Allegheny County Medical Society

Bulletin

February 2021

Profile: Meet your 2021 ACMS president

Unmasking appreciation

Specialized cardiac care for your patients.

When your patients need the best possible specialty care, AHN has physicians with the right expertise — like our new System Chair of Thoracic and Cardiovascular Surgery.

Dr. Bailey offers some of the most advanced treatments and techniques, so your patients can have the best possible outcomes.

To refer your patient, call

1-844-MD-REFER (1-844-637-3337).

Most major insurance plans are accepted.

AHN

Stephen Bailey, MD

System Chair, AHN Thoracic and Cardiovascular Surgery

Locations:
Allegheny General Hospital
Forbes Hospital
ACMH Hospital
Hempfield Hospital

Specialties:
Complex redo heart surgery and second opinions for no-option patients

Percutaneous and minimally invasive valve repair/ replacement

Coronary bypass, aneurysm, heart transplant, and mechanical circulatory support surgery

Allegheny County Medical Society

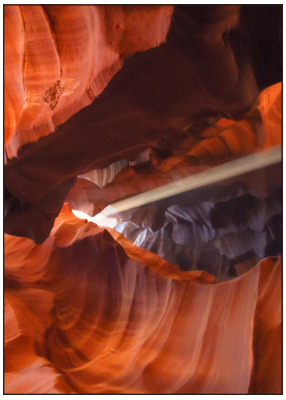
Bulletin

February 2021 / Vol. 111 No. 2

Opinion

Departments

Articles



On the cover

Antelope Canyon
Terence W. Starz, MD

Dr. Starz specializes in rheumatology and internal medicine.

For up-to-date resources on COVID-19, visit: www.acms.org/covid-19-resources

ALLEGHENY COUNTY MEDICAL SOCIETY

Bulletin

Medical Editor
Deval (Reshma) Paranjpe
(reshma_paranjpe@hotmail.com)

Associate Editors
Richard H. Daffner
(rdaffner@acms.org)
Kristen M. Ehrenberger
(kehrenberger@acms.org)
Anthony L. Kovatch
(mkovatch@comcast.net)
Joseph C. Paviglianiti
(jcpmd@pedstrab.com)
Anna Evans Phillips
(evansac3@upmc.edu)
Maria J. Sunseri
(mjsunseri@msn.com)
Andrea G. Witlin
(agwmfm@gmail.com)

Managing Editor
Meagan K. Sable
(msable@acms.org)

www.acms.org

EDITORIAL/ADVERTISING OFFICES: **Bulletin** of the Allegheny County Medical Society, 850 Ridge Avenue, Pittsburgh, PA 15212; (412) 321-5030; fax (412) 321-5323. USPS #072920. PUBLISHER: Allegheny County Medical Society at above address.

The **Bulletin** of the Allegheny County Medical Society is presented as a report in accordance with ACMS Bylaws, Articles 6, 8, and 11.

The **Bulletin** of the Allegheny County Medical Society welcomes contributions from readers, physicians, medical students, members of allied professions, spouses, etc. Items may be letters, informal clinical reports, editorials, or articles. Contributions are received with the understanding that they are not under simultaneous consideration by another publication.

Issued the third Saturday of each month. Deadline for submission of copy is the SECOND Monday preceding publication date. Periodical postage paid at Pittsburgh, PA.

Bulletin of the Allegheny County Medical Society reserves the right to edit all reader contributions for brevity, clarity and length as well as to reject any subject material submitted.

The opinions expressed in the Editorials and other opinion pieces are those of the writer and do not necessarily reflect the official policy of the Allegheny County Medical Society, the institution with which the author is affiliated, or the opinion of the Editorial Board. Advertisements do not imply sponsorship by or endorsement of the ACMS, except where noted.

Publisher reserves the right to exclude any advertisement which in its opinion does not conform to the standards of the publication. The acceptance of advertising in this publication in no way constitutes approval or endorsement of products or services by the Allegheny County Medical Society of any company or its products.

Annual subscriptions: $60

Advertising rates and information available by calling (412) 321-5030 or online at **www.acms.org.**

POSTMASTER—Send address changes to: Bulletin of the Allegheny County Medical Society, 850 Ridge Avenue, Pittsburgh, PA 15212.
ISSN: 0098-3772

Improving Healthcare through Education, Service, and Physician Well-Being.

Winter nourishment

Deval (Reshma) Paranjpe, MD, MBA, FACS

Six inches of snow are on the ground, and the temperatures are about to drop to single digits this weekend before yet another round of snow.

You've probably cooked everything you can cook, and are looking at another weekend full of soup, or pasta, or beans. The couch looks inviting, and bed more tempting still.

If you're like me, there's a heated throw on both. Once under its toasty, enthralling spell, I am a goner. The Blue Blanket wins.

So why would anyone, no matter how tired of cooking, venture out for food? What could be delicious enough to merit forsaking the Blue Blanket and wading through half a foot of snow in the middle of a pandemic?

Behold, the best of winter pandemic takeout awaits you:

Oak Hill Post (600 Brookline Blvd., Brookline; (412) 254-2970; www.Oakhillpost.com; Wednesday-Saturday, 11a.m. to 8 p.m.)

Feast on a selection of sandwiches, salads, pastas and entrees to delight the senses; vegetarian/vegan options available. Check out the Henny Penny sandwich (chicken liver mousse, sauce gribiche, bacon, red onion and dill), Octopus Tortelloni, Bat out of Hell (meatloaf sandwich) and Chicken and Gnocchi Soup. Don't forget the ready-to-bake buttermilk biscuits. The griddled pork chop entrée is the spendiest dish on the menu at $20.

Gaucho Perrilla (146 Sixth St., Downtown; (412) 709-6622; eatgaucho.com)

Now located at Sixth and Penn avenues downtown (the former Six Penn Kitchen), Gaucho has expanded their line-around-the-block-worthy offerings to larger digs and a more glorious wood fired oven. Argentinian grilled steaks, chicken, seafood and vegetables are the highlight of the entrees, sandwiches and salads. Signature sauces, each tastier than the next, perfectly complement the dishes. They've also scored a liquor license, which means you can order Spiked Horchata, Gaucho Hot Toddy or Pisco Sours to go as an authentic accompaniment to your meal.

Dagu Rice Noodle (5829 Forbes Ave., Squirrel Hill; (412) 504-4672; dagu-usa.com)

Squirrel Hill has a new regional Chinese restaurant; this one specializes in Yunnanese "crossing the bridge" soup. It is quite amenable to takeout as the broth is deliberately packed separately from the other ingredients so as to be extra fresh after travel (crossing the bridge). Takeout tailor-made for crossing Pittsburgh's bridges! Also look for more than 30 specialty nonalcoholic drinks including Boba (bubble) tea and various milk teas. One of three branches in a national chain of Chinese rice bowl restaurants; the Pittsburgh Dagu Rice Noodle is worth a visit.

Black Radish Kitchen (https://blackradishkitchen.com/)

Kate Romane's delicious and hearty fare from E2 has morphed into pop-up deliveries (free within 10 miles of Pittsburgh; pickup may be available). $150 for a multicourse meal with sides, breads, condiments and dessert for four; menu changes weekly.

Black Radish Kitchen Belly Basket (https://clavichord-bear-d8g5.squarespace.com/belly-basket)

A weekly delivered meal plan with dishes freshly prepared by Black Radish and sourced from Churchview Farm, Tiny Seed Farm and Who Cooks for You. Each Basket ($150) feeds two to three people and is delivered on Wednesday afternoon. Tagline: "Like Hello Fresh, but Fresher." It includes

- 2 crockpot stew type meals
- 2 prepared farm fresh salads
- 1 heat and serve pasta dish
- 1 heat and serve protein dish
- fresh produce or herb bundle
- bread and a "dip/jam or butter type situation"
- sweet treat
- gluten free and vegetarian options available upon request.

Continued on Page 38

From Page 37

Penn Avenue Fish Company (2208 Penn Ave., Strip District; https://pennavefishcompany.com)

Craving fresh seafood, sushi delights and dreaming of an island paradise? You can order all the fresh delicious sushi, seafood sandwiches and other dishes you desire from this stalwart shop online. A variety of sushi platters for a crowd are available for an extraordinary family dinner night.

DiAnoia's (2549 Penn Ave., Strip District; Tuesday – Saturday, 4 to 8:30 p.m.; (412) 918-1875; https://www.dianoiaseatery.com/covid-19/)

Delicious Italian food in many incarnations. Choose from takeout or delivery from the full menu, pop-up multicourse dinner takeouts, family style takeout and meal kits that let you prepare your own DiAnoia's Italian feast in your kitchen and pass it off as homemade. Well, semi-homemade, as they say. I won't tell.

Pizzeria Davide (Strip District; Carnegie; Robinson; https://www.pizzeria-davide.com/)

DiAnoia's Pizza Spinoff; quite fantastic pies.

Pane e Pronto (2627 Penn Ave., Strip District; (412) 815-3300; https://paneepronto.com/)

Another DiAnoia's spinoff, but in a storefront takeaway format. Featuring fresh bakery/pastry items, breads, deli menu, frozen dishes such as meatballs, lasagna and sauce, and ice creams.

Remember, it's OK not to cook all the time. Support your local restaurants; most have pivoted to do a brisk takeout and delivery business. Call up your old favorites and discover some new ones to keep your winter warm and delicious and your local eateries in business.

Dr. Paranjpe is an ophthalmologist and medical editor of the ACMS Bulletin*. She can be reached at reshma_paranjpe@hotmail.com.*

Bullies

Richard H. Daffner, MD, FACR

Bullying is in the news all too often today. Bullying is defined as intentional aggressive behavior on the part of one individual toward others. It is deliberate and hurtful, repeated over time, and is characterized by a relationship involving an imbalance of power, such as size, age, social status, leadership position, or popularity. Bullying can take many forms – verbal, physical, psychological, social. Bullies often have a sense of entitlement as well as a feeling of superiority. There is a difference between bullying and good-natured joking. Bullying is intentionally hurtful, occurs repeatedly, and as mentioned above, involves an imbalance in power (real or perceived) between the bully and the victim. Joking, on the other hand, particularly between friends, has none of the negative elements of bullying. Bullies can be male, female, youth, or adults. While most of the media coverage of bullying involves children,[1] a significant amount occurs in adults. We've all experienced or witnessed bullying at some time in our lives, either as a victim, a bystander, or, perhaps, as a bully.

The medical profession, unfortunately, is not immune from this character disorder. In medicine, the majority (but not all) of bullies are found in the surgical specialties. The late famous cardiovascular surgeon, Dr. Michael DeBakey, for all his brilliance and innovative surgical skills, is considered the prototype of the medical bully. My (super)specialization in musculoskeletal (MSK) imaging as well as expertise in imaging of spine trauma[2] has forced me to deal with orthopedic surgeons and neurosurgeons who were bullies.

Psychologists and psychiatrists have long argued about what makes a bully. Is it genetic? Is it due to environmental or social conditions? Are certain types of parenting to blame? There is general agreement that bullying behavior begins in early childhood and most likely is a result of a combination of the factors mentioned above. One of the biggest myths about bullying is that the bully acts to cover his/her sense of inadequacy or poor self-esteem.[1] Research has shown, however, that bullies often have normal, if not higher levels of self-esteem. Common characteristics found in bullies include: the need to feel powerful and be in control; the need to feel superior; the need for attention; a sense that (s)he can do no wrong; a propensity to anger quickly and act aggressively; a sense of enjoying causing pain and suffering; and a lack of empathy. Most of these characteristics also are seen in the spectrum of narcissistic personality disorders. As such, bullies see themselves in a positive light, with little or no awareness of what others really think of them. And, unfortunately, nobody is willing to suffer the bully's wrath by telling them the truth.

On the other hand, research also has shown that there are warning signs in early childhood that may predict bullying behavior. These include: a low tolerance for frustration; showing little respect for authority and difficulty in conforming to rules; impulsiveness; exhibiting antisocial behavior; and cruelty to animals.

So, how do some of our colleagues become bullies? First, medical bullies come into the profession having already exhibited bullying behavior since childhood. Traditional training in medicine, particularly in the surgical specialties, fosters bullying behavior, particularly if the groundwork has already been laid in childhood. As a rule, residents and fellows look up to their mentors as examples of how to behave in their specialties. While training conditions have improved for residents and fellows, some programs remain oppressive. Academic chairs are considered gods, whose decrees are to be followed without question. Institutions that are highly inbred are more likely to demonstrate this since everybody follows the exact same protocols. The very idea of a resident

Continued on Page 40

From Page 39

questioning a chairperson or a senior attending is simply out of the question. I remember an incident that happened in the surgery department when I was a radiology resident. A chief resident (who had already completed nine years of training) had, what was described by a third party, an honest difference in opinion with the chairman while on morning rounds. That afternoon, the resident was called into the chairman's office and was told he (the chair) could not recommend him for his board exam at that time. Furthermore, he told his resident that he needed another year of training, to be taken at another program beginning the first of the month! This was the power of an academic chair.

I had my own introduction to the same chairman the first week of my residency. Every Saturday morning, we attended a combined surgery/radiology/pathology conference. Clinical cases would be presented by a senior surgical resident. A radiology resident would present the appropriate imaging, after which various senior attending surgeons would give their (very erudite) opinions on what they considered to be the diagnosis and what surgical procedure should be recommended. Finally, the presenter would tell what operation had been performed and a pathology resident would present the pathologic findings. Following this, the attending surgeons would discuss the findings. And, at the end of each case, the presenter would ask the audience if there were any additional questions or comments. And so, being new and not understanding the system, I raised my hand following a pediatric case. (I had spent eight months in pediatrics at the end of my Air Force service). In retrospect, I remember the look of abject terror on the presenter's face as he glanced at me, as well as at someone in the front row. I asked my question and remember that a man in the front row looked back at me and gave me a stare that would have melted steel. At the end of the conference, my own chairman, a saintly man, came up to me and said, "Geez. Don't do that again."

"But he asked if anyone had any questions," I replied.

"That's all B.S. This whole conference is for the entertainment of Dr. S… (the chairman who glared at me). All those surgeons who seemed so erudite are his 'trained monkeys,' who already knew the diagnoses and outcomes of the cases. Dr. S… is like God here."

The lesson was learned.

Years later, as an attending at the same institution, I was in the reading room we had in the orthopedic clinic. One day, in walked the chairman of orthopedics accompanied by his retinue of residents and students. Dr G… never missed an opportunity to inform anyone within earshot of his disdain for radiologists, whom he compared to parasites. Dr. G… put a lumbar spine series of a patient with low back pain on the view boxes and announced to the assembled multitude how he was going to demonstrate how a good orthopedist (him) didn't need a radiologist (me). He began pointing out all he classic findings of lumbar spondylosis (disc space narrowing, spur formation and facet disease). Before pointing out each finding he said, in a condescending fashion, "Isn't it true, Dr. Daffner, that there is…?" to which I answered, "Yes Dr. G…" He concluded with, "And isn't it true that this patient has severe spondylosis?"

"Yes," I answered.

He turned to the group and said triumphantly, "You see. Who needs a radiologist?"

"You do," I said as he was about to take the films down. Then I put my hand on the frontal film and I pointed out the enlarged left renal shadow with a large mass off the lower pole. The mass contained flecks of calcium. This was the classic appearance of a hypernephroma, which frequently presents as low back pain. I concluded by pointing out that the patient didn't need a good orthopedist but needed a good urologist. Dr. G… turned red, grabbed the films and stomped out. This case was a proverbial gift from heaven that allowed me to stop a bully in his tracks.

An hour later he returned, pointed to my resident, and said, very unprofessionally, "You. Get out!" After she left, he slammed the door and said, "You son-of-a-b…h! You embarrassed me in front of my people." "No, sir," I replied. "You embarrassed yourself. I don't play those games. We're here to provide a service to you and your patients. If you choose not to avail yourself of our services that's your business. You're very good at what you do. We, on the other hand are also good at what we do. We look at the *whole patient,* the *whole study,* and not just at the areas pertaining to the patient's complaints." From that day on, I was the only radiologist to whom he was civil.

Years later, I received a call from another department chair, who unleashed a stream of profanity that would have made a sailor proud. He had ordered the wrong study; we had done the exam he had ordered. In the

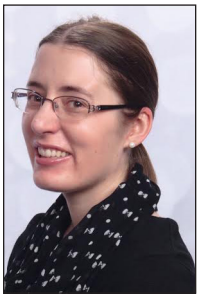
middle of his rant, I interrupted him and said, "Bud (not his real name), my mother didn't raise her son to take crap from a schmuck like you." There was dead silence on the other end of the line. "Now," I continued, "If you want to have a conversation like a reasonable human being, I'll try to help you. If not, I'm hanging up. What'll it be?" He calmed down and told me what he needed. I told him that the patient would not be charged for the first study. I also reminded him that we are available anytime for consultation regarding the most appropriate imaging study for a specific problem. He was never rude to me again.

So, what were the lessons learned from these incidents? Bullies succeed because their victims are afraid of physical harm in most cases. Bullies in the workplace don't act out physically. They may, however, have the power to terminate your employment or to threaten your reputation. How does one deal with bullies in our profession? First, acknowledge that there are bullies in your workplace. Second, respond in a professional, respectful manner. (In the second instance, my initial reply was designed to get his attention, and it did.) When you are right, point out the reasons; when you're wrong, apologize. Dealing with bullies is not a reason to go into full curmudgeon mode. And, if necessary, report bullying and unprofessional behavior to the hospital administration or to the professional organization's Ethics Committee.

Dr. Daffner, associate editor of the ACMS Bulletin*, is a retired radiologist who practiced at Allegheny General Hospital for more than 30 years. He is emeritus clinical professor of Radiology at Temple University School of Medicine and is the author of nine textbooks. He can be reached at bulletin@acms.org.*

References

1. Carpenter D. *The Everything Parent's Guide to Dealing with Bullies.* Avon, MA, Adams Media 2009.
2. Daffner RH. *Imaging of Vertebral Trauma,* 3rd ed, New York, Cambridge University Press, 2011.



Unmasking appreciation

Amy J. DiPlacido, MD, CWSP

Dr. Andrea Taylor-Cummings said, "People go where they feel welcome, but stay where they feel valued."

Not all attempts to show appreciation are equal, especially through the eyes of the recipient. A recent online search for "how to show appreciation" led me to YouTube, where a millennial couple talked about how they've never felt more appreciated by one another until they started to recognize their so-called "love languages." I've never read Dr. Gary Chapman's 1992 book on the subject, but watching this video intrigued me enough to take a crash course via Google. Dr. Chapman's five love languages are words of affirmation, acts of service, receiving gifts, quality time and physical touch. There are practical ways that this concept can be applied to professional relationships.

Using words of affirmation, whether verbally or in writing, is a go-to way for many people to show appreciation to others. Now, I personally love a hand-written greeting card any day of the year, but I know that not everyone feels the same way. How many times have we all seen someone be thanked only to shrug it off with an eyeroll as soon as the other person leaves? There are many factors that could influence a situation like that, of course, but maybe the person would prefer a different form of recognition.

Physical touch is mostly off the table right now for people outside your household due to the COVID-19 pandemic. We're not shaking hands or offering high-fives like we usually would, but that does not mean that touch is irrelevant. I had a patient burst into tears in December when I felt her wrist to check her pulse. Her explanation was that she had not been touched by anyone in months. It meant the world to her in that moment to feel connected to someone again in that way. We both left the exam room with wet masks.

It makes sense to me that quality time is one of the love languages. Life is especially hard right now. Everyone has a lot going on within work and outside of it, so let's take a few minutes to be curious about each other and have a real conversation. It can make people's day to ask about something specific that's going on with them. It's important to be mentally present with the person, whether you're talking at a safe distance in person, speaking on the phone, or making funny faces at each other over a video chat.

Receiving gifts is another way we can show appreciation, and of course the gift does not need to cost a lot of money. This is a good opportunity to get creative. An example could be to bake a co-worker a gluten-free cake for his birthday. (Hold the candles again this year!) You could bring in a spare strap extender for someone whose ears are raw from wearing masks. You could buy lunch for your office, or maybe give a financial bonus to people for helping to meet quality measures.

And, lastly, acts of service. Find a way to help lighten the load for someone else. The best example I can think of for this is to recognize that many times, our well-intentioned gifts create additional work for someone else. Sure, probably everyone in my office would appreciate lunch from a local restaurant, but there are a couple of people I know who would feel *even more* appreciated if I either placed the order myself or helped to clean up the breakroom afterwards.

Some people might not know what makes them feel appreciated. If someone is unhappy or struggling right now, which is not uncommon, then I suggest asking the person what's going on, and listening really well to the response.

We are getting through this pandemic together as a team. Maybe we can all better communicate our appreciation to those around us with these insights from Dr. Chapman.

Dr. DiPlacido specializes in family medicine and geriatrics at Renaissance Family Practice, Millvale, and Seneca Place Skilled Nursing Facility. She can be reached at diplacidoaj@upmc.edu.

ACMS, ACMS Foundation, DCPP host vaccination clinics

The Allegheny County Medical Society and the ACMS Foundation's Front Line Relief Fund have mobilized again to fight COVID-19. Now on the offensive against the virus, vaccinations are underway in partnership with the Direct Care Physicians of Pittsburgh. On Jan. 10, 101 doses of the Moderna vaccine were administered to non-affiliated ACMS physicians and front-line providers.

ACMS additionally received interest in the vaccine from more than 1,000 front-line personnel. To help scale up the administration of the vaccine, ACMS hosted a second vaccination clinic on Jan. 17 at the new ACMS office at 850 Ridge Avenue. From 9 a.m. to 4 p.m., physicians, medical students and volunteers served more than 300 Phase 1A eligible providers. ACMS and the DCPP have directly vaccinated more than 400 patients and directed hundreds of others to additional vaccination sites. Four more vaccination clinics are planned through the end of February. The Jan. 17 event was covered by both KDKA and WTAE.

From left are Jeremy Bonfini, ACMS CEO; Sam Urick, DO; Natalie Gentile, MD; Kirsten Lin, MD; Lela Dougherty, MD; and medical students Madalyn Fritch and Marie Schwalbe.

At left, ACMS President Patricia Bononi, MD, vaccinates ACMS member Neal Niren, MD. Below, ACMS Board Member Bruce MacLeod, MD, vaccinates a Phase 1A healthcare professional.

Above, ACMS CEO Jeremy Bonfini is joined by medical students to greet patients and collect vaccination intake forms. At right, from left, Marie Schwalbe, Madalyn Fritch and Terri Dowd staff the registration and patient text messaging desk to check in more than 300 patients.

POS announces virtual program offerings in March

The Pittsburgh Ophthalmology Society (POS), under the leadership of President David G. Buerger, MD, FACS, is pleased to announce the 56th Annual Meeting and the 41st Meeting for Ophthalmic Personnel will be offered in a virtual format Friday, March 12, 2021. This is the most responsible path forward to maintain safe conditions for attendees, presenters, exhibitors and all involved in planning and executing the programs. We look forward to offering an engaging and robust virtual experience and ask for patience as we finalize details for each program. Registration information has been sent to members and past attendees via email.

56TH Annual Meeting


Dr. Osher

The Society is pleased to welcome Robert H. Osher, MD, as the 40th annual Harvey E. Thorpe Lecturer. Dr. Osher is professor of Ophthalmology at the College of Medicine of the University of Cincinnati and medical director emeritus of the Cincinnati Eye Institute.

He is the recipient of numerous awards including the American Society of Cataract and Refractive Surgery's two highest honors, the prestigious Binkhorst Medal and the Innovator's Award. He also has received the Lifetime Achievement Award and the Kelman Award, the highest honor given to a cataract surgeon by the American Academy of Ophthalmology and more recently the Kelman Award from the Brazilian Society of Cataract and Refractive Surgery.

Dr. Osher has designed many of the contemporary intraocular lenses and instruments used in cataract surgery, in addition to developing new techniques in this subspecialty. His surgical videos have won more than 25 first-prize honors at the American, European, Asian and South American Cataract Societies including three Grand Prizes at ASCRA and ESCRS.

Dr. Osher has delivered more than 100 named lectures to implant societies in more than 40 countries and has contributed to a dozen textbooks in his subspecialty.

He is the founder and editor of the Video Journal of Cataract, Refractive, and Glaucoma Surgery and has published more than 250 videos and peer-reviewed articles.

Distinguished guest faculty include:


Dr. Briceland

Daniel J. Briceland, MD, medical director, Spectra Eye Institute, Sun City West, Ariz. He was elected senior secretary for Advocacy by the American Academy of Ophthalmology (AAO) in 2015 and is a 2000 graduate of the Academy's Leadership Development Program (LDPII), serving as the program's director for six years. Dr. Briceland currently serves on the Academy's Awards Committee, Nominating Committee, and Executive Committee and was previously the Academy's secretary for State Affairs and a member of its Committee on Aging.

Hans Bruhn, MHS, risk manager, Ophthalmic Mutual Insurance Company (OMIC), San Francisco, Calif. Mr. Bruhn has more than 30 years of experience working exclusively in the medical malpractice/professional liability insurance field. In his position, Mr. Bruhn works with physicians and their staff, advising them on how to reduce the risk of medical malpractice claims in their practice.


Mr. Bruhn

In addition, Mr. Bruhn travels across the United States, giving presentations to various medical and subspecialty societies on risk management topics. He also is a contributing writer on risk management topics for OMIC and other publications


Dr. Carter

Keith D. Carter, MD, FACS, Lillian C. O'Brien and Dr. C.S. O'Brien Chair in Ophthalmology; chairman and head, Department of Ophthalmology, University of Iowa Health Care; professor of Ophthalmology and Visual Sciences and professor of Otolaryngology, University of Iowa Carver College of Medicine, Iowa City, Iowa. Dr. Carter served as the 2018 president of the American Academy of Ophthalmology. He was elected by the Academy's community of ophthalmologists in recognition of his scientific leadership, international reputation as a leading academician and teacher and his deep commitment to advocacy for patients.

John Pollack, MD, practitioner, Illinois Retina Associates, PC, Chicago, Ill., is an internationally recognized retinal clinician, surgeon and educator. He

Dr. Pollack

is associate professor of Ophthalmology, Rush University Medical Center, and current president, American Society of Retinal Specialists (ASRS) – the largest organization of retina specialists in the world. Dr. Pollack, who has published extensively in scientific papers and book chapters, has served as director or invited faculty at more than 100 scientific meetings and has delivered more than 200 scientific presentations at national or international meetings.

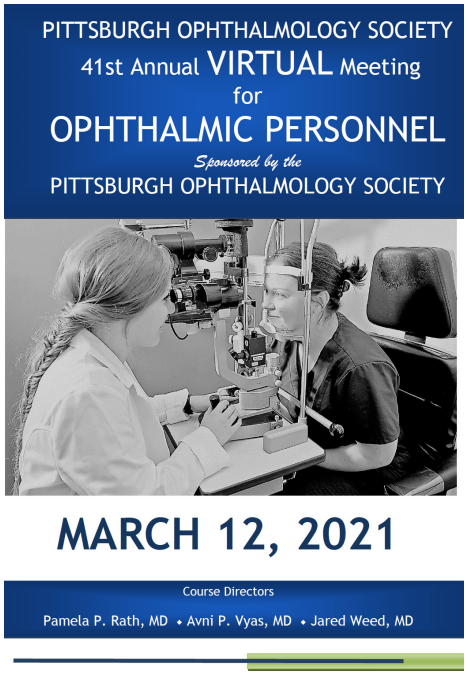
41st Annual Meeting for Ophthalmic Personnel

The 41st Annual Meeting for Ophthalmic Personnel, presented by the Pittsburgh Ophthalmology Society (POS), will run concurrently with the POS Annual Meeting Friday, March 12, 2021. The virtual meeting offers a maximum of 7 JCAHPO credits.

Course directors Pamela Rath, MD, Avni Vyas, MD, and Jared Weed, MD, have prepared an exceptional educational offering for Ophthalmic staff. Highlights of the course include presentations on intravitreal retina injections, glaucoma update, uveitis, pediatric emergencies and more.

The conference provides exceptional educational opportunities for ophthalmic personnel in and around the region and continually attracts well-respected local faculty, who present relevant and quality instruction through numerous breakout sessions.

Online registration can be found at www.pghoph.org. Contact Nadine Popovich, administrator, for details and more information at npopovich@acms.org.



GPDC to host annual Spring Program virtually April 28

Dr. Stewart

The Greater Pittsburgh Diabetes Club (GPDC) will host their annual spring program, virtually, on Wednesday, April 28, 2021, at 6 p.m. The meeting is open to members and non-members (guest fee will apply).

The GPDC is pleased to welcome guest speaker Andrew F. Stewart, MD, director, Diabetes Obesity and Metabolism Institute; Irene and Dr. Arthur M. Fishberg Professor of Medicine Icahn School of Medicine at Mount Sinai, NY. Thank you to Michelle Roberts, MD, for inviting Dr. Stewart.

For the last 20 years, Dr. Stewart has focused on defining human beta cell cycle control, with the goal of developing therapeutic approaches to regenerating the beta cells lost in Type 1 and Type 2 diabetes. In 2015, his research identified the first small molecule agonist of human beta cell proliferation – harmine – using high throughput screening approaches. He then reported the first comprehensive effort to decipher the molecular control mechanisms of human insulinoma to identify key control points for beta cell replication that would serve as drug targets for human beta cell expansion.

Finally, in 2019, a number of novel drug combinations were found to induce human beta cell regeneration. He currently is focusing on approaches to target those regenerative drugs to the human beta cell.

Among his many distinctions and honors, Dr. Stewart received the Columbia University Alumni Recognition Award for Excellence in Clinical Investigation, The Endocrine Society Gerald D. Aurbach Award for Outstanding Scientific Achievement and the University of Uppsala Diabetes Center Ray Kroc Scientific Award.

For more information and to register for the program, please visit www.pghdiabetesclub.org. Registration begins March 20. Members receive complimentary registration. The guest fee of $35 includes one year of membership in the GPDC. Questions can be directed to Nadine Popovich, administrator, at npopovich@acms.org or (412) 321-5030.

Clinical Update in Geriatric Medicine set for April 8-9

The 29th Annual Clinical Update in Geriatric Medicine will be held virtually April 8-9, 2021, in observance of CDC regulations during the COVID-19 pandemic. Presented by the Pennsylvania

Continued on Page 48

2021 ACMS Membership Benefits

NEW! FOR OUR INDEPENDENT PRACTICES

ALLEGHENY COUNTY MEDICAL SOCIETY

Prosurant
medical·technology·services·insurance

Get the support your practice needs.

EDUCATION. ADVOCACY. SAVINGS.

Your Allegheny County Medical Society Membership is enhanced with a $624 credit that can be applied to an annual subscription to our Group Purchasing Organization, Prosurant. We empower independents to deliver exceptional care.

PROSURANT INCLUDES:

Professional Liability, Patient Acquisition
Population Health Management
Revenue Cycle Management
Payer Relations, Health Insurance

HIPAA Compliance, OSHA Compliance
Legal, PA State Required Training
Staffing, Recruiting, IT Services
Hardware/Software Solutions

Medical and Office Suppplies
Personal Benefits (Home, Auto,
Life Insurance, Physician Wellness)
And More!

prosuranthealth.com | acms.org

2021 EMPLOYED PHYSICIAN MEMBER BENEFITS

ALLEGHENY COUNTY MEDICAL SOCIETY

Advocacy. Education. Resources.

Allegheny County Medical Society.

Membership benefits ($1792 value)

ACMS Bulletin
- Free annual subscription, 12 monthly issues.
- $60 value

Physician Wellness Program
- Confidential assistance
- $800 value

Insurance Programs: term, whole, long-term care, and disability
- Personal coverage
- Group discounts not available on the public market

Liberty Mutual Auto & Homeowners Insurance
- Up to 20% savings
- $782 value

Educational Programming
- State-mandated training programs for license renewal
- $150 value

Legal Advice from Tucker Arsenberg
- Resident/Fellow contract review
- Flat rate — even with multiple contracts
- Salary negotiation. Save over $150

acms.org

For information, contact James Ireland
at jireland@acms.org, or (412) 321-5030, ext. 101.

2021 ACMS Membership Benefits

Empowering independents.
Driving exceptional care.

Prosurant
medical · technology · services · insurance

GROUP PURCHASING DISCOUNTS

Valid for 12 months

	Platinum	Gold	Silver
Professional Liability Practice Start Up Support Patient Acquisition Population Health Management Revenue Cycle Management Payer Relations Health Insurance	●	×	×
HIPAA/OSHA Compliance Staffing/Recruiting Hardware/Software/IT Solutions Physician Only Mortgages Credit Card Processing	●	●	×
Medical and Office Supplies Personal Benefits (Home, Auto, Life Insurance, Physician Wellness) Verizon & Sprint Cell Phone Plans And More!	●	●	●
Independent Physician Community - Annual Meeting - Membership Directory - Practice Optimization	●	●	●

**Advanced practice providers platinum offering includes professional liability and health insurance group discount access.*

→ **To learn more, contact Terri Dowd at 412-321-5030 or email terri@acms.org.**

info@prosuranthealth.com | Phone: 412-321-5030 | Fax: 412-321-5323 | prosuranthealth.com

From Page 45

Geriatrics Society – Western Division, UPMC/University of Pittsburgh Aging Institute and University of Pittsburgh School of Medicine Center for Continuing Education in Health Sciences, the program will be an evidence-based approach to help clinicians take exceptional care of these often frail individuals. This conference is set with question-and-answer sessions, vendor halls and opportunities to engage in conversations with speakers, exhibitors and fellow attendees.

Dr. Goyal

Dr. Krishnaswami

With the fastest-growing segment of the population comprised of individuals more than 85 years of age, this conference is a premier educational resource for healthcare professionals involved in the direct care of older people. As the recipient of the American Geriatrics Society State Achievement Award for Innovative Educational Programming, the Clinical Update attracts prominent national and international lecturers and nationally renowned local faculty. Continuing Medical Education credits are available to participants.

Dr. Orr

Dr. Forman

Back by popular demand, a Geriatric Cardiology Expert Panel will be part of the agenda with Parag Goyal, MD, MSc, providing an update in heart failure; Ashok Krishnaswami, MD, MAS, FACC, discussing a case-based approach of balancing benefit and harm during hypertension treatment in older adults; Nicole Orr, MD, FACC, presenting post-acute cardiac management; and Daniel Forman, MD, offering a statins update. All of these physicians will participate in a live, rapid-fire question-and-answer session. In addition, Jennifer McComb, MD, will be featured in a live session of "Ask the Pulmonologist," and Krishna Tummalapalli, MD, will conduct a similar live session of "Ask the Cardiologist."

Dr. McComb

Dr. Tummalapalli

Registration began Feb. 5. Members of the PAGS-WD receive a discount when registering. To check on your membership status, please contact Michelle Besanceney at michelle@acms.org.

For more information on conference details, please visit our website: http://www.dom.pitt.edu/UGM, or email us at pagswd@acms.org.

In Memoriam

Richard M. Mann, MD, 96, of White Oak, died on Sunday, January 17, 2021.

Dr. Mann graduated in medicine from the University of Pittsburgh, and served his residency at Magee Women's Hospital in Obstetrics and Gynecology.

He practiced Obstetrics and Gynecology in the McKeesport area and was honored with the distinction of being the head of the Department of Obstetrics and Gynecology at McKeesport Hospital for 20 years.

He also served a term as president of the Pittsburgh Obstetrics and Gynecology Society.

A World War II veteran, Dr. Mann served as an officer on a destroyer mine-sweeper in the South Pacific.

Surviving are his wife, Karen (Weyman) Mann, and children Susan Mann and James Mann.

Services were private.

***

Dr. Abraham J. Twerski, 90, formerly of Pittsburgh, died Sunday, January 31, 2021, in Israel.

Dr. Twerski graduated in medicine from Marquette University and served his internship at the University of Pittsburgh's Western Psychiatric Institute, where he gained interest in treating alcoholism.

Prior to embarking on his medical career, he enrolled in the Hebrew Theological College of Chicago and was ordained a rabbi in 1951.

He was an international authority on addiction and founded Gateway Rehabilitation Center, a drug and alcohol treatment center in Center Township, Beaver County, in 1972, and was its medical director emeritus. He also served for 20 years as the clinical head of Psychiatry at the now-defunct St. Francis Hospital in Lawrenceville.

Dr. Twerski authored more than 60 books addressing religious subjects and self-help topics.

His work in addiction was not limited to drugs and alcohol. In 2006, Twerski spoke on Internet addiction at Congregation Beth Shalom in Squirrel Hill.

Surviving are his second wife, Dr. Gail Bessler-Twerski; three sons, Isaac, Ben and Shlomo; and a daughter, Sarah.

His first wife of 43 years, Goldie, died from breast cancer in 1995.

ACMS physician members: We want to hear your opinions on important topics affecting healthcare. Email Meagan K. Sable at msable@acms.org to learn more about submitting a Perspective column to the *Bulletin*.

Meet your 2021 ACMS president: Patricia L. Bononi, MD, FACP

Nancy J. Kennedy

Patricia L. Bononi, MD, FACP, has been named 2021 ACMS president, becoming the 155th president and the fifth woman to hold that position. A native of Greensburg, Dr. Bononi knew at an early age that she wanted to be a physician, and found inspiration from her mother, a registered nurse, and from Elizabeth Blackwell, the first woman to receive an MD degree in the United States, in 1849. "I liked to read a lot, and I read a biography of Blackwell when I was nine," she recalls. "It made a strong impression on me."

Dr. Bononi attended undergraduate school at Georgetown University, where she became acquainted with the Ignatian-Jesuit principle known as "curae personalis" – a Latin phrase that translates as "care for the entire person." It expresses the ideal of promoting human dignity and caring for the health of the whole person, body, mind and soul. "The Jesuits had a profound effect on me, through this philosophy and a mentor I was fortunate to have," Dr. Bononi says. "They are social justice advocates, and they opened my eyes to a lot of things. It still surprises me to recognize how significantly they influenced me. Curae personalis is inspirational for me, personally and professionally. It includes caring for others with great respect and encouraging their fullest possible development."

Dr. Bononi

Dr. Bononi went on to earn her medical degree from the University of Pittsburgh and completed her internship and residency in internal medicine and her fellowship in endocrinology at UPMC. Originally envisioning a career in pediatrics, she decided to switch to endocrinology, finding that the complexity and long-term relationships with patients were deeply rewarding.

"Diabetes is difficult, but there has been so much progress – new medications and technologies are changing it. It's a huge burden every day to cope with diabetes; you have to think about it all day, every day, with never a day off. Some patients strive for perfection, but I tell them that is not the goal; no one can be perfect. You shoot for 80/20 and do the best you can."

Since 2013, Dr. Bononi has served as the medical director of the Allegheny Health Network (AHN) Center for Diabetes and Endocrine Health and has been site Principal Investigator for more than 20 clinical trials testing medications for diabetes mellitus. She is board certified by the American Board of Internal Medicine and the American Board of Endocrinology, Metabolism and Diabetes Mellitus. She serves on the Board of Directors of the Juvenile Diabetes Research Fund of Western Pennsylvania and is a past member of the Community Leadership Board of the American Diabetes Association of Western Pennsylvania. She has been recognized by Pittsburgh magazine as one of Pittsburgh's best doctors since 2015.

As ACMS president, Dr. Bononi hopes to grow the organization and help it become more relevant to the needs of diverse physicians, those in private practice and those who are employed. She states that as a leader, she is a consensus builder: "I take in many opinions and find a mutual path forward. I bring to the role of president a sense of fairness and balance. I'm reasonable – I'm not the loudest voice in the room. I am another doctor, trying to support physicians in the area where we live and practice. It all goes back to that."

A member of ACMS since 1992, Dr. Bononi has served on the Board of Directors since 2012 in various capacities: treasurer in 2017; secretary in

2018; and vice president in 2019. She has served on the Executive Committee since 2017 and has co-chaired the Foundation Gala Committee since 2014. Since 2017, she has been an ACMS delegate to the Pennsylvania Medical Society.

Soft spoken and thoughtful, Dr. Bononi's quietude belies the intensity of her convictions about medicine. "Medicine is more than a job, it's a vocation. You don't just put in your hours. I think it's important for physicians to be invested in their communities. I'm heartened by seeing young doctors who are interested in this and are giving to their communities. The new Asthma Clinic is a good example of this. I'm very supportive of advocacy, and I hope to see more advocacy for patients and communities among the young doctors and medical students. This is part of the value of membership in ACMS: There are lots of opportunities for community service."

She expresses concerns about the impact of the COVID pandemic on the mental health of front-line workers, including, of course, the physicians. "The stress for physicians is tremendous, and we have established a mechanism for them to get counseling very privately. It's anonymous and they can have four sessions. I'm pleased to say that they are taking advantage of this program." ACMS was able to offer additional support to front-line workers, Dr. Bononi says, by providing PPE to members, through the ACMS Foundation Front Line Relief Fund in collaboration with the Allegheny County Health Department.

In addition, ACMS and the ACMS Foundation, with the help of Direct Primary Care Practice, were able to administer more than 700 COVID-19 vaccinations to healthcare providers and medical students who were not affiliated with a major healthcare system. This allowed many more people to have access to the vaccine.

Dr. Bononi's own stress management consists mostly of relaxing with good books at her home in Wexford and connecting with her family. She has two children: son Chris, 27, is in the U.S. Navy, stationed in California, and flies F-35s; daughter Maura, 24, works in the fashion and beauty industry in New York City. Dr. Bononi also has a sister who is a retired internist in Philadelphia. Dr. Bononi especially likes to read biographies and is enjoying former President Barack Obama's book at present; she recently has taken up needlepoint. "It's a new COVID activity for me!" she says.

In her practice, Dr. Bononi likes to focus on helping her patients achieve and maintain a high quality of life despite having a chronic illness. She also emphasizes diabetes prevention. "There is a tsunami coming, unfortunately, with greater numbers of people having diabetes for a longer portion of their lives. We need to do more pre-diabetes education and prevention, starting with children and families. We need to keep kids healthy and fit with more activity, healthier diets and reasonable body weights. We have improved, but we have a long way to go."

"Serving as ACMS president is an opportunity to have a greater impact, to support and encourage other physicians."

-Dr. Bononi

As a physician and leader, Dr. Bononi embodies the Jesuit ethic of academic achievement coupled with service to humanity. "I have lived that quietly, and I have no regrets at all. I'm doing what I always wanted to do. Serving as ACMS president is an opportunity to have a greater impact, to support and encourage other physicians."

Ms. Kennedy is a communications consultant for ACMS. She can be reached at nkennedy@acms.org.

Omadacycline (Nuzyra®) for the treatment of CAPB and ABSSSI in adult patients

Amisha Mehta, PharmD
Archana Raghavan, PharmD, BCPS

Omadacycline (Nuzyra®) is a tetracycline class antibacterial that inhibits protein synthesis by binding to the 30S subunit of the bacterial ribosome. It has a novel modification to its chemical structure which increases antimicrobial potency and allows the drug to bypass resistance mechanisms commonly used against doxycycline and minocycline, such as tetracycline efflux and ribosomal protection. Omadacycline demonstrates activity against multi-drug resistant organisms that were previously tetracycline resistant.[1]

The spectrum of activity of omadacycline covers gram-positive organisms (including methicillin-resistant Staphylococcus aureus and vancomycin-resistant enterococci), gram-negative organisms, atypical organisms and anaerobes. Specifically, omadacycline displayed activity against 90% – 100% of Staphylococcus aureus strains (including those resistant to tetracycline), streptococcal strains, and enterococcus strains (including those resistant to tetracycline or vancomycin) with an MIC_{90} value of 0.5 mg/L. Gram-negative coverage includes 91-100% of E. coli, Klebsiella, Haemophilus influenzae, Moraxella catarrhalis and Acinetobacter strains with an MIC_{90} values of 1, 2 or 4 mg/L. No strains with induced resistance to omadacycline have been reported yet.[1]

Omadacycline is approved by the FDA for the treatment of Community-Acquired Bacterial Pneumonia (CABP) and Acute Bacterial Skin and Skin Structure Infections (ABSSSI) in adult patients. CABP is a lower respiratory tract infection acquired outside of the hospital setting. Common bacterial pathogens include Streptococcus pneumoniae, Haemophilus influenzae, Mycoplasma Pneumoniae, Staphylococcus aureus, Legionella species, Chlamydia pneumonia and Moraxella catarrhalis.[2] ABSSSI encompass a variety of diagnoses including cellulitis/ erysipelas, wound infections, and major cutaneous abscess, all that have a minimum lesion surface area of 75 cm^2. Common bacterial pathogens include Streptococcus pyogenes, and Staphylococcus aureus.[3]

Safety

The use of omadacycline is contraindicated in patients with known hypersensitivity to tetracycline-class antibacterial drugs.[4]

In second- or third-trimester pregnant women and children up to the age of 8 years, the use of omadacycline may cause permanent discoloration of the teeth (yellow-gray-brown), although this is most common during long-term use and/or high doses. This population also is at risk of reversible inhibition of bone growth due to the formation of stable calcium complex in bone-forming tissue. This reaction was shown to be reversible when the drug was discontinued.[4]

While no cases of Clostridium difficile-Associated Diarrhea have been reported thus far with the use of omadacycline in phase 3 trials, a warning still exists regarding mild diarrhea to fatal colitis.[4]

A mortality imbalance was observed in patients with CABP in the OPTIC trial with eight deaths (2%) occurring in patients treated with omadacycline compared to four deaths (1%) in patients treated with moxifloxacin. Patients at higher risk for mortality included geriatric patients > 65 years of age, of whom most had multiple comorbidities which were not specified. The causes of death varied between progression of the underlying pneumonia or respiratory compromise, hospital-acquired pneumonia, cardiac or vascular events, and cancer.[4]

Omadacycline is a tetracycline-class antibacterial drug and thus can have similar adverse reactions such as photosensitivity, pseudotumor cerebri and anti-anabolic action, which has led to increased BUN, azotemia, acidosis, hyperphosphatemia, pancreatitis and abnormal liver function tests. Specific to hepatic safety, increased serum alanine or aspartate aminotransferase was reported in 2-4% of patients in phase III studies. These studies all excluded patients with elevated liver enzymes at screening (>2 × upper limit of normal [ULN] in OASIS-1 and OPTIC and >3 × ULN in OASIS-2). Elevations in ALT and AST were mostly asymptomatic, and transient, with most

patients having resolution on therapy or at completion of therapy. Liver function tests should be monitored during therapy periodically. [4]

Tolerability

Omadacycline is well tolerated with nausea (2-22%) and vomiting (3-11%) being the most common side effects. Infusion site reactions were reported in 5% of patients receiving intravenous (IV) therapy.[5]

Effectiveness

Three trials were conducted to evaluate the efficacy of omadacycline within each indication and dosing strategy. All three were noninferiority trials with a margin of 10 percentage points for their end points.

1. The OPTIC trial was a multi-national double-blind, double-dummy, randomized trial in which adults with CABP received either omadacycline or moxifloxacin IV therapy for seven to 14 days. A transition to oral therapy was allowed after three days. Inclusion criteria consisted of adults over 18 years who had radiologically confirmed pneumonia with at least three of four symptoms (cough, sputum production, pleuritic chest pain and dyspnea), abnormal vital signs and a Pneumonia Severity Index (PSI) risk class II – IV. Efficacy of omadacycline was determined by number of patients achieving early clinical response (ECR), assessed at 72 to 120 hours after the first dose of trial drug, and defined as investigator's assessment, on a four-point scale (absent, mild, moderate, or severe), of improvement from baseline in at least two of the four symptoms listed above and no worsening of symptoms without rescue antibacterial therapy. Investigators also assessed clinical success at a post-treatment evaluation (PTE) five to 10 days following the last treatment dose, defined as resolution or improvement in signs and symptoms (S/S) of infection not needing further antibacterial therapy. Omadacycline (386 patients) was noninferior to moxifloxacin (388 patients) for ECR (81.1% and 82.7%, respectively; difference, −1.6 percentage points; 95% confidence interval [CI], −7.1 to 3.8). At the PTE, omadacycline was noninferior to moxifloxacin for rates of investigator-assessed clinical response (87.6% and 85.1%, respectively; difference, 2.5 percentage points; 95% CI, −2.4 to 7.4).[6]

2. The OASIS and OASIS-2 are multi-national double-blind, randomized trials comparing omadacycline to linezolid in adults with ABSSSI. In OASIS, patients received either omadacycline or linezolid IV therapy, with an option to transition to oral therapy after three days. In OASIS-2, only oral omadacycline or linezolid therapy was studied. Both trials had a seven- to 14-day treatment duration. Inclusion criteria consisted of adults over 18 years with a qualifying ABSSSI skin infection who had evidence of an inflammatory response. Efficacy of omadacycline was determined through number of patients achieving ECR, defined as reduction in lesions size of at least 20% at 48-72 hours after the first dose of a trial drug without rescue antibacterial therapy. Clinical success, defined as investigator assessment of resolution or improvement in S/S of infection not needed further antibacterial therapy, was studied at a PTE seven to 14 days after the last dose of a trial drug. Reported results only include patients who did not have a sole gram-negative causative pathogen at baseline.[3,7]

a) In OASIS, omadacycline (316 patients) was noninferior to linezolid (311 patients) for ECR (84.8% and 85.5%, respectively; difference, −0.7 percentage points; 95% CI, −6.3 to 4.9) and investigator-assessed clinical response at PTE (86.1% and 83.6%, respectively; difference, 2.5 percentage points; 95% CI, −3.2 to 8.2).[3]

b) In OASIS-2, omadacycline (360 patients) was non-inferior to linezolid (360 patients) for ECR (88% and 83%, respectively; difference, 5.0 percentage points; 95% CI −0.2 to 10.3) and investigator-assessed clinical response at PTE (84% and 81%, respectively; difference, 3.3 percentage points; 95% CI −2.2 to 9.0).[7]

Price

Omadacycline IV solution costs approximately $414 per each 100mg reconstituted solution. For a seven- to 14-day course of only IV therapy, including the loading and maintenance dose for CABP and ABSSSI treatment, this amounts to $3,312 – $6,210.[5]

Omadacycline oral tablets cost approximately $237 per each 150mg tablet. For a six- to 13-day maintenance dose treatment following one IV loading dose for CABP or ABSSSI, this amounts to $2,844 – $6,162. For a seven- to 14-day treatment of ABSSSI using only oral tablets, this amounts to $4,266 – $7,584.[5]

A central patient support enrollment form can be filled out by the prescriber for patients with no prescription coverage for omadacycline who have an income at or below 350% of federal poverty level.[8]

Continued on Page 54

From Page 53

Simplicity

For treatment of CABP and ABSSSI, omadacycline should be administered with an initial loading dose of 200mg IV infusion over 60 minutes or two 100mg IV infusions over 30 minutes on day one. This is followed by either a once-daily 100mg IV infusion or once-daily 300mg oral tablet for seven to 14 days.

Treatment of ABSSSI also can use oral therapy alone. An initial loading dose of once-daily oral 450mg tablets should be administered on day one and two. Then a maintenance dose of 300mg orally once daily should be continued for seven to 14 days. [4]

Omadacycline injection should not be administered with any solution containing multivalent cations (ex. calcium, magnesium) through the same IV line. Omadacycline tablets should be taken with water after fasting for at least four hours. After oral dosing, no food or drink (except water) should be consumed for two hours and no dairy products, antacids, or multivitamins for four hours.[4]

Tetracycline-class antibacterial drugs have been shown to depress plasma prothrombin activity. Patients who are on vitamin K antagonist therapy may require downward adjustment of their anticoagulant dosage while taking omadacycline. Additionally, absorption of oral tetracyclines is impaired by antacids containing aluminum, calcium, or magnesium, bismuth subsalicylate and iron-containing preparations. No dose adjustment is required for renal or hepatic impairment.[4]

Bottom line

Omadacycline (Nuzyra®) is approved for the treatment of CABP and ABSSSI in adult patients and overcomes mechanisms of tetracycline resistance, with once-daily dosing and a broader spectrum of activity compared to other tetracycline-class antibacterial drugs. It is well tolerated with the most common side effect being nausea and vomiting. Omadacycline has shown to achieve early clinical response and resolution of signs and symptoms at rates similar and non-inferior to moxifloxacin or linezolid for CABP or non-solely gram negative causing ABSSSI, respectively.

At the time of authorship, Dr. Mehta was a PGY1 Pharmacy Practice resident at UPMC St. Margaret and can be reached at mehtaap@upmc.edu, and Dr. Raghavan was a PGY2 Geriatric Pharmacy resident at UPMC St. Margaret and can be reached at raghavana2@upmc.edu. Heather Sakely, PharmD, BCPS, BCGP, provided editing and mentoring for this article and can be reached at sakelyh@upmc.edu.

References

1. Barber, Katie E, et al. "Omadecycline Enters the Ring: A New Antimicrobial Contender." *Pharmacotherapy,* vol. 38, no. 12, doi: 10.1002/phar.2185

2. Metlay, Joshua P., et al. "Diagnosis and Treatment of Adults with Community-Acquired Pneumonia. An Official Clinical Practice Guideline of the American Thoracic Society and Infectious Diseases Society of America." *American Journal of Respiratory and Critical Care Medicine,* vol. 200, no. 7, 2019, doi:10.1164/rccm.201908-1581st.

3. O'Riordan, William, et al. "Omadacycline for Acute Bacterial Skin and Skin-Structure Infections." *New England Journal of Medicine,* vol. 380, no. 6, 2019, pp. 528–538., doi:10.1056/nejmoa1800170.

4. Nuzyra [package insert]. Boston, MA: Paratek Pharmaceuticals, Inc; 2019

5. Nuzyra. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com. Accessed October 29, 2019.

6. Stets, Roman, et al. "Omadacycline for Community-Acquired Bacterial Pneumonia." *New England Journal of Medicine,* vol. 380, no. 6, 2019, pp. 517–527., doi:10.1056/nejmoa1800201.

7. O'riordan, William, et al. "Once-Daily Oral Omadacycline versus Twice-Daily Oral Linezolid for Acute Bacterial Skin and Skin Structure Infections (OASIS-2): a Phase 3, Double-Blind, Multicentre, Randomised, Controlled, Non-Inferiority Trial." *The Lancet Infectious Diseases,* vol. 19, no. 10, 2019, pp. 1080–1090., doi:10.1016/s1473-3099(19)30275-0.

8. "WHAT IS NUZYRA?" *NUZYRA® (Omadacycline) | Home,* June 2019, www.nuzyra.com/hcp/.

Legal Summary

D.C. Court: Being the 'best' does not preclude patient termination

Beth Anne Jackson, Esq.

In a Dec. 10, 2020, decision, the D.C. Circuit Court denied a woman's second attempt to obtain a preliminary injunction to force a fertility clinic to take her back as a patient pending a lawsuit she had filed against them.[1] The case was decided on two factors. The first factor was the plaintiff's likelihood of success on the merits, which the court determined was unlikely. The second factor was whether the issuance of a preliminary injunction was "in accord with the balance of equities or public interest." Due to the deterioration of the physician-patient relationship, the court determined that her reinstatement as a patient was not feasible. Another factor in the defendant fertility clinic's favor was that it did everything right.

Background. The plaintiff, who was not married, had her eggs harvested and frozen. When she later decided to attempt fertilization and implantation, she inquired regarding financial assistance. The fertility clinic advised her of its established policies, which stated that if she had a partner (whom she had previously listed on her paperwork as the sperm donor), then the partner's income would be counted for the purposes of determining eligibility for a discount. If the person was not a "partner," but rather just a sperm donor, his income would not be counted, but he would be treated as a sperm donor, which required, among other things, that his sperm be screened and frozen prior to attempted fertilization of the plaintiff's eggs. The plaintiff was not happy with either option and attempted to negotiate changes to the policies. When the fertility clinic, which had adopted the policies in accordance with ethical and other industry guidelines, resisted, the plaintiff accused it of discriminating against her because she was unmarried and on other bases. The fertility clinic subsequently discharged her first orally, and then in writing, and offered to transfer her eggs to another fertility clinic at its own cost. The plaintiff filed suit, stating that this particular fertility clinic was the "best," that others could not provide comparable care and that shipping her eggs to another clinic would cause them to deteriorate and delay their implantation, thereby interfering with her "fundamental right" to procreate. The fertility clinic presented evidence that there were at least seven other comparable fertility clinics in her geographic area and that shipping the eggs would not cause a substantial risk to their viability.

Import. Under Pennsylvania law, physicians are considered to have abandoned patients when they withdraw services after a physician-patient relationship has been established without giving the patient notice of their intent to withdraw in sufficient time to allow the patient to obtain necessary medical care. This can be difficult for primary care physicians who managed a complex patient's overall health. But it is perhaps even more difficult for highly trained subspecialists and physicians who treat a specific, complex condition, as they can be very reluctant to discharge patients who may have difficulty finding truly comparable care. However, physicians are not required to tolerate disruptive or non-compliant patients. Very few published cases regarding patient abandonment under Pennsylvania law exist; however, the lawsuit discussed above, although it has no legal effect here in Pennsylvania, provides some key elements that a practice would want to meet in the event it is accused of patient abandonment:

- Have established, written policies that are disclosed to patients at the time they join the practice.
- Ensure that staff review applicable policies with the patient and explain their application when a dispute arises and attempt to gain the patient's understanding and acceptance of the policies.
- Document policy violations and related discussions and maintain them separately from the medical record.
- Enforce policies consistently: Ensure that they are not enforced in a discriminatory or arbitrary manner.
- Provide written notice, but care for any urgent or imminent need until the effective date of termination (30 days or longer, if necessary).
- Provide assistance, if necessary and appropriate, depending on the patient's abilities and resources. For example, you may need to assist in obtaining a referral and/or prior authorization to an out-of-network specialist if you are the only sub-specialist that is in-network.
- Facilitate the transfer of records to ensure continuity of care.

There are two potential situations that may complicate ending an established patient relationship: first, if the patient is in the global surgical period for which you have already been paid and the patient is in need of further follow-up; and second, if you are truly the only physician in a geographic area competent to perform a procedure or treat a particular condition.

Conclusion. Allegations of patient abandonment are serious and may lead

Continued on Page 56

Legal Summary

From Page 55

to disciplinary action against a physician's license. But that doesn't mean that patients have a right to remain or be taken back as a patient once they have violated established practice policies or created hostilities with the practice or its staff even if you are the "best" clinic or practice, or individual physician, for a given condition. However, be sure to review your contract with the patient's insurance company for any further parameters on discharging patients. On a final note, tread carefully and consider consulting a qualified attorney if special circumstances exist.

DICLAIMER: This article is for information purposes only and does not constitute legal advice. You should contact your attorney to obtain advice with respect to your specific issue or problem.

Ms. Jackson is a shareholder in the Health Care Practice Group of Brown & Fortunato, P.C., which is headquartered in Amarillo, Texas, and serves healthcare providers nationally. She is licensed in both Pennsylvania and Texas and maintains an office in the greater Pittsburgh area. She may be reached locally at (724) 413-5414 or bjackson@bf-law.com. Her firm's website is www.bf-law.com.

Reference

1. E.M. v. Shady Grove Repr. Sci. Ctr., No. 19-657 (D.D.C. Dec. 10, 2020).

One year later

Mary Lou Marsh

I've been the business manager for Weinstein Imaging Associates for 40-plus years. During that time, I've seen major changes in technology, health-care policies/practices, insurances (introduction of HMOs!), not to mention fashion, music and hairstyles. You would think the saying "I've just about seen it all" would apply. Sadly, the early months of 2020 and the rapid spread of COVID-19 contradicted that statement.

Everyone in every part of the world had their reality turned upside-down in 2020. And our thriving, independent Radiology practice was no exception. COVID-19 was the pandemic of our lifetime, which would eventually infect more than 20 million and kill 486,000+ Americans (according to the CDC at time of print), and crush our economic way of life.

Strict "shelter-in-place" orders would help limit the population's exposure to this highly contagious disease. As a result, many businesses would have to close their doors. We made the tough decision to close in mid-March, and managing the business became somewhat of a roller coaster ride, shaping the routine of our doctors and myself for many months. We now faced mounting accounts payable vs. dwindling accounts receivable, scores of patient appointments that needed to be canceled/rescheduled, along with taking the necessary steps to eventually reopen (but *when?*). All of this often had me working seven days a week.

For the rest of our loyal staff, they were now on unemployment, adjusting to their new normal: not working. For many, this was a new concept. I have employees who are in their 50s/60s who never in their lifetime had filed for unemployment. Many of them kept in touch via group texts and emails, talking about reorganizing their closets, starting new hobbies, cooking new recipes and the latest shows to binge watch on Netflix.

My physicians and I did not have that same experience. We spent time closely following what hospitals and other imaging centers were doing regarding imaging, both locally and nationally. We kept up with Gov. Wolf's announcements and state protocols. I familiarized myself with new acronyms, such as FFCRA (Families First Coronavirus Relief Act) and PPP (Paycheck Protection Program), to name a few. It was time for this "old dog" to learn some "new tricks." I participated in many webinars, and pored over multitudes of articles to stay on top of "all things COVID."

New apps and workflows were on the horizon from our software vendors, which would be ready to implement upon reopening our practice. The "Wait in Car" app was our favorite. This is a wonderful tool that keeps patients in their car until we are ready to see them, therefore reducing the traffic in our office. This app could be a keeper, even post pandemic.

Given the reported PPE shortages, I went in search of supplies I knew our office would need to reopen. I visited each of our office locations to rearrange just about everything. With the help of my husband (tape measure, tools and *wire ties* in tow), we plotted six-foot distances between work stations and began the process of moving computers. We spread out furniture in all the waiting areas to distance our patients and installed new signs regarding facemasks. We were finally ready to open our doors again, scary as that thought might be!

With reopening day just around the corner, there was some trepidation with how it would all work out. But we all felt prepared to safely begin seeing patients again, with new "staggered" schedules, new apps and boatloads of new protocols. We initially worked evenings every day, plus Saturday hours, in an effort to catch up on the two months we were closed. We adjusted; we did it! The new workflows we put in place are now an accepted part of our lives and have become routine. We

Continued on Page 58

From Page 57

"go with the flow" to get through each challenging day. We've learned to deal with many questions from our patients (along with the occasional misunderstanding) regarding the COVID protocols we've put in place. Welcome to these challenging COVID times.

On a positive note, we have received many compliments from our patients, who appreciate less contact with others in our waiting room, applaud us for our COVID precautions and express feeling "safe from the virus." Our new COVID efficiencies seem to be working.

As we approach the one-year anniversary of the pandemic, I think it's a good time to reflect. We have sadly lost more than 486,000+ lives to COVID-19. Many of us have been directly affected with personal losses of our own. We watched businesses close for good. We somehow found strength in adapting to new ways of living our lives, whether we liked it or not.

This pandemic is far from over. Wearing a mask is still so important, to protect ourselves and protect others. We must keep practicing social distancing, and continue to not shake hands or share hugs with people. If we treat others with respect and kindness, and help our patients, friends/family and strangers, it will provide us with uplifting feel-good moments. Those are our rewards.

We will get to the other side of this, and come out stronger doing it. We've broadened ourselves and are better because of it. Unfortunately, this won't be the last time something like this will happen. Next time, though, we all will be better prepared, and believe it or not, we'll be better individuals for having lived through this pandemic nightmare.

Ms. Marsh has been the business manager for Weinstein Imaging Associates since 1980 (the year of their inception), with three office locations, four radiologists and 32 employees. She lives in Mars with her husband, Richard. She can be reached at bulletin@acms.org.

Classifieds

FOR SALE

Solo ophthalmology turnkey opportunity for sale/successor near airport. Suitable satellite for established group. Three lanes, minor surgery suite, IOL Master, Spectralis, Humphrey AVF, DIopsys, topography, cosmetic lasers. EHR with seamless practice management and billing team. Real estate option with additional office suite, off-street parking for 22 cars. Willing to stay on during transition. Contact Box1022@acms.org.

For classified advertising information, including special member rates, email msable@acms.org, or call (412) 321-5030.

Where to turn…

Domestic Abuse Palm Cards Available at ACMS

Where-to-Turn cards give important information and phone numbers for victims of domestic violence.

The cards are the size of a business card and are discreet enough to carry in a wallet or purse.

Call ACMS at (412) 321-5030 for more information.

Special Report

REPORTABLE DISEASES 2020: Q1-Q4

Allegheny County Health Department
Selected Reportable Diseases/Conditions

Selected Reportable Disease/Condition*	January to December**		
	2018	2019	2020
AMEBIASIS	1	1	4
CAMPYLOBACTERIOSIS	144	118	96
COVID-19	0	0	54,654
CRUETZFELDT-JAKOB DISEASE	4	1	0
CRYPTOSPORIDIOSIS	31	33	12
DENGUE FEVER	1	1	0
GIARDIASIS	67	71	53
GUILLAIN-BARRE SYNDROME	1	3	5
HEPATITIS A	17	8	5
HEPATITIS B ACUTE	6	9	8
HEPATITIS B CHRONIC	61	72	44
LEGIONELLOSIS	95	86	53
LISTERIOSIS	5	3	3
MALARIA	4	3	0
MEASLES	1	7	0
MUMPS	2	3	1
NEISSERIA MENINGITIDIS	1	1	1
PERTUSSIS	22	40	23
SALMONELLOSIS	137	125	87
SHIGELLOSIS	24	16	11
SHIGATOXIN-PRODUCING E COLI	24	24	20
STREPTOCOCCUS PNEUMONIAE INVASIVE	47	43	27
TOXOPLASMOSIS	3	3	0
TUBERCULOSIS	20	11	15
TYPHOID FEVER	1	1	0
VARICELLA	27	28	7
WEST NILE VIRUS	5	0	0
ZIKA VIRUS	1	0	0

* Case classifications reflect definitions utilized by CDC Morbidity and Mortality Weekly Report.

** The 2020 counts do not reflect official case counts, as numbers are not yet finalized. Inaccuracies in working case counts may be due to reporting/investigation lag.

NOTE: Disease reports may be filed electronically via PA-NEDSS. To register for PA-NEDSS, go to https://www.nedss.state.pa.us/NEDSS. To report outbreaks or diseases reportable within 24 hours, please call the Health Department's 24-hour telephone line at 412-687-2243.
For more complete surveillance information, see ACHD's 10-year summary of reportable diseases: https://www.alleghenycounty.us/Health-Department/Resources/Data-and-Reporting/Infectious-Disease-Epidemiology/Epidemiology-Reports-and-Resources.aspx.

headspace

Download Headspace for free with your membership to the Pennsylvania Medical Society and Allegheny County Medical Society ($65 value).

Learn the life-changing skills of meditation and mindfulness with hundreds of guided exercises for any mood.

Visit our Member $avings Page: **www.pamedsoc.org/MemberSavings**.

Pennsylvania Medical Society®

ADVOCATE. EDUCATE. NAVIGATE.

ALLEGHENY COUNTY MEDICAL SOCIETY FOUNDATION

855-PAMED4U (855-726-3348) • KnowledgeCenter@pamedsoc.org • www.pamedsoc.org/Join