

LEHIGH COUNTY

# Health & Medicine

Official Publication of The Lehigh County Medical Society



## healthy SWIMMING

PG 14

### BOXING

*Keeps Parkinson's  
Patients Stickin'  
and Movin'*

### LEHIGH VALLEY FRESH FOOD BUCKS

*Helping More Families  
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*Proposed Changes to  
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AT THE PENNSYLVANIA MEDICAL SOCIETY

Welcome to the summer issue of *Lehigh County Health and Medicine*. It's hard to believe that summer is finally here after such a cold and rainy spring. We are focusing on some seasonal topics in this issue, including pool safety. Take a read; some of what you learn may surprise you. And make sure the people who run the pool read this too!

You'll find an interesting article on Parkinson's disease. Millions of people suffer from this disease, but you might be surprised at the type of activity that is aiding many patients. There also is an article on regenerative medicine. This relatively new aspect to orthopedics is fascinating and there is a lot of great information in this piece. You'll want to read more.

You may have heard the term Physician Engagement, and as a patient you probably look for that in your doctor. Learn more about it in the article "Why physician engagement is the key to better health care and how to improve it." The topic is broader than we realize. It segues into another piece on "Why it's important to remove the sutures you place."

In our efforts to cover important, health related topics in our community, we have an article on The United Way of the Greater Lehigh Valley. Did you know that one in ten people in the area, and one in four children, don't have steady access to enough food for an active, healthy life? The United Way, along with several other local institutions – such as our health networks – are trying to cut these numbers in half. Find out more inside this issue.

We hope that you enjoy the magazine and find it both educational and relevant to your interests. If you wish to see past issues, they can be found at <https://lcmcdsoc.org/our-publication>.

As always, we hope you will enjoy reading our magazine! We will see you again in the fall.+



BY PETER THOMAS, DO  
Director of Trauma, St. Luke's University  
Health Network

**U**ncontrolled bleeding accounts for approximately one-third of trauma-related deaths worldwide with the majority of those deaths, occurring within the first 48 hours. In fact, uncontrolled bleeding is the number one cause of preventable death from trauma. There's no doubt that quick thinking and quick action in the event of any kind of trauma, especially bleeding, can save lives, so it's important for everyone to know how.

Stop the Bleed (STB) is one of the country's newest public health campaigns. Its mission is to educate and train first responders, medical personnel and the general public about the importance of bleeding control in trauma situations. First responders often take an average of 7-10 minutes to arrive, so it's imperative for bystanders to know how to control bleeding since they are often first on the scene.

The Stop the Bleed initiative has its roots in the Sandy Hook school shooting that sadly took the lives of so many children and staff. Teachers and school personnel simply didn't have the training and equipment to help the wounded. Unfortunately, mass shootings and terrorist attacks have become a frequent

occurrence in this country, so Stop the Bleed was started to train bystanders, medical professionals, law enforcement, fire, rescue and EMS teams to help make a significant difference in these terrifying situations.

While traditional first aid kits and AEDS are certainly vital in emergency situations, Stop the Bleed training focuses primarily on bleeding. When we train lay people or community organizations, we try to keep things as simple as possible so they can recall what they've learned if they are ever involved in these highly stressful and tragic situations. We break it down by A, B, C...

- A - ALERT - Call 9-1-1**
- B - BLEED - Find the bleeding injury**
- C - COMPRESS - Apply pressure to stop the bleeding**

The one-hour training includes a 30-minute presentation from a certified Stop the Bleed trainer and a 30-minute hands-on training to teach participants how to place a tourniquet and pack a wound. Our goal is to partner with schools, community

organizations and places of worship as well as EMS, police and fire departments, so that as many people as possible are trained and equipped in Stop the Bleed. Individuals can also attend St. Luke's Stop the Bleed training, held monthly at St. Luke's University Hospital in Bethlehem.

There are many examples throughout the country of how bleeding control after trauma works and has saved lives. One local example is Pennsylvania State Police Corporal Seth Kelly, who was involved in a routine traffic stop when gunfire erupted. Corporal Kelly sustained multiple wounds, including one to his leg. He was equipped with a tourniquet and was able to apply it to stop the bleeding and save his own life until he was transported to St. Luke's University Hospital for definitive treatment.

In the last 20 years, there have been two million traumatic deaths in the U. S., and it is estimated that over half a million of those deaths could have been prevented with proper bleeding-control training and equipment. No one should die from uncontrolled bleeding. +

# ShareCare



**MISSION STATEMENT:**

ShareCare Faith in Action provides free volunteer services to elderly or disabled persons in order to enhance quality of life.



ShareCare provides transportation services at no cost to older adults in the Lehigh Valley. The adults receiving services are transported to and from medical appointments, social events, grocery shopping, non-grocery shopping, personal care appointments, pharmacy, and other locations. These services are made available to customers that have been evaluated and assessed. Trained volunteer drivers from local faith organizations and the community at large provide all transportation services in their privately owned automobiles. They are trained to provide personal, safe, and secure assistance.

Volunteers provide more than basic transportation, they become companions. For example, when transporting a frail or disabled older adult to a medical appointment, the volunteer is available to go into the building with the customer, assist them in locating the office, and stay with them until called for their appointment. After the completion of the appointment, the customer is escorted back to the car and driven home. Volunteers take customers grocery shopping and will assist in

locating groceries, bagging the groceries and making sure the groceries are taken into the home. Also, transportation can be provided to social events where the volunteer is a companion and as a result volunteer/customer relationships build. The volunteer can stay with them and give them gentle assistance and social support.

As part of the grocery shopping program volunteers will also go shopping for the customer. There are customers who cannot physically walk or navigate through a grocery store.

As part of the other services, program volunteers will help with visitation, chores, Canine Caregivers® program, and respite care. The coordinator who coordinates the above services also helps with our Spanish speaking clients who may need transportation, grocery shopping and other services. She is bi-lingual.

All services are provided at no cost to customers regardless of their income status. However, we do prioritize low income individuals needing

medical appointments. It is recognized that all older adults need to be connected socially to the community in order to maintain a healthy and fulfilling life. +

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# WHY PHYSICIAN ENGAGEMENT

is the key to better health care and how to improve it

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BY NICOLE SULLY, DO  
Associate Medical Director of Quality,  
Valley Preferred

“Engage” has become a buzzword in 21st century communications. It’s one of those all-encompassing words that as a verb elicits synonyms such as attract, involve, interlock, and hold the attention of, among others. As an adjective, it has become perhaps the most important word in the language when describing parents, employees, and especially doctors. In this respect, engaged means “to be committed to or supportive of a cause.”

Based on this definition, it’s not difficult to understand that patients, hospitals, peers, and health care leaders would prefer engaged physicians over those who are not engaged in their work.

## THE RIPPLE EFFECT OF COMMITMENT TO QUALITY

Patients can tell immediately whether their doctor is listening and if they truly care about their condition or situation. For health care leaders and hospitals, focusing on engagement is a matter of quality and also profitability, as caring, committed physicians turn out to be much more productive than their less involved counterparts. In a 2015 Gallup® study at one hospital system, physicians rated as “engaged” or “fully engaged” delivered an average of 51 percent more inpatient referrals than those who were not engaged. Results of the study showed that the most engaged physicians were 26 percent more productive than the others, and each one accounted for an average of \$460,000 more in patient revenue per year.

Building on this idea, engagement has been shown to contribute to overall organizational performance. For that reason, it becomes vital as the very structure of health care undergoes a dramatic evolution. Physician performance is increasingly tied to reimbursement from payers. Physicians who are engaged in their work are more resilient and determined when it comes to change and can be the make-or-break factor in a health care system's quality of care and value for patients.

### GETTING TO THE HEART OF DISENGAGEMENT

Lots of attention in the last few years has been directed to physician burnout, or as some would prefer to characterize “moral injury.” Provider health is at risk across the country as clinicians express frustration with administrative overload, lack of autonomy, and reduced interaction with patients and peers. This kind of frustration has impacted physician engagement.

Now that physician well-being has surfaced as a concern, conscientious leaders at health care systems and PHOs are working on ways to mitigate the problem. While moral injury is not the only cause underlying disengagement, it certainly is a major contributor. According to Gallup®, the following four elements have been identified as critical factors of physician engagement. As you can see, they incorporate many of the same issues that have caused clinicians to feel burned out while practicing medicine today.

**Personal well-being:** Focuses on work/life balance and programs that can promote healthy living

**Communication and support:** Relates to communication across the system, and getting the staffing support physicians need

**Scheduling and workload:** Time available for clinical practice and research, as well as having control over their own schedules

**Involvement with leadership:** Speaks to whether physicians feel they play a part in decision-making related to clinical and administrative policies

### THE DRIVE POTENTIAL OF DATA AND INCENTIVES

In any conversation about turning the tide on physician disengagement, two factors rise to the top. The first is data. At the core, physicians are scientists and always appreciate seeing the data behind a decision or why leadership may be making a certain request. There is also power in the numbers related to a physician's performance, particularly when comparing the results with that of their peers. This information is available through the kind of advanced health care analytics available today.

Delivering insightful data directly to providers can have a highly motivating effect, since the data can be used to track patient outcomes and performance with the payers. This is why organizations who are more successful at increasing physician engagement are working together with an analytics provider to keep physicians informed about their performance metrics, their patient outcomes, their episode costs, and overall trends.

Another powerful weapon for stimulating engagement is financial incentives. This is not just a bonus. Effective incentives are structured in a way that aligns with an organization's overall goals for cost-effective care and quality outcomes. Such programs should start with clearly defined, measurable, and trackable (analytics again) metrics. To encourage the switch to value-based incentives, the metrics should be aligned with value-based contracts. Appropriately, higher performing providers should earn higher rewards.

### WHAT DOES A SUCCESSFUL MODEL OF PHYSICIAN ENGAGEMENT LOOK LIKE?

Improving physician engagement involves not just one but many entities. Like all successful organizational endeavors, a physician engagement strategy starts at the top—with CEOs, presidents, and leaders—who understand the importance of the physician voice and its vitality as part of the structure of the organization.

From there, a hospital or PHO needs to have strong leadership: individuals who are not just clinical proponents, but those who can pool their collective knowledge in the areas of health care finance, population health strategies, quality management, and health care technology.

These leaders should be onboard with creating opportunities for physicians themselves, so they can contribute and feel as though they are a valued part of the organization. By including physicians' ideas and addressing their concerns, the physicians will regain the autonomy they yearn for, thus hopefully making them more productive in their work.

Providing educational opportunities for physicians and allowing them to express their point of view are priorities as well. Staying abreast of organizational policies, changes driving the industry, and medical news enables physicians to be more effective providers. Avoiding meetings that are podium-based, but instead opting for interactive sessions allows physicians to have time to express their thoughts and offer input. To this, add the motivation of a structured incentive program and the insight provided by analytics data and you have the basic components of a good physician engagement strategy. Having engaged physicians will revitalize providers, thus leading to better patient care/satisfaction, quality outcomes and performance in the value-based contracts.

The ability to envision and implement this is more important now than ever. Experts contend that the organizations who are likely to succeed in a fee-for-value health care system are those who have prioritized this issue and placed time, energy, and effort into the engagement and well-being of their physicians. +

*Nicole Sully, DO, Associate Medical Director of Quality, Valley Preferred*

*Dr. Sully is a family medicine physician practicing at Parkland Family Health Center, Schnecksville, Pa. As Valley Preferred's Associate Medical Director of Quality, she oversees the Achieving Clinical Excellence® (ACE) program, which incentivizes physicians for meeting performance and quality measures aligned with contracted payers and Valley Preferred goals.*

#### ABOUT VALLEY PREFERRED

*Valley Preferred is a clinician-led Preferred Provider Organization (PPO) formed in 1993 by Lehigh Valley Health Network and the Greater Lehigh Valley Independent Practice Association, Inc. The organization is dedicated to supporting member physicians through education, collaboration, analytics, and with financial incentives tied to quality measures through the Achieving Clinical Excellence® (ACE) physician incentive program. Valley Preferred continues to develop and implement innovative programs and form relationships to improve health care delivery and increase health care value across the region. Visit valleypreferred.com to learn more.*



# BOXING

## KEEPS PARKINSON'S PATIENTS STICKIN' AND MOVIN'

BY DORI BILLOWITCH, PTA

Each year, about 60,000 people in the United States are diagnosed with Parkinson's disease, a neurodegenerative disease that has no cure. About 10 million people worldwide — including an estimated 1 million Americans — are currently diagnosed and living with the disease.

Its cause remains unknown. The disease's symptoms include shaking or tremors while at rest, shuffling gait, balance instability, slowed movements and stiff or rigid arms, legs or trunk. Aside from the physical symptoms, a Parkinson's diagnosis can lead to feelings of isolation. Those diagnosed can fear being seen in public because of their physical symptoms. Or, they are worried about falling.

Research shows that high intensity, whole-body exercise like boxing can slow the disease's progression, lessen the symptoms, pull people out of their comfort zone and offer a fun, social, team-like setting. The very nature of non-contact boxing, which has been identified as one of the world's most well-rounded exercises, offers Parkinson's patients a challenging workout to help with:

**BALANCE**  
**WALKING FOR DISTANCE**  
**STRENGTH TRAINING**  
**HAND-EYE COORDINATION**  
**CORE**  
**STRETCHING**

Non-contact boxing covers a variety of activities or exercises that can be more challenging for someone diagnosed with Parkinson's, such as putting on and using gloves, hitting a variety of targets or performing calisthenics. Boxing also can help with practicing large, sweeping, exaggerated movements in arms and legs. This is helpful to those who suffer from Parkinson's since they often make smaller, inward movements with their hands, arms, legs and feet due to fear of falling.

Other boxing training methods include using a Hula hoop to address potential back stiffness commonly associated with Parkinson's disease. When the Hula hoop falls to the floor, it's an effective way to practice picking items up. Also, boxers learn how to fall properly using techniques that can help prevent serious injury.

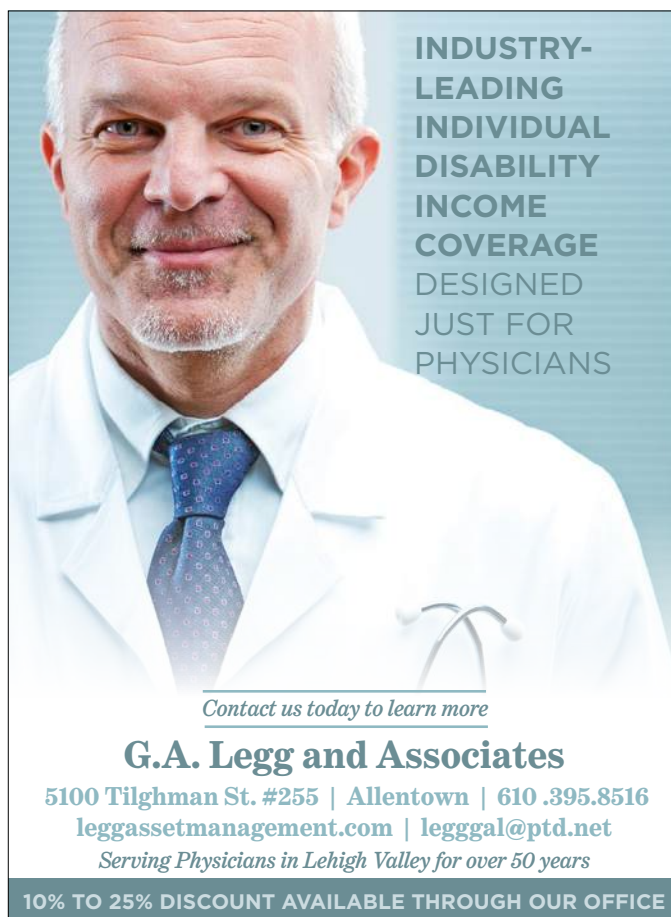
Since 2016, individuals with Parkinson's disease have participated in Good Shepherd Rehabilitation Network's twice-a-week boxing program, which follows the teachings of the U.S.-based Rock Steady Program. Patients must be referred and screened for participation in the program for safety and baseline measurements. Workouts

are tailored to each participant's needs, whether they're fairly independent or require wheelchair assistance. Rock Steady-certified coaches share workout ideas on an internet message board to keep exercises fresh, challenging and impactful.

Aside from positive outcomes in walking speed, reaction time and other measurements, a boxing workout provides other benefits to Parkinson's patients. For one, exercising in a group creates a strong sense of camaraderie, which can chip away at those feelings of isolation. People get out, get moving and they enjoy it. The activity leads to positive attitudes, which also play a key role in continuing to slow the disease's progression.

Thanks to exercise programs like boxing, patients can feel like they control Parkinson's disease, rather than the other way around. +

*Dori Billowitch, PTA, works in outpatient neurorehabilitation at Good Shepherd's Health & Technology Center in Allentown, and is coordinator of Good Shepherd's Rock Steady Boxing program. She specializes in caring for patients who have suffered or are suffering from a neurological disease, such as Parkinson's disease, traumatic brain injury, stroke and spinal cord injury.*



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# healthy swimming

BY DANIEL BOWMAN

Registered Sanitarian, Allentown Health Bureau

**C**hlorine kills everything instantly! At least this is what I was led to believe as a kid. My two sisters and I were encouraged to jump into the pool immediately after using that dreaded public restroom. Before I started working in public health this is what I believed. Those waters could wash away a multitude of sins. Now I know better.

I spent many years of my life blissfully ignorant to what really goes on in the pool. I believe that many people suffer from this same ignorance. From diarrhea to skin rashes, recreational water illnesses (RWIs) come in many varieties.



Diarrheal RWIs are of particular concern. It has been estimated that on average a person has about 0.14 grams of feces on their buttocks. These feces can wash off the person and enter the water at an aquatic venue. If an individual is or has recently been sick, they may be shedding millions of pathogens in their stool. Cryptosporidium may be shed in the stool of an infected individual for up to two weeks after symptoms resolve. Ingestion of this contaminated water (generally accidental) can cause illness in others.

Some pathogens are readily killed by chlorine. Two notable exceptions are the pathogenic parasites giardia and cryptosporidium. Both appear in the top ten list of RWIs. Giardia can survive for up to 45 minutes even in a properly chlorinated aquatic venue. The parasite cryptosporidium, encased in a tough protective shell, can survive for days. It is little wonder that it is #1 on the top ten list of RWIs:

**TABLE 1: RANKING CAUSES OF RECREATIONAL WATER ILLNESSES**

RANK	PATHOGEN	PATHOGEN TYPE	MODE
1	Cryptosporidium	Parasite	Gastrointestinal
2	Pseudomonas	Bacteria	Dermal
3	Shigella	Bacteria	Gastrointestinal
4	Legionella	Bacteria	Respiratory
5	Norovirus	Virus	Gastrointestinal
6	E. Coli	Bacteria	Gastrointestinal
7	Giardia	Parasite	Gastrointestinal
8	Disinfection agents and their byproducts	N/A	Various
9	Avian schistosome	Parasite	Dermal
10	Leptospira	Bacteria	Various

This underlines the need for the proper operation of aquatic venues, an important aspect of which is the exclusion of ill and recently ill individuals from the venue. Additionally, disinfectant and pH levels must be maintained in the acceptable range and filtration must be operational. Where Pennsylvania’s Public Bathing Place Law is the regulation of authority, the free chlorine residual in a pool or spa must be maintained at or above 0.4 ppm and the pH must be maintained between 7.2 and 8.2. The turnover period (the amount of time it takes

for a volume of water equal to the volume of the pool to be passed through the filtration system) may not exceed 8 hours for swimming pools and 2 hours for wading pools.

If a county or municipality has adopted its own local ordinance, these values may be more restrictive. In 2007, two large outbreaks and five smaller outbreaks resulted in 136 identified cases of cryptosporidium in Montgomery County, PA. The Pennsylvania Department of Health released their updated “Public Swimming and Bathing Places Operational and Biological Contamination Protocol Recommendations,” in part, to address cryptosporidium concerns. Montgomery County passed a local ordinance which is more stringent than Pennsylvania’s Public Swimming and Bathing Places Law. Check with your county or municipality to see if there is a local ordinance in place.

The Model Aquatic Health Code (MAHC), the result of a collaboration led by the CDC between public health, the aquatics sector, and academic partners from across the United States, is a good reference for information on proper aquatic venue operation. The information found in the MAHC is current and represents the latest in scientific research and best practices. According to the MAHC, the free chlorine residual (parts per million) in an aquatic venue should be maintained between 1.0 and 10.0 ppm (2.0 and 10.0 ppm if a chlorine stabilizer is used) and 3.0 to 10.0 ppm if the aquatic venue is a spa. The pH should be maintained between 7.2 and 7.8. The MAHC recommended turnover periods vary greatly by aquatic venue type, but none is longer than six hours.

Some aquatic venues use bromine instead of chlorine as the primary disinfectant. According to the MAHC, bromine concentrations in an aquatic venue should be maintained between 3.0 and 8.0 ppm and 4.0 to 8.0ppm if the aquatic venue is a spa. Additionally, aquatic venues may also employ a form of secondary disinfection. Some examples of secondary disinfection are UV light, ozone and copper/silver ions.

There are other popular places to cool off in the summer. Many individuals swim in natural bodies of water such as oceans, lakes and

*Continued on page 16*

# Country Club Style Living Dellhaven



**BUCKS COUNTY/LEHIGH VALLEY**

This 18th-century Manor home (additions in 1986 and 2006) preserves history with modern amenities. Residence: 5 bedrooms, 6+ baths, a massive entertainment wing with bar/custom theater, & gym w/pool. Outdoors: tennis court & pool. Bank barn has 8-car garages and a 2-BR, 2-bath apartment. 24+ private acres with views and a country club lifestyle.



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## FEATURE

rivers. Natural bodies of water can be contaminated by surface runoff and sewage discharge. Before swimming in a natural body of water it is important to know the water quality. The PA Department of Conservation and Natural Resources, as well as some local health departments, regulates and tests natural bodies of water where established bathing beaches are located. Because the water cannot be disinfected, the level of e. coli present is used as the determining factor for bather safety. In Pennsylvania, 235 colony forming units per 100 milliliters or more will trigger a contamination warning to bathers or closure of the bathing beach. It is not recommended to swim in water of unknown quality. Information on beach water quality monitoring can be found on the EPA's website at <https://www.epa.gov/beaches>.

Swimming is an enjoyable activity for many and there are numerous health benefits. Avoidance of aquatic venues should not be the solution to RWI outbreaks. Instead the public must insist that the managers of aquatic venues operate them in a safe and responsible manner, in compliance with all applicable laws. Additionally, in areas where science is advancing faster than laws are updated, it is important that operators take it upon themselves to follow current best practices so long as they are not in direct contradiction to existing law.

## THE FOLLOWING ARE A FEW SUGGESTIONS TO HAVE A SAFE AND ENJOYABLE EXPERIENCE WHEN SWIMMING:

- Do not swim when ill or recently ill.
- Do not swim for 14 days after having symptoms of diarrhea.
- Shower prior to entering the pool.
- The bottom of the pool should be clearly visible.
- The drain covers should be securely attached.
- The filtration system should be operational.
- The pH should be in range.
- The free chlorine or bromine level should be in range.
- Take note of whether a lifeguard is present. Never swim alone.
- Enjoy your swimming season safely! +

### Sources:

- <https://www.cdc.gov/healthywater/swimming/index.html>
- <https://www.cdc.gov/mabcl/index.html>
- [https://www.pacode.com/secure/data/028/chapter18/028\\_0018.pdf](https://www.pacode.com/secure/data/028/chapter18/028_0018.pdf)
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# Lehigh Valley Fresh Food Bucks

*Helping more families buy fresh, healthy food*

BY LAURA MCHUGH  
United Way of the Greater Lehigh Valley

**C**ould you feed a family of four with \$21 a day? It's a challenge approximately 1.8 million Pennsylvanians will face this year as users of SNAP – the Supplemental Nutrition Assistance Program operated by the U.S. Department of Agriculture and formerly known as food stamps. In Pennsylvania, more than 695,000 children rely on SNAP along with more than 184,000 older adults. The maximum monthly benefit for a family of four is \$642, which breaks down to about \$160 a week or \$21 a day.

So, how can we encourage these seniors and families on limited incomes to eat locally grown, nutrient dense produce? With Lehigh Valley Fresh Food Bucks.

“Helping more families buy fresh, healthy food from local farmers is a simple, yet powerful idea. Lehigh Valley Fresh Food Bucks provides matching funds for people using SNAP benefits to buy more locally grown fruits and vegetables at farmers markets, farm stands, mobile markets, neighborhood corner stores and other retail locations,” said Allison Czapp, Director of Buy Fresh Buy Local of the Greater Lehigh Valley, which manages the incentive program.

“Buying local ensures customers are getting the freshest, most nutritionally dense produce, while also keeping their food dollars local and supporting family farms,” she added. “The program also

*Continued on page 18*

## FEATURE

works toward creating food equity in the Lehigh Valley.”

Supported by United Way of the Greater Lehigh Valley, the program matches what SNAP recipients spend with free Lehigh Valley Fresh Food Bucks to buy fresh and local produce up to \$10 a day.

In the Lehigh Valley, United Way reports that one in ten people are food insecure, and one in four of them are children.

“That means they don’t have consistent access to enough food for an active, healthy life,” said Priscilla Rosado, Assistant Director of Food Access and Emergency Services for United Way of the Greater Lehigh Valley.

“Our goal with our partners is to cut that number in half by 2022. Through our work with the Lehigh Valley Food Policy Council, we envision a community where all residents of the

Lehigh Valley eat healthy and nutritious local food for a strengthened local economy. Incentive programs, such as Lehigh Valley Fresh Food Bucks, are a key strategy to help us achieve that goal. They work to make healthy food affordable and accessible to everyone,” added Rosado.

Buy Fresh Buy Local launched the incentive program, then known as Double SNAP, in 2015 with funding from the U.S. Department of Agriculture, United Way of the Greater Lehigh Valley and Northampton County. Since then, they’ve partnered with the Lehigh Valley Health Network, St. Luke’s University Health Network, the Kellyn Foundation, the Greater Easton Development Partnership and the Lehigh Valley Community Foundation to expand to more than 30 locations in Lehigh and Northampton counties.

All locations provide Fresh Food Bucks that shoppers can use immediately. Some farmers’ markets use a token system, but many locations

apply Fresh Food Bucks at check out.

“We strongly support and recommend this program. Educating about healthy lifestyle choices is important, but it is also crucial to remove barriers that prevent residents from accessing affordable, nutrient dense produce,” remarked Meagan L. Grega, M.D., and Eric Ruth, Co-Founders of Kellyn Foundation, which accepts Lehigh Valley Fresh Food Bucks at its travelling Eat Real Food Mobile Market.

“Lehigh Valley Fresh Food Bucks not only provides community members with the freshest, most nutritionally dense food available, it also creates additional revenue channels for our local farmers and keeps more money circulating in our local economy,” said Rosado. “It’s a win-win.”



For more information, including a full list of locations, visit [lfreshfoodbucks.org](http://lfreshfoodbucks.org).



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# DOES VENUE MATTER IN MEDICAL MALPRACTICE CASES?

## EXPLORING THE “PHILADELPHIA EFFECT”

BY JAMES MIRANDA, MD, GERALD WYDRO, MD, JOHN SCHROEDER, DO,  
Department of Emergency Medicine, Jefferson Health Northeast

### INTRODUCTION

The risk of medical malpractice litigation is an area of significant concern for physicians, hospitals and health care systems. It results in significant economic and non-economic costs to the health care system. Although most cases are settled or otherwise dispositioned via arbitration, mediation, or even dropped, prior to trial, some cases proceed through the legal system and are ultimately decided by jury. This study seeks to explore whether a certain venue, Philadelphia, is less favorable to defendants in terms of likelihood of the verdict and in the case of a plaintiff verdict, whether dollar amounts awarded to plaintiffs are higher.

Under current state law in Pennsylvania, a malpractice case must be filed in the county where the alleged malpractice occurred. A proposal by the Civil Procedural Rules Committee of the Pennsylvania Supreme Court to change Act 27-2002 would allow a broad selection of venue for medical malpractice cases. The proposed change would allow the filing of a lawsuit in any county where the health care provider regularly does business. This has caused much concern among physicians and health systems, as it is widely believed that certain venues are less favorable to health providers and more favorable to plaintiff attorneys. It is a reasonable hypothesis that this will result in more cases being filed in plaintiff-friendly courts, and prompt more case filing, resulting in higher payouts and increased medical malpractice premiums. This study reviews publicly available data from the Pennsylvania state website (<http://www.pacourts.us/news-and-statistics/research-and-statistics/>) and evaluates the extent of disparities for verdicts and awards between Philadelphia County, which is believed to be plaintiff-friendly, and the rest of Pennsylvania cases that go to trial.

### METHOD

Data from the Pennsylvania State Courts website is publicly available in an online format and provides data from 2000-2017. It reports the number of cases filed by county, the number of cases decided by jury verdicts and ranges of awards. This data was analyzed to identify trends where cases were filed, how often a jury returned verdicts for defendants or plaintiffs, and ranges of awards in dollars for plaintiff verdicts. Odds ratios were calculated to compare the relationship between plaintiff victories in Philadelphia versus the rest of the state and to analyze potential differences in monetary awards.

### RESULTS

The number of medical malpractice cases filed in Pennsylvania from 2000 to 2017 is seen in Table 1. In 2003, the annual number of cases filed declined significantly. This coincided with the institution of Act 27-2002, which limited venue to the county in which the alleged malpractice occurred.

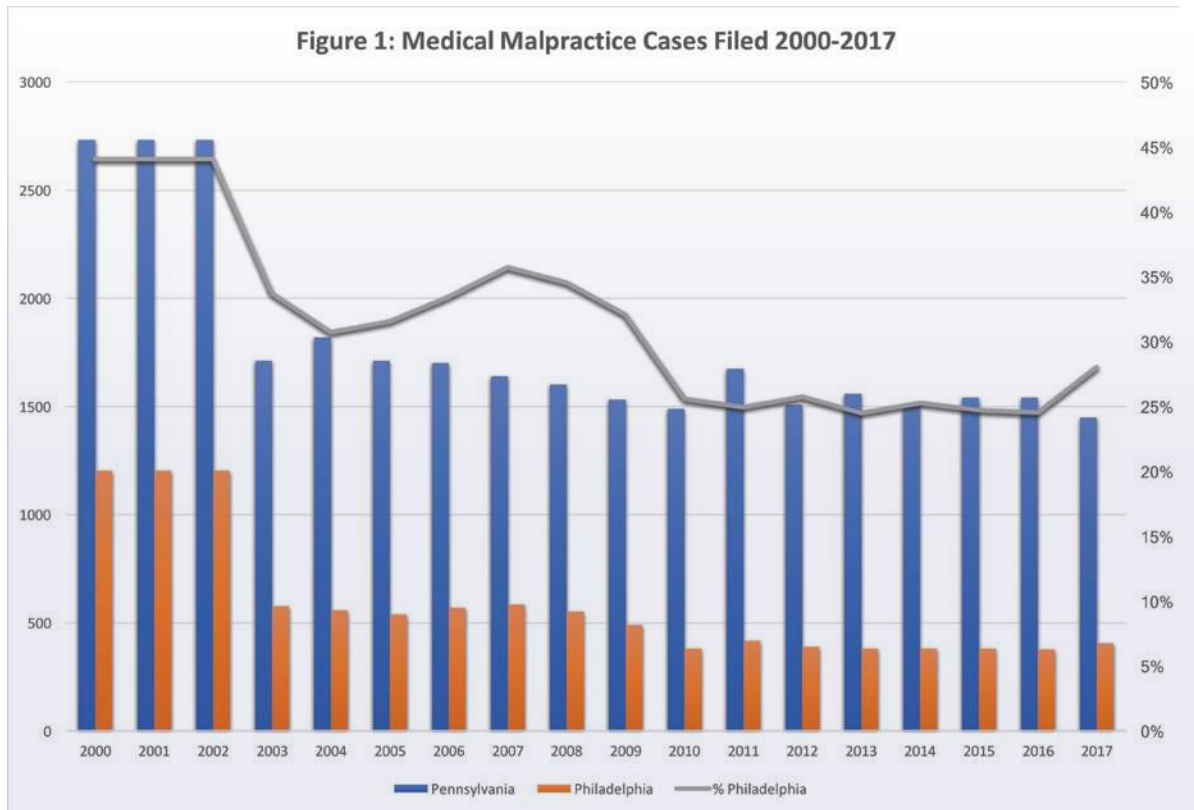
**Table 1: Malpractice Cases Filed in Pennsylvania**

	Pennsylvania	Philadelphia	% Philadelphia
2000	2,733	1,204	44%
2001	2,733	1,204	44%
2002	2,733	1,204	44%
2003	1,712	577	34%
2004	1,819	559	31%
2005	1,711	540	32%
2006	1,702	569	33%
2007	1,640	586	36%
2008	1,602	553	35%
2009	1,532	491	32%
2010	1,490	381	26%
2011	1,675	418	25%
2012	1,510	389	26%
2013	1,560	382	24%
2014	1,512	382	25%
2015	1,530	381	25%
2016	1,541	378	25%
2017	1,449	406	28%
Total	32,195	10,604	33%

\*2000-2002 based on 3-year average. Individual annual data unavailable

*Continued on page 18*

Following enactment of legislation requiring litigation to be venued in the county in which the alleged malpractice occurred, both the total number of cases filed and the percentage of total cases filed in Philadelphia County declined. The percentage of all cases filed in Philadelphia dropped from 44% in 2000-2002 to 29% in subsequent years (Figure 1).



As is the case nationally, a very small percentage of cases are decided at trial. Of the total of 32,195 medical malpractice cases filed in Pennsylvania between 2000-2017, only 3,507 or 10.9% were decided at a jury trial.

Table 2: Trials and Outcomes

	Jan 2000-Jul 2003	Annualized 1/2000-7/2003	Jul 2003-Dec 2004	Annualized 7/2003-12/2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Totals 2000-2017
PA State Total Trials	1144	326.9	449	299	223	230	185	161	154	164	110	135	110	128	102	110	102	3507
PA Total Defense Verdicts	835	238.6	352	235	179	191	153	131	131	133	78	106	85	105	80	93	81	2733
PA Total Plaintiff Verdicts	309	88.3	97	65	44	39	32	30	23	31	32	29	25	23	22	17	21	774
Philadelphia Trials	407	116.3	181	121	56	46	37	31	42	34	25	27	20	18	21	16	21	982
Philadelphia Defense Verdicts	241	68.9	123	82	35	33	27	21	33	26	14	14	11	12	13	11	13	627
Philadelphia Plaintiff Verdicts	166	47.4	58	39	21	13	10	10	9	8	11	13	9	6	8	5	8	355
Defense verdicts outside Philadelphia	594	169.7	229	153	144	158	126	110	98	107	64	92	74	93	67	82	68	2106
Plaintiff verdicts outside Philadelphia	143	40.9	39	26	23	26	22	20	14	23	21	16	16	17	14	12	13	419

\*Divided by 3.5

\*Divided by 1.5

The disposition of cases decided by jury trial is seen in Table 2.

# OVERALL, PHYSICIANS TAKING THEIR CASE TO TRIAL IN PENNSYLVANIA HAVE A GOOD CHANCE OF OBTAINING A FAVORABLE VERDICT FROM THE JURY.

## THE “PHILADELPHIA EFFECT” AT TRIAL.

Overall, physicians taking their case to trial in Pennsylvania have a good chance of obtaining a favorable verdict from the jury. In Pennsylvania from 2000-2017 out of the 3,507 cases decided by jury, 2,733 or 78% were found in favor of the defendants (i.e. the physician or health system). Figure 2 shows the results of cases decided by jury. From 2000-2017, state-wide juries outside of Philadelphia found in favor of defendants, physicians or health systems, 83% of the time. In contrast, Philadelphia juries found for the defendant only 64% of the time. Put in reverse, the plaintiff prevailed at trial 36% of the time in Philadelphia, but only 17% of the time across the rest the state. This is an increase of over 100%, and with an odds ratio of 2.84 (95% CI 2.4-3.4,  $P < 0.0001$ ).

## DOES VENUE INFLUENCE VERDICT FINANCIAL AWARDS?

Another possible effect of venue selection may be related to the amount that is awarded to the plaintiff given a verdict in favor of the plaintiff. Figure 3 shows that 29/53 and 24/41 verdicts greater than \$5 million and \$10 million occurred in Philadelphia County which is 55% and 58%, respectively. Statewide, 28% of malpractice trials in Pennsylvania from 2000-2017 occurred in Philadelphia County. Overall, the plaintiff verdicts in Philadelphia

have a higher chance of being greater than \$5 million (OR 1.61, 95% CI 1.04-2.49,  $P = 0.0310$ ).

For awards greater than \$10 million, the odds ratio is 1.71, 95% CI 0.90-3.23,  $P = 0.0993$ .

As seen in Figure 4, higher verdicts occur at greater percentages in Philadelphia County meaning that there appears to be a positive correlation between Philadelphia and large verdicts.

## CONCLUSION

There does appear to be a statistically significant “Philadelphia Effect” in malpractice cases compared to the rest of the state, indicating that venue does indeed play a role in outcomes. From 2000-2017, there was a statistically significant difference in the number of cases decided in favor of the plaintiff in Philadelphia (OR 2.84, 95% CI 2.4-3.4,  $P < 0.0001$ ). In terms of payouts, awards greater than \$5 million were more likely to occur in Philadelphia with statistical significance (OR 1.61, 95% CI 1.04-2.49,  $P = 0.0310$ ). Awards greater than \$10 million, while more likely to occur in Philadelphia, did not reach the level of statistical significance (OR 1.71, 95% CI 0.90-3.23,  $P = 0.0993$ ). The disparity in odds in terms of winning at trial and in jury awards greater than \$5 million explains why certain advocacy groups such as plaintiff attorneys fight for broader latitude in choosing where a case is adjudicated. And why physician groups and other health care entities fear that the proposed rules change would have a negative impact on access to the quality health care expected from citizens of Pennsylvania.

## LIMITATIONS

This study does not take into account the reason for alleged malpractice, specialties involved, or the number of defendants in various cases. +

1 <http://www.pacourts.us/news-and-statistics/research-and-statistics>, accessed 1/25-1/30/2019

2 Jena AB, Chandra A, Lakdawalla D, Seabury S. Outcomes of Medical Malpractice Litigation Against US Physicians. *Arch Intern Med.* 2012;172(11):892–894. doi:10.1001/archinternmed.2012.1416



# Orthobiologics *and* Cartilage Restoration

BY JAY KALAWADIA, MD  
Orthopedic Sports Medicine &  
Cartilage Restoration Surgeon  
OAA Orthopaedic Specialists,  
JILL CROSSON, DO, MBA  
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OAA Orthopaedic Specialists,  
MICHAEL KRAFczyk, MD  
Primary Care Sports Medicine  
OAA Orthopaedic Specialists

Orthobiologics, regenerative medicine, and cartilage restoration have become very exciting topics in sports medicine and orthopedics. The technology in these fields is constantly evolving and often leads to confusion, skepticism, and unfortunately false claims. As patients are beginning to inquire more and more into these treatments, the importance of physician education and staying current with evidence-based medicine is beneficial.

The term orthobiologics refers to treatments that use our body's own cells to help revitalize, heal, and/or regenerate tissue. More specifically, the term refers to platelet rich plasma (PRP) and stem cells. Both treatments can be used in a non-operative setting or to augment the results of surgery.

PRP is obtained by a venipuncture blood draw and centrifuging the blood to a platelet concentration above baseline. BMAC, or bone marrow aspirate concentration, is a procedure in which stem cells are removed from the patient's bone marrow. The posterior iliac crest is the area most commonly used due to its large reservoir of mesenchymal stem cells. In general, PRP is used to treat acute or chronic ligament injuries, tendinopathies and early arthritis (pathologies with a blood supply to promote healing). Stem cells, on the other hand, are used more often for chronic, diffuse cartilage wear where a robust blood supply does not exist. For both treatments, it is important to optimize a patient's metabolic status for the purpose of healing so checking glucose and thyroid function labs are imperative.

PRP and stem cells are considered experimental in nature by the FDA as more randomized controlled trials are needed. Standardization among clinical trials has proven to be difficult as many growth factors, cell concentration, scaffolds, and intrinsic/exogenous substances exist. Early literature demonstrates successful application. For example, a systematic review of intra-articular mesenchymal cells on knee osteoarthritis published in *Arthroscopy* in 2019<sup>1</sup> showed improvement in pain and function at about



2 years. A level 1 randomized control trial has shown PRP to be superior to trephination and/or cortisone injections for lateral epicondylitis of the elbow. Animal models have shown the ability for stem cells to regrow cartilage in the proper conditions. Further research is needed to determine efficacy and the best treatment protocols.

The most ubiquitous injectable treatment are steroid injections (i.e., triamcinolone, cortisone, dexamethasone), which can be used to help with both acute and chronic pain. However, they do not help with healing and function only as an anti-inflammatory. With repeat use, steroid injections have been shown to cause deterioration and fibrosis of soft tissue and chondrocyte damage in joints.

Regenerative medicine differs in that it provides pain relief by attempting to heal tissue, rather than mask the inflammatory cascade.

The surgical counterpart to orthobiologics is termed cartilage restoration. Surgical solutions exist for focal cartilage defects. For the complete absence of cartilage associated with high pain levels and loss of motion, there is no surgery other than a total joint replacement which will help the patient.

However, in the presence of a focal cartilage defect, several options exist. Focal cartilage defects can exist due to trauma, a sporting injury, or degeneration. For small cartilage

*Continued on page 24*

# Orthobiologics and cartilage restoration are fields of medicine that are *constantly evolving.*

defects (size of a dime or a nickel), a procedure called microfracture has existed for decades. This procedure involves drilling small holes into the bone, typically done through an arthroscopic technique. The goal is for the body to release the subchondral stem cells naturally and form a small cartilage plug over the defect. While this new cartilage plug is not entirely normal (fibrocartilage rather than articular joint cartilage), the presence of any cartilage is better than the absence thereof. The long-term results of this have been recently called into question. Previously, there were no other alternatives, but now with newer solutions, physicians are beginning to explore other options. Microfracture is still frequently performed but generally reserved for smaller defects, as it is easy to perform and can be done arthroscopically.

For mid-size defects (size of a quarter), microfracture has poor outcomes, especially long term. In these mid-sized defects, there are newer products that can be used to “plug and seal” the cartilage defect. This is analogous to filling a pothole in the road. These options termed osteochondral allografts are viable cartilage products. They have the potential to grow and form articular cartilage. These procedures require an open arthrotomy to access the defect and implant the allograft. The rehabilitation after surgery is similar to a microfracture. Early and mid-range studies are encouraging. On post-operative histologic studies, articular cartilage is seen to fill the defect. These products are constantly evolving and improving. Three such products on the market are DeNovo (Zimmer), Cartiform (Arthrex), and ProChondrix (Stryker). The advantage of these procedures is that they can

be performed in one setting as these products are readily available.

One additional option which deserves its own discussion is autologous chondrocyte implantation (ACI). This is a technique that has been widely available in Europe for several years. The technique involves a two-stage procedure. During the first surgery, a small graft of cartilage is harvested from the patient through an arthroscopic surgery in one of the non-weight bearing regions of the knee. The graft is about the size of a Tic Tac and sent to a laboratory for enzymatic degradation and cell division. After preparation is completed, a sheet of live viable cartilage on a porcine membrane is produced. These cartilage cells are living and have the DNA of the patient. In a second surgery, about one month from the first, through an open incision, this cell-impregnated membrane is secured into a prepared site over the cartilage defect. Several studies have examined this treatment option. Articular cartilage is seen to grow and fill the defect on second look arthroscopic studies as well as on post-operative histological studies. For defects involving the femoral trochlea and patella where the three-dimensional contour is different in every patient, ACI is considered the gold standard.

For larger defects, a traditional osteochondral allograft is used. The surgery has been performed for over 20 years with a very good track record. In a single surgery, the damaged cartilage and underlying bone is removed from the patient and a similar sized plug is fashioned from a fresh cadaveric specimen. Because the allograft is fresh and within 45 days of procurement, the cartilage cells are

living and viable. The prepared allograft plug is transferred into the patient. The patient's bone grows into the allograft bone, which ultimately provides fixation. This technique can be used in all the joints of the body. In years past, finding a donor of similar dimensions was problematic. However, with new three-dimensional mapping software provided by MRIs, tissue banks are now able to find donors with very similar characteristics and arcs of curvature such that the donor and recipient morphologies are one and the same.

It is important to recognize that these procedures are not intended to treat diffuse arthritis. These procedures are reserved for focal cartilage defects. There are several other factors that can preclude patients from being potential candidates. These include obesity, limb malalignment, rheumatologic disease, ligamentous instability, or meniscal insufficiency.

Except for microfracture, most of these procedures are done through a small open incision. They all roughly have the same post-operative rehabilitation. While the aforementioned paragraphs provide an introductory discussion of the various options available, there are several other factors that play a role in the decision. Not only is the size of the defect important, the depth of the cartilage defect, the quality of the underlying bone, and the location of the defect within the joint have to be taken into consideration. It is important that the treating physician individualize the treatment to best suit the needs of the patient.

Orthobiologics and cartilage restoration are fields of medicine that are constantly evolving. More research is necessary to determine how best to use these treatments to help treatment patients. At the current state of technology, judicious discussion and decision-making is necessary to select the patients who best stand to improve. We are excited to admit that the treatments of today will likely become historical discussions in the years to follow as newer techniques and treatments are developed. +



# Why it's important to **REMOVE THE SUTURES YOU PLACE**

BY JAY TALSANIA, MD

**A**s a surgeon who has been practicing for more than 20 years, I have had a front row seat to both positive and negative changes that have taken place in our evolving medical field. As a community hand surgeon who values many of the recent advances in hand surgery, there is one piece of tried-and-true advice that I still find helpful in my practice to this day: Remove your own sutures.

Removing sutures is a critical touchpoint with your patient who has just allowed you the privilege of operating on them. This is a valuable opportunity to observe the effects of your recent surgical procedure and, most importantly, to connect with your patient. The encounter lets patients know that you are concerned about their outcome. Imagine telling someone that you are not going to see them after surgery for 91 days (just outside global), or, perhaps, never after a procedure.

Many patients eagerly await their first post-operative visit as they do not remember the details from the discussion in the recovery room. Often, second-opinion patients present with complaints that they rarely saw their first surgeon. Some complain that they were booked for surgery by a mid-level provider, then after surgery all subsequent visits were with a same or different mid-level provider.

**FACE-TO-FACE COMMUNICATION WITH YOUR PATIENT IS VITAL. REMOVING YOUR OWN SUTURES IS AN EXCELLENT OPPORTUNITY TO ENSURE YOUR PATIENT IS GETTING THE CARE AND ATTENTION THEY DESERVE.**

I realize that a surgeon does not collect RVUs or extra dollars for office visits during the global period. Some may even view it as a “waste of valuable time” since someone else can do it while you’re evaluating a new patient. I think of this time as a chance to talk with my patient while providing excellent patient care, avoiding post-operative complications (most commonly swelling and stiffness), and reiterating recovery instructions and expectations. This visit fosters communication between the patient and surgeon team and sets expectations that guide the treatment pathway.

In the long run, I believe it is an oversight to not make time for this important visit. To see your patients, touch them, and speak with them helps them to experience your compassion, and encourages them to spread the word about their experience, which will help to build your practice. Removing your own sutures is in essence “marketing.” Patients want the physical touch and are eager to spend time with their surgeon, especially in the new world of EMR. +

*Jay Talsania is an orthopedic surgeon.*

# Meeting Great Expectations - your Legislative Meeting

BY LARRY LIGHT  
retired from PAMED  
Senior Vice President for Political Affairs

*Originally published in the Delaware and Lehigh County Medical Society publications, Delaware County Medicine & Health and Lehigh County Health & Medicine*

**T**he first months of 2019 have been filled with an unusually high level of political activity for a year in which only municipal elections are normally held. Generally it is a time period when first term legislators, newly elected caucus leaders and first time committee chairs are settling into their comfort zone. However, the winter and spring months of this year have instead seen an escalation of political intensity as a series of seven special elections were held to fill seven vacant legislative seats in districts across the Commonwealth.

After the May 21st date of the Pennsylvania primary election, three new State Representatives, three new State Senators and one new Congressman will have been selected and will be sworn into office. And in typical Pennsylvania political fashion of late, the reasons for several of the special elections are noteworthy. The Congressional seat of Tom Marino was vacant due to his resignation for personal reasons, while State Senators Rich Alloway and Don White resigned for the same reason. The third State Senate special election was required when Guy Reschenthaler was elected to the Congress. Things were somewhat different in the House. Special elections there were held to fill the seats of two members facing legal issues, Brian Ellis and Vanessa Lowery-Brown. There was also

a need to replace Representative Sid Michaels Kavulich who died before the 2018 General Election but was none the less re-elected to his House seat posthumously.

The result of each special election is considered an important factor in measuring the potential for a shift in the balance of political power for the respective chambers, so to the party leaders and political analysts these are critically important. Words like momentum and karma are regularly mentioned.

With those special elections in the background, Pennsylvania physicians have never had a better time to meet with their own state and federal legislators and begin the process of building a productive advocacy relationship.

Legislators at every level react to the stimuli around them and they are especially interested in hearing from their constituents. Physicians who provide health care to their constituents and who live in their district are uniquely positioned to influence health care public policy. Generally their views are both sought after and respected. A legislative “district” meeting is the best way to achieve that effect.

Legislators at both the state and federal levels soon discover that voting on legislation and enacting new laws are not the most critical elements of their job. In fact, the days they spend either in Harrisburg or Washington, DC are likely their least productive. In comparison, a day spent meeting with constituents in their district can pay significant political dividends. So while they may not eagerly anticipate a full schedule of constituent meetings, they do understand the inherent value of learning which issues are on their constituents' minds.

For the constituent, the district meeting is equally important. It presents a unique opportunity to personally discuss a key issue and advocate for or against specific legislative action in almost a "safe zone," far away from the busy schedule of a session day under the capitol dome. In fact, that makes it valuable to both the legislator and constituent alike.

## **PHYSICIANS SHOULD KNOW THAT THERE ARE A FEW COMMON SENSE PRINCIPLES TO GUIDE THEM AS THEY PREPARE FOR A SUCCESSFUL MEETING WITH THEIR LEGISLATOR:**

### **All Politics is Local**

Being a constituent from the legislator's district is important.

### **Voters are Invested**

Being a registered and regular voter, regardless of your party affiliation, is equally important.

### **Confirm the Meeting**

Once the date, time & place are set, contact the legislator's office to confirm the meeting 24-48 hours in advance. Be prepared to provide the names of those expected to attend and the primary issues to be discussed.

### **Research**

If you are discussing a specific legislative bill, go online and see if the legislator is already a sponsor or if he/she serves on the committee that may consider the bill.

### **Follow Policy**

If you are representing an organization, know their policy on the bill or issue. Enhance the discussion with your own views and insights, but don't create new policies (or problems).

### **Ignore Party Labels**

Most important legislation passes with bi-partisan support. It's not important that the legislator you visit is in the majority party, all legislators have a vote.

### **Ask, Don't Tell**

It is important to "ask" for help in addressing an issue or problem, without "telling" the legislator what he/she "must" do.

### **Questions**

If the legislator has questions, don't invent answers. Find the appropriate response and contact the office with your follow up answer.

### **Thank You**

A brief email of thanks is always appreciated. And, if you are asking for a vote for or against a bill – and the legislator makes that vote – make sure that you express your appreciation in a letter or email.

### **Staff are Important**

Meetings in either Washington, DC or Harrisburg are typically held on days when the legislator's schedule is driven by the committee meetings and voting schedule set by leadership. Having a key staffer sit in for your legislator, or having the legislator quickly stop for an introduction, actually signifies the importance of your meeting.

### **Share**

If you are representing an organization, the leaders and professional staff of the group will be anxious to hear from you following the meeting.

Keep in mind that the final basic principle is to plan a next meeting, either to follow up on your issue or to explore common ground on other health care policy matters. If the goal is to establish a relationship, then it is critical that you don't show up only for the big ask on a pending bill.

And remember that the relationship is as important for the legislator as it is for you. +

# Umbilical Cord Blood Banking

BY ELISA GIUSTO, D.O.  
Family Medicine PGY-1  
PAMPAC Resident Representative

In honor of July being Cord Blood Awareness Month, here is a brief review of the umbilical cord blood bank process in regards to hematopoietic stem cell transplantation:



Hematopoietic stem cells can be obtained from bone marrow, peripheral blood, and umbilical cord blood in order to treat leukemia, lymphoma, aplastic anemia, sickle cell anemia, and thalassemia major, among other diseases. Umbilical cord blood is obtained from the blood remaining in the umbilical cord and placenta following the birth of an infant. The advantages of using umbilical cord blood include expanded donor pool, ease of procurement, lack of need to complete human leukocyte antigen match, and decreased graft-versus-host disease. The disadvantages of using umbilical cord blood includes increased risk of graft failure, delayed immune reconstitution, limited number of stem cells, and unavailability of the donor for additional donations. There are two main types of cord blood banks that exist to store cord blood for potential future transplantation. Public cord blood banks perform collections at a limited number of hospitals and place them in a public database accessible to health care providers. Maternal blood testing is performed within seven days to screen for Hepatitis B and C, HIV, Cytomegalovirus, Syphilis, Malaria, West Nile, and Chagas disease. Some public banks also require saliva testing of the infant to screen for Cytomegalovirus as well as a six-month follow-up examination. On the other hand, private cord blood banks are for-profit enterprises that facilitate collections for families that want to pay for it and reserve it for their personal use regardless of maternal blood testing results. Regardless the type of cord blood bank, informed consent must be obtained by the infant's mother.

**THE CORD BLOOD COLLECTION PROCESS IS TO NEVER COMPROMISE THE SAFETY OF THE MOTHER OR INFANT DURING CHILDBIRTH AND CAN EITHER BE PERFORMED PRIOR TO OR FOLLOWING THE DELIVERY OF THE PLACENTA.**



Within 48 hours, cord blood units must be tested, processed, and stored for future use, but the overall process varies as it is relatively unregulated. This may soon change as the US Food and Drug Administration is now requiring donor cord blood establishments register with them, making them subject to inspection. Private banking fees vary but average \$2,000 for processing the initial specimen with a \$125 storage fee per unit per year. There is no accepted shelf life of cord blood units, but studies have shown anywhere between 12 and 23 years of storage showed minimal loss of hematopoietic progenitor cells. Given the uncertainty of this medical advancement, the American Academy of Pediatrics does not recommend that parents store their infant's umbilical cord blood unless there is an immediate medically-indicated use for a sibling. The American College of Obstetricians and Gynecologists does not recommend routine storage of umbilical cord blood as biologic insurance against possible future disease, but does support providing patients with balanced and

accurate information regarding the process if requested. Legal aspects surrounding cord blood banking is actively evolving considering it is relatively new and there continues to be unresolved ethical issues. Regardless, it is an interesting topic and one that can potentially offer great benefits to the ever-changing medical field. +

#### SOURCES:

[https://www.uptodate.com/contents/collection-and-storage-of-umbilical-cord-blood-for-hematopoietic-cell-transplantation?search=cord%20blood&source=search\\_result&selectedTitle=1-150&usage\\_type=default&display\\_rank=1](https://www.uptodate.com/contents/collection-and-storage-of-umbilical-cord-blood-for-hematopoietic-cell-transplantation?search=cord%20blood&source=search_result&selectedTitle=1-150&usage_type=default&display_rank=1)

<http://www.bonemarrowmx.com/umbilical-cord-blood-transplant/>

# PAMED to Court

*Proposed Changes to Med Liability Venue Rule Threaten Patient Care in Pennsylvania*

*Last Updated: Feb 21, 2019*

**O**n Feb. 21, 2019, the Pennsylvania Medical Society (PAMED) submitted its objections to the Civil Procedural Rules Committee's proposed amendment of rules governing venue in medical professional liability (MPL) actions.

## VIEW PAMED'S COMMENTS

In the early 2000s, Pennsylvania was losing the national competition for quality physicians due to the MPL crisis the state was experiencing at that time. And, as a result of the adverse practice climate, health care in the Commonwealth suffered. Fortunately, due to the 2003 MPL venue reform and a series of other legislative efforts, Pennsylvania recovered from the crisis and is once again a leader in the health care arena.

Regrettably, the proposed changes to the venue rule threaten to undo the positive gains the Commonwealth has made since the early 2000s by resurrecting forum shopping in MPL cases. This could result in a domino-effect of negative implications for the MPL insurance market and access to quality patient care for all Pennsylvanians—particularly in the state's rural areas.

In PAMED's 101-page comment document, we support our opposition to the proposed amendment by:

- Demonstrating the positive impact the current rule had on eliminating forum shopping in the Commonwealth;
- Underscoring the importance of the current rule in maintaining the stability of Pennsylvania's health care system; and
- Offering an analysis of the estimated impact of the proposed rule changes on MPL costs and insurance rates.

PAMED's comments also advocate for collaboration between Pennsylvania's legislative and judicial branches, as well as an open public process in the development of any new rule.

Pennsylvanians cannot afford to allow the gains realized by the 2003 MPL venue reforms to be undone by the Committee's proposed changes. Accordingly, PAMED recognizes the great importance of this issue and appreciates the opportunity to comment on the proposed amendments. +



# LCMS NEWS

## NEW MEMBERS

Yahira Acevedo-Santiago, MD (PM)  
Waqas Adeel, MD (IM)  
Saira Agarwala (Medical Student)  
Faisal Akbar, MD (IM-Resident)  
Sayed Arian (Medical Student)  
Stephanie M Bayruns, MD (Resident – IM)  
Robert Brackbill, III, DO (IM- Resident)  
Sharon Chaing (Medical Student)  
Benjamin Michael Ciccarelli (Medical Student)  
Jason L Forgeon, MD (Resident – EM)  
Kira J Galeano, MD (Resident)  
Lohit Garg, MD (Resident – CD)  
Chelsea Christine Giagni, MD (OBG- Resident)  
David C. Frame, MD (ORS-Retired)  
Daniel Scott Heckman, MD (ORS)  
Aimee Marie Johnson, MD (PD)

Roua Kahila, MD (Resident – N)  
Michal Kloska, MD (IM- Resident)  
Priyanka Lauber, DO (EM- Resident)  
Julia Leix, MD (Resident)  
Hannah Darkow Loebel, MD (GS-Resident)  
Angel Ramon Lopez, MD (Resident – GS)  
Ahmed Mahmoud Mansour, MD (Resident)

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## RE-INSTATED MEMBERS

Shoaib Mansoor, MD (Resident – NEP)  
Nikhil Mehta, MD (Resident)  
Natasha Mozumdar, MD (FM- Resident)  
Jorge Antonio Otero-Aponte, MD (PD)  
Preysi Patel, DO (Resident – IM)  
Puja Patel, DO (Resident)  
Danielle M Peters, MD (Resident)

Babak S Sadri, MD (Resident – GS)  
Jared Etan Sapin (Medical Student)  
Mahima Shah, DO (Resident – PAN)  
Emily Skutnik, DO (Resident)  
Chun Ting Siu (Medical Student)  
Melinda Q. Toney, MD (FM)  
Ayza Taimur, DO (Resident)  
M Bruce Viechnicki, MD (OBG)  
Kellen Welch, MD (Resident-CRS)  
Mark A. Wendling, MD (FM)  
James T. Wertz, DO (IM)  
Wenjun Zhou, MD (Resident)



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Our patients  
ARE family.

– Nicholas Taylor, MD, *Women's Cancer*

Cancer is a journey. And our team of experts is by your side every step of the way. Because, as Dr. Taylor, puts it: "Our sole focus is on always doing what is right for each patient. We don't let anything get in the way of that. We don't just treat patients like family – they are family. They touch my life as much as I hope I touch theirs."

**Learn more about Nick Taylor, MD and view Stories of Healing at [sluhn.org/cancer](http://sluhn.org/cancer).**

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