

HEART OF THE MATTER

President's Message



Howard C. Herrmann,
MD, FACC, President

I've recently returned from our Chapter's annual legislative meeting in Harrisburg. Although the meeting was superb, I came away concerned about our ability

as physicians to adequately influence our elected representatives. We have had some successes over the past year—particularly, the restoration of the planned reductions in Medicare physician reimbursement. But our influence on meaningful tort reform has not yet yielded any long term solutions.

Our opponents on the tort reform issue are strong, organized, and well-armed. Last year alone, the American

Trial Lawyers Association and individual law firms made more than \$62 million in federal political contributions. How much did you give to any of your elected representatives?

In addition to supporting the "Code Blue" political protest organized by the Pennsylvania Medical Society, you must support candidates for the legislature and judiciary that will act in the best interests of physicians and our patients to ensure their access to quality health care. Let your legislators know how any pending legislation affects you and consider making a contribution to the ACC's Political Action Committee (PAC).

Through the PAC, the ACC can influence the campaign process by contributing to candidates who support legislation that is consistent with the mission and goals of the ACC. These

include funding for medical research, Medicare regulatory and reimbursement reform, and tort reform such as the national cap on pain and suffering awards. Any individual can become a PAC member by making a contribution to the ACC PAC by personal check or with a credit card. This shouldn't substitute for a direct grassroots effort, but it allows the professionals at national ACC to work on our behalf in Washington DC. More than \$100,000 has now been raised in the first few months of the ACC PAC. Currently, only 20 of the 1,100 Pennsylvania members have contributed to the ACC PAC. To make your contribution, use the envelope enclosed in this newsletter, or for more information go to www.acc.org/advocacy/pac/pac.htm. ■

Spring 2003



Pennsylvania Chapter

777 East Park Drive
Harrisburg, PA 17105-8820
888-633-5784

Maria Elias
Chapter Administrator
melias@pamedsoc.org

www.pacc.org

Quality ... Education ... Advocacy

by Steven M. Ettinger, MD, FACC, Government Relations Committee Chair,
PaACC Governor-Elect

On April 14-15th, the PaACC annual Legislative Conference was held at the Harrisburg Hilton and Towers. In an effort to assist cardiovascular specialists and their practice groups in the care of their patients, informative and provocative lectures were given by Dr. John W. Hirshfeld, Jr., Professor of Medicine and Director of the Cardiac Catheterization Laboratory at the Hospital of the University of Pennsylvania; Dr. Gerald V. Nac-

carelli, Professor of Medicine, Chief of the Division of Cardiology, and Director of the Cardiovascular Center at the Pennsylvania State University College of Medicine/Milton S. Hershey Medical Center; Dr. James G. Kitchen III, Associate Professor of Medicine, Jefferson Medical College and Chief of the Cardiac Catheterization Laboratory at Lankenau Hospital and Ms. Darlene Kauffman, Associate Director, Division of Medical Economics at the

Pennsylvania Medical Society.

The guest speaker, Dr. Carl J. Pepine, President of the ACC, highlighted the evening by providing an overview of the past accomplishments and defining the future goals of the ACC. Dr. Pepine provided critical insight into the pivotal roles state chapters will have in the future regarding medical liability reform and issues

continued on page 2

Quality ... Education ... Advocacy

continued from page 1

relating to the delivery of health care in the United States. Dr. Pepine emphasized the need to support the national Political Action Committee, which serves to improve the position of health care providers as it relates to Federal regulators and policy writers.

The second day of the conference was devoted to state advocacy issues and lectures were provided by Mr. Scot Chadwick, Esq., Director, Governmental Affairs of the Pennsylvania Medical Society; Mr. Peter Hoffman, Esq., Member of Governor Rendell's Medical Malpractice Task

Force; Mr. Adam Nelson, CAE Specialist, State Legislative Affairs of the ACC; Dr. Stephen Foreman, Esq., Director, Health Services Research Institute of the Pennsylvania Medical Society and Dr. C. Richard Schott, Chairman of the Division of Medicine and Cardiology at Riddle Memorial Hospital. The keynote speaker during the second day of the conference was the honorable Senator Jeffrey Piccola [PA 15th District] who gave an impassioned speech regarding malpractice reform and the challenges facing not only health care providers but also state legislators. Of note, Senator

Piccola is a sponsor of Senate Bill 50, which calls for a change to the state's Constitution to allow limits on non-economic damages.

In addition, the members of the PaACC executive council recognized and strongly supported the current efforts of the Pennsylvania Medical Society and its call to force government to deal with the current medical liability crisis facing all physicians practicing in the state. The "disappearing doctor" phenomenon is progressing and poses a serious

continued on page 5

Chapter meeting attendees enjoyed the social portion of the meeting which included a special IMAX Theater presentation.



Left to right are Drs. Herrmann, Pepine, Hirshfeld and Casale.



Dr. Pepine enjoying the 3-D IMAX presentation, "Spacestation."



Left to right are Dr. Ancil Jones and Dr. Dick Schott.



Left to right are Dr. Steven Ettinger, Program Chair, and Dr. Paul Casale.

An Action Plan for PA Cardiologists

(A modest proposal for a collaborative approach to the medical liability/malpractice mess)

by James G. Kitchen III, MD, FACC

A. Understand that:

Pennsylvania cardiologists today are fighting two *separate* battles:

1. The battle for civil justice (medical liability)
2. The battle against decreased reimbursements

Both battles are being waged simultaneously in two venues: Harrisburg and Washington D.C. Unfortunately, the issues in the two conflicts are often mingled and confused.

B. Maintain separation between discussions about liability and discussions about reimbursement so that our patients (and legislators) do *not* confuse the two. For optimal strategy, these two battles should generally not be mentioned in the same breath, or even in the same conversation! When talking about civil justice, stay focused on civil justice. When talking about reimbursement, don't confound the issue by bringing up liability.

C. Realize that patients care about the fact that the current broken liability system blocks access to medical care as doctors retire early, leave, or curtail services. While the same could be said of decreased reimbursements, at the end of the day *no one* but doctors are interested in increasing or even maintaining doctors' incomes. On the other hand, *everyone* is interested in being able to get the medical care they need, when they need it.

D. Realistically accept that there is no quick fix.

"There may be light at the end of the tunnel, but it's a very long tunnel!"

Even if tort reform is enacted tomorrow, premiums may continue to rise or at least will not fall quickly. The best we can hope for from tort reform is that it will stabilize the medical liability environment in Pennsylvania,

but physicians will still need to deal with high premiums, probably for years to come.

In effect, today's medical activists are fighting for the next generation of physicians (California has had tort reform for 27 years, and although their premiums are much lower than those in Pennsylvania, upward pressure on these premium is ever present).

E. Know your political enemy

The opposition in this battle is the plaintiff bar; those trial lawyers who routinely sue physicians. They spend almost all their money and political energy on just one issue: blocking tort reform!

F. Know your ally (and secret weapon):

Your patients are probably not much interested in your income, but they will almost certainly be up in arms if they think their ability to get good, timely cardiac care in being threatened. Enlist the aid of your patients (the plaintiffs' bar hopes that you won't, because they have no comparable advocacy group)!

G. Pay to win!

This battle is *political*. Politics runs on money and influence. She who pays, plays; don't contribute: don't complain. Leverage your monetary contribution by supporting your county, state, and national medical societies whether or not you love their leaders and whether or not you agree 100% with their policy platforms. None of us can win this war alone, and we will surely lose if we do not (at least temporarily) put aside our differences in the house of medicine and join the offense.

H. Proclaim one simple two-fold message, proclaim it over and over again, and never deviate from it:

1. "*The present liability insurance system is broken down, and is blocking patient access to care.*" Completely avoid

parallel themes such as complaints that malpractice insurance costs too much. Although that statement is actually true, *no one* but doctors is interested in saving doctors money! On the other hand, *everyone* is interested in being able to get the medical care they need, when they need it.

2. "*Push legislation patterned after California's Medical Injury Compensation and Reform Act of 1975 (MICRA) to restore patient access to care.*"

Get patients involved in pressuring their legislators to enact MICRA style legislation (preferably with a \$250,000 cap). Don't just give statistics; give patients stories about colleagues packing their bags, and patients who are turned away from emergency rooms. Give them a sample letter to send to their legislator and, if they need it, information on how to get their legislators postal and email addresses and phone numbers. Deliver the message personally to your policy maker (legislator).

I. Think twice before participating in a job action. Will it anger patients, and thereby blunt our unique and most effective weapon?

J. Play to win.

There is hope! We have a *strategy* to win. We have access to the material (dollars) needed to win the war, and we have a unique "*weapon*" that the plaintiff bar *does not* have. If our patients can be made to understand that their *access* to care is in jeopardy, they may well go to bat for us with their legislators.

Doctors are generally not poor (although they soon may be), yet the plaintiff bar outspends physicians left and right. Until PA cardiologists are willing to contribute to

continued on page 4

Action Plan

continued from page 3

the political action committees of the ACC and designated action committees of the Pennsylvania chapter of the ACC, the tide of the battle cannot turn.

I am indebted to Dr. Donald Palmisano for review of the perspectives described above. ■

Medicare Physician Payment Update

provided by ACC

BACKGROUND: The Medicare physician fee schedule for 2003 became effective March 1 with an overall 1.6% increase for physician payments after the scheduled 4.4% reduction was averted through efforts made by the ACC together with the organized medicine community. ACC-advocated technical changes in CMS's practice expense methodology resulted in the average cardiologist receiving a 2.2% increase. In general, procedures performed in offices will receive higher increases than procedures performed in hospitals. The average echocardiography procedure will rise 4.2%, pacing and electrophysiology procedures will rise 2.5%, nuclear procedures will rise 4.6%, interventional procedures will rise 0.7% and general cardiology procedures will rise 1.3%.

HOW THIS AFFECTS YOU: Although fees for most in-office

procedures will increase, in-facility procedures will not do as well. In general, though, payments for all cardiovascular-related procedures will increase. Below is a breakdown:

Echocardiography—4.2%

Pacing/EP—2.5%

Nuclear—4.6%

Interventional—0.7%

General Cardiology—1.3%

Total—2.2%

*Because many cardiologists perform a mix of procedures, the overall impact on individual physicians will vary.

HOW WILL CLAIMS BE PROCESSED? Claims filed by physicians with dates of service January 1, 2003, through February 28, 2003, and processed on or after March 1, 2003 will still be adjusted in July to pay the 2002 rates as planned. However, it should be noted that payment for the vast majority of services paid by

Medicare would be increasing not decreasing from 2002 to 2003. It is likely that physicians will now owe money to Medicare for the differences between the 2002 and 2003 payment amounts. Overpayments that result due to these adjustments will be recouped using normal procedures. Calendar year 2003 payment amounts for all services not paid under the Medicare Physician Fee Schedule (MPFS) are effective Jan. 1, 2003.

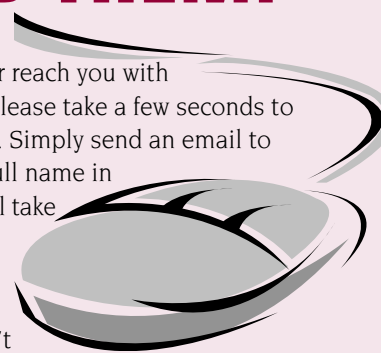
Claims submitted with new 2003 MPFS HCPCS codes for services performed on or after Jan. 1, 2003, will be suspended and the entire claim will be held until further notice from the Centers for Medicare & Medicaid Services (CMS). Physicians/practitioners should not submit the new 2003 MPFS HCPCS codes for services performed until notification from Carrier of the effective date of the 2003 MPFS.

WHAT IS AHEAD? CMS' last forecast for 2004, made in August 2002, called for a positive 1.7% update, but that was washed away by lower-than-expected economic growth and an unexpected spike in physician volume, CMS told MedPAC. Physician spending grew 7% in 2002, despite a 5.4% average cut in reimbursements, the agency noted.

The resulting "ripple effect," as described by CMS Administrator Tom Scully in a recent teleconference, now means the agency sees doctor fees falling for the next 4 years. CMS estimates an overall range for the 2004 update of anywhere from -5.8% to a 0.6% increase, with the current point estimate being the -4.2%. ■

EMAIL ADDRESSES— YOU HAVE THEM, WE NEED THEM!

Have you changed your email in the past year? If so, we can no longer reach you with our chapter email communications. Please take a few seconds to help us update our email address list. Simply send an email to melias@pamedsoc.org and type your full name in the subject field. It's that easy—we will take care of the rest and you will begin receiving only important alerts, no junk email, from the PaACC. If you've acquired an email address and haven't provided it to us yet, please send us a note now! Thanks.



National CAC Meeting

by Donald C. Durbeck, MD, FACC

It was my privilege to attend the ACC National Carrier Advisory Committee meeting held on March 30th in conjunction with the ACC's national convention in Chicago. Dr. Joseph V. Messer chaired the 2-hour session at which a number of subjects of interest were discussed.

The meeting started with a "warning" that, while we had not experienced the predicted 4.2% decrease in overall reimbursement in 2003, that we should expect such a decrease, or more, in 2004. The ACC is actively lobbying to prevent this from happening.

There has been a 9% increase in the frequency of performance of imaging services. Look for cuts in reimbursement for these services. There is consideration of providing coverage for LVADs, and of providing additional coverage for MRI and MRA. Payments for nuclear studies are currently being reevaluated by Medicare.

Fraud and Abuse changes were then addressed. Medicare's position, presented by Dr. Trent Hayward, is that charges of fraud and abuse are related to intent, such as billing for services, which were never performed. Unintentional errors will be considered as "overpayment". However, Medicare will continue to extrapolate the repayment they expect based upon a relatively small sample of cases. A new initiative to deliver Provider Education regarding claim accuracy is available at www.lmrp.net.

An extensive ACC Policy Statement for transthoracic echo was presented. It is hoped that this document, considered standard of care by the ACC Local Medical Care Provider Committee will become the standard for Medicare. A multitude of other CAC position documents were

reviewed, including some from our state, and will be refined into standard of care documents as well.

Finally, quality improvement efforts by Medicare are now being extended into private physician offices, not only for errors in claims, but also for quality improvement in six or so AMA approved chronic conditions. An example given was the use of ASA in diabetics. Pilot studies

are currently under way in Iowa, New York, and New Jersey.

I came away from the meeting feeling that a true understanding is possible between the presenters from Medicare who need us to define standards of care, and the ACC's CAC, which is actively pursuing deserved reimbursement. I look forward to my personal continuing participation in these processes. ■

Quality ... Education ... Advocacy

continued from page 2

threat to the citizens of the state and their ability to access quality health care. Hopefully, *Code Blue* will send the message to all Pennsylvanian's that medical liability insurance is **eroding access to care** and creating a divide between patients and doctors.

Participants were provided with information regarding the Pennsylvania grassroots program designed to enhance communications between the Chapter and state legislators and regulators. In an effort to foster optimal delivery of cardiovascular specialty care services members of the chapter are invited to become *Key Contacts*. Chapter members interested



Senator Jeffrey Piccola

in learning more about this newly developing program are encouraged to contact their District Councilor

Finally, it is extremely important given the current political climate and the concerns of all those involved in the health care system, that the executive council of the PaACC are made aware of and recognize your concerns. Every effort should be made to attend the annual Chapter Meeting/Legislative Conference in 2004. By listening to your concerns, the Chapter will take the appropriate actions to fulfill its mission as your *advocate*. The executive council encourages its members to *get involved*. ■



Carl J. Pepine, MD, MACC

HGSA Carrier Advisory Committee Reports

December 2002
by James MacKrell, MD, FACC
CAC Representative

The first item for discussion was the 2003 Medicare fee schedule, which has not yet been released by CMS. It was stated that until this fee schedule is finalized, services provided in year 2003 will be paid at the 2002 fee schedule reimbursement. Once the 2003 fee schedule is released, there is a sixty day period until it takes effect. In addition, once the fee schedule is released Medicare providers have a 45 day time period where they have the opportunity to decide whether or not to continue participation in the Medicare program.

Next was a lengthy review of the outpatient prospective payment system (OPPS), which involves reimbursement to hospitals for outpatient services and testing. This discussion was informational only, since this actually involves Medicare Part A. Dr. Paula Bonino is the Medical Director for the Veritus Part A intermediary. This OPPS program was introduced in August of 2000 and at this point they have two years of data and experience. The current rules and reimbursements are being revised and recalibrated for year 2003. The full text of this revised policy is found under the Federal Register website at www.archives.gov. It was explained the various items which go into the APC (Ambulatory Payment Classification) code, including hospital and nursing services, as well as the various drugs and biologicals which are integral to the service or procedure being provided. Certain items which are currently paid as a pass-through will now be bundled into an APC as of January 1, 2003. Again, this only applies to "hospital out-patient procedures".

New for year 2003 are codes for "observation status" in the emergency department for the following diagnoses: congestive heart failure, chest pain, and asthma.

Next was a review of the HIPAA privacy guidelines, the text of which can be found under the website www.hhs.gov/OCR/HIPAA/privacy/html. Of note, the privacy guidelines in particular are monitored by the Office of Civil Rights, not CMS.

Several local medical review policies were then discussed, two of which were relevant to cardiovascular specialists. The first was a new policy for myocardial SPECT. This was developed in an effort to "carve-out" myocardial applications of SPECT from the previous global SPECT policy. It was stated up front by the medical director that frequency utilization is *not* a problem in Pennsylvania. Several comments were solicited by me from various cardiologists active in the field of nuclear cardiology, and Dr. Bill VanDecker was of great help in providing his comments as well as comments from the American Society of Nuclear Cardiology (ASNC). Additional comments were forwarded by Dr. William Follansbee. Our main objection to the draft policy was that it was worded in such a way that myocardial perfusion imaging should be second-line, "generally indicated when other studies are inconclusive or contradictory". We argued (with great success) that the policy should allow proceeding directly to SPECT imaging in most settings of intermediate and high pre-test probability of underlying coronary artery disease. In addition we suggested several additions to the indications for SPECT imaging, and also suggested several additional ICD9 codes that support medical necessity. In summary, I was very pleased that the medical director

whole-heartedly agreed with all of the suggestions that we provided.

We also raised some concerns regarding inappropriate "bundling" of drug charges, specifically pharmacologic stress agents and radiopharmaceuticals. This problem occurs most frequently in the hospital setting, and as such it was stated that this problem would need to be addressed with the Medicare Part A intermediary.

The next policy on which we provided some comments was regarding "co-management of surgical procedures". Relevant to providing care to the cardiovascular patient when a patient undergoes surgical therapy, i.e. coronary bypass surgery or surgical valve repair or replacement, there is usually a 90 day global period during which time the cardiovascular surgeon is expected to provide postoperative care. There have been problems with cardiologists being reimbursed for care of the cardiac patient for problems unrelated to the actual surgery (i.e., atrial fibrillation, congestive heart failure, hyperlipidemia etc.). We argued that the cardiovascular surgeon should be reimbursed for provision of surgical care, and that the cardiologist should also be reimbursed for medical care of the patient (even during the 90 day global period). It was stated by the medical director that if the appropriate codes for care are submitted, then reimbursement should not be a problem. In practices where cardiovascular surgeons are actually members of the cardiology group, since these services are being billed under the same provider number, there may be a system problem which disallows simultaneous reimbursement. Dr. Bloschichak assured me that he would look into this system problem.

continued on page 8

Legislative Update

provided by the Pennsylvania Medical Society

Emergency Constitutional Amendment

House Bill 1326

Sponsored by Representative Mike Turzai (R-Allegheny), this legislation has been approved by the House State Government Committee. The bill would amend the state Constitution through an emergency process to allow the General Assembly to enact a limit on non-economic awards for medical liability only. The bill does not set a specific limit, as that step requires a separate piece of legislation. In addition, the bill does not impact economic awards or those for medical care. The bill needs a two-thirds majority in both the House and Senate before being placed on the ballot for all Pennsylvanians to decide this November.

Capping awards

Senate Bill 50

Amending the State Constitution

House Bill 3

Sponsored by State Senator Jake Corman (R-Centre), this legislation would in effect remove the constitutional restriction that currently prohibits the General Assembly from enacting legislation capping damage awards in civil tort cases. In order to achieve success, Senate Bill 50 must be approved, in identical form, in two consecutive legislative sessions and further approved by Pennsylvania voters through a ballot referendum. Given that we are in the beginning of a two-year session, the earliest the constitutional amendment could take effect, under this proposal, would be the spring of 2005.

Reduction of Coverage limits

Senate Bill 266

Senate Bill 287

House Bill 21

In some form or another, these measure are intended to lower the limits of medical liability insurance currently re-

quired under state law. While the limits vary from \$500,000 to \$250,000, the Society supports lowering the mandated insurance limits. These measures remain in the committee to which they were originally referred. Consideration of any one of these measures is not expected in the near term.

Insurer Fee Disclosure

House Bill 20

Senate Bill 254

Introduced by Rep. Ellen Bard (R-Montgomery) and Sen. Tommy Tomlinson (R-Bucks), both measures address the issue of third party reimbursement for physicians when one or more surgical procedure is performed on the same patient by the same surgeon during one continuous operating procedure. Currently, insurers do not pay for multiple surgical procedures on the same case arguing that an additional procedure does not require an appreciable amount of time since the surgical field already exists. The Society strongly supports this legislation. Both bills remain in committee.

Physician negotiation

Senate Bill 202

House Bill 84

This measure is similar to others that have been introduced in past legislative sessions. Sponsored by Sen. Connie Williams (D-Montgomery), the bill proposes to allow physicians to jointly negotiate fees with health insurers. The language in the bill is drafted in such a way to insure that this practice would fall within the guidelines of current Federal anti-trust laws. The Society supports the measure. It is currently awaiting consideration in the Senate Banking and Insurance Committee. ■

Congratulations

To the following Pennsylvania winners of the ACCF MRI/CT Fellow In Training Scholarship Award

Svetlana Nikitina, MD
Graduate Hospital,
Cardiology Fellowship,
Philadelphia

Rajiv A. Patel, MD, PhD
Lankenau Hospital,
Jefferson University

Fellow's Corner

by Farhad Elmi, MD

The Executive Council meeting of the American College of Cardiology/Pennsylvania Chapter took place during the national American College of Cardiology meeting in Chicago, April 1, 2003. Key points of interest included a planned survey of graduating cardiology fellows in Pennsylvania. The survey will help identify the percentage of graduates that are leaving the state and why. It was reiterated that fellows are encouraged to become more involved in the educational activities of the Chapter. The Chapter will continue to concentrate on providing educational opportunities that would supplement any perceived void in existing fellowship programs as determined by fellows-in-training (FIT) representatives of the respective programs. The next planned educational activity will be on heart failure and will take place in the fall.

We welcome Dr. Jeffrey Friedel and Dr. Tejas Mehta from Allegheny General Hospital as our two new additional FIT representatives from the western part of the state. Their input will be much appreciated and is expected to further facilitate interaction between the FITs from eastern and western Pennsylvania. ■

Chapter News

Drs. Smith and Ettinger Named New Chapter Leaders

A.J. Conrad Smith, MD, FACC, of Pittsburgh and Steven M. Ettinger, MD, FACC, of Hershey, have been named Governors-Elect by the American College of Cardiology's Board of Trustees. After the ACC Annual Meeting in March 2004, Dr. Smith will serve as Chapter president and ACC Governor for Western Pennsylvania and Dr. Ettinger will become the Chapter vice president and ACC Governor for Eastern Pennsylvania.

Eastern Governor-Elect: A.J. Conrad Smith, MD



Dr. Smith has been in practice at the University of Pittsburgh Medical Center since 1994. Dr. Smith graduated from the University of California, San Francisco School of Medicine in 1987 and continued his internship and residency at Massachusetts General Hospital, Harvard Medical School. He continued with his fellowship at Massachusetts General Hospital. At Massachusetts General he was part of the Internship Selection Committee, Minority Recruitment Committee, and Co-Director of the Summer Research Trainee Program.

Since arriving at the University of Pittsburgh in 1994 as an Assistant Professor of Medicine, Dr. Smith has been a valuable part of the infrastructure of the Cardiovascular Institute of the University of Pittsburgh. His major clinical activities include cardiac consultation with a particular interest in the cardiac catheterization laboratory. In 1998 Dr. Smith became Director of the Cardiac Catheterization Laboratories at the University of Pittsburgh and implemented changes that included five new catheterization laboratories and a state of the

art reporting system. Dr. Smith has now been promoted to an Associate Professor of Medicine and also the Interim Chief of Cardiology and Director, Cardiovascular Institute. In this new role he has again implemented changes that will have far-reaching positive outcomes.

Dr. Smith's teaching activities include a preceptorship of all interventional fellows and an intensive teaching curriculum with the interventional fellows. He also lectures to the medical students at the University of Pittsburgh School of Medicine. His activities also include lecturing at various hospitals throughout the year.

Eastern Governor-Elect: Steven M. Ettinger, MD

Dr. Ettinger is an Associate Professor of Medicine at Penn State University and has been a



member of the Section of Cardiology at the Milton S. Hershey Medical Center since 1993. His major clinical activities and responsibilities include being Co-Director of Interventional Cardiology and Co-Director of the Interventional Cardiology Fellowship training program at the Milton S. Hershey Medical Center. Dr. Ettinger's teaching activities include instruction of third and fourth year medical students.

Dr. Ettinger completed his Cardiology training at Penn State University, Milton S. Hershey Medical Center in 1992. He completed his Interventional Cardiology training at Penn State University, Milton S. Hershey Medical Center in 1993. He served as a Medical Resident at Long Island Jewish Medical Center and Queens General Hospital from 1986 to 1989 and is a graduate of the Sackler School of Medicine in Tel Aviv, Israel in 1986. He attended college at the State University of New York at Albany graduating with a BS in 1982.

His major clinical activities include cardiac catheterization and cardiac consultation. Dr. Ettinger has been the recipient of numerous American Heart Association awards. Dr. Ettinger's research efforts focus on the effects of gender and hormones on muscle metaboreceptor response in men and women during exercise. Dr. Ettinger participates in multi-center clinical trials of pharmacological and device therapies for the treatment of acute coronary syndrome.

Dr. Ettinger has been very involved in chapter activities and serves as the District II Councilor and Chairperson of the PaACC Nominating Committee and Government Relations Committee. He has also served as Program Chair for the PaACC Legislative Conference for the past three years. ■

HGSA Carrier Advisory Committee

continued from page 6

It has been my pleasure to serve as the Pennsylvania ACC Carrier Advisory Committee representative for the last five years. I am sure Dr. Durbeck will do a superb job as my replacement.

March 2003 by David Scher, MD, FACC, Alternate CAC Representative

There were no cardiology items on the March agenda, but the committee wanted people to know about updates to the website which include CME-eligible lectures online. Go to www.hgsa.com for more information. ■

Clinical Briefs from Journal Watch Cardiology

ACE Inhibitors vs. Diuretics for Hypertension: Round II

In the recent ALLHAT double-blind randomized trial, U.S. researchers found that a thiazide diuretic (chlorthalidone) was the most effective of several first-line therapies for hypertension, including the ACE inhibitor lisinopril (JAMA 2002; 288:2981). Now, Australian researchers have conducted an open-label randomized trial of hydrochlorothiazide (3039 subjects) versus enalapril (3044 subjects) in hypertensive patients (age range, 65–84; 95% white; mean BP, 168/91 mm Hg) recruited from family-practice settings. Among the exclusion criteria were any recent adverse cardiovascular events and serum creatinine level >2.5 mg/dL. The study was partly supported by a manufacturer of enalapril.

The randomization protocol served as a recommendation; the final decision lay with each patient's physician. In both groups, 83% were initially treated according to randomized assignment.

During a median 4-year follow-up, BP reduction was similar in the 2 groups (about –25/–10 mm Hg). Incidence of the primary endpoint (all adverse cardiovascular events or death from any cause) was lower with enalapril than with hydrochlorothiazide (695 vs. 736 events; hazard ratio, 0.89; 95% CI, 0.79–1.00; P=0.05), with post-hoc subgroup analyses showing a significant benefit in men but not in women. The number needed to treat was 32 overall and 23 in men. All-cause mortality incidence trended slightly lower with enalapril but did not reach significance.

Comment: ALLHAT and this trial are both community-based studies of first-line therapy for hypertension, the former favoring the diuretic and the latter the ACE inhibitor. However, the diuretics and ACE inhibitors tested were not the same in these 2 trials. Also, the diuretic yielded better BP control in ALLHAT, whereas both drug types controlled BP similarly in this study. In addition, the ALLHAT study population was younger, was more racially diverse, and had more comorbidities. An editorialist still generally favors diuretics, except when ACE inhibitors are specifically indicated. The bottom line is that this study's results challenge the initial persuasiveness of the ALLHAT findings; the best overall choice of first-line treatment for hypertension now appears unclear. An individual patient's needs and characteristics often will provide the best guidance for which treatment or combination of treatments to use.—**Harlan M. Krumholz, MD, SM**

Wing LMH et al. for the Second Australian National Blood Pressure Study Group. A comparison of outcomes with angiotensin-converting-enzyme inhibitors and diuretics for hypertension in the

elderly. *N Engl J Med* 2003 Feb 13; 348:583-92.

Frohlich ED. Treating hypertension—What are we to believe? *N Engl J Med* 2003 Feb 13; 348:639-41.

Is It Time to Replace Heparin Use During PCI?

Unfractionated heparin (UFH) is the standard for indirect inhibition of thrombin during percutaneous coronary intervention (PCI). Recently available direct thrombin inhibitors (DTIs) such as bivalirudin have shown some advantages over UFH in terms of dosing and bleeding complications. Now, researchers have done a large, randomized comparison.

In the REPLACE-2 trial, funded by bivalirudin's manufacturer, 6010 patients were randomized to intravenous bivalirudin (with provisional glycoprotein IIb/IIIa inhibition) or to UFH (with planned GPIIb/IIIa inhibition) during elective or urgent PCI that was unrelated to acute MI or acute coronary syndrome (ACS). For bivalirudin, dosing was a 0.75-mg/kg bolus before PCI, then a 1.75-mg/kg-hour infusion for the duration of PCI; the pre-PCI bolus of heparin was 65 U/kg.

About 85% of both groups received clopidogrel more than 2 hours before PCI. About 97% of the UFH group and about 7% of the bivalirudin group ended up receiving a GPIIb/IIIa inhibitor. In both groups, GPIIb/IIIa-inhibitor use was roughly evenly divided between eptifibatid and abciximab. Five minutes after UFH bolus administration, the median activated clotting time (ACT) in that group was 317 seconds, longer than most current targets.

The bivalirudin and UFH groups had similar 30-day rates of the primary composite endpoint—death, MI, urgent repeat revascularization (URR), or in-hospital major bleeding (9.2% vs. 10.0%, respectively)—and of just death, MI, or URR (7.6% vs. 7.1%). Among endpoint components, MI incidence trended slightly higher, and bleeding incidence was significantly lower, with bivalirudin.

Comment: In this large, randomized trial in PCI patients, the DTI bivalirudin, combined with provisional GPIIb/IIIa inhibition, was as safe and effective as UFH with planned GPIIb/IIIa inhibition, suggesting that the former regimen is a suitable alternative to current practice. However, before we have a clear best choice of antithrombin agent, several questions must be answered: Do the REPLACE-2 data apply to high-risk ACS patients? Will the trend toward more MIs with bivalirudin result in more late mortality? Is bivalirudin use cost-effective at roughly \$395 per patient (vs. \$615 for eptifibatid and \$1300 for abciximab)? Did the longer-than-usual ACT in the UFH group increase bleeding

continued on page 10

Clinical Briefs from *Journal Watch Cardiology*

continued from page 9

risk? Could a strategy of bivalirudin with *planned* GPIIb/IIIa inhibition add further benefit—and cost? Finally, were outcome differences related to the choice of GPIIb/IIIa inhibitor?—**Howard C. Herrmann, MD**

Lincoff AM et al. for the REPLACE-2 Investigators. Bivalirudin and provisional glycoprotein IIb/IIIa blockade compared with heparin and planned glycoprotein IIb/IIIa blockade during percutaneous coronary intervention: REPLACE-2 randomized trial. *JAMA* 2003 Feb 19; 289:853-63.

Antman EM. Should bivalirudin replace heparin during percutaneous coronary interventions? *JAMA* 2003 Feb 19; 289:903-5.

Adding Enoxaparin to Eptifibatide Improves ACS Outcomes

Newer antiplatelet and antithrombotic therapies improve outcomes in acute coronary syndrome (ACS) patients who are treated with aspirin and unfractionated heparin (UFH). However, combination use of these newer agents is not yet established as safe and effective. In this multicenter, open-label, randomized, Canadian trial, partially funded by manufacturers of the glycoprotein IIb/IIIa

inhibitor eptifibatide, 746 patients with elevated levels of cardiac markers or with chest pain and ECG abnormalities were treated for 48 hours with aspirin, eptifibatide, and either UFH or the low-molecular-weight heparin enoxaparin.

Incidence of 96-hour, non-CABG-related bleeding (the primary safety endpoint) was lower with eptifibatide/enoxaparin than with eptifibatide/UFH (1.8% vs. 4.6%, $P=0.03$). Minor-bleeding incidence by 96 hours was higher with enoxaparin, and transfusion rates were similar between groups. Ischemia incidence, assessed by ST-segment shifts with continuous ECG monitoring, was significantly lower with enoxaparin than with UFH in the first 48 hours (14.3% vs. 25.4%) and in the second 48 hours (12.7% vs. 25.9%). The 30-day composite incidence of death or MI was significantly lower with enoxaparin (5% vs. 9%). Despite strict adherence to dosing guidelines, only 17% and 47% of UFH recipients had achieved a therapeutic activated partial-thromboplastin time by 12 and 24 hours, respectively.

Comment: This study demonstrates both the safety

of enoxaparin and its superior efficacy over UFH in high-risk ACS patients who receive aspirin and eptifibatide. The difficulty in achieving rapid therapeutic anticoagulation with UFH likely contributed greatly to the better outcomes with enoxaparin. The study's limitations include its open-label design and short duration of therapy with relatively late angiography (median, 100 hours). Many practitioners already use newer antiplatelet and antithrombotic agents in combination; large trials that can more definitively test the soundness of this shift in practice are forthcoming. —**Howard C. Herrmann, MD**

Goodman SG et al. for the Integrilin and Enoxaparin Randomized Assessment of Acute Coronary Syndrome Treatment (INTERACT) Trial Investigators. Randomized evaluation of the safety and efficacy of enoxaparin versus unfractionated heparin in high-risk patients with non-ST-segment elevation acute coronary syndromes receiving the glycoprotein IIb/IIIa inhibitor eptifibatide. *Circulation* 2003 Jan 21; 107:238-44.

The Challenge of Secondary Prevention in Women with Heart Disease

What are the risk factors for recurrent events in middle-aged and older women with coronary heart disease? To answer this question, researchers analyzed data from 2763 postmenopausal women with CHD in HERS, a randomized trial of combination hormone replacement therapy

From the publishers of the *New England Journal of Medicine*

JOURNAL WATCH CARDIOLOGY

Keep up with the news in Cardiology . . . in a Heartbeat!

Journal Watch Cardiology delivers timely, relevant, easy-to-read updates from more than 20 journals written by cardiologists for cardiologists.

Journal Watch Cardiology is an 8-page monthly newsletter designed to help clinicians worldwide stay current with the latest developments in cardiology.

- Each issue provides concise summaries of 15 to 20 of the most significant studies in cardiology published in the past month, selected from the most important journals in the field.
- Each summary is followed by editorial commentary that puts the summary in perspective for the practicing clinician and includes complete reference information.
- *Journal Watch Cardiology* is written and edited by cardiologists from major institutions.
- The full, searchable, online archive of *Journal Watch Cardiology* is accessible exclusively to subscribers at www.jwatch.org.

CALL 1-800-843-6356 FOR SUBSCRIPTION INFORMATION

versus placebo. Mean follow-up was 4.1 years.

In multivariate-adjusted analyses, 11 risk factors for nonfatal MI or CHD death were identified: African American ethnicity, treated diabetes, angina, congestive heart failure, >1 previous MI, lack of exercise, high blood pressure, high LDL, low HDL, elevated lipoprotein(a) level, and poor creatinine clearance. Risks for CHD events were also observed for Latin American ethnicity, older age, and current smoking, though these associations were weaker. The annual CHD-event rate was 3.4%, ranging from 1.3% in women with no risk factors to 8.7% in women with 5 or more. About half the women had >2 risk factors.

The researchers also attempted to use the HERS data to determine whether women with risk factors were receiving effective secondary-preventive therapy. However, lack of data on contraindications to therapy renders these findings less than illustrative.

Comment: As the editorialists note, this study did not include diagnostic tests such as electrocardiograms, echocardiography, and exercise testing, which are used in practice to predict CHD outcomes in high-risk women. Had these tests been used, the list of risk factors might have been a bit different. Regardless of the precise list, having known CHD poses a clear risk for future adverse cardiac events, and clinicians should offer women with CHD individually appropriate secondary-preventive treatment, including beta-blockers, ACE inhibitors, aspirin, and lipid-lowering therapy.—**Joel M. Gore, MD**

Vittinghoff E *et al.* Risk factors and secondary prevention in women with heart disease: The Heart and Estrogen/progestin Replacement Study. *Ann Intern Med* 2003 Jan 21; 138:81-9.

Miller AP and Oparil S. Secondary prevention of coronary heart disease in women: A call to action. *Ann Intern Med* 2003 Jan 21; 138:150-1.

Reducing Nephrotoxicity with Iso-Osmolar Contrast

Nephropathy, a serious complication of contrast angiography, is common in diabetes patients with preexisting renal impairment. In this double-blind, multicenter, European trial, 129 diabetes patients with a stable serum creatinine level (≥ 1.5 mg/dL in men, ≥ 1.3 mg/dL in women, ≤ 3.5 mg/dL in both) were randomized to iohexol or iodixanol before coronary (126) or aortofemoral (3) angiography. Iohexol is a nonionic, monomeric contrast medium with relatively low osmolarity (780 mOsm/kg water); iodixanol is a nonionic, dimeric contrast medium that is iso-osmolar to blood (290 mOsm/kg water). The study was supported by a company that makes both agents.

The iodixanol and iohexol groups had similar baseline characteristics, including mean serum creatinine level (about 1.5–1.6 mg/dL), creatinine clearance (about 50 mL/min), and contrast volume received (about 162 mL). All pa-

tients also received about 1 L of intravenous hydration.

Three days after angiography, the mean increase in peak serum creatinine level was lower in iodixanol recipients than in iohexol recipients (0.13 vs. 0.55 mg/dL, $P=0.001$). A ≥ 0.5 -mg/dL increase in creatinine level occurred in 3% and 26%, respectively ($P=0.002$). The odds of nephropathy were 11 times higher with iohexol than with iodixanol. All 6 incidents of acute renal failure occurred with iohexol; 2 resulted in death, 1 in persistent renal failure.

Comment: In diabetes patients with renal dysfunction undergoing mostly coronary angiography, less nephrotoxicity occurred with the iso-osmolar contrast agent iodixanol than with the somewhat higher-osmolarity agent iohexol. For both agents, contrast volumes were high; use of less contrast might have diminished the difference in nephrotoxicity between the 2 groups. Acetylcysteine, which has been shown in some studies to reduce nephrotoxicity, was used in only a few patients in this study and did not affect the findings. High-risk patients undergoing angiography should receive intravenous hydration and a minimal volume of contrast; these patients may benefit further from acetylcysteine and an iso-osmolar contrast agent.—**Howard C. Herrmann, MD**

Aspelin P *et al.* for the NEPHRIC Study Investigators. Nephrotoxic effects in high-risk patients undergoing angiography. *N Engl J Med* 2003 Feb 6; 348:491-9.

Sandler CM. Contrast-agent-induced acute renal dysfunction—Is iodixanol the answer? *N Engl J Med* 2003 Feb 6; 348:551-3.

Prognostic Importance of the Metabolic Syndrome

The metabolic, or insulin-resistance, syndrome is highly prevalent and is associated with the development of cardiovascular disease (CVD) and type 2 diabetes. To determine the prognostic significance of this syndrome, researchers studied 1209 of the 2862 men enrolled in a population-based, prospective study from Finland. At baseline (1984–1989), the 1209 men (age range, 42–60) had no histories of CVD, cancer, or diabetes. The researchers used definitions of the metabolic syndrome published by the National Cholesterol Education Program and the World Health Organization (each with different specifications for hyperinsulinemia, abdominal obesity, dyslipidemia, and hypertension).

Depending on the definition used, 8.8% to 14.3% of the men had the metabolic syndrome at baseline. During a median follow-up of 11.6 years, 109 deaths occurred. Regardless of the definition used, men with the metabolic syndrome were significantly more likely than men without it to die of coronary heart disease (CHD) after adjustment for multiple cardiovascular risk factors (relative risks

continued on page 12

Clinical Briefs from *Journal Watch Cardiology*

continued from page 11

ranged from 2.9 to 4.2). The men with the most underlying features of the metabolic syndrome were the most likely to die of CHD, CVD, or any cause.

Comment: These data add to the emerging body of evidence illustrating the public health importance of the metabolic syndrome. More aggressive strategies are needed to screen for and treat this disorder.—**JoAnne M. Foody, MD**

Foody, MD

Lakka H-M et al. *The metabolic syndrome and total and cardiovascular disease mortality in middle-aged men.* **JAMA** 2002 Dec 4; 288:2709-16.

PTCA vs. Thrombolysis for Acute MI: Updated Meta-Analysis

A 1997 meta-analysis showed that for patients who present early with ST-segment-elevation MI (STEMI), primary percutaneous transluminal coronary angioplasty (PTCA) yields better short-term clinical outcomes overall than thrombolysis does (*JAMA* 1997; 278:2093); however, the survival benefit was not definitive statistically. Now, researchers have conducted an updated meta-analysis with long-term data from previously analyzed trials and data from 13 new trials. In a total of 23 randomized trials of primary PTCA versus thrombolysis (7739 patients), streptokinase was used in 8, fibrin-specific thrombolytic agents in 15, stents in 12, and glycoprotein IIb/IIIa inhibitors in 8.

In the short term (4–6 weeks), significantly lower rates of several clinical outcomes were achieved with PTCA than with thrombolysis, respectively: death (7% vs. 9%);

nonfatal reinfarction (3% vs. 7%); recurrent ischemia (6% vs. 21%); total stroke (1% vs. 2%); and death, nonfatal MI, or stroke combined (8% vs. 14%). These benefits were maintained long term (6–18 months), though long-term data for stroke were unavailable. Including or excluding the SHOCK trial, which had special characteristics (*N Engl J Med* 1999; 341:625), did not change the findings.

Although significantly more short-term major bleeding complications occurred with PTCA than with thrombolysis (7% vs. 5%), overall rates were lower than those reported in 1997, possibly because of lower IV heparin doses and improved operator technique during PTCA in the 13 new trials.

Comment: This updated meta-analysis reinforces that primary PTCA is better than thrombolysis for limiting short- and long-term adverse events, including death, in acute-STEMI patients. As the authors note, however, the findings apply only to hospitals with well-established primary-PTCA programs and experienced operators. Future studies must clarify the value of combination therapies (e.g., heparin and GPIIb/IIIa inhibition plus thrombolysis) and of transfer strategies from smaller community hospitals.—**Beat J. Meyer, MD**

Keeley EC et al. *Primary angioplasty versus intravenous thrombolytic therapy for acute myocardial infarction: A quantitative review of 23 randomised trials.* **Lancet** 2003 Jan 4; 361:13-20. ■

Reprinted with permission from *Journal Watch Cardiology*.
©2003 Massachusetts Medical Society. All rights reserved.

Classifieds

Georgia

Live in Georgia! A Cardiologist is wanted to join an existing cardiologist or have a solo practice if preferred. We are looking for someone with the following skills: diagnostic cath, echo, trans-esophageal echo, nuclear studies, stress. Pacemaker implant skills would be a plus but not a necessity. Some experience with peripheral vascular disease both non-invasive and invasive would be appropriate. This would be a very competitive salary package and no Managed Care. If interested in this excellent opportunity, please contact Shelley Stewart at 877-622-1881 or e-mail at ahcshelley@aol.com.

Michigan

If you are looking for an opportunity in Michigan, this is it! This beautiful community is looking to add an Invasive or Interventional Cardiologist that will do diagnostic catheterizations, stress tests, TEE's, echo's and pacemaker implants locally; may do PTCA's and stents at tertiary hospital. Call will be 1:3. Competitive salary package. If this opportunity is for you, please contact Shelley Stewart at 877-622-1881 or e-mail at ahcshelley@aol.com

Risk Retention Groups: What you don't know might help you

by Barton L. Post, Esquire; Lawrence Kessel, MD; and James Judd, MD

Congress authorized the formation of risk retention groups (RRGs) in 1986 to compete with insurance companies and drive down premium rates. RRGs have since emerged and thrived in many industries and professions, including medicine, law, and accounting. RRGs protect their members like insurance companies, but they are different in some ways.

RRGs only insure groups whose members do the same kind of work and risk the same kind of liability. Practicing physicians, for example, are potentially exposed to the same kind of liability - malpractice liability. Physician RRGs, therefore, insure only practicing physicians.

Another difference is that RRGs only insure their owners, also called "member-owners." Joining a RRG therefore requires you to contribute capital to the group as well as pay an insurance premium. Member-owners of certain RRGs can withdraw their capital after a fixed period of time, or use it toward purchasing "tail" coverage.

Since RRG members are also owners, it would seem they risk personal financial exposure if the group's funds are insufficient to make a payout. But this has never happened to member-owners of a physician RRG, according to industry sources.

A RRG can curb this possibility by purchasing a reinsurance policy from a reinsurance company. Covered by reinsurance, an RRG can protect itself from unusually large losses, and pass this additional financial protection on to its members.

Before joining a RRG, questions you might ask include:

- **Competitive combined rates.** Are the RRG's combined premium and capital contribution rates competitive with the premium-only rates of insur-

ance companies? These rates, combined, should be competitive.

- **Finite capital contribution.** Does the RRG require single or multiple capital contributions? Some RRGs require a one-time-only contribution, but others require multiple contributions over several years, sometimes on an unpredictable, as-needed basis.
- **Reinsurance.** Does the RRG have reinsurance? Reinsurance is simply insurance for the group as a whole. Reinsurance protects the group against unusually large losses, providing group members additional financial protection and stability.
- **Tail coverage.** Will the RRG apply your capital contribution to your eventual purchase of tail coverage? For the day when you retire or move, make sure you

can opt to "recycle" your capital contribution into a premium payment for tail coverage.

- **Integrated Internal Management.** Does the RRG integrate claims, legal, and underwriting expertise into its internal management team? An integrated internal management team is more effective and convenient to work with than outsourced management service providers.

Barton L. Post, Esquire, a veteran malpractice defense attorney, is a founder of the reinsurance-backed risk retention group, Professional Risk Retention Group, Inc

Lawrence Kessel, MD, is a primary care physician practicing in Philadelphia, where he is the managing partner of an internal medicine/geriatric medicine practice group

James Judd, MD, is a primary care physician practicing in Hatboro, where he is the managing partner of Hatboro Medical Associates. ■

Interested in representing cardiology on a Pennsylvania Medical Society council or commission?



Contact

Maria Elias, PaACC Chapter Administrator,
prior to June 5, 2003
for more information on the nomination process.

Call 888-633-5784 x1475 or e-mail
melias@pamedsoc.org

The Pennsylvania Chapter of the American College of Cardiology

EXECUTIVE COUNCIL

President

Howard C. Herrmann, MD, FACC
Philadelphia
(215) 662-2180

Vice-President

Joseph G. Cacchione, MD, FACC
Erie
(814) 453-7767

Secretary/Treasurer

Michael D. Ezekowitz, MD, FACC
Philadelphia
(215) 762-8397

Governor-Elect—East

Steven M. Ettinger, MD, FACC
Hershey
(717) 531-7457

Governor-Elect—West

A.J. Conrad Smith, MD, FACC
Pittsburgh
(412) 647-6136

Past Governor—East

James G. Kitchen, III, MD, FACC
Wynnewood
(610) 649-7625

Past Governor—West

Alan H. Gradman, MD, FACC
Pittsburgh
(412) 578-6934

COUNCILORS

District I

Ancil A. Jones, MD, FACC
Upland
(610) 876-2400

District II

Steven M. Ettinger, MD, FACC
Hershey
(717) 531-3907

District III

Jack E. Smith, MD, FACC
Erie
(814) 453-7767

District IV

John S. Wilson, MD, FACC
Pittsburgh
(412) 321-7500

Medicare Carrier Advisory Committee

Donald Durbeck, MD, FACC, Primary
Harrisburg
(717) 782-5737

David L. Scher, MD, FACC, Alternate
Harrisburg
(717) 920-4458

The Pennsylvania Chapter of the ACC Celebrates an Anniversary

The ACC recognized the Pennsylvania Chapter's 15th Anniversary at this year's chapter reception. The annual chapter reception was held jointly this year in Chicago with Indiana, Ohio, and West Virginia.



Chapter Recognition Awards

A current and a past chapter leader received recognition at the April Chapter Meeting/Legislative Conference in Harrisburg.



Dr. Joseph G. Cacchione was recognized for his service, dedication and leadership during his term as Western Governor and Chapter President, 2001-2002.

Dr. Charles A. Laubach, Jr., Danville, was recognized for his long-standing contributions to Pennsylvania cardiology. A past chapter leader, Dr. Laubach also served as the cardiology representative to the Interspecialty Section of the Pennsylvania Medical Society and has been active with the PaACC Government Relations Committee for many years.



PENNDOT Medical Advisory Board Opportunity

PENNDOT is seeking a Pennsylvania Cardiologist for their Medical Advisory Board which consists of 13 professionals appointed by PENNDOT's Secretary of Transportation—5 from state government and 8 from various medical practices/disciplines.

The eight medical practitioners come from a wide range of practicing specialties. They include: one cardiologist, one neurologist, one optometrist, one ophthalmologist, one orthopedic surgeon, one doctor of internal medicine, one family practitioner, and one psychiatrist. This diverse panel gives the Medical Advisory Board a wide range of opinions to consider when formulating or amending regulations that apply to the general public with respect to minimum health requirements that all drivers must meet.

The five state government employees on the board include a representative from the Bureau of Driver Licensing, one from the Department of Justice, one from the Governor's Council on Drug and Alcohol Abuse, another from the Department of Health, and finally, a representative from the Pennsylvania State Police.

The Board meets typically once every two or three years, at the discretion of PENNDOT's Bureau of Driver Licensing, to review the regulations and to decide if any amendments to them are necessary. They establish the physical and mental (including vision) requirements relating to the licensing of drivers in the Commonwealth of Pennsylvania.

Board members are sometimes asked to proffer their medical opinions on specific cases throughout the course of the contract year. Often,

these cases only require a few minutes to read, evaluate, and render a decision of the driver's competency.

Each Board physician is given a contract to sign to cover his/her expenses incurred throughout the contract year; it basically works as a blanket purchase order, against which the physician can bill his/her expenses.

Physicians on the Medical Advisory Board, as well as those who report patients to PENNDOT, are immune from civil and/or criminal liability as a result of their participation in the physician reporting program.

If you are interested in this position, please contact:

Mr. J.P. Duvall, Manager
Driver Qualifications Section
PENNDOT
Bureau of Driver Licensing
jeduvall@state.pa.us
(717) 783-4534 ■

Attention PaACG District I (SE PA) and District IV (SW PA) Chapter Members

District Councilor Elections

Watch your mail this summer for an election ballot to elect a new District Councilor for your District

The Chapter thanks the two out-going District Councilors
Dr. Ancil Jones and **Dr. John Wilson**
for their service
representing district members
for two consecutive two-year terms



COMMITTEES

Payor Relations Committee

David L. Scher, MD, FACC
Chair, Harrisburg

D. Lynn Morris, MD, FACC
Vice-Chair, Philadelphia

James Blankenship, MD, FACC
Danville

Ancil Jones, MD, FACC
Upland

Bindukumar Kansupada, MD, FACC
Langhorne

Victoria Vetter, MD, FACC
Philadelphia

Expert Panel Members

Education/Communications Committee

William A. Van Decker, MD, FACC
Chair, Philadelphia

David Callans, MD, FACC
Philadelphia

Leroy Moore, MD, FACC
Pittsburgh

D. Lynn Morris, MD, FACC
Allentown

Leslie Poor, MD, FACC
Ridley Park

Saul Silver, MD, FACC
Pittsburgh

Mark Turco, MD, FACC
Doylestown

John Wilson, MD
Pittsburgh

Government Relations Committee

Steven Ettinger, MD, FACC
Chair, Hershey

Joseph G. Cacchione, MD, FACC
Erie

Paul Coady, MD, FACC
Wynnewood

Jonathan Gold, MD, FACC
Langhorne

Lee Konecke, MD, FACC
Norristown

Charles Laubach, Jr., MD, FACC
Danville

James Lynch, MD, FACC
Reading

Gerald Naccarelli, MD, FACC
Hershey

Michael Rossi, MD, FACC
Allentown

C. Richard Schott, MD, FACC
Media

Nominations Committee

Steven Ettinger, MD, FACC
Chair, Hershey

Leonard Ganz, MD, FACC
Pittsburgh

Paul Casale, MD, FACC
Lancaster

William Follansbee, MD, FACC
Pittsburgh

Alan Gradman, MD, FACC
Pittsburgh

James Kitchen, III, MD, FACC
Wynnewood

Michael Rossi, MD, FACC
Allentown



Pennsylvania CHAPTER

777 East Park Drive
PO Box 8820
Harrisburg, PA 17105-8820

PRSRT STD
U.S. POSTAGE
PAID
HARRISBURG PA
PERMIT NO. 922

Code Blue Demonstration

More than 3,000 physicians, patients, and medical personnel demonstrated their unity and support for medical liability reform on May 6 at the State Society's Code Blue Emergency event in Harrisburg. The PaACC was one of more than 150 organizations which supported the "We Are United" pledge document that was delivered to state legislators.

