BULLETIN

of the
MAHONING COUNTY
MEDICAL SOCIETY

Volume LIV *Number 7*

OCTOBER, 1984

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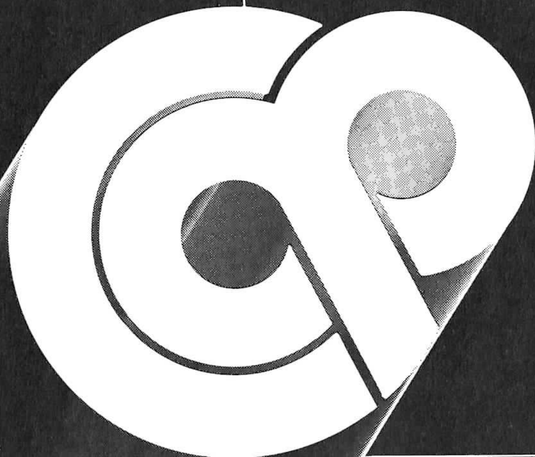

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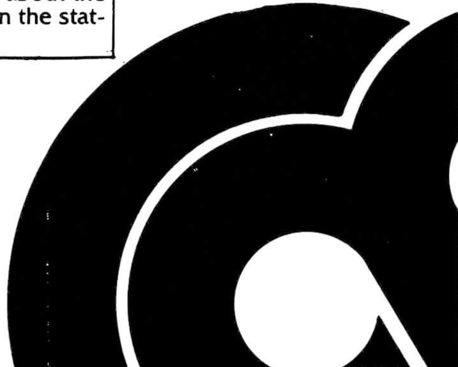

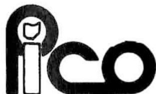

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1984 - MAHONING COUNTY MEDICAL SOCIETY MEETINGS - 1984

Tuesday	Tuesday	Tuesday	Tuesday	Tuesday	Tuesday
Jan. 17	Mar. 20	May 15	Sept. 18	Nov. 20	Dec. 18

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From the Desk of the President

Our first Medical Society meeting of the fall season was held at the Youngstown Maennerchor Club on September 18. Attendance, again, included only an interested core group of physicians and dedicated members.

There was a lively discussion, precipitated by Dr. Raymond Catoline's questioning the propriety of the use of the Dr. Jack Schreiber's office, after hours and on weekends, by the Youngstown Hospital general practice residents. Dr. Schreiber explained his motives and noted they are non-financial. Feelings at the meeting were generally ambivalent, as we know we must fill the void of night and weekend medical care needs; but we do not feel that our hospitals should assume the office-care of medicine, which is where most of us practice.

Dr. Schreiber noted that a PPO group is coming to Youngstown and many other health-care plans are soon to descend on Northeast Ohio, where we have been relatively competition-free in relation to other parts of our State and in comparison with what is happening in California.

There was general agreement that an open-staff policy is logical and could help us compete in the future medical market.

It was noted that hospitals in surrounding communities are "bed rich and patient poor" and are seeking to extend their markets to our area. It is obvious that some hospitals are going to have to close in the future because of pressures to admit only the critically ill.

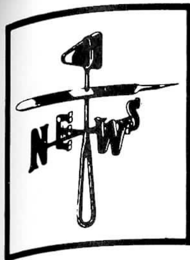
By now, we must have all made our decision about being a government medical participant or non-participant and must live for one year with our decision. Our Society can be informational and help us live with and react to the new avalanche of government regulations.

If the AMA loses its suit against the government and the discriminatory rules and fines to be levied against non-participating physicians, then it will be time to start a job-retraining program.

Don't criticize *YOUR* Medical Society if you *DON'T* attend its meetings and don't criticize your government if you don't *VOTE*.

See you at the next meeting, November 20, when the program will be on Cosmetic Plastic Surgery.

Glenn J. Baumblatt, M.D.



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The opinions and conclusions expressed herein do not necessarily represent the views of the Editorial staff nor the official views of the Mahoning County Medical Society.

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Editorial

LAB PROVISIONS FOR MEDICARE

The new Medicare law establishes a fee schedule for all clinical laboratory procedures. The fee schedule applies to laboratory services provided in physicians' offices, independent laboratories, and hospital outpatient laboratories. The fee schedule for services in physicians' offices and independent labs will initially be set at 60% of the prevailing charge for services in your carrier area as of July 1, 1984. For hospital outpatient labs the initial fee schedule amount will be 62% of the prevailing charge. In July 1987, a nationwide fee schedule will go into effect.

A physician is only permitted to bill for those clinical laboratory procedures personally performed or supervised (or for services performed or supervised by another physician sharing a practice with the billing physician). Therefore, physicians are prohibited from billing for services provided by outside laboratories.

QUESTIONS AND ANSWERS ON THE LAB PROVISIONS

Q: Am I prohibited from billing for the services of the outside lab even if I am not accepting assignment on the claim? (Question #18)

A: Yes. The party performing the test (i.e., the independent lab) must bill for such services whether or not the referring physician accepts assignment. It is *illegal* for you to bill Medicare beneficiaries or the program directly for this service.

Q: What is Medicare's policy on acceptance of assignment for lab claims? (#19)

A: Non-participating physicians are free to decide whether or not to accept assignment on lab claims on an individual claim-by-claim basis. Independent labs are required to accept assignment for all laboratory services. When the physician accepts assignment on a lab claim, reimbursement is at 100% of the fee schedule amount with the co-insurance and deductible from the patient waived. If assignment is not accepted on a lab claim, Medicare will reimburse the patient 80% of the fee schedule amount after the deductible is satisfied, and the patient will be responsible to the physician for the full amount of the physician's charge (i.e., the physician's full charge, including the 20% co-insurance, the amount of reimbursement from Medicare, and any billed amount in excess of the fee schedule amount).

Q: When do these lab provisions take effect? (#20)

A: The fee schedule applies to all services rendered on or after July 1, 1984. Medicare provided a grace period until August 31, 1984, to give physicians time to change their billing arrangements (if necessary) for tests done by outside labs to assure compliance with the prohibition on billing for these tests. ASIM requested HCFA to extend the grace period for 60 days to facilitate as smooth a transition to the new billing procedures as possible. HCFA has decided not to extend the grace period. Therefore, *as of September* 1, 1984, *physicians have been prohibited from billing Medicare or Medicare patients for outside lab tests.*

Q: May I compensate for the prohibition against billing for tests done by outside labs by charging for a higher level of office visit (e.g., by billing for an "extended" or "comprehensive" level of service for visits that used to be coded as "intermediate" or "limited")? (#21)

A: It is not a good idea to bill for higher levels of care simply to increase your Medicare reimbursement. The coding of office visits should be based on the complexity or seriousness of the case and on the level of diagnostic and therapeutic services rendered. Postpayment utilization review (see Question #14) may result in your having to repay Medicare the difference for services that were coded at an inappropriately high level. For example, Medicare carriers are likely to question any increase in the number of office visits coded at the higher levels of service, unless you can document that the severity and complexity of individual patients' conditions necessitated a higher level of office visit.

In addition, if you are a non-participating physician, such a change in your pattern of charges may lead to questions about whether or not you are complying with the freeze on actual charges.

Once the freeze on actual charges by non-participating physicians expires on October 1, 1985 — and once the AMA's voluntary freeze is lifted— it would be appropriate for internists to begin including professional interpretation of lab tests in charges for office visits, as recommended by existing ASIM House of Delegates policy. By doing so, you appropriately would be increasing your fee for certain levels of office visit, but not the number (frequency) of visits billed at the higher levels of care (as described above). *Current Procedural Terminology* (CPT) codes for limited, intermediate, extended, and comprehensive visits allow for the inclusion of laboratory test ordering and evaluating. *However, this option is not yet available to non-participating physicians or to physicians complying with the AMA/ASIM voluntary freeze.*

Q: Will Medicare continue to pay for drawing and handling? (#22)

A: The law provides for payment by Medicare of one nominal charge (currently #3) per encounter with a patient for "specimen collection." This means that regardless of how many specimens are drawn during one meeting with the patient, Medicare will pay no more than one specimen collection charge. Medicare will allow this amount for such service by a physician when the lab work is being sent out. Unlike under previous policy, Medicare will also allow the nominal amount for specimen collection when you perform the lab testing in your office. The Health Care Financing Administration has indicated, however, that this specimen collection amount would only be paid for venipunctures and catheterized urine samples.

You should keep in mind, however, that the above limitation on the Medicare payment level for specimen collection does not prevent non-participating physicians who choose not to accept assignment on a lab claim from charging patients more than the Medicare allowable amount, provided that this does not represent an increase in actual charges to Medicare patients over base period levels.

Q: Can I bill for interpretation of tests performed by independent labs? (#23)

A: Until October 1, 1985, if you are a non-participating physician, the answer to that question depends on whether or not you can do so without increasing your charges to Medicare patients (e.g., if, during the base period, your charge for a lab service performed by an outside lab was $25 and $10 of this was the lab's charge to you and $3 represented your drawing and handling charge, then you would be permitted to charge up to $12 for interpretation during the freeze period).
Current Procedural Terminology (CPT) includes two ways to identify and bill separately for the physician component of laboratory tests; coding the service as "09926" or adding "-26" to the usual CPT code for the test. It is important to recognize, however, that Medicare will not under any circumstances reimburse for professional interpretation of outside lab tests. As a result, this will be an out-of-pocket cost for your patients.

Q: What is the difference between a physician office lab and an independent lab? (#24)

A: Under current law and regulation, an "independent lab" is one that is certified as such by Medicare, holds itself out as available to perform tests on a referral basis and is subject to detailed "Medicare Conditions for Coverage of Services of Independent Laboratories" that require proficiency testing, adherence to personnal standards, and quality controls. These labs are independent of either an attending or a consulting physician or hospial. "Physician office laboratories," on the other hand, are operated by one or more physicians for their own patients and are exempt from the above conditions. To qualify for the exemption, your office lab must meet the following conditions at the present time:

- You must be the attending or consulting physician, and the testing must be performed as an incident to the treatment of your patients.
- As a physician (including pathologists) you must not hold yourself and your laboratory out to other physicians as available to perform diagnostic tests.
- Your laboratory may not accept more than 100 specimens from both Medicare and non-Medicare patients on referral from other physicians in any one year in any of the following six categories:
  - -- microbiology and serology;
  - -- clinical chemistry;
  - -- immunohematology;
  - -- hematology;
  - -- pathology; and
  - -- radiobioassay.
- For group practice laboratories, each of the physicians in the group practice must exercise the degree of supervision and control over the laboratory's operation that a single physician would show with respect to his own office laboratory (i.e., with regard to reviewing tests on a physician's own patients and being available for special assistance when needed).

(Note: In view of the incentives created by this legislation to form physician office labs, HCFA is considering restricting the definition of physician office labs, especially in connection with larger shared service and group practice arrangements. Therefore, you should exercise caution before getting involved in new arrangements such as a group of physicians in your building or community joining together to purchase collectively a lab for your patients' testing. It is a good idea to check with your own legal counsel as well as with HCFA on whether or not -- given the particular circumstances of the lab arrangements you are considering -- it will be considered a physician office lab and therefore not subject to either the "Medicare Conditions for Coverage of Services of Independent Laboratories" or mandatory assignment as are independent labs.)

Q: Must the equipment used to perform a laboratory test for which I bill be physically located in my office? (#25)

A: No, As long as you can perform or supervise tests done in a lab that meets the criteria for a "physician office lab" summarized under question 24 you can bill for them. The lab equipment lab need not be physically located in your office.

Q: Can laboratory work performed in the office of a group practice for patients of the members of the group *only* be billed as physician office laboratory services? (#26)

A: Yes, you can bill for lab services when you, or another physician with whom you share a practice, personally perform or supervise the performance of the tests in a physician office lab (see Question 24).

Q: Is it advisable to purchase new laboratory equipment so that I can perform more tests in the office and bill for them? (#27)

A: That depends. It is true that placing additional lab equipment in service in your office will give you additional billing opportunities. There are some tests that may be done easily and cheaply in your office due to increased automation. In addition, such in-office testing may be more convenient for your patients. However, you should exercise caution in making such an investment due to the uncertainty that exists in this area. As discussed in Question #24 above, the Health Care Financing Administration is considering narrowing the definition of physician office labs; this may at some future time result in your arrangement no longer being considered such a lab and therefore being subject to mandatory assignment and the conditions for coverage. In addition, although physician office labs are now exempt from the conditions for coverage, Congress might move to regulate them in the future, with personnel and quality control measures, which will result in increasing your costs. Also, changes in Medicare and private insurer reimbursement policy might make such an investment seem less prudent in the future. Annual updates in Medicare fee schedule amounts, tied to the Consumer Price Index, might not keep pace with your own lab's costs, and the *national* fee schedule -- which is scheduled to go into effect in 1987 -- will make it even less likely that reimbursement will cover costs in some high overhead areas of the country. In addition, possible Congressional action in the future to mandate assignment could limit your revenue from lab services to Medicare patients to the fee schedule amounts.

Finally, the impact on your patients must be considered. While performing more tests in your office will enable you -- under current law -- to bill your full charge, this may result in increased out-of-pocket costs for your patients. This results from the fact that Medicare will only pay patients 80% of the fee schedule amount when you bill patients directly as opposed to 100% when an independent lab performs and bills for the test (or when you accept assignment). In addition, your patients will be responsible for any amount you bill them over the fee schedule level. Such an increased patient burden, if it occurs widely, could lead Congress toward more restrictive Medicare reimbursement policies in the future (e.g., mandatory assignment - - see Question #14). A more thorough discussion of these and other laboratory issues may be found in "Laboratory Testing in Practice," a practice management guide published by and available from ASIM.

Q: I still have questions. Where can I go for help? (#29)

A: If you need further assistance, you can contact:

- the ASIM staff (toll-free number: (800) 368-5652);
- your Health Care Financing Administration regional office
- your local Medicare carrier;
- state and county medical societies; or
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THE REPUTATIONS OF HONORABLE MEN

by Dr. John K. Layle Jr., Editor
Greater Kansas City Medical Bulletin
(Continued from September *Bulletin*)

That attitude may explain the nature of the effluvium which occasionally passes for news nowadays. But is it justified? One might have presumed that one difference between sewage and news is that the latter has been processed by an editor. Yet, one occasionally wonders if that step really improves the final product:

"Newspaper editors are men who separate the wheat from the chaff, and then print the chaff." *—Adlai Stevenson*

Others insist that where truth is concerned a good newspaper should be evenhanded:

"The indispensable requirement for a good newspaper: as eager to tell a lie as the truth." *—Norman Mailer*

However, there seems to be a perceptive portion of the citizenry, especially the victims of character assassination, which objects to the "we're-not - responsible - for - what - goes - through - our - sewer - pipe" ethic.:

"The truth? You don't print the truth, you print what people tell *you."* *—Paul Newman in* Absence of Malice

The public is occasionally able to make its own independent observations and judgments about the validity of such news distortion (as I did with McClure's Dictum):

"Everything you read in the newspaper is absolutely true except for the rare story of which you happen to have first-hand knowledge."
—Ervin Knoll, American Editor

In the case of physicians for example, the news media's frequently negative stereotype seemingly does not fit the actual firsthand experience of much of the populace and is therefore rejected. Multiple surveys have demonstrated that the credibility of doctors remains much higher than that of newsmen, politicians or just about any other group. Time reported a study by the National Opinion Research Center:

% Who have a great deal of confidence in . . .

Medicine	52.3%	Press	13.7%
Scientific Comm.	44.4%	Federal Gov. Executive	13.3%
Education	29.2%	Television	12.7%
U.S. Supreme Court	28.3%	Congress	10.2%
Banks	24.1%		

The Judas Transformation

Attempts to discredit physicians have, therefore, been much more successful when they attacked doctor-targets which the public is unable to independently verify or refute. The most effective of these tactics assumes the following posture: Well, OK, your personal docs may be honorable men and women, but if they get elected by their peers to a responsible position within *organized medicine* a malignant metamorphosis occurs in their psyche so that they then become unconcerned about the welfare of sick people.

"Doctors care very seriously about their patients, but you have doctors organized into the American Medical Association and they're interested in protecting the interests not of patients but of doctors. And they've been the major obstacle to the progress in our country to having a better health care system in days gone by."

—President Jimmy Carter[3]

(Continued on Page 179)

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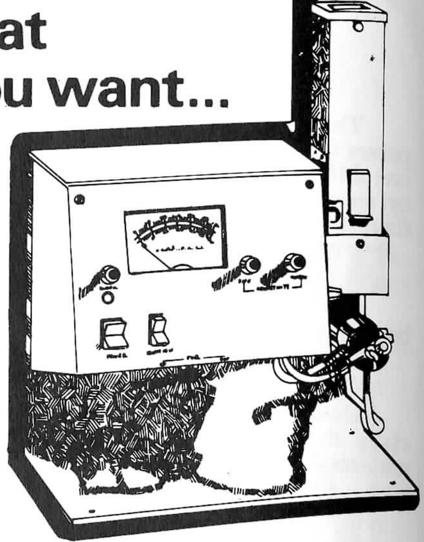

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Postulating the existence of the Judas Metamorphosis allowed the President to imply that although the AMA believed his national health insurance plan was a bad idea, rank and file physicians really thought it was good. Carter offered no evidence to support that hypothesis.

Carter's assertion that the AMA is the "major" impediment to improving our health care system was also unsupported by evidence and seems extravagant, at least to me. But, a layman might believe it. If so, the layman would be justified in thinking: "If only we lived in a country where the AMA did not exist, where the 'major obstacle' to an optimal health care system were not present, then skyrocketing health costs would likely disappear or at least be much slower than in the U.S." Such an erroneous belief could be held only as long as American news media kept the populace insulated from the news that *health costs are rising even faster in many other countries which have no AMA.* Present evidence suggests that such insulation may continue indefinitely.

It is not possible to know with certainty whether Carter's tactical decision to attack organized medicine on the one hand while simultaneously praising the individuals of which it is composed on the other is a result of his own political intuition or is a result of attention to polls showing that the public would find any other device incredible, but one suspects both play a part:

"Don't worry about polls — but if you do, don't admit it."
—Rosalynn Carter

Impugning the Image

In any case, the media's tendency to blame rising health costs on the lack of moral integrity within our profession has been popular and has taken several forms. One is to attack the image rather than the performance of the AMA. As Lawrence Peter pointed out:

"An ounce of image is worth a pound of performance."

Thus, decades of responsible public service — of actual performance — by the AMA can be impugned by a few subtle attacks on its image.

In its October 11, 1982 issue the *Kansas City Business Journal printed* a cartoon by Gamble showing a masked surgeon stealing money out of the pants of a bedfast patient. The FTC was looking over the doctor's shoulder and was taking notes while the AMA was complaining to Congress (while giving it money): "Now would you remove this intruder (the FTC). He's interfering in our operation." The cartoon was not accompanied by and did not follow any discussion of the litigation between the FTC and AMA. The audience was given no information about the respective claims and merits of each case. It was only given pejorative images—not to amplify, illustrate or interpret the news but rather it was given images *instead* of news. It was given an image of doctors (in general) stealing money from patients with the knowledge, consent, complicity and active support of the AMA.

(To Be Continued Next Month)

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SOCIETY MET AT MAENNERCHOR IN SEPTEMBER

The September meeting of the Mahoning County Medical Society was held in the Old Fashioned Style at the Youngstown Maennerchor Club and featured Dan Blake, financial planning expert, as guest speaker.

It was announced that the nominating committee to select candidates for election to offices on the Council of the Society will be chaired by Dr. Glenn Baumblatt, president, and Dr. Paul J. Mahar, Jr., immediate past president, and will include Dr. Samuel Goldberg, Dr. Carl Klodell, Dr. Simon Chaisson and Dr. Robert Jenkins.

Dr. Baumblatt announced that nominations for the "Doctor of the Year" award, presented annually, should be in the Society office by October 1.

Accepted for intern/resident membership by vote of the Society were: Andrew C. Bott, M.D.; Magdy Iskander, M.D.; Mark J. DuFine, M.D.; Norman A. Holmes, M.D.; Christopher Southwick, M.D.; Gordon Genskow, M.D.; Mark Chaplick, M.D.; Kevin McCarragher, M.D.; Michael Nestor, M.D.; Sheeyip Chan, M.D.; Jonathan Rubinow, M.D.; Elton Gaddy, M.D.; Barbara Modic, M.D.; Rashmi Patel, M.D.; Antonio Sison, M.D.; James Race, M.D.; Juan Golle Jr., M.D.; David Clevenson, M.D.; Edward Cabrera, M.D.; Joseph Ross, M.D.; Wydell Williams, M.D.; Armand Minott, M.D.; Gerardo Trillo, M.D.; Mary Gorda-Lewis, M.D.; Essam Ragheb, M.D.

A lengthy discussion was held concerning satellite medical care facilities being operated by hospitals and staffed by residents. It was a prelude to the revelation that competition in many forms is slowly coming on the scene in Mahoning County. A further discussion of this is expected at the November 20 meeting of the Society.

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Oct. 27
L. N. Harichand

Oct. 28
I. H. Chevlen
M. M. Szucs

Nov. 2
R. A. Abdu

Nov. 3
D. R. Brody
R. J. Brocker

Nov. 4
R. A. Hernandez
K. J. Hovanic

Nov. 5
V. D. Lepore

Nov. 6
L. O. Gregg

Nov. 8
R. H. Wetzel

Nov. 9
J. B. Birch

Nov. 10
N. J. Badjatia
J. C. Melnick

Nov. 13
Mahoning County Medical Society

Nov. 14
G. Nagpaul
D. E. Pichette

Nov. 15
J. S. Gregori
R. W. Juvancic
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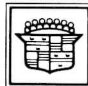

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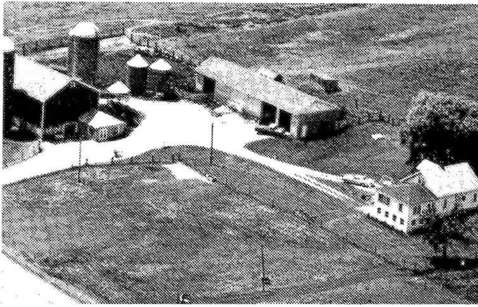

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From the Bulletin

FIFTY YEARS AGO — OCTOBER, 1934

Dr. McClenahan of the Public Health Committee urged the doctors to see that all children were immunized against diptheria. For those unable to pay, the Health Department would supply the Toxoid and pay the physician fifty cents for each immunization. There were no vaccines for polio, pertussis, measles, or mumps.

The Medical Economics Committee announced that the cost of treating indigent families under the State Relief Plan had exceeded the allotment of seventy cents per family.

FORTY YEARS AGO — OCTOBER, 1944

Captain Barclay Brandmiller was heard from down in New Guinea. Others were too occupied with the grim struggle to write many letters. In Europe, Paris had been liberated; in the Pacific the Philippines were being invaded and the fighting on Leyte Gulf was bitter. Captain DeCicco was there on the beach, diving into foxholes during air raids.

At home President Roosevelt, in very poor health, was campaigning for his fourth term. The government was making it tough for the doctors, claiming that medical care was inadequate for low income groups and pushing compulsory socialized medicine.

With so many doctors at war, medical care was inadequate for nearly everybody. Doctors were trying frantically to meet their obligations and stave off government regimentation.

THIRTY YEARS AGO — OCTOBER, 1954

The *Bulletin* said that a union between Doctors of Medicine and Osteopaths would be unholy syzygy. Actually, there is such a word. It is pronounced "siz-i-jee" and means a "joining together."

New members that month were: Simon W. Chiasson, Paul A. Dobson, Donald R. Dockry, Ulrich H. Boenig and Paul Fuzy, Jr.

Edward M. Thomas was certified by the American Board of Urology. President Detesco was at Mount Sinai Hospital for a course in cardiovascular disease.

The Scott Company advertised fancy vests for $13.50 up in silk, flannel or corduroy.

TWENTY YEARS AGO — OCTOBER, 1964

A Clinical-Pastoral Conference, first of its kind in the United States was held by the Mahoning County Medical Society on Sept. 23 at Youngstown South Side Hospital. Seventy persons, including both physicians and clergymen, attended the meeting.

Dr. F. L. Schellhase presented the protocol. Following comments by several physicians directly involved in the case, the entire group participated in questions and answers and discussion about the role of both medicine and religion in the problems presented by the case.

Observing the new approach was Arne Larson, Asst. Dir. of the Dept. of Medicine and Religion, American Medical Association, who came to Youngstown specifically for the meeting. The conference was planned by the Medicine and Religion Committee, R. M. Kiskaddon, Chairman.

New Members were: Frank James Kocab, Samuel G. Adornato, Demetrius J. Dallis, Milosav Petrovich, William Robert Torok and John F. Kroner.

TEN YEARS AGO — OCTOBER, 1974

The members were still muttering about PSRO and vowing to not participate in the government program. The Mahoning County Medical Society and the Ohio State Medical Association passed resolutions rejecting the concept of government controlled Professional Standards Review and urged its members not to participate in the program. DRG's, HMO's and participating and non-participating physicians were still hidden in the crystal ball of the future.

Dr. Maurice Lieber, speaker for the September meeting warned that the Governor's Task Force on Health recommended doing away with local health departments, taking over Blue Cross, and phasing out Blue Shield, and putting control of all post-graduate education under the Board of Regents.

Dr. McDonough wrote a letter to Council calling attention to a Pennsylvania Blue Shield Form which contained an agreement for the physician to sign, that he would accept as full payment the amount indicated in the "Fee Schedule Program". Even then, the "Blues" were trying to drag practicing physicians into a contract that existed only between the patient and the insurance carrier.

Two prominent Youngstown physicians passed away. Dr. James L. Calvin, Youngstown Hospital's first full-time Cardiologist, died of cancer of the lung on Tuesday, September 10. He was 51. Dr. Frederick S. Coombs, Internist, died of an aortic aneurism on October 6. He was 67. Both of these men were leaders in the community as well as in their respective fields.

New members that month were: Active - Lorenzo M. Farolan, M.D., Jae J. Lee, M.D., Godal J. Nigam, M.D., Josef R. Smith, M.D. Associate members were C. A. Ariza, M.D., Eduardo Calanternik, M.D., Milton H. Hamblin, M.D., Raymond W. Jackson, M.D., Ung-Gill Jeong, M.D., James A. Lambert, M.D., Herbert A. Parris, M.D., Robert R. Rich, M.D., Gerald Sevachko, M.D., J. P. Shah, M.D., Intern-Resident; Anthony M. Marinelli, M.D.

Robert R. Fisher, M.D.

CME AT ST. ELIZABETH HOSPITAL MEDICAL CENTER

FAMILY MEDICINE GRAND ROUNDS

Oct. 12, RHEUMATOLOGY "Steroids and NSAID's: Indications and Complications. Thomas M. Zizic, M.D., Associate Professor of Medicine at John Hopkins University School of Medicine.

Oct. 19, ORAL MEDICINE "Oral Pathology", Carl Allen, D.D.S., diagnostic services, Ohio State University.

Oct. 26, ENDOCRINOLOGY "Diabetes Insipidus-DDAVP", Alan G. Robinson, M.D., Professor of Medicine, Chief of Division of Endrocrinology and Metabolism, University of Pittsburgh School of Medicine.

Nov. 2, CARDIOVASCULAR "Recent Advances In The Treatment of Ventricular Arrhythmias", William Miles, M.D., Assistant Professor of Medicine, Indiana University School of Medicine.

Nov. 9, GASTROENTEROLOGY "Differential Diagnosis Of An Enlarged Liver", Robert Scheig, M.D., Professor of Medicine, State University of New York at Buffalo.

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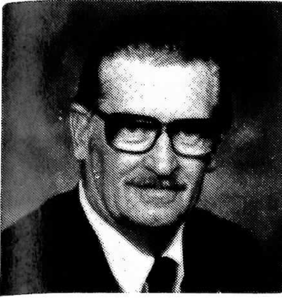

ITEMS

From the Exec's Desk

ROBERT B. BLAKE, Executive Director

The article "The Reputations of Honorable Men" running in the *Bulletin* is quite lengthy and has to be segmented to fit into the pages of *our* magazine. It is probably the best insight into the way the image of the physicians, nationally, is handled. We are not handled too badly locally, when other areas are considered and the article points out the public relations images that many of the physicians have to cope with.

* * * * *

The Arizona Veterinary Medical Association is up in arms. The Arizona chiropractors are now accepting animals as patients. The vets charge the chiropractors don't know enough about four-legged physiology to do the job. It is probably a case of "whose ox is being adjusted!"

* * * * *

The July 5, 1984 edition of The Wall Street Journal carried an excellent piece about the problem of health care costs. It was written by Peter F. Drucker, the guru of modern managment and Clarke Professor of Social Sciences at Claremont Graduate School. He points out that the health-care systems in every western nation are in trouble, whether the system is nationalized or entirely free. Current proposals for "solving" the health cost problems are only going to shift the costs around . . . not reduce them significantly.

Drucker suggests that there are only two options for effectively handling the health-care cost problem. One is to utilize the "market mechanism" by requiring the individual family to pay its own health costs up to a certain percentage of pre-tax income. The other option is to initiate a medical rationing system. He concludes that neither option is feasible because society . . . and, in turn, the political establishment . . . refuse to even consider them.

Drucker predicts we will continue to enact rules and regulations designed to control health-care costs, knowing full well that they are going to fail. As long as the population continues to age and medical science continues to advance, health-care costs will continue to climb.

Increased longevity may well end up being the nation's curse.

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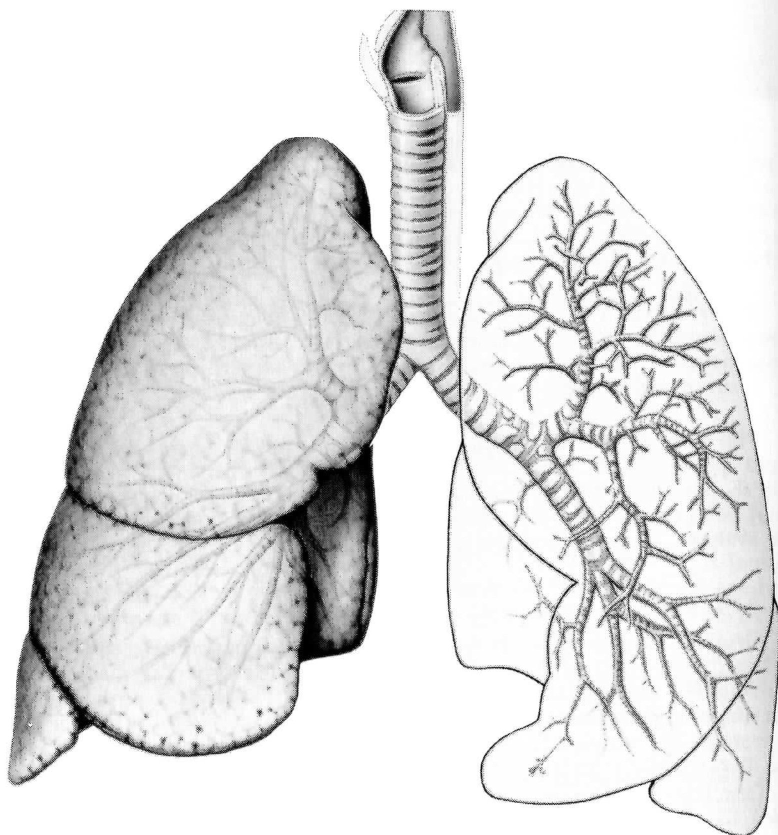

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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor™ (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest™ tablets but not with Tes-Tape™ (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbiliform 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 (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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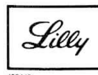

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