he has evidence that it has been reported by a physician. When no physician is in attendance it shall be the duty of any individual having knowledge of a person suffering from a disease presumably communicable or suspected of being communicable to report forthwith to the board of health all the facts relating to the case, together with the name and address of the person who is ill.

3701-3-05. Time of report.

(A) Diseases listed in Class A and Class B under rule 3701-03-02, of the Administrative Code shall be reported to the board of health wherein such case or suspected case has occurred within twenty-four hours after the existence of such case or suspected case is known, except that reports of cases of inflammation of the eyes of the newborn and gonorrhea ophthalmia shall be submitted within six hours, as required by section 3701-52 of the Revised Code.

(B) Diseases listed as Class C in rule 3701-3-02, of the Administrative Code shall be reported only when there occurs any outbreak or unusual prevalence of such disease. Physicians or other persons having knowledge of such occurrences shall report such facts immediately to the health commissioner of the health district wherein such outbreak or unusual occurrence exists. The health commissioner shall investigate all such reports and shall take all necessary control measures and report the results of his investigation and control measures taken to the department.

The following are the diseases which Ohio law requires to be reported. Missing from the list are AIDS Related Complex (ARC) (reportable since 1986) and HIV 1 and HIV 2 (reportable since 1989).

Neil H. Altman MPH
Health Commissioner
City of Youngstown

Communicable Disease Reporting (Continued)

CLASS A (Individual case reports required within 24 hours)

(1) Diseases of major public health concern because of endemicity and/or potential for epidemic spread: Campylobacter; Chlamydial infection of newborns; Encephalitis (Arthropod-borne, Other viral, Post-infectious); Gonococcal infections; Hepatitis (A, B, unspecified); Legionnaire's disease; Measles; Meningococcal disease; Meningitis, aseptic, including lymphocytic choriomeningitis, and viral meningoencephalitis; Meningitis, other bacterial; Mumps; Mycobacterial disease (Tuberculosis, Other); Pelvic Inflammatory Disease, Gonococcal; Pelvic Inflammatory Disease, Nongonococcal; Pertussis; Reye Syndrome; Rocky Mountain Spotted Fever; Rubella (including congenital rubella syndrome); Salmonellosis; Shigellosis; Syphilis.

(2) Low frequency diseases of major public health concern:
Acquired Immune Deficiency Syndrome (A.I.D.S.); Amebiasis; Anthrax; Botulism; Brucellosis; Chancroid; Cholera; Cytomegalovirus (congenital only); Dengue; Diphtheria; Granuloma inguinale; Herpes (congenital only); Leprosy; Leptospirosis; Listeriosis; Lymphogranulma venereum; Malaria; Mucocutaneous lymph node syndrome (Kawasaki disease); Plague; Poliomyelitis (including vaccine associated); Psittacosis (Ornithosis); Rabies; Rheumatic fever; Smallpox; Streptococcal B in newborn; Sudden Infant Death Syndrome (S.I.D.S.); Tetanus; Toxic Shock Syndrome (T.S.S.); Toxoplasmosis (congenital); Trichinosis; Tularemia; Typhoid fever; Typhus fever; Vibriosis; Yellow fever; Yersiniosis.

CLASS B (Report by number of cases only)

Chickenpox; Herpes-genital; Influenza; Nongonococcal urethritis; Streptococcal infections.

CLASS C (Report situation when epidemic is suspected)

Blastomycosis; Conjunctivitis, acute; Diarrhea of newborn; Foodborne disease; Giardiasis; Histoplasmosis; Infectious mononucleosis; Nosocomial infections of any type; Pediculosis; Scabies; Sporotrichosis; Staphylococcal skin infections; Toxoplasmosis; Waterborne disease. □

The following application for membership was approved by Council.

Second Year in Practice:
Linda L. Cuculic MD

Information pertinent to the applicant should be sent to the Board of Censors.

Society Honors Scholars

Academic achievement and scholastic excellence were recognized when 71 students from 24 area high schools gathered for the 24th Annual Scholarship Recognition Dinner held at the Wick Pollock Inn on Thursday, April 26, 1990. Dr. James Lambert, president and Dr. Robert Spratt, program chairman presented each student with a certificate and pin. The program titled *Germany: Birth and Death of the Cold War* was given by Dr. Verena Botzenhart-Viehe, professor of American and European History and American Foreign Policy at Youngstown State University.

Hosts for the evening were: Dr. and Mrs. James Anderson, Dr. and Mrs. Ernesto Angtuaco, Dr. and Mrs. Mounir Awad, Dr. Raymond J. Boniface Jr. and Dr. Nancy Gantt, Dr. and Mrs. Anand Garg, Dr. Brian Gordon, Dr. and Mrs. James Lambert, Dr. and Mrs. Gopal Nigam, Dr. and Mrs. Robert Spratt and Dr. Eric Svenson. □

1990 Roster of Scholars

Austintown-Fitch High School
Ralph Brown
Tyler Cazin
Noel DePietro
Anthony Direnzo
Sheri Donnan
Harold Liller
Reena Mehra
William Spencer
Eric Tofil

Boardman High School
Lynn Repasky
Rees Engelhardt
Asha Garg
Melissa Mazi

Campbell Memorial High School
Michael Evangelista
Michael Szenborn

Canfield High School
Mark Checcone
Su-Ting Fu
Amit Nigam

Cardinal Mooney High School
Thomas Yager
Thomas Baker

Chaney High School
Anthony DePinto
Neil Kennedy
Rebecca Himes

East High School
Marla Smith
Jessica Carter
Isaac Blair

Girard High School
Michele Kay
Jennie Hammerschmidt

Hubbard High School
Michael Robek
Kimberly Love
Nicholas Cassimatis

Jackson-Milton Local School District
Kate Giammarco
Chrissy Nell
Lisa Williams
Carmela Stevens

Liberty High School
Marla C. Haims
Charles Oliver Stanier

Lowellville High School
Melody Curtis
Jamey Delullo
Jeanette Barone

Poland Seminary High School
Amy C. Yorkoski
Lynn A. Kear
Cristin Bishara
Michael E. Davies
Deborah Perkins

Rayen High School
David Sayyed
Stanton Fleming
Arisha Williams
Jason Switka

Sebring McKinley High School
Lisa Andrews
Karen Clark

South High School
Laneece Ballinger
Cynthia Holbrook

South Range High School
Mindy Martz
Robbie Johnson

Springfield Local High School
Toni Ohlin
Paula Persing

Struthers High School
Justin Noble
Michele Hodge

Ursuline High School
Hilary Ames
William Dobosh
Alexander Nemeth

West Branch High School
Dick Warner
Cindi Streblo
Ada Walton

Western Reserve High School
Kathleen McCoy
Heather Truitt

Woodrow Wilson High School
Nick Cascarelli
Mark Thomas

Youngstown Christian School
Rosanna Dean
Crystal O'Neil

Forgoing Life-Sustaining Interventions

I spoke about forgoing life-sustaining interventions at the Medical Society's March meeting, and I welcome the opportunity to reconsider the subject.

Let "forgo" mean "withhold" and/or "withdraw". Then, the title gains helpful specificity. Forgoing connotes withholding and withdrawing familiar medical treatments and interventions: placement in the ICU, surgeries, transfusions, chemotherapies, radiation, dialysis, lab tests, antibiotics, vasopressors, the ventilator, resuscitation, artificial nutrition and hydration. Forgoing connotes that patients die. So specified, the title heightens clinical, ethical and legal sensitivities. Can physicians kill patients? Allow them to die? What's right and wrong here? Who are the appropriate decision makers? Are there legal guidelines? Ethical decision trees? Let's answer these questions with questions and answers.

Who may legitimately refuse a life-sustaining intervention?

A competent terminal patient or the legitimate surrogate of an incompetent terminal patient may give informed consent for forgoing life-sustaining interventions. The patient's diagnosis and terminal prognosis should be firmly established.

Is forgoing life-sustaining interventions suicide?

Not upon establishment of a terminal prognosis. Competent patients and legitimate surrogates may, after careful consideration, accept death rather than extend life.

Is withholding or withdrawing treatments by physicians murder?

Again, not when there's a terminal prognosis and informed consent from the patient or legitimate surrogate. Physicians should intervene aggressively to save life when prognosis is positive, or when prognosis or the patient's or surrogate's wishes are not known (eg a life-threatening emergency situation). In terminal cases physicians may elicit and respect the patient's or surrogate's preferences. You should remember traditional medical objectives for treatments and interventions: restore health, relieve suffering, palliate, preserve dignity. Treatments and interventions that do not deliver these objectives can be judged futile or extraordinary and se forgoable. Neither per so preserving life nor protracting death have ever been goals of medicine.

Is it killing?

Medical killing is implementing a lethal intervention extrinsic to management and intended to directly cause death. I am opposed to medical killing on both principled and consequentialist grounds. It's wrong for physicians to kill patients, and once an accepted practice, we could not confine the killing to the kinds of cases advocates currently emphasize. Withholding or withdrawing interventions is not killing, but rather "allowing to die" or "letting die." You do not implement interventions or you pull them off, and the patient lives or dies.

Doesn't such action cause death, however?

No. Remember, again, the importance of terminal and irreversible prognosis. The patient's diagnosed underlying anomalies cause death. In forgoing life-sustaining interventions you might foresee and even hasten death. You permit death. You do not cause it.

So letting die is always morally right!

By no means is letting die always morally right! Just because it's not killing or causing death doesn't make it always morally or medically right. For example, suppose the ill and/or elderly competent but non-terminal patient requests a non-aggressive approach. You talk with the person and cannot persuade him or her otherwise. Except in the emergency situation, you should not treat aggressively against the person's wishes. Instead, if you cannot respect the person's wishes, you can rightly inform him or her of your wishes and that you will resign from the case without compliance.

When is forgoing life-sustaining interventions generally permissible?

Consider this decision tree: terminal, irreversible prognosis + competent pa-

James E. Reagan, Ph.D.
Medical Ethicist
St. Elizabeth Hospital
Medical Center

tient's or legitimate surrogate's documented informed consent + documented clinical, ethical and legal consultations prn + written orders including provisions for comfort + education of surrogates about the final symptoms of dying + a narrative, summarizing progress note + management consistent with the institution's approved, written terminal care policies.

There's permissible letting die.

Is this impersonal?

Clinical accuracy. Acknowledgment of person's condition and respect for patient's or surrogate's wishes, rights and interests. Rigorous, detailed, accountable standard of care. Careful and sensitive communication. Such allowing to die is person-centered, not impersonal.

Who are legitimate surrogate decision makers?

By custom and tradition (but in Ohio, not by statute) family members (spouse, parents, children, siblings). Statutorily, the patient's the legal guardian or attorney-in-fact (holder of the patient's Durable Power of Attorney for Health Care).

How should these surrogates make decisions?

In accordance with the patient's previously expressed wishes, or, consistent with what they know the patient would want (substituted judgment), or, upon assessment of the patient's quality of life (best interests).

How can anyone justifiably judge another's quality of life? Isn't this playing God?

Three replies. First, we cannot avoid quality of life judgments in caring for terminal, uncommunicable patients whose preferences are not known. We make a "quality of life" commitment whether we intervene or forgo. As for "playing God", I dislike this phrase because it's usually inflammatory, but as with "quality of life", it walks on both sides of the street here. You play God as much in indefinitely aggressively intervening as you do in withholding or withdrawing. Third, my faith community, Roman Catholicism, offers generally rational criteria for legitimate medical and moral assessment of the terminal patient's "best interests": treatments and interventions which are futile (disproportionate) for recovery or comfort or economically devastating of the patient or family are against people's best interests.

You mention economics. Isn't forgoing life-sustaining treatments simply a product of recent health care economic scarcity?

No and yes. In 1951, well before the economic boom in western medicine and health care, the Jesuit Gerald Kelly cited costs as a legitimate *and traditional* personal and social criterion in deciding about interventions. To be sure, the currently real and felt squeezes of scarcity influence thinking about forgoing interventions. But we must accurately relate cause and effect here: futile and indefinitely implemented aggressive end-stage interventions largely contribute to the scarcity that elicits economic talk of withholding or withdrawing.

Isn't it unjust that people die because of economic scarcity?

Asked that way, I answer yes. But ask another question: in light of individual and social priorities (eg. preventive and rehabilitative medicine and health, an affordable tax rate and savings, housing, education, infrastructure, the environment) competing for *available* resources, isn't it desirable to attempt democratic, reasonable, generous and fair rationing of resources for terminal care? If ever, given such rationing, similarly diagnosed terminal patients were then similarly dying, our deaths would be unwelcome as many are now, but not unjust.

Is forgoing life-sustaining interventions legal?

In Ohio, the competent terminal patient can give consent to withhold or withdraw any life-sustaining intervention. The legal guardian or attorney-in-fact of the incompetent, terminal, dying patient can consent similarly, with certain restrictions on the attorney-in-fact on withdrawing artificial nutrition. By

tradition, custom and many institutions' policies (but not by statute), family members of the incompetent terminal and irreversible patient can give consent to forgoing life-sustaining interventions.

Is forgoing life-sustaining interventions legally safe?

Yes, provided sufficient clinical consultation and terminal prognosis, informed consent from competent patients or statutorily empowered surrogates, consensus among customary surrogates (family) and consent from one of them, appropriate documentation, clinically competent and sensitive end-stage care, and management consistent with written institutional policies.

Do we need living will legislation in Ohio?

Yes. The statute will explicitly legitimize allowing to die. I hope it authorizes the advanced directive known as "declaration": a written statement by a competent citizen of the type of care desired when dying and unable to communicate. And I know it will—finally—explicitly legally recognize the tradition and custom in Ohio of family surrogates making decisions for dying persons who lack advance directives.

Why is there so much confusion and apparent complexity about forgoing life-sustaining interventions?

A series of short replies. First, for many people, death is the ultimate taboo experience, and these people, whether living or dying, react ultimately ambivalently. The medical profession presents notoriously in this respect. But let's be fair here. Physicians draw disproportionate criticism for our society's reluctance to withhold or withdraw treatments. I get consulted on cases where the physicians are ready to not start or stop things and the patients' families, even after comprehensive and sensitive communication of hopeless prognoses, continue to insist that "everything" be implemented. This phenomenon of "the unreasonable family" is one that physicians must more widely report so that others in society can see it and help you address it.

Second, withholding and withdrawing interventions is new and counterintuitive for physicians primarily socialized into the post 1945 high-tech, aggressive, bottomlessly financed practice of American medicine.

Third, physicians' legal freedom to forgo, while now clearly established, is recent, somewhat inconsistently developed, and not sufficiently understood and trusted by physicians themselves.

Fourth, we make forgoing life-sustaining interventions more difficult by the way we routinely talk about it. We routinely label withholding or withdrawing interventions "euthanasia". We call it "passive euthanasia". But "euthanasia" primarily means medical killing and/or assistance in suicide, directly intending and causing death. The phrase "passive euthanasia" is paraplegic. There's nothing "passive" about withholding and withdrawing life-sustaining interventions from terminal patients. Rather, forgoing interventions is precisely "active" *and* not killing. Calling it "passive" covers over this conjunction. And, "euthanasia" summons "causing death" in the clinical and popular minds alike. "Euthanasia" conjures killing. The prospect of regular medical killing confounds clear thinking, sabotages consensus, and postpones public standard of care about withholding and withdrawing interventions.

How can physicians help the rest of us improve our approach to withholding and withdrawing treatments and interventions?

Examine personal attitudes and professional reactions regarding sickness, suffering and death. Some deaths are harsh, inexplicable, unacceptable or tragic: ambivalence is appropriate! But other deaths are timely: it's the dying that's untimely. You can replace ambivalence with a feeling for these deaths as graced or natural experiences, as permissible.

Always look to restore health first. And when you can't, you need not technologically indefinitely prevent death. Physicians recognizing and allowing irreversible dying is, indeed, an

extremely traditional expression of patient advocacy. Continue to *communicate* when you cannot cure. Consultations to clergy, chaplains and social workers are often helpful.

Stay informed of clinical, ethical and legal baselines. Know the terminal care policies of hospitals *and nursing homes* to which you admit, follow, refer or recommend, and lobby for informed policies at these institutions. Physicians, patients and families cannot afford ignorance, apathy or misinformation here!

Encourage your patients, especially those terminal and/or elderly, to share their expectations of terminal care with you and to carefully draft advanced directives (Durable Power of Attorney for Health Care, Living Will) expressing their wishes.

Lastly, help us reform our language. Reserve "euthanasia" for directly intending and causing deaths (medical killing). Say no more the misleading "passive euthanasia." Say "allowing to die" and "permitting death" and "letting die" in talking about withholding and withdrawing treatments and interventions. □

Members Hear Ethicist

James E. Reagan, Ph.D., a medical ethicist from St. Elizabeth Hospital Medical Center spoke on "Forgoing Life Sustaining Intervention" when members and guests met at Paonessa's Restaurant for the general meeting held on Tuesday, March 20, 1990.

Dr. James Lambert presided over the business meeting at which time the resident membership application of Jeffrey Mark Moldovan, D.O. was approved and the application of Patricia Pearson, M.D. for resident membership was presented. The emeritus status of George L. Altman, M.D. and of Robert G. Warnock, M.D. was approved.

In other business, the members approved the following resolution:
RESOLVED, THAT THE OFFICE OF VICE-PRESIDENT BE ELIMINATED AND REPLACED WITH THE OFFICE OF PRESIDENT-ELECT.

This resolution, was in accordance with the By-Laws, presented to the membership at the January 16, 1990 meeting. □

50 Years Ago - April 1940

Many changes were in the making in Mahoning County. Judge Woodside was urging new facilities for local care of the mentally ill, and advocated the changeover of the Municipal Contagious Disease Hospital on Indianola Avenue to a mental hospital. Dr. Ivan Smith's committee was studying plans for voluntary health insurance as an alternative to compulsory government insurance plans. Dr. Joe Hall's committee on indigent relief was negotiating with Mr. Feuer to provide compensation for care of indigent patients in the hospitals. Dr. Gordon Nelson's public health committee was working with the County Commissioners to organize a medical staff for the Mahoning County Tuberculosis Sanitorium on Kirk Road.

New members that month were Donald A. Gross and John E. Allgood.

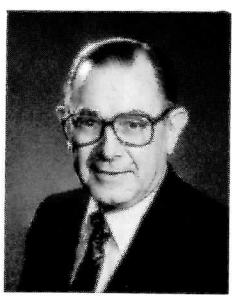
40 Years Ago - April 1950

President Gordon Nelson was still deriding the members for their poor voting records. He quoted some figures, but didn't identify their source. "18% of the county physicians did not vote, 18% of druggists did not vote, 32% of bank employees, 33% of the ministers, 34% of retail grocers, and even 21% of the Chamber of Commerce members did not vote in the 1948 election."

Editor Fred Coombs complained that only 110 members at the meetings showed a lack of interest in the society. Today we'd be delighted with that many.

Dr. Frank Gelbman had an interesting article on the technique for using Antabuse in the treatment of Alcoholism.

New members that month were John R. Willoughby, Frederick A. Resch, and Earl E. Brant.



Robert R. Fisher, MD

30 Years Ago - April 1960

President Fred Schlecht wrote "Perhaps the most serious complication of modern medicine is the loss of understanding of the patient as an individual. In our preoccupation with scientific medicine, the patient tends to be fragmented and depersonalized. . . Medical care is similar to religion in that it must be personal."

Dr. Robert Kiskaddon addressed the Ohio Psychological Association on "Allergies and the Phychosomatic Approach to Them." Dr. Elsa Shapira spoke on "The Clinic Team and the Ideal Approach." Dr. Stephen Ondash was elected to the Presidency of the Ohio Surgical Association.

New members that month were Dr. Leonard Blum, Youngstown's first full time Health Commissioner, and Dr. A.R. Dziadzka.

20 Years Ago - April 1970

President Dr. Robert Jenkins wrote about the care of the dying. "To help the dying we must come to grips with our own feelings about death." He urged the use of the community services, the clergy, social services, etc. Two well loved physicians passed on at that time. Dr. Francis W. McNamara was the first intern at St. Elizabeth Hospital and went on to become Director of Surgery and President of the Staff. The other was Dr. Joe Hall, a well known and loved family physician who practiced in Youngstown for thirty-seven years.

New active member that month was Dean J. Limbert. New associate members were Robert A. Bacani, Charles A. Crans and Earnest Perry.

10 Years Ago - April 1980

The $30,000,000 lawsuit filed in 1976 by the Northeast Ohio Health Care Foundation was finally settled for $6000.00. The Medical Society's share was $1,666.66 for itself and the individual physician defendants. To cover this expense and another related lawsuit, council agreed to assess each active member $150.00. It was necessary, but it was not a popular decision.

Howard Rempes was retiring as Executive Secretary, and Dr. Y.T. Chiu and his committee were looking for a replacement. Howard wasn't very big, but his shoes were going to be hard to fill.

There was no mention of any new members that month. □

John Andrew Rogers, M.D.

John Andrew Rogers, M.D., died at Jekyll Island, Georgia, April 20, 1990—two days short of his 81st. birthday. He was born in Salineville, Ohio and graduated from high school as top male student. Dr. Rogers was awarded a 4 year scholarship to Adelbert College of Case Western Reserve University. He received his medical degree from the University of Rochester, and interned and completed his residency in internal medicine at the Youngstown Hospital Association.

He enlisted in the U.S. Army Dec. 8, 1941 and served 26 months in Europe, being discharged in Nov. 1945. Upon returning home, he joined the late William H. Bunn Sr. in the practice of cardiology with offices in the Home Savings and Loan Building. He retired in 1978 and moved to Jekyll Island where he became very active as the chief medical adviser to the local fire department in the training of the paramedics.

Dr. Rogers developed the first blood bank in the city and directed the Cardiac Clinic at the South Side Hospital for 25 years. For many years he served as chief of the medical service and also served as President of the medical executive committee of the hospital. He was a long time member of the Board of the American Red Cross and was a member 25 years and a director 10 years of the Youngstown Rotary Club.

Dr. Rogers was the second president of the Youngstown Area Heart Association and later named president of the of the Ohio Heart Association. He was the first Youngstowner to be named a life member of the Association.

Dr. Rogers was considered one of the foremost cardiologists in northeast Ohio. Even at the time of his retirement, he as making almost daily house calls. He was an accomplished golfer having won the club championship and the President's Cup at the Youngstown Country Club. During his retirement on Jekyll Island, Dr. Rogers enjoyed making and giving as gifts wind chimes and animal "critters" made from sea shells.

He is survived by his wife, the former Blodwyn James, a son James of Richmond, Va. and a brother Harold of Louisiana.

John Rogers was truly a "doctor's doctor". Loved dearly by his patients, highly respected by his colleagues, and honored by his profession, his warm smile and calm demeanor will be sorely missed. A John Rogers, M.D. comes along only rarely, and we who knew and loved him are richer indeed because he walked among us for a little while.

Jack Schreiber, MD

Do You Believe in Impossible Things?

"There's no use trying," Alice said. "One can't believe impossible things."

"I dare say, you haven't had much practice," said the Queen. "When I was your age, I always did it for half an hour a day. Why, sometimes, I've believed as many as six impossible things before breakfast."

Lewis Carroll—Through the Looking Glass'

For the past decade, our community has been struggling economically to overcome the major steel shutdown of the late seventies and early eighties. Throughout this period, both our major hospitals—St. Elizabeth Hospital Medical Center and Western Reserve Care System, have struggled to succeed in the annual recruitment of residents—the MATCH. The 1990 MATCH has come and gone and again we are unsuccessful. Are we believing in "impossible things"? What factors may be overpowering our ability to recruit effectively?

For the past decade, and most assuredly the last five years, both hospitals have, with medical staff/faculty support, allocated significant resources to upgrade residencies, recruit students, pursue candidates, and still we are only marginally successful. Why? If one examines the NEOUCOM record on our campus, the vast majority of student evaluations of clinical teaching rotations on-site are rated as average to above average in quality. Exit interviews at St. Elizabeth's for all major clerkships show that NEOUCOM students believe they are well-educated, were part of a quality educational environment, and had meaningful clinical rotations. Why didn't they come to our campus? Further, looking at the number of graduates for the past decade graduated from Youngstown State University who have entered medical schools in Ohio and elsewhere, why the low number who have matriculated in our residencies or returned to the community as practitioners after their residency experience?

Is it possible that the hospitals are trapped in an environment that guarantees failure? I believe that if Western Reserve Care System or St. E's were located in Dayton, Pittsburgh, or other cities with stable and/or growing economies, our programs would have enjoyed our overall successful MATCH. It is my opinion that the problems of recruitment to the graduate medical education programs in our community are *not* directly related to the collective activities of our respective medical staffs, the resource allocation by the hospitals, the availability of resources for resident use, patient volumes, or any of the factors contributing to quality training programs. *Other factors are at work.*

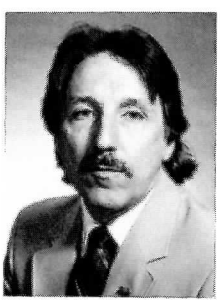
THE MATCH IS A SERIOUS PROBLEM NOT ONLY FOR LOCAL HOSPITALS BUT ALSO FOR OUR COMMUNITY.

While there may be specific educational areas that can be tarqeted for improvements within the two major hospital systems, this effort may have minimal impact upon future MATCH selections. Our community has suffered for over a decade with the national perception that the steel industry left the community a ghost town and, I suggest, economic stagnation is continuing. I believe many students see graduate medical education as wedded to their further development as physicians by providing an economic base for the development of their practices.

What is the impact of our community's image or reputation?

Why don't NEOUCOM graduates and YSU graduates return to their community? Do they believe that our community is failing in its recovery effort with little future prospect of success? It has been suggested that only a handful of all local National Merit Scholars are remaining or returning to our community after graduation. It is no anomally that local surveys of high school and college students show that most eventually leave the area. At present, the census shows that we are losing many more educated, young, skilled people than we are attracting to the region.

At present the major employers in our community are the hospitals and



W. Robert Kennedy, Ph.D.

Youngstown State University. The region is in economic trouble. Why is the leadership community so ignorant of this fact? Why are the community's traditional institutions failing to address this problem? Why is there no sense of urgency? The region is like a sinking ship with the captain asleep at the helm.

When the region suffers economically, the hospitals suffer, physician practices suffer, and ultimately, the remaining populace as patient services decrease. The two major hospital systems of Mahoning County are striving to be regional centers offering quality patient-services. Can this plan be successful if there is no economic development locally? What would be the impact of a 15-20% decrease in employment if one or more large firms cut back? Such an occurance will exacerbate a difficult situation by causing the outward migration of young families and individuals. Such a migration occurred in the Mahoning Valley when steel declined. If we believe the statistics that approximately 18%+ of the Mahoning County basin is over 65 years of age at present, what will the region have in 5 years? The impact will be truly dramatic on both hospital systems and many physician practices. Alteration of major employers may have tremendous spillover effects. They provide many jobs in related endeavors. What will those feeder companies do? We will see a significant cut-back in our patient population and patient services.

What are the implications to our local health care system of further unemployment? Staggering!

If steps are not taken to remedy our economic circumstances regionally, to secure physicians for the future, we will seriously jeopardize maintenance of our graduate medical education programs by the end of this decade. The hospital resources will be in decline. This will occur as third party payers and medicare modify their practices financially to the detriment of large training systems and more and more emphasis will be placed on the training of physicians outside of hospital walls.

Five years is not far off. We must take action to turn our community around.

Further serious economic, cultural, and society system decline must be arrested. For those of us who know and love the region and know its many benefits of ethnic origin, religious tolerance, family orientation, nuclear family awareness...all could be put asunder.

What is our community record in economic recovery? What is perceived to be Akron's assets? Do we have leaders able to confront our plight and plan solutions?

Outsiders cannot save us. We must develop mechanisms to highlight our dilemma while forcefully planning for change. Few communities can attest to the reality that hospital systems have been able to stem the tide of economic decline within a given area. Where is the political community? Agencies? Major institutions? The University? Our legislative leaders? Where is any appreciation of regional orientation linking the five to ten county zone on either side of the Pennsylvania-Ohio border? Over the past decade, community leaders have not succeeded. Isolated individuals contributing a great deal have helped, but they cannot (and should not) be made to shoulder the load alone.

Our local and institutional medical education mission has frequently been compared to the Akron hospital programs: Akron hospitals are winners in the MATCH, Youngstown hospitals are losers. While we are in economic decline, Akron is perceived to be in economic ascendancy. Why did this come about? It is this writer's opinion that Akron is perceived as having been blessed with not only a knowledgeable medical community, enlightened leadership within their hospital systems from the board to the administration, but they also have created a positive image for their city. Private sector and public sector leaders have worked in partnership and the community has profited tremendously. When the rubber industry elected to leave Akron there were sufficient numbers of locally

oriented, well intentioned, community and business leaders who sought the aid of unions and forced change, built mechanisms for growth and development and succeeded in spite of overwhelming odds to maintain the integrity of their community. Youngstown has lost in this regard. The departure of 50,000 plus steel industry related jobs did not afflict just individual families forced to uproot or to take lower standards of living with alternate job opportunities. We lost our leaders—what few existed. The mills in this community were run by people not from the community. White collar workers left. We did not, and maybe, DO NOT, have high visibility community leaders in numbers to stem this tide. This is not to imply, in any way, that there aren't well-intentioned and, to some degree, well-qualified people trying their best to overcome great adversity and see regrouping and growth within our community. The problem is there is no foundation for change. We do not have a nuclear mass of critical thinkers. We seem to lack long-term planning, lack long-term goals, and are besieged by traditional rivalries whether it is in the political communities, the urban/suburban areas, or the economic development areas. The product is everyone going it alone and my expectation—continued limited success if any occurs at all.

What causes a young person to decide on a hospital for training and/or a region for career development?

I suggest our MATCH data constitutes an all-to-apparent indication of predominately community, not hospital failure. Young, aspiring, entrepreneurs are not inclined to gamble and loose. It is their life, their career, and their profession. Very few physicians enter the practice of medicine through altruism and self-denial. They require and, to a great degree, deserve a higher quality of life for themselves and their families. If they perceive a potential poor quality of life, lack of economic opportunity, and no prospect for positive economic change, they will go elsewhere.

We as a community are stumbling, economically will potentially fail, and may be beyond assistance. The situation begs for attention beyond the hospital/medical community. The region, to be maintained with its remaining quality of life, vitality, and hope for the future must be viewed for what it is. The world is no longer defined at the city, county, but rather the regional level. Multiple communities compete for the same resources. our region is an insulated, parochial, arena between two large and developing economic fortresses, Pittsburgh to the southeast, Cleveland to the Northwest. Geography dictates that there will be little spillover of any economic recovery that occurs in either of these centers. Like it or not, the Youngstown economy includes Columbiana County, Trumbull County, Mercer and Lawrence Counties in Pennsylvania. Western Reserve Care System and St. Elizabeth Hospital Medical Center were the only institutions providing graduate medical education in the region. If one were to go one county beyond that immediate region, there are no residencies there either. As a matter of fact, if one travels north from Columbiana County in Ohio and Lawrence County in Pennsylvania on either side of the border one must go to Erie, Pa. before one finds a residency program. Who will produce the physicians for this area to serve patient's needs?

We must recognize that communities have as bell-weather indicators, job security, quality of public education, quality of health care delivery, and the availability of physicians. Further economic growth and redevelopment is standing in no small part on the success of our institutions. We must recognize that we all have a vested interest if we are to maintain our programs, our health-care system vitality, and in turn, the vitality of the quality of life in this region. We must find mechanisms to address our problems. Outside saviors are not coming to help us. After a decade, we must believe in "possible things"!

Any ideas? □

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(415). Large car lot on Rt. 7 Market St., approx. 13,000 sq. ft. bldg. on 360′ frontage on Market St. Excellent for car dealer or large volume used care dealer, south of the mall and Boardman, $300,000. By appt. only.

O.S.M.A. Annual House of Delegates Meeting at the Stouffer Hotel, Cleveland on May 4-6. Right to Left are delegates Dr., H.S. Wang and Dr. E.V. Angtuaco from Mahoning County and Dr. C.E. Smith from Stark County.

Medical Students Reach Out To Elementary Students

Health education, nutrition, drug abuse and smoking, AIDS. Conveying important information on these topics to elementary school students can be a difficult task.

Who will they listen to? What choices will they make?

I and other medical students at Northeastern Ohio Universities College of Medicine (NEOUCOM) hope to make an impact on youngsters throughout northeast Ohio through a "Student to Student" program, which will enable us to teach the younger students about health-related issues and information.

Through the American Medical Students Association (AMSA), we have already been involved in the "Adolescent Health Project," a program aimed at supplementing the health education of middle school students. For the past two years, we have provided instruction in the Youngstown City Schools and have reached approximately 500 adolescents.

Curriculum for the project was developed largely by the medical students and focuses on such subjects as AIDS, substance abuse, teenage sexuality, and sexually transmitted diseases. During a regular class period, the medical students present information on one of the topics and then divide students into small groups to encourage interaction. Generally, one male and one female student team teach the subjects. We have worked closely with Cynthia A. Myers, Director, St. Elizabeth Health Education Center, and faculty adviser of the Adolescent Health Project.

Recently, several NEOUCOM students attended an Ohio State Medical Association (OMSA) conference where the Student to Student program was discussed. The program currently exists at several medical schools throughout the state.

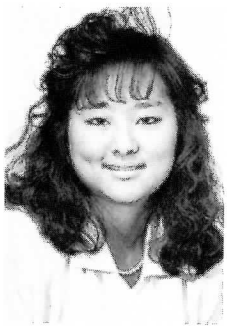
We are now hoping to expand the Adolescent Health Project to the Student to Student program, utilizing more medical students and reaching more schools in the counties served by the medical school, including Mahoning, Portage, Stark, Summit, and Trumbull. A questionnaire has been sent to local schools throughout the five counties to gauge interest in the program.

An all-day conference, sponsored by NEOUCOM's Human Values in Medicine program, is planned for the medical students in August to discuss the health-related issues and the proper techniques for teaching various age groups and cultures.

As student coordinator of the Student to Student program, I am responsible for scheduling the programs with school systems, developing curriculum, and coordinating the instructors' teaching schedules. Co-chairmen for the Student to Student program are Guy Neff, Class of 1992, and Joy Mosser, Class of 1993. The board of directors are Sandy Kwak, Jennifer Uvena, Sunny Chung, Deepti Rao, all Class of 1992; Cindy Buchman, and Carol Blanchong, Class of 1993.

"We hope that the students will be more responsive to the information if it is presented by other students," Jennifer Uvena said. "We want to help the educational process by providing up-to-date medical knowledge," she added.

For more information on the program, call Mona McNeely, Coordinator for Student and Alumni Activities, Northeastern Ohio Universities College of Medicine, at 747-2247, ext. 355. □



Susie Kwak, Class of 1992 Student Coordinator, Student to Student Program

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