BULLETIN

Founded 1872

Vol. 60, No. 9 | Bulletin of The Mahoning County Medical Society | December, 1990

***Self Portrait*, Lithograph**
by Thomas Hart Benton (1889-1975)

Born in 1889, Thomas Hart Benton grew up in the Missouri Ozarks drawing frontier subjects at an early age. After studying art briefly in Chicago and Paris, he moved to New York in 1912 where for 20 years he continued to experiment with the modern art forms evolving at that time. During those years in New York, Thomas Benton became involved in various art guilds and activities which eventually changed his direction of art back to the American scene

Cover Story continued on pg. 32

Founded 1872

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BULLETIN

Mahoning County Medical Society
Volume 60 December1990 No. 9

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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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Communications

Physicians have various areas of communication derived concerns. These areas involve contact with other physicians, individual patients and the public in general .

PHYSICIAN-PHYSICIAN

The progress notes in the patient record are the main arena for communication involving the in-patient. Two major areas of concern are legibility and treatment plan.

"People like 'their' doctor but are unsure about all the others."

Physicians frequently consider the progress note to be their personal domain. Usually the progress note is regarded as the least important aspect of the patient encounter. The note is often hastily written with little regard for whether or not others can decipher the meaning. However, participation in the treatment by consulting physicians and paramedical personnel is often developed from the progress notes.

The problem oriented record was proposed as a method of coercing the treating physician to put in the record the pertinent portions of the patient's progress and treatment plan. However, even many of these notes are not informational or constructive.

The physician needs to conceptualize the progress notes as a necessary means of communicating with others involved in the patient's care. Illegible and uninformative notes are a disservice to all involved.

PHYSICIAN-PATIENT

The relationship between the physician and patient can be either directive/paternalistic or decision sharing.

There is a tendency to be directive since we know what is best for the patient. We know the best method of therapy, the best consultants and the best hospitals. Some patients respond favorably to the directive approach because of fear of the unknown or of offending the physician. Others want a more participatory status and push for more dialogue in the decision-making process. The ideal relationship is dependent on the specific circumstances and must be tailored to the individual patient.

How the physician deals with his own biases is of concern. The process by which a physician refers patients to other physicians deserves consideration. A referring physician may have a positive or negative inclination toward another physician. How should this bias be presented to the patient? Should the patient always be given alternative choices or should the patient be directed to a specific "best" therapist?

I have encountered both situations. The referring physician has concerns about the care given by an individual physician and consequently does not refer to him. Alternatively, the patient may have a specific choice for a consulting physician but be directed to a different physician. What is the proper basis for recommending referrals? There is no simple answer, but each of us must remind ourselves continually of our own personal biases.

PHYSICIAN-PUBLIC

The last area involves how we are perceived by the public.

People like "their" doctor but are unsure about all the others.

The medical society is attempting to build a speakers bureau. There are already three specified physicians who have been trained through the Ohio State Medical Association to deal with local speaking engagements regarding UHIO. There was also a media-training seminar given by OSMA in Youngstown. Hopefully, the training seminar can become a regularly scheduled event to increase the number of trained speakers.

The other problem is informing the public that we are available. Our county society is attempting to make local public inter-

James A. Lambert, MD

est and fraternal groups aware of our availability. The more that we can establish our image as concerned allies of our patients, the more positive will be our image in the community.

We must always strive to improve communications among ourselves and our patients. This is a continually evolving arena. There is a need for positive input from the physician community regarding new and different ways of dealing with these problems.

Did You Know?

According to the American Association of Medical Assistants, medical assistants comprise a workforce of over 1 million. The association represents the second-fastest growing career in the United States today.

Holiday Cheer

"...I can truly say I thoroughly enjoy what I do, and as others - given the chance - I wouldn't do anything else."

The holiday season is often a time for reflection and thanks. It has also been nearly a year that I've been editor of the *Bulletin*. Looking back, I have discussed some of the negative aspects of medicine. There are, however, many things I enjoy about medicine.

People. The patients are wonderful. For all of the problems and government agencies, reimbursement, etc., my patients are a joy to see. I think most physicians would agree patients are the reason we continue to exist. Certainly these days, the financial rewards are less, and administrative headaches are high. I had a medical student with me for one month who was amazed at the amount of paperwork to be done. He was more amazed that I knew each patient and a little bit about their family and that I could recite it to him without looking at the chart. I told him that's part of being a physician and taking care of people - whether primary care or specialist - you need to know the person.

Flexibility. Although some people would disagree, there is some amount of freedom in a medical career. I can chose to be as busy as I like. This leaves time for important activities, raising children and pursuing other interests. There are many options available for physicians entering practice from managed care to multi-group specialists, as well as the traditional solo practitioner.

Camaraderie. I have found enjoyment in the company of medical colleagues. Established physicians have been helpful and honest with their advice and assistance. I don't know exactly what I expected, but I somehow thought it wouldn't be easy to blend in. Everyone has similar problems and complaints. So many of the physicians I've met are not only excellent in their field but have remarkable interests outside of medicine as well.

Denise L. Bobovnyik, MD

For all the times I have complained and protested about the field of medicine, I can truly say I thoroughly enjoy what I do, and as others - given the chance - I wouldn't do anything else. □

OSMA Practice Management Seminars

Productive Practice:

January 22, 1991 - Cleveland Marriott Airport.

January 23, 1991 - Hyatt Regency, Columbus.

To register, call the OSMA Dept. of Administrative and Educational Services, 800-282-2712.

PT-TIME PHYSICIAN NEEDED

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The following applications for membership were approved by Council.

Active:

Nicholas G. Proia, MD
Maria Sarma Vassilaros, MD

First Year:

Gerald A. Matteucci, MD
Michael J. Choban, MD
Ronald J. Prizant, MD

Information pertinent to the applicants should be sent to the Board of Censors by December 28.

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Hospice and Terminal Illnesses

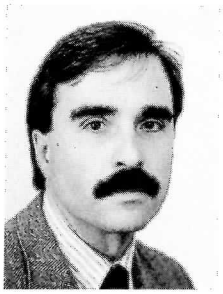
When we physicians find it necessary to explain to patients and families that the disease is terminal, it helps to suggest to them that they call Hospice of Youngstown. It helps for these reasons:

1. Hospice believes that caring for patients with a limited life expectancy often can be done in the home with the family as the "unit of care" an alternative to institutional care, which is more costly, less personal and probably less effective.
2. Hospice helps patients and families help themselves by teaching them to cope and by helping the patient live as fully and comfortably as possible.
3. Hospice is a team, an interdisciplinary team, made up of nurses, psychologists, social workers, dietitians, physical therapists, companions, clergy and specially trained volunteers and physicians who work in conjunction with the patient's physician to provide the most professional care possible. It is intensive, comprehensive care.
4. Hospice affirms life and regards dying as a normal process. Hospice neither hastens nor postpones death.
5. Hospice nurses care exclusively for the terminally ill, are highly skilled, and are an excellent link between the patient and his/her personal physician. The nurses are on call 24-hours a day, 365 days a year – a comfort in itself for the patient and family. Each patient is assigned a primary nurse who follows the patient and family through the program. Nurses are skilled in pain and symptom control, state-of-the-art equipment, catheter care, I.V. and epidural analgesia, Medi-port care, tracheostomy care, gastro-enterostomy therapy, colostomy care, decubitis care and veni-puncture.
6. The Hospice organization accepts all regardless of race, creed, national origin, or ability to pay. Thirty percent of its income is derived from insurance, 20 percent from memorials and 50 percent from community contributions. It is Medicare and Medicaid approved. Some are eligible for and elect Part C of Medicare (the Hospice Benefit). Under Part C, Hospice is paid a daily rate and all of the patient's needs (related to the terminal illness) are paid for by Hospice durable medical equipment, drugs, medical supplies, etc. The physician continues to bill under Part A.

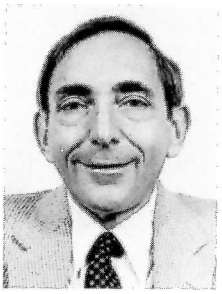
To be Hospice eligible, the patient must be aware of his/her diagnosis; there must be an eligible identified caregiver in the home; there must be a physician's statement that the person has an anticipated life expectancy of less than six months if the disease runs its normal course; the physician must be willing to continue to follow the care and provide orders for the patient's care; and patients must live within an approximate 20-25 mile radius of Youngstown.

Hospice of Youngstown is celebrating its tenth year of caring for patients. Hospice has been a great support to families and can be of great assistance to physicians. Though 95 percent of the patients have cancer, Hospice will assist with any patient with a terminal illness.

Hospice helps. Helps the patient, the family and the physician. □



Chris A. Knight, MD
Medical Advisor



Lawrence Pass, MD
Member, Medical Advisory Committee

If You Can't Take It With You, at Least Leave It Behind!

"There is a big budget deficit out there, and be assured that government is looking to you to help balance it."

Tax rates were lowered dramatically in the 1980s, enabling many professionals to retain more of their earnings and accumulate significant estates. However, these same individuals, while successfully earning money during their lifetimes, are too often lax about seeing that their assets will keep working for their loved ones when they are gone.

There is a big budget deficit out there, and be assured that government is looking to you to help balance it. Many an unwary person has left his bereaved family the additional burden of having to make a hefty contribution against the national debt. The fact is, although income tax rates are low, combined estate taxes are high - they can total over 60 percent - and without careful planning a lifetime of savings can be unnecessarily depleted. This month begins a series of articles on different estate planning techniques that can make a big difference to you and your family.

First of all, you do not need to be "rich" to think about an estate plan. Many people, by the time the house, Keogh, IRA, place at the lake and life insurance are added in, reach the plateau where the government starts asking for money. Secondly, there are good non-tax reasons to contemplate using estate planning devices such as trusts.

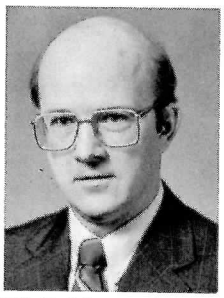
Estate planning relates to the arrangement of your affairs so that upon your passing, your assets will go to those whom you wish to benefit, while being subjected to the least amount of taxes and transfer costs. Often, too, it speaks of setting things up so that your assets can be professionally managed for the benefit of a less sophisticated loved one when you are gone. Planning is something, too, that is not merely done for the benefit of the spouse by the breadwinner. In these days of working couples, knowing that a plan is in place, as will be seen, provides protection, and, thus, comfort to both wife and husband.

One begins with the desire to keep federal and state taxes to a minimum. Federal taxes begin at 18 percent, reach 41 percent at one million on their way up to 55 percent at three million. (There also may be additional taxes if you pass assets across more than one generation.) Ohio also imposes a smaller tax that begins at 2 percent and runs to 7 percent on amounts over $500,000.

Fortunately, for federal tax purposes, we each are given a tax credit which allows us to pass $600,000 tax free to our heirs. Additionally, if we are married, there is available a marital deduction, which allows us to deduct from our taxable estate the value of assets effectively transferred to a surviving spouse. In other words, anything left outright to a spouse passes tax free. (Uncle Sam lets us do this on the theory that property passing from one spouse to the other will be ultimately subject to tax in that generation when the surviving spouse passes it on.) Ohio imposes no tax on qualified bequests to spouses, as long as they do not exceed $500,000.

With this information in mind, the outline of a basic estate plan emerges. The trick is to be able to have the estates of both husband and wife fully use their credits so that a total of $1,200,000 might be passed free and clear to the next generation.

As a first step, it is advisable that to some extent the assets of husband and wife be balanced between themselves, for no one knows whether husband or wife will first pass on. To understand the reason for balancing, take the not unusual situation in which nearly all family assets are in the husband's name alone. Assume that he dies with $1,200,000, and that the wife owns nothing (unlikely, but bear with me...). As mentioned, because everything in this example will pass to the wife, the existence of the marital deduction means no federal



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

tax. However, a big tax bite will come on the wife's death, since, in dying with an estate of $1,200,000, she has only the $600,000 deduction, leaving a taxable estate of $600,000. The federal tax alone on this amount is nearly $200,000. If a way could be found to "pass" the $600,000 deduction amount on to the next generation, while at the same time making it available for the surviving spouse if needed during her life ....

Naturally, the lawyers have found a solution, which calls for setting up mirror credit shelter trusts. A credit shelter trust calls for placing in trust an amount up to the $600,000 amount that each estate can pass tax free using its credit. The surviving spouse enjoys income only from this trust during life, and on death the fund passes to specified beneficiaries, typically the children. (The spouse can get at the fund if other assets are depleted and can also be given a limited annual invasion power.)

Thus, an initial $600,000 will pass to the next generation tax free via the credit shelter trust, and the taxable estate of the second to die will only contain $600,000, instead of $1,200,000. Since the second estate will also enjoy a deduction in that same amount, there will be no federal tax in that estate either. Over $200,000 is saved for the family.

Funds not going into the credit shelter trust go either outright to the surviving spouse, or, as is more common, to a second trust, called the marital deduction trust. The surviving spouse enjoys access to everything in this trust, and, therefore, as per the general rule, the trust assets qualify for the marital deduction. The reason a trust vehicle is used is to provide a spouse who is not financially sophisticated with professional asset management.

A tax law change several years ago created an important exception to the requirement that in order to get a marital deduction the spouse must receive the property outright or, if it be in trust, have access to it. Now, a person has the ability to set up a Qualified Terminal Interest Property ('Q-TIP') trust. With a Q-TIP trust, money is put into the marital deduction trust, the surviving spouse gets the trust income for life, but the person setting up the trust is able to name the persons who are going to get the proceeds left when the surviving spouse passes on. This device is often used when someone with children remarries and desires that their children by an earlier marriage be protected.

If estate taxes are so high, why can't a person just give assets away toward the end of their life? Uncle Sam really does need the money, folks, and, as you would think, gifts are taxed, too. In fact, the 1980s tax law changes equalized the gift and estate taxes, so that it matters not how assets are transferred, the government is going to get its share. Fortunately, there is one substantial loophole: you are allowed to give away up to $10,000 per year, per donee. Furthermore, a husband and wife can join in the gift (even if the asset given is owned only by one of them) thereby raising the amount to $20,000. Thus, if there is harmony in the family, and Mom and Dad are flush, $100,000 can be annually passed tax free where there are five kids. Where donees are young or improvident, trusts can be utilized as a vehicle to receive and manage the gifts.

In sum, successful medical practitioners ought to consider sitting down with their lawyers from time to time to review their estates. The employment of basic planning methods, such as those just outlined, can furnish both a way of conserving family assets and of providing financial management for family members left behind. Other valuable techniques will be discussed in future articles. □

Comparison of Physicians to Population

In a recent executive report, the Lake to River Health Care Coalition made some comaprisons of the number of medical practitioners to the local population. The coalition compiled this information to give insight into various aspects of health care in our region. Highlights from the report follow. (All rates were calculated on 100,000 population equivalents.)

Office-Based Practice - Overall

Mahoning County's rate (214.6) is approximately 13 percent higher than the state's rate (190.5).

General and Family Practitioners

Mahoning County's rate (36.8) exceeds the state's rate of 33.4.

Internal Medicine

Mahoning County's rate (37.1) is approximately 29 percent higher than the states rate (29.8). Rural areas show a markedly reduced number of specialists in internal medicine to population.

Pediatricians

While Mahoning County reflects a higher ratio of pediatricians to the pediatric population, the combined metro region rate (57.0) is about 12 percent less than the state's rate (65.0). Fewer pediatricians in rural areas required general and family practitioners to fill this void.

General Surgeons

Mahoning County's rate (14.1) is approximately 25 percent higher than the state's rate (11.2). The metro rate (11.4) is comparable to the state rate.

Obstetricians and Gynecologists

Mahoning County's rate (24.0) is about 10 percent higher than the state's rate (21.8). Relative lower rural rates suggest that women in these areas may be underserved and/or are traveling to other communities for their special care needs.

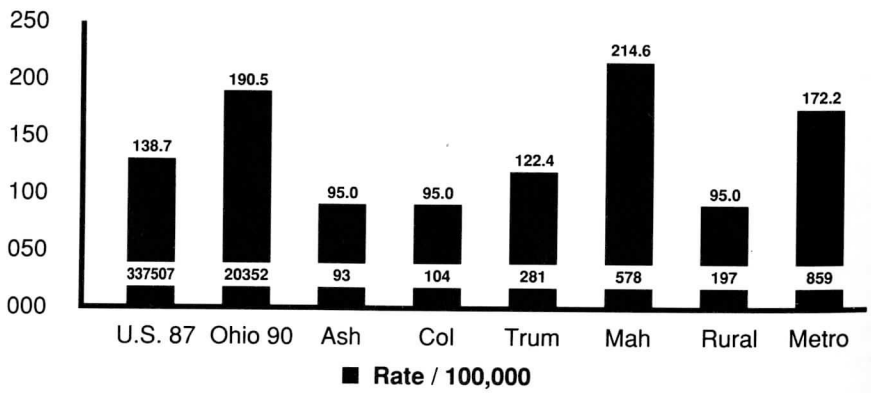
Cardiovascular Specialists

Mahoning County's rate (6.3) is about 54 percent higher than the state rate of 4.1.

Orthopedic Surgeons

All four area counties reflect rates ranging from 41 percent to 70 percent of the state's rate of 6.6. □

Physicians to Population • Office Based Practice



INTRODUCING

OSMA LONG TERM CARE

to protect you and your family against the ever increasing costs of long term care.

Fact #1:
Long term care costs can be devastating (a year in a nursing home now costs on average $22,000 or more)*

Fact #2:
Medicare pays little, if any, long term care costs (Medicare actually covered less than 2% of the $35 billion spent on nursing homes in 1985)**

Fact #3:
Medicaid covers long term care costs only after family assets have been exhausted and beneficiaries have little choice regarding where they receive care.

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This new benefit is available through American Physicians Life, the OSMA's life and health carrier, committed to maintaining the finest protection at the best possible price. For more information and to apply for coverage, contact your OSMA Benefits representative at APL tollfree, 1-800-742-1275.

*Source: Consumer Reports, May 1988 **Source: U.S. News and World Report February 9, 1987

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The Physician and Infectious Waste Disposal

Despite the media attention given to needles and syringes washed up on the nation's beaches during the last three summers, the Agency for Toxic Substances and Disease Registry (ATSDR) has concluded that such infectious waste products generated in traditional health-care settings are not a health risk for the general public.[1] Nevertheless, ATSDR estimates that one to four AIDS cases and 80 to 100 hepatitis B cases per year may occur as a result of contact with infectious waste sharps. In addition, the aesthetic degradation done to the environment by infectious wastes is a concern in the public health community.

In the last two years, Congress and the majority of states, including Ohio, have enacted measures to provide for the tracking of infectious wastes. As a result of this legislation, Ohio has specific regulations regarding the disposal of infectious waste. The detailed requirements can be found in Chapter 3734 of the Ohio Revised Code and Chapters 3745-27 and 3745-37 of the Ohio Administrative Code.

In general, two categories of infectious waste generators are created by the Ohio regulations. In this article, I will address the **small quantity generator**, or one who generates less than fifty pounds of infectious waste in any one month. The average physician in a solo practice is likely to be classified as a small quantity generator.

The regulations detail several categories of infectious wastes:

1. Cultures and stocks of infectious agents and associated biologicals. This includes discarded live and attenuated vaccines.
2. Laboratory wastes likely to come in contact with infectious agents.
3. Pathological wastes, including human and animal tissues, organs, body parts, body fluids and excreta.
4. Waste materials from the rooms of humans, or the enclosures of animals that have been isolated because of diagnosed communicable disease.
5. Human and animal blood specimens and blood products.
6. Contaminated carcasses, body parts, and bedding of animals that were intentionally exposed to infectious agents.
7. Sharp wastes used in the treatment or inoculation of human beings or animals.

Small generators of infectious wastes **MUST segregate** these wastes from their municipal waste stream, **weigh** them and **maintain a written record** of the quantity generated for each calendar month.

All sharps must be placed in rigid, puncture resistant containers that have a "sharps" label on them. If used sharps are not treated to render them noninfectious, they must also be labelled with the international biohazard symbol. Once packaged this way, they can be transported and disposed of as solid waste (placed in a dumpster, picked up by solid waste haulers, taken to a landfill). A small generator may take sharps to a hospital for treatment provided the small generator has staff privileges there, and the hospital agrees to accept such waste.

Specimen cultures and cultures of viable infectious agents must be treated on the premises where they are generated or else transported to a licensed waste treatment facility. Untreated liquid or semiliquid infectious wastes consisting of blood, blood products, body fluids and excreta may be discharged into a sanitary sewer system. **IT IS NEVER APPROPRIATE TO DISCHARGE INFECTIOUS WASTES INTO A PRIVATE SEPTIC SYSTEM.** One of three different methods – chemical treatment, autoclaving and incineration -

Matthew A. Stephanic, MPH
Health Commissioner
Mahoning County

may be be used to render cultures noninfectious on the site where they are generated. Once treated by any one of these methods, the wastes may be disposed of as municipal solid waste.

Specimen cultures and cultures of viable infectious agents shipped off-site to a licensed infectious waste treatment facility have strict handling requirements. Such wastes must be placed in plastic bags that are impervious to moisture, red in color and thick enough to prevent bursting. Before leaving the generator's premises, these bags must be placed inside of a second sealed bag or inside a fully enclosed, rigid container with an international biohazard symbol. An infectious waste transporter registered with the Mahoning County Health Department and the Ohio Environmental Protection Agency must be used to transport untreated cultures.

In my next article, I will discuss the consultative and enforcement role of the local health department in the infectious waste program and the requirements for generators of more than fifty pounds of infectious waste in any one month. Physicians with questions about requirements placed on them by these regulations may contact the Mahoning County Health Department Solid Waste Program at 788-0428 for guidance.

[1]*ATSDR. The public health implications of medical waste: a report to Congress. Atlanta: US Department of Health and Human Services, Public Health Service, Agency for Toxic Substances and Disease Registry, 1990; document no. PB91-100271.*

OFFICE POSITION WANTED

Dependable young woman seeking work in doctor's office. Medical Assistant and experienced Secretary/Receptionist. Wide range of knowledge in billing, payroll, accounting and insurance procedures. Excellent references. Call 758-1501.

Dr. Deppisch Speaker

Dr. Ludwig M. Deppisch, chairman of the Department of Pathology and Laboratory Medicine at Western Reserve Care System and a member of the Mahoning County Medical Society presented an irreverent review of the medical maladies of Ohio's eight U.S. presidents when members met for the November 20, 1990 Society meeting at the Youngstown Club.

Dr. James Lambert, president, read the application of Dr. Robert B. McConnell for emeritus membership. The non-resident membership of Dr. Z. Nicholas Zakov and the emeritus membership of Drs. Henry Ellison, Gene Fry and Jack Schreiber were approved.

Dr. Karl Wieneke, chairman, gave the report of the nominating committee. The following slate was nominated by the members.

President Elect	J.F. Butterworth
Treasurer	D. Chung
1996 Delegate	J.A. Lambert
Alternate Delegate	J.F. Butterworth
	D.J. Dunch
	D.W. Handel
Council Member at Large	C.A. Amedia
	G.J. Baumblatt
	C.E. Molloy
	R.G. Spratt
	M.N. Warner
Foundation Trustee	J.G. Guju
	S.M. Kalavsky

The election will be held at the Annual Meeting on December 18, 1990.

Brief Summary.
Consult the package literature for prescribing information.
Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci).
Contraindication: Known allergy to cephalosporins.
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.
Precautions:
• Discontinue Ceclor in the event of allergic reactions to it.
• Prolonged use may result in overgrowth of nonsusceptible organisms.
• Positive direct Coombs' tests have been reported during treatment with cephalosporins.
• Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
• Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
• Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.
Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
• Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of **serum-sickness-like** reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, **serum-sickness-like** reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
• Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.
• Gastrointestinal (mostly diarrhea): 2.5%
• Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
• As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
• Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
• Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology.
• Slight elevations in hepatic enzymes.
• Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
• Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
• Abnormal urinalysis; elevations in BUN or serum creatinine.
• Positive direct Coombs' test.
• False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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President to Step Down

Colin Campbell, M.D., will step down as president and dean of Northeastern Ohio Universities College of Medicine (NEOUCOM) in June 1992. Campbell announced his plans December 3 at the regular meeting of the college's Board of Trustees held at Children's Hospital Medical Center of Akron.

Campbell, 63, came to the medical school as provost and dean in 1983. He has also served as director of the Division of Clinical Sciences and professor of Obstetrics and Gynecology.

During his tenure, Campbell said, his major goal has been to provide a quality education for medical students. He was also instrumental in the establishment of the clinical teaching subsidy for all the state-supported medical schools and in securing financial stability for the young medical school during a time of limited funding.

"By the time I retire, there will be about 700 NEOUCOM graduates who began practicing medicine while I was at the college," Campbell said. "I can't think of anything more important than increasing the quality and availability of health care."

"The College of Medicine and all of northeast Ohio have benefited because of Dr. Campbell's leadership and accomplishments," said Glenn Meadows, chairman of the NEOUCOM Board of Trustees.

"Through Dr. Campbell's efforts, we now have a strong, established and well-respected medical school," Meadows said. "Also, our graduates are compiling an impressive record of success as practicing physicians."

During Campbell's tenure, the master plan for construction at the Rootstown campus will have been completed.

Campbell succeeded Robert Liebelt, Ph.D., M.D., charter dean and later provost and dean. Earlier this year, Campbell was named president and dean.

Meadows announced the formation of a committee to undertake a nationwide search for Campbell's replacement. NEOUCOM Board of Trustees member James E. Fleming, M.D., will chair the committee. Fleming has been a practicing physician in northeastern Ohio for about 25 years. He has served on the NEOUCOM Board since 1977 and was chairman from 1985-1987. He is very familiar with the college, its history, and its needs for the future, Meadows said.

Before coming to NEOUCOM, Campbell was dean of the School of Primary Medical Care, the University of Alabama in Huntsville. He also served as director of Medical Affairs, Huntsville, and associate dean for the University of Alabama School of Medicine, Birmingham.

From 1964-1978, he was on the faculty of the University of Michican Medical School, where he also served as an associate dean.

He received the A.B. degree in 1949 from Stanford University, Stanford, CA, and the M.D. degree in 1953 from McGill University, Montreal, Canada. He also received an Ed.M. degree from Temple University, Philadelphia, PA, in 1967.

He is a member of the Council of Deans of the American Association of Medical Colleges and was chairman, Section on Community-Based Medical Schools, 1985-1988.

On completing his term as President, Campbell plans to develop a course on economics and finance for medical students and to pursue graduate work in history and business. □

If you had it to do over, would you become a doctor?

The editors of North Carolina Medical Society's Bulletin surveyed its physician-readers last summer to form a picture of medical practice within the state. The answers — while not surprising these days — are troubling. Here's what I think about them.

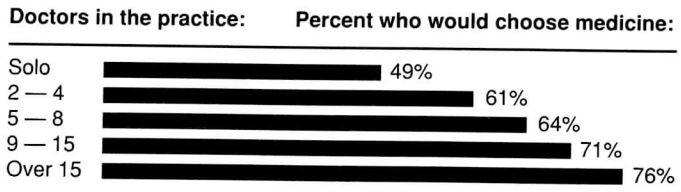
Physicians bash their own profession something awful, but I don't always buy their complaints. While medical practice may have been more personally satisfying in earlier times, so too was the practice of law, banking, retailing, teaching, politics, the oil business or — you name it! Doctors are not alone in recalling a "kinder and gentler" time.

Still, the survey results deserve attention. They illustrate various sentiments which affect your personal approach to your work, whether one of enthusiasm or of paranoia.

Satisfaction Index

Only 58 percent of the respondents said they would go to medical school again if they had to do it over. While I'm relieved that a majority would do so, a 42 percent "no" vote is not very gratifying.

Some of the breakdown data was particularly noteworthy. For one, there was a direct relation between size of practice and physician satisfaction. The numbers came out like this:



Unfavorable Responses

The survey also found great differences in satisfaction between specialties. If they had it to do over, surgeons were 62 percent more likely to take up medicine again, versus a 52 percent willingness among primary care doctors and — still lower — 42 percent for internal medicine subspecialists. Perhaps Medicare rears its ugly head the most for subspecialty internists, while surgeons have higher incomes and lower daily patient counts than do primary care physicians.

Confirming the old saw about not recommending medical school to your son or daughter, 64 percent of the respondents said they wouldn't want their children to become physicians; only 36 percent said they would.

Greener Grass

I hear what these doctors are saying, but I don't agree with them. Sure, medicine is a much different profession than it was in the past. Doctors flourishing in the 1960s, '70s and early '80s had the best of many worlds: unique professional independence, uniformly high patient confidence, exciting new technologies and automatically high incomes. The combination — though also plagued with overwhelming time and energy demands — was too good to continue.

Time never stands still, and those good features have obviously changed. But to say the changes mean you would not choose

the same career path seems terribly naive. What would you choose? Law? Education? Banking? The other choices aren't really that great unless they appeal to you intellectually and emotionally, nor do they assure you of higher pay.

As the old saying goes, "The grass is always greener on the other side of the fence." It's so true for physicians as they work in a changing environment. But their careers are still in a truly serving activity which provides higher incomes and more respect than any other profession.

Several years ago, I wrote an article entitled "Why Your Children Should Become Physicians." I'll be happy to send you a copy of it upon request, for I continue to believe — very strongly — that doctors are dead wrong in wishing they were something else.

Leif C. Beck
LL.B., C.P.B.C.

Editorial Note: We acknowledge the cooperation of Leif Beck, who has granted reprint rights for topics which have appeared in his regular monthly publication, The Physician's Advisory. His organization, The Health Care Group, with offices in Plymouth Meeting, PA, is a group of leading national consultants and attorneys specializing in medical practice organization and management.

50 Years Ago — December 1940

Among the year-end committee reports that year was a report from the Public Health Committee indicating that they had inspected the Contagious Disease Hospital on East Indianola Avenue and found it to be in "deplorable condition." They recommended sweeping changes and modernization. Years later, this hospital was converted to what is now known as Woodside Receiving Hospital for the mentally ill.

Also reported was a newly organized medical staff for the Mahoning County Tuberculosis Hospital on Kirk Rd. Dr. John Heberding was appointed the first president of the staff.

40 Years Ago — December 1950

World War II was over, but now we were embroiled in the United Nations "police action" in Korea, and the war was going badly for our forces. Here in the United States, the A.M.A. donated a half million dollars to medical schools in order to forestall federal subsidies. A.M.A. President Bauer said, "There is a growing public awareness that federal subsidy has come to be a burden not a bounty, for it is bringing intolerable increases in taxation and is dangerously increasing federal controls over our institutions and the lives of our people."

30 Years Ago — December 1960

President Dr. Fred Schlecht summed up the year in one word - apathy. "Apathy," he wrote, "is still our most dangerous foe." And editor Dr. Jack Schreiber added: "It is not enough just to practice medicine. We must also serve the profession itself!"

A new radio program called "Diagnosis" was being broadcast every Tuesday night over WFMJ radio, the work of our public relations committee, chaired by Dr. Andrew Detesco and Dr. John McDonough. Moderator of the program was "Mitch" Stanley, and the format was in the manner of "Meet the Press."

Dr. John J. Turner became a Fellow of the American College of Surgeons. His father, Dr. Walter B. Turner, attended the ceremony.

20 Years Ago — December 1970

Editor Dr. John Melnick wrote: "It is believed by many that socialized medicine will be of the highest priority in the next Congress. The proponents of socialized medicine cite the increasing cost of medical care." And this was twenty years ago!

December always brings election of officers. The new president was Dr. Henry Holden; secretary was Dr. Carl Raupple; and treasurer was Dr. Kenneth Lloyd. The new editor of the *Bulletin* was not yet appointed. Everybody hoped the new year and the new decade would see improvement in the interest and in the activities of the MCMS.

10 Years Ago — December 1980

The big news this month was the announced retirement of our beloved Executive Director, Howard Rempes, after serving for over 22 years. Also being announced was the appopintment of Robert B. Blake as the new executive director. Mr. Blake was the former editor of the Columbiana "Ledger." Newly elected officers for the coming year were: president, Dr. D.J. Dallis; vice president, Dr. R.M. Kiskaddon; and treasurer, Dr. A.Z. Rabinowitz. Dr. Walter J. Tims was elected Doctor of the Year for his contributions to the community, and for his accomplishments when he was health commissioner from 1947 to 1953. □

Robert R. Fisher, MD

Harold Joseph Jeghers, MD, 1904-1990

A giant of twentieth century medical education has departed the scene. Dr. Harold Joseph Jeghers passed away on September 21, 1990, at his home in Massachusetts. In 1980, Dr. Jeghers donated his lifetime achievement, a research library representing more than half a century of a career dedicated to research in medical education, to St. Elizabeth Hospital Medical Center and to the Northeastern Ohio Universities College of Medicine (NEOUCOM). The transfer of his unique library to Youngstown, through the diligent efforts of Dr. Leonard Caccamo former Director of Medical Education at St. Elizabeth Hospital Medical Center, brought Dr. Jeghers on quarterly trips to contribute time, insights, and labor. These several day sojourns were spliced with many opportunities for him to talk about "old times, old friends, and old places". To talk to Dr. Jeghers was to speak to an experienced historian of modern-day medicine. Nearly every major physician in American medicine since the mid 1930's he knew personally. Many were his chief residents in internal medicine including Dr. Louis Sullivan and Dr. Bob Moser.

Dr. Jeghers was born September 26, 1904, in Jersey City, New Jersey. After high school graduation, he attended the Rensselar Polytechnic Institute to major in electrical engineering. In his sophomore year, he was persuaded to enter the school's newly established program in premedical science. He graduated with the school's first Bachelor of Science degree in Biology. In 1928, he entered Western Reserve University College of Medicine. While there, he co-authored two scientific papers. As a Fellow, he actively researched the deficiency disease, *pellagra*.

Prior to starting his internship with the Boston University Medical Service, Dr. Jeghers spent five months as a resident physician at the Mahoning County Tuberculosis Sanitarium in Youngstown, Ohio.

Following his internship, Dr. Jeghers was asked to accept a research fellowship with the Evans Memorial Institute in Boston. In 1936, he joined the faculty of Boston University and accepted a full-time teaching position at Boston City Hospital. During his tenure at Boston University, he began to cull articles from medical journals and file them systematically for future reference.

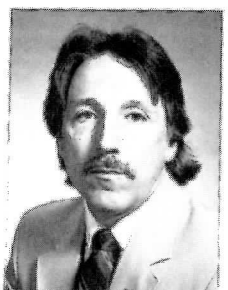
In 1939, Dr. Jeghers astute observations enabled him to describe a condition of "generalized intestinal polyposis and melanin spots on the oral mucosa, lips and digits." The gene-linked disorder is now known as *Puetz-Jeghers syndrome*.

In 1946, Dr. Jeghers accepted the position of director of the Department of Medicine at the Georgetown University School of Medicine. While there, he established a plan to attract specialists to Catholic hospitals as physician educators.

Dr. Jeghers left Georgetown in 1956 to help establish a new medical school at Seton Hall College of Medicine. After 10 years as director of the Department of Medicine, he left to become the medical director at St. Vincent's Hospital in Worcester, Massachusetts, where he continued to make major contributions to medical education and patient care until 1978.

Dr. Stanley Olson, the first provost and dean of NEOUCOM pointed to Dr. Jeghers methods at St. Vincent's as an academic model and goal for the affiliated hospitals in northeast Ohio.

The Jeghers Research Library reflects Dr. Jeghers' dedication to using research in medical education as his major lifetime creative effort. This national resource remains a lasting tribute to a great teacher and master clinician. □



W. Robert Kennedy, Ph.D.

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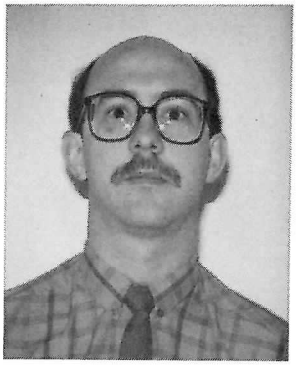

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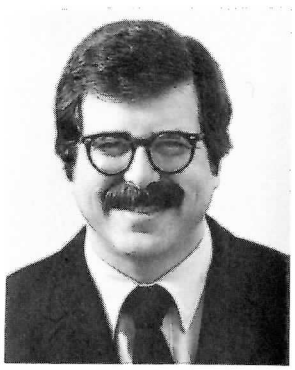

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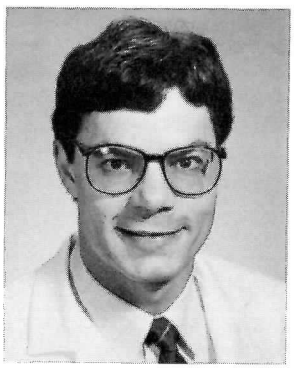

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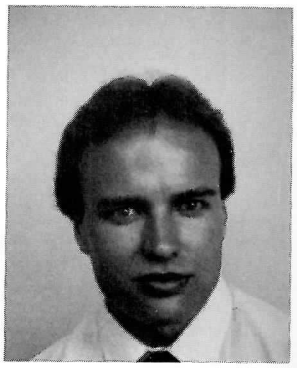

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Self Portrait, Lithograph

by Thomas Hart Benton (1889-1975) *continued from cover*

and realistic renderings. Benton returned to his home state of Missouri where he lived the remaining years of his life, although he maintained a home at Martha's Vineyard for summer retreats. Benton traveled widely throughout the United States, exploring swamps, bayous, rural back roads and rivers, mountains, desert, the plains, even following along the Oregon Trail. He could identify with the common man and capture the American spirit, all of which he translated with narrative skill into his paintings and drawings.

Benton is best known for his paintings and large scale murals. He was also a master of the lithographic medium. The tonal changes possible with lithography allowed Benton's characteristic painting style to carry over quite beautifully into his lithographs. Every line of his defiant forms and dramatic conceptions was rhythmic and as full and fluid as water flowing lazily over paper. Between 1929 and his death in 1975, Benton created a series of over 100 lithographs. As one of his biographers Creekmore Fath wrote, "The aspects of American life and lore portrayed in...(Benton's) lithographs are close to the soil and as American as black-eyed peas and sow belly, corn pone and six-shooter coffee." These down to earth impressions have tended to cause controversy among art critics and historians who find his occasional portrayal of the ugly side of man distasteful and crude. Most people prefer to avoid looking into this mirror of history, but if we don't look, how can we change the image to one we like? Benton paraded the common and the uncommon across his canvasses...perhaps the mark of an honest man.

Some of Benton's lithographs were done as preparations for paintings, or he would make studies from already finished paintings. His "Self Portrait" was a lithograph done in 1972 as a study from his 1970 painting "Self Portrait." Benton wrote of this particular piece, "This is a study, from the mirror image, of an old artist, "Grandaddy Benton" as all the kids call me. I had a belly when I did it but after building a stone retaining wall, 65 feet long and in some places 10 feet high, on our place in Martha's Vineyard, I got rid of it. It hasn't come back." Most of Benton's lithographs were printed in editions of around 250, and, in those days, sold for $5 apiece.

Barely standing 5'3" tall, Thomas Hart Benton may have been small in stature, but his art placed him as a giant of twentieth century American art. As Harry Truman once said of Benton, he was "the best damned painter in America." □

Jeannine Lambert

Jeannine Lambert –

Auxiliary member Jeannine Lambert selected this month's cover art and wrote the accompanying commentary. She will be contributing in the same capacity to future issues of the *Bulletin.*

After attending Marietta College and Youngstown College, Jeannine taught briefly in the Cleveland Area. For more than a decade, she was an active volunteer in the Liberty school system. The Liberty Board of Education recognized her volunteer work in education with a commemorative plaque. (This was the first time the Board had officially recognized a volunteer's efforts.) In 1986, she was honored as a YWCA Woman of the Year.

Jeannine is currently enrolled at Youngstown State University where she is pursuing an interest in art history. She is married to Dr. James Lambert, an otolaryngologist practicing in Youngstown and the current president of the Mahoning County Medical Society. The Lamberts have four daughters and one grandson. Jeannine and her husband are avid art collectors whose extensive collection features a wide range of works.

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