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A PUBLICATION FOR THE MEDICAL STAFF OF KENNEDY HEALTH SYSTEM

Welcome
Dr. Boehler



Welcome to Richard Boehler, M.D., MBA, FACPE Kennedy's New Chief Medical Officer

Richard Boehler, M.D., MBA, FACPE, has been named Chief Medical Officer for the Kennedy Health System. Dr. Boehler joins Kennedy from the St. Joseph Medical Center in Towson, MD, where he had served as Vice President of Medical Affairs and Chief Medical Officer since December 2004.

In his new role at Kennedy, Dr. Boehler will provide executive medical oversight for the health system. Dr. Boehler will support the activities of Kennedy's Medical Staff, serving as a direct liaison between the doctors and hospital administration. He will also expand on existing clinical services, as well as implementing new programs.

A 1980 graduate of Albany Medical College in Albany, NY, Dr. Boehler completed his Internship and Residency in Internal Medicine at Albany Medical Center. He earned his MBA from SUNY Empire State College in 1984. He also holds an MS, Ed.S. degree in counseling and personnel services from SUNY at Albany.

Dr. Boehler was a private practice Internal Medicine physician from 1983 until 1991, when he moved into a series of progressively responsible leadership roles at hospital systems in New York, Massachusetts and Maryland. He served as an Instructor in Medicine at Harvard Medical College in Cambridge, MA, from 2001 to 2004 and at Johns Hopkins University School of Medicine in Baltimore, MD, from 2006 to the present.

A fellow of the American College of Physician Executives and a member of the American College of Healthcare Executives, Dr. Boehler was named "Best Samaritan" in 1999 by *Hudson Valley Magazine* for his community service to the homeless and chemically addicted. *The Daily Record*, a Maryland newspaper, recently selected Dr. Boehler as one of their 2010 "Health Care Hero" finalists for his work in mortality reduction and healthcare for the uninsured.

See insert with
key phone numbers
and contact names
for all of Kennedy's
ambulatory services.

Physician News



Carman A. Ciervo, D.O., FACOFP, has been elected to the Board of Governors for the American College of Osteopathic Family Physicians (ACOPF), a national organization of 21,000 osteopathic family physicians, residents and students that promotes excellence in osteopathic family medicine through responsible advocacy, quality education and visionary leadership. As an ACOFP Board Member, Dr. Ciervo will help establish national healthcare policy and training standards for the profession of osteopathic family medicine. He will also serve as Department Chair for five committees within the ACOFP Department of Governance & Operations.

James C. D'Amico, DO, FACOI, a member of the Kennedy Cancer Committee, has passed the certifying examination and is now board certified in hospice and palliative care by the American Osteopathic Board of Internal Medicine. Dr. D'Amico is also a medical director for Caring Hospice Services.

Neil M. Cohen, MD; Evan Scott Sorokin, MD; and Paul S. Panebianco, DO; were named Nurses' Choice list of top doctors in the February 2010 *New Jersey Monthly* magazine. All licensed New Jersey nurses were invited to make their choices through an online survey from April 20-July 31, 2009.

New Appointments

Department of Family Medicine

Joseph Gallagher, DO
Richard S. Weiss, DO

Department of Medical Imaging

Justin Bekelman, MD
Amit Maity, MD

Department of Medicine

Cardiology
Kevin Duffy, MD

General Internal Medicine

Sreedevi Boliseti, MD
Ahsan Jafir, DO
Mini Mathew, DO
Sajjad A. Sabir, MD

Nephrology

Richard L Specter, MD

Department of Obstetrics/Gynecology

Roberta R. Milligan, CNM
Kathleen Riley, CNM

Department of Pediatrics

Harold George Marks, MD
Neurology
Erin Wright, MD

Department of Psychiatry

Lisa Abrams, APN
Rafael Baez, MD
Sally A. French, APN
Akhil Sethi, MD

Department of Surgery

Anesthesiology
Myrna Morgan, CRNA

Cardiothoracic

Kenneth Lee, MD

General Surgery

Karen Angel, RNFA
Alejandro Gandsas, MD

Oral Surgery

Jennifer Cully, DMD

Vascular Surgery

Kent S. Haas, MD

Orthopedic Surgeon Volunteers in Haiti

Imagine preparing for a surgery without the x-ray, CT scan, MRI, and other major medical equipment, such as suctions and tourniquets. How would you go about your surgery?

This is one of many challenges that Kennedy's Orthopedic Surgeon Joseph Daniel was faced with when he devoted two weeks of his time and expertise to those devastated by the earthquake in Haiti.

Instead of his normal, sterile operating room, Dr. Daniel performed countless surgeries in the back of a circus-style tent that housed about 200 children.

Performing mostly amputations and external fixations, one Bovie was shared among four operating tables. Additionally, most patients were only given conscious sedation anesthesia.

A team consisting of Dr. Daniel and two other surgeons would perform 25 to 35 surgeries a day as opposed to the five a day he completes in New Jersey.

"The trip has made me much more thankful for where I live and the quality of surgical and clinical care that I can provide for my patients," commented Dr. Daniel.

The surgeon had the opportunity to sleep, eat, and operate with doctors and medical staff from all over the United States – and from countries as far away as Israel and Czech Republic.

"Where I stayed, there were four very large tents with plywood floors," Dr. Daniel recalled. "The first tent was a common sleeping area for about 300 healthcare providers. The second tent housed about 200 adult patients on cots. The third tent held both operating room and about 200 pediatric patients on cots. The last tent was for supplies."



Dr. Joseph Daniel (left) and Dr. Anel Abreu performed orthopedic surgeries in Haiti.

Dr. Daniel could not view the total devastation of Port-au-Prince, since it was recommended that he and the other doctors stay in the tent community, which was safely guarded by the 82nd Airborne. However, Haitians arrived to the site by the truckload for medical assistance.

Working in Haiti was challenging for the Chief of Orthopedic Surgery at the University of Medicine and Dentistry of New Jersey's School of Osteopathic Medicine, but being able to help a country in need was life changing.

"There were two things about being in Haiti that affected me deeply," Dr. Daniel said. "It redefined how giving human beings are to people less fortunate than themselves, and it amazed me how thankful the population was that we were there helping them."

Many of the Haitian people have nothing. No home to go to, no clean clothing to wear. The country is going to need help for a long time to come.

Dr. Daniel asks that Americans donate money if they can afford to. In the meantime, before flying back to the states, Dr. Daniel left behind his sleeping bag, mosquito netting and clothing because he felt they might be put to better use by someone in Haiti.

– Stephanie Libes

Bariatric Program Accredited by American College of Surgeons

More than 11 million people in the U.S. suffer from severe obesity, and the numbers continue to increase. Kennedy surgeons have performed more than 200 bariatric surgeries over the past three years, and now Kennedy can proclaim accreditation by the Bariatric Surgery Center Network Accreditation Program of the American College of Surgeons (ACS). The ACS looks for positive outcomes, evidence-based practice and staff and patient education before bestowing the accreditation.



Bariatric Program Coordinator **Lisa Shaw, RN, CMSRN, CBN**, on board with Kennedy since summer 2009, worked diligently to put together all of the program's clinical pathways. A former bariatric patient herself, Lisa finds inspiration from the patients she counsels and offers support to, both pre- and post-surgery. Lisa also spent a great deal of time educating staff, developing the pre-op class, standardizing bariatric discharge instructions and post-operative order sets – all requirements for accreditation.

The Bariatric Teaching Room – where Lisa meets with prospective weight-loss patients – is located at Kennedy-Stratford. This pre-op education class is a program requirement, with emphasis on the importance of the post-op lifestyle change – a key to successful bariatric surgery.

Another key component to bariatric success concerns proper nutrition information. Each Kennedy bariatric surgical patient is required to see nutritionist **Valerie Joo, RD**, who provides both pre- and post-surgical nutrition counseling. Valerie also sees every bariatric patient as an inpatient to go over what they can and cannot eat, and the proper amounts of those foods.

Kennedy's support doesn't end after the patient is wheeled out of the recovery room, either. A monthly support group, led by Kennedy associate and former bariatric patient **Eileen O'Brien** is held the 4th Monday of the month at Healthtrax in Washington Township. This group has 25-45 people in attendance and features various guest speakers. Both Kennedy bariatric surgeons – **Dr. Marc Neff** and **Dr. Louis Balsama** – attend the support group.

For more information about the Kennedy Bariatric Surgery Program, contact **Lisa Shaw** at **856/346-6470**.

Malignant Pleural Effusions By Kenneth Adam Lee, MD



Malignant pleural effusions (MPE) are commonly diagnosed, evaluated, and treated at Kennedy and are most frequently caused by carcinomas of the breast, lung, GI tract, ovary or lymphomas. The literature indicates that either pulmonologists or thoracic surgeons are the first specialists consulted for this diagnosis.

An international survey on managing MPE was performed by the Society of Thoracic Surgery. Physicians who participated were actively involved in managing MPE and were asked to consult on a middle-aged inpatient diagnosed with stage IV non-small cell lung cancer with a symptomatic uniloculated unilateral MPE.

The most common response was that definitive intervention should follow an attempt at therapeutic thoracentesis, although nearly an equal number of respondents indicated that definitive intervention was appropriate at the time of diagnosis.

More than 50% of participants recommended a VATS (Video Assisted Thorascopic) pleurodesis as the optimal intervention, whereas about 28% indicated chest tube and sclerosis as their treatment of choice. The degree of symptoms exhibited influenced the type of treatment recommended by most of the respondents. Talc was the most preferred sclerosing agent and the most common chest tube management strategy was removal after 2-4 days.

VATS pleurodesis can be performed under local, regional or general anesthesia and can potentially reduce the patient's length of stay. Other advantages over a chest tube drainage and pleurodesis are:

- thoracoscopy with biopsy of suspicious pleural lesion
- lysis of adhesions
- evaluation of lung expansion
- installation of the sclerosing agent during the same procedure

The use of a pleuroperitoneal shunt has also been shown to control the dyspnea associated with MPE's, although about 25% of shunts will become occluded during the patient's lifetime.

Save the Date: 2010 Golf Outing

Once again, Kennedy will hold its annual golf outing at **Galloway National Golf Course** in Galloway Township, NJ. Mark Tuesday, **September 28th** on your calendar!



Legislation Initiatives for Organ and Tissue Donation

By Dr. Livia Bratis, Kennedy-Stratford Intensivist



New Jersey now leads the way with legislation that is more supportive of organ and tissue donation. Recently, three initiatives were signed into NJ law regarding the organ and tissue donation process. In April, Dr. Livia Bratis and the Gift

of Life staff conducted Ethics Grand Rounds to review these initiatives in honor of National Donor Month.

The *first initiative* is called the **Revised Uniform Anatomical Gift Act**. This act is broad in scope and first involves **donor designation status**, where the organ procurement organization (OPO) has access to the Department of Motor Vehicles (DMV) for the purpose of checking donor status. When the patient is a candidate for donation, and the donor designation is on the license, the intention is to develop a clinical plan that supports the identified opportunity. In the absence of a donor designation, the hierarchy of decision-making has slightly changed using the following:

In the absence of a refusal or a designation, who may make a gift?

HIERARCHY

- An Agent
- Spouse, Civil Union Partner or Domestic Partner
- Adult Child
- Either Parent
- Adult Sibling
- Another Adult who is related by blood, marriage or adoption; or exhibited special care and concern such as a special guardian
- Any Other Person having authority to dispose of the body

The Hero Act is the *second initiative* and involves required questions regarding organ donation at the time of applying for or renewing a driver's license, as well as required curriculum in high school and medical/nursing schools dispelling myths of donation.

The *third initiative* is the **Anatomical Recovery Act** which provides legislature to ensure the standards for operating an anatomical research recovery organization so that families can be confident that these organizations are non-profit and accountable.

Clinicians are reminded how they can make a real difference in the donation opportunity and outcomes by making timely referrals to the Gift of Life using these triggers:

- At the first indication that a patient has suffered a non-recoverable neurological injury or non-recoverable illness (patient begins to lose reflexes)
- Prior to the first formal brain death exam
- Prior to withdrawal of support (e.g., pressors, ventilator, defibrillator, pacemaker, etc.) or withholding support (e.g., DNR order) - **NEW trigger added to Kennedy's policy!**

Physicians need not be alarmed about initiating a referral to Gift of Life, as any onsite coordinators will stay in the background until the patient is determined to be a suitable donor and the clinical team feels the family/proxy is ready to be approached regarding donation. The Kennedy policy was recently revised to stress that the attending physician will be notified when his/her patient is referred to Gift of Life as a donor candidate. Research has shown that the best chance for consent for donation is when the family/proxy is approached by both the trained Gift of Life designated requestor in collaboration with members of the clinical team, once there is acceptance of death/impending death. As such, physicians are reminded that neither party should discuss donation without the other present. Other triggers that will prompt a family discussion about donation include: 1.) if the family has made a decision to forego life-sustaining therapies; 2.) if the patient becomes hemodynamically unstable and the opportunity for donation is compromised; 3.) if a member of our team broaches the topic independent of support from Gift of Life; 4.) if the family expresses interest or requests information.

It should be noted that sometimes testing is needed to determine if a patient is an organ donor candidate. As a result, the law now provides that as part of the medical evaluation for donor suitability, Gift of Life may conduct any blood or tissue test or minimally invasive exam reasonably necessary for the purpose of determining medical suitability. Neither patient nor family consent is necessary and these services/tests are reimbursable by Gift of Life.

State-of-the-Art Fine Needle Aspiration Cytopathology Service Offered

Kennedy now offers state-of-the-art pathology services at all three campuses. Among these is the fine needle aspiration cytopathology service.

Fine needle aspiration (FNA) is a non-invasive diagnostic procedure used to sample either palpable masses or non-palpable lesions using ultrasound or CAT-scan guidance. In an FNA procedure, a very thin needle is inserted into a mass to extract cells, which are placed on a slide, stained, and examined under a microscope. The FNA procedure is very safe and non-invasive. Often, major surgery can be avoided by performing an FNA.

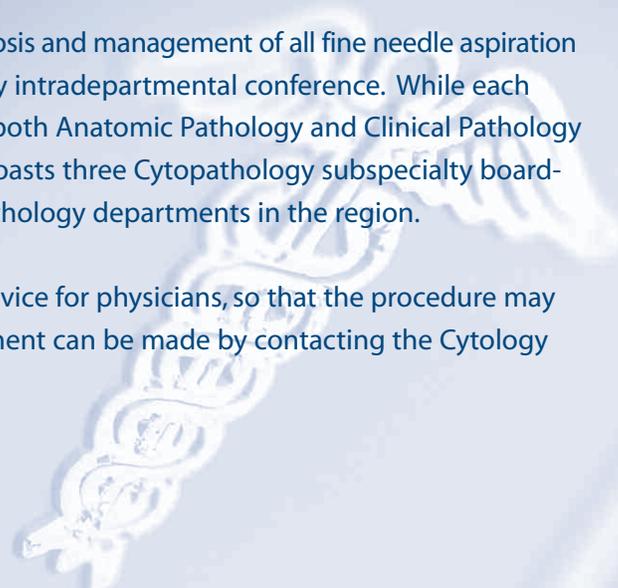
"Kennedy is very fortunate to have top-notch cytopathologists and technicians who process and diagnose these often difficult fine needle aspiration specimens," states **Janusz Godyn, M.D., F.C.A.P., F.A.S.C.P.**, Chief of Pathology and Laboratory Medicine at Kennedy. He adds, "The outstanding level of expertise shown by the pathologists and cytotechnologists at Kennedy is truly impressive."

In January 2010, **Alan Shienbaum, D.O., F.C.A.P., F.A.S.C.P.**, Director of Anatomic Pathology and Section Head of Cytopathology, instituted the new Bethesda System for reporting thyroid fine needle aspiration specimens at Kennedy University Hospital. In doing so, Kennedy became one of the first medical centers in the region to adopt this new cutting-edge reporting system.

"The Bethesda System for thyroid FNA allows for the clear, concise, and uniform reporting of thyroid aspiration specimens," states Dr. Shienbaum. He further adds, "The diagnostic categories are predicated on the different risk associations for malignancy of the various thyroid lesions that are encountered." Among the many benefits of this new reporting system are improved communications and facilitated cytologic-histologic correlation.

The Kennedy pathologists are each highly skilled in the diagnosis and management of all fine needle aspiration specimens. Each malignant diagnosis is reviewed at the daily intradepartmental conference. While each member of the Pathology Department is board-certified in both Anatomic Pathology and Clinical Pathology by the American Board of Pathology, the department also boasts three Cytopathology subspecialty board-certified members, giving Kennedy one of the finest cytopathology departments in the region.

The Cytology Department offers a customized "travel to" service for physicians, so that the procedure may be offered at the physician's practice location. This arrangement can be made by contacting the Cytology Department at **856/488-6560**.



Underage Drinking – The Facts Are Startling!

By John Pellicane, Behavioral Health Case Management Specialist

According to the Surgeon General, “For the most part, parents and other adults underestimate the number of adolescents who use alcohol. They underestimate how early drinking begins, the amount of alcohol adolescents consume, the many risks that alcohol consumption creates for adolescents, and the nature and extent of the consequences to both drinkers and nondrinkers.”¹

Underage drinking – defined by the Surgeon General as drinking under the age of 21 – is a serious issue in the United States, as alcohol plays a big part in American culture. Statistics prove that the earlier in life a person engages in alcohol use, the greater the likelihood the use will become abuse – with all of the associated negative consequences on a person’s health and lifestyle.

1. <http://www.surgeongeneral.gov/topics/underagedrinking/CommunityGuide.pdf>
2. http://www.ncadd.org/facts/underaged_drinking.html

FAST FACTS²

- Alcohol is the drug of choice among America’s adolescents
- Approximately 10% of 9-10 year-olds have started drinking
- Nearly 1/3 of youth begin drinking before the age of 13
- People who report an age of first use of alcohol prior to 15 are five times more likely to report past-year alcohol dependence compared to those whose age of first use is 21 or older.

Annually:

- 600,000 students are unintentionally injured while under the influence of alcohol
- 700,000 students are assaulted by someone under the influence
- 100,000 students are victims of alcohol-related sexual assault or date rape
- Alcohol plays a key role in accidents, homicides and suicides – the leading causes of death among youth
- Alcohol kills six times more young people than all illicit drugs combined



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