Huntington Hospital

medical staff news

JUNE 2016 VOLUME 54, ISSUE 6

INSIDE THIS ISSUE

From the president

Speak your Mind

James Shankwiler, MD | Medical Staff

Previously, thought was considered to be independent of language. However, it is increasingly being noted that the language we use shapes not only our thinking but also our perceptions of the world. Humans utilize a vast array of symbols and sounds to help frame and communicate thoughts, concepts and basic information to each other. Medicine has its own unique lexicon to help express and unite ideas and convey data effectively. The language of medicine, like all languages, has grown and changed over time. It now incorporates with increasing frequency terminology on cost containment, outcomes and a broader community focus. One has to wonder is this changing the way we think and perceive of ourselves as physicians?

> **"A different language is a different vision of life."**
> – Federico Fellini

The idea that language significantly impacts cognition has a long and storied history. It has been a topic of philosophical and scientific contention for quite some time and in fact was even argued by Greek philosophers and sophists (IEP). In the 1930's, the idea became associated and championed by American linguists Edward Sapir and Benjamin Lee Whorf (Kay). Despite this, it is only in the last few decades that empirical evidence has begun to support the hypothesis that language may indeed change one's thoughts and perceptions.

There are approximately 7,000 different languages in the world today. Each has its own rules and semantics concerning the conveyance

continued on page 3

Board meeting. As provided by the Bylaws of the Governing Body and as the designated sub-committee of the Governing Board the following items were presented and approved by the Medical Executive Committee of May 2, 2016.

Medical staff appointments

Seruya, Mitchel, MD
Plastic Surgery
3160 Geneva Street
Los Angeles, CA 9002
Phone: (213) 388-3151
Fax: (213) 387-7528

Medical staff resignations

Gade, Rajesh, MD – effective 06/30/2016
Gin, Greg, MD – effective 06/30/2016
Greengold, Nancy, MD – effective 06/30/2016
Kao, Eric, I., MD – effective 04/08/2016
Kao, Anne, MD – effective 06/30/2016
Kardos, Steven, MD – effective 06/30/2016
LaRue, Aaron, CCP – effective 06/30/2016
Medici, Rochelle, PhD – effective 06/30/2016
Mehta, Akshay, MD – effective 06/30/2016
Paronian, Gregor, MD – effective 06/30/2016
Schooler, Wesley, G., MD – effective 04/30/2016
Senane, Jora, RNFA – effective 06/30/2016
Swamy, Ramya, N., MD – effective 03/31/2016
Velkuru, Hymavathi, MD – effective 06/30/2016
Vickers, Laura, MD – effective 06/30/2016
Williams, George, F., MD – Retirement effective 02/29/2016
Yung, John, MD – Effective immediately

Huntington Hospital

medical staff **news**

If you would like to submit an article to be published in the Medical Staff Newsletter please contact Gladys Bonas, **(626) 397-3770** or **Gladys.bonas@huntingtonhospital.com.**

Articles must be submitted no later than the first Friday of every month.

CME *corner*

Medical Grand Rounds

TOPIC	**Updates in Venous Thromboembolism: Prophylaxis, Treatment, Complications**
SPEAKER	Gabriella Sherman, MD; Daphne Stewart, MD; Gabriel Akopian, MD; Ashish Patel, MD
DATE	June 3, 2016
TIME	12 – 1 p.m.
PLACE	Research Conference Hall
AUDIENCE	Internal Medicine, & Primary Care Physicians
METHOD	Lecture
CREDITS	1.0 AMA PRA Category 1 Credits™

Second Monday

TOPIC	**Finally, New Drugs for CHF**
SPEAKER	Gary Conrad, MD; Mayer Rashtian, MD
DATE	June 13, 2016
TIME	12 – 1 p.m.
PLACE	Research Conference Hall
AUDIENCE	Cardiology, Internal Medicine, & Primary Care Physicians
METHOD	Lecture
CREDITS	1.0 AMA PRA Category 1 Credits™

If you would like a copy of your CME credit report please contact Gladys Bonas via email at Gladys.Bonas@huntingtonhosptial.com

Administrative *reports*

Please go to SharePoint → Medical Staff Services → Board Approved Items → 2016 and select May 2016.

Celebrating milestones

The following physicians hit a service milestone in the month of June. The medical staff would like to recognize the following physicians for their **service and dedication** to Huntington Hospital.

35 years (on staff 06/1981)

Koehler, Stephen, MD
Hematology/Oncology

30 years (on staff 06/1986)

Fisher, Alan J., MD
Otolaryngology

Loitz, Robert D., MD
Pediatric Cardiology

15 years (on staff 06/2001)

Singla, Neil K., MD
Anesthesiology

10 years (on staff 06/2006)

Akopian, Gabriel, MD
General Surgery

Feldman, Clifford R., MD
Psychiatry

Linna, Alexander, MD
Pediatrics

Yi, Tom Y., DO
Family Medicine

President Message CONTINUED

of information. It is within these linguistic restrictions that cognitive differences become apparent. Research has shown that language shapes some of our thoughts concerning basic aspects of existence such as space, time and causality of events. For instance, native Kuuk Thaayorre speakers, a language spoken in Northern Australia, use the cardinal points of the compass to determine spatial relationships. For example, one would be sitting southeast from someone while reading this, not just across the table. In fact, they even structure the passage of time in an east to west direction. On the other hand, western speakers tend to always organize their temporal events from left to right while Arabic and Hebrew speakers organize from right to left, despite the orientation of the compass (Boroditsky). Moreover, there is increasing evidence to show that what we say actually molds how we think. For example, studies have shown that teaching people new words for colors helps enhance their ability to discern different color variations. Also, bilingual speakers have been shown to alter their biases and interpretations of events depending upon which language they are asked in. In fact, it has been proven that competing verbal tasks, which impede language, can impact basic thought processes such as counting and color interpretation (Ogunnaike, Boroditsky).

Physicians are defined by their thinking. We analyze, organize, and conceptualize the body of medical knowledge and information and add our personal experience to the equation in order to help find safe paths for our patients to walk. In the coming era, with the advent of new concerns and perceptions that not only drive the way we communicate but also create neologisms that define the concept of quality medicine, we will undoubtedly also change the way we perceive and think of our patients as well as ourselves as doctors.

Bibliography

Boroditsky, Lera. "How Language Shapes Thought." *Scientific American* (2011): 63-64. *Psych.stanford.edu*. Stanford University. Web. 8 May 2016. <https://psych.stanford.edu/~lera/papers/sci-am-2011.pdf>.

"Internet Encyclopedia of Philosophy." *Internet Encyclopedia of Philosophy*. Ed. James Fieser and Bradley Dowden. Internet Encyclopedia of Philosophy, n.d. Web. 08 May 2016. <http://www.iep.utm.edu/sophists/>.

Kay, Paul, and Willet Kempton. "What Is the Sapir-Whorf Hypothesis?" *American Anthropologist* 86 (1984): 65-79. Print.

Ogunnaike, Oludamini, Yarrow Dunham, and Mahzarin R. Banaji. "The Language of Implicit Preferences." *Journal of Experimental Social Psychology* 46.6 (2010): 999-1003. *Fas.harvard.edu*. Harvard University, 18 July 2010. Web. 8 May 2016. <http://www.fas.harvard.edu/~mrbworks/articles/2010_Ogunnaike_JESP.pdf>.

From the

Clinical Documentation Specialists

Congestive Heart Failure

CHF increases the severity of illness of the patient, whether it is chronic or acute. Extra resources such as diuretics, potassium, daily weights, special diets and fluid restrictions are utilized. It is important to document it correctly to accurately reflect the complexity of care and management of the condition

Acuity:

- Acute (first event)
- Acute or chronic (subsequent events)
- Chronic (maintained on any combination of home meds: diuretics, ace inhibitors, nitrates, beta blockers, angiotension II receptor blockers, calcium channel blockers

Type:

- **Systolic** (EF<40%) or **HFrEF** (heart failure with reduced ejection fraction) Evidence of impaired contraction; left ventricular dilation/enlargement and low cardiac output due to impaired emptying. Sometimes called left heart failure.

- **Diastolic** (Normal EF) or **HFpEF** (heart failure with preserved ejection fraction)
  EF >50%. Concentric ventricular hypertrophy/thickening causing impaired relaxation and poor filling. Sometimes called right heart failure.

- **Systolic and Diastolic**
  Reduction in stroke volume; both ejection fraction and stroke work are decreased.

Points to remember:

- Dysfunction ≠ Failure
- EF 35% ≠ HFrEF
- Always **document type and acuity**
- Avoid use of ''history of CHF'' if treating or monitoring CHF during the admission
- Avoid: CHF –stable, CHF compensated, H/O CHF

New dates for H@nk One

New go-live dates have been confirmed for Phase 1 of the H@nk One initiative.

The new dates are as follows:

- **6 West** goes live on **June 7**,
- **Emergency Department** goes live on **June 14**, and
- **4 East** goes live on **June 22**

H@nk One introduces technology that will transform your clinical system user experience at Huntington Hospital. On H@nk One workstations, clinical users will access their own personal desktop by tapping their badge and entering a 4 character numeric PIN. Other features include:

- ➢ Roaming from workstation to workstation, your session will resume exactly where you left it, and the closest printer will automatically be selected.
- ➢ You will automatically be logged on when you launch a select group of applications, e.g., Cerner.
- ➢ Print jobs can be sent to "the cloud" and held until you tap a printer with your badge.

Management of Severe Pain

At times we all need reminders of the physical and psychological consequences of severe pain. It can affect recovery from an illness and the patient's responses to pain in the future. Some patients can be challenging to manage. Sometimes it may be a matter of simply increasing the dose or frequency of medication, and sometimes it may require changing or adding medications. During the most recent CMS survey, an opportunity for improvement was identified with respect to our pain management protocol and as such we have reminded RN's to notify the physicians when a patient has two assessments in a row with a documented pain level of 8 or higher. Further, when a physician is reviewing the patient's medical record and identifies unrelieved severe pain, the physician has an opportunity to consult with a pain management and/or a palliative care physician.

With all of the media and political focus on the addiction and misuse of pain medications in the community, physicians may be concerned about using higher doses of opioids to manage a patient's severe pain. The World Health Organization recommends using non-opioids for mild pain, adding opioids and adjuvant agents for moderate pain, and higher doses of opioids for severe pain. If an individual physician is not comfortable doing this, there are resources for management of patients with severe pain. The Palliative Care team is available for consult on patients whose pain is difficult to manage, regardless of diagnosis. The patient does not need to be at the end of life. Palliative Care physicians are experts in pain management. The Anesthesia Pain Management Team is another

expert resource for physicians.

In the event the plan of care is to withdraw opioids for a specific patient, this should be clearly documented in the progress notes and communicated to nursing in person. Alternatives to opioids should be incorporated into the plan of care, and the team of nurses and physicians caring for the patient should all know that this is the plan.

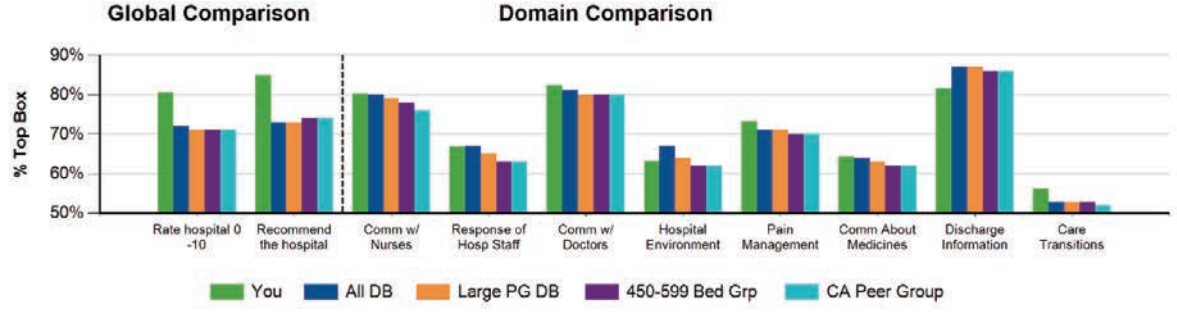
Press Ganey Results

PRESS GANEY®

HCAHPS Summary Report

Huntington Memorial Hospital

Surveys Returned: February 2016 - April 2016



Comm w/ Doctors	213	79.7%	82.3%	▲	58	67	80	67
Doctors treat with courtesy/respect	213	86.2%	85.4%	▼	33	34	42	51
Doctors listen carefully to you	212	79.1%	79.7%	▲	48	54	61	62
Doctors expl in way you understand	213	73.6%	81.7%	▲	79	89	94	85

From the

Health Sciences Library

Searching Open Access Journals in Ovid

You may have seen the pale orange OPEN ACCESS RESULTS panel (see Figure 1) when you use the **Basic Search** mode in Ovid and wondered, *What is that?* Or, maybe you have just ignored it. This article hopes to shed some light on how to best use this option. First, what is meant by 'open access'? As the phrase implies, 'open access' refers to those journals or journal articles that are freely accessible without restriction (such as pay-per-view, memberships or subscriptions). It is wise to keep in mind that while open access journals (or articles) in the biomedical literature are increasing not all are equal in terms of peer-review, quality and authority. If you are doubtful about the quality of an OA journal, check Beall's List of probable predatory scholarly open-access publishers.

What is included in Ovid's Open Access (OA) Results?

What you really need to know about the OA results in Ovid is that these results are a subset of what's available from the OA body of literature. They come from two sources.

About 1800 of the titles included in Ovid come from journals deposited in PubMed Central (PMC). While some of these titles are also indexed in Medline, some are not (I could not find an exact percentage). PMC journals are required to meet certain scientific quality and technical standards before being included in the PMC repository.

Additionally, another 370+ titles come from Medknow, an OA publisher which originated in India as a means for medical societies to disseminate peer-reviewed, scientific research. Medknow was acquired by Wolthers Kluwer (OvidSP's parent company) in 2011. Since 2011, Medknow has expanded its publishing outside of India to China, the Middle East and other international markets.

Searching the Open Access literature on Ovid

When searching OA articles via Ovid, know that it is much like a surprise gift bag – tempting for the promise it holds, but usually, not all it's cracked up to be.

Figure 1

continued on page 7

OA results appear alongside your other results in the Basic Search mode only. They are ranked by relevancy and you can filter by year, author or journal but not subject or publication type. The summary panel only provides the title and authors of each article. To see more, click on the **View All Open Access Results** link at the bottom of the panel (see Figure 1). Once you are in the All Open Access Results list you can see more information about each article, click on an abstract and also see how many OA articles were returned by looking under the **Search Information → Search Returned** section of the left-side **Results Tools** panel (see Figure 2). Under **Results Tools** you can also sort the OA results by Year of Publication or other factors and customize the display to see keywords.

Figure 2

Usefulness of Ovid's OA Results?

Although the search function via Ovid is rather limited, the results may still be useful in finding articles written in other languages or information about:

- rare diseases or conditions
- diseases not often seen the U.S.
- emerging medical topics, or, treatments
- discovering medical research done in the international arena (typically anywhere from 43~46% of citations indexed in Pubmed/Medline each year are published in the U.S.)

In short, it takes no extra effort on your part to search the OA literature in Ovid (provided you are searching in the Basic mode); however, the options for searching are limited and it is not a comprehensive source of open access literature. As such, it provides limited usefulness.

If one is serious about searching the OA literature but wants to steer clear of untrustworthy publishers, it may be better to search each OA collection separately using the search interfaces provided at their websites.

Another open access platform that aims to provide comprehensive access to quality-controlled OA journals is the Directory of Open Access Journals (DOAJ). DOAJ includes Medknow journals, however, it may not include all the articles that are included in PMC and its subject range is broader than just biomedical literature, "covering all areas of science, technology, medicine, social science and humanities".

Do you peruse the Ovid OA Results when you conduct searches on Ovid? What have you found it useful for? Give us your feedback and we can pass it on to our rep at Ovid for future improvements.

For information on how to access Ovid and other library resources from off-site visit ***http://huntingtonhospital.libguides.com/physicianoffsiteaccess*** *or contact the library* **(397-5161, library@huntingtonhospital.com)** *for individual username & password access.*

Sites Referenced:

Beall's List of Predatory Open Access Publishers: https://scholarlyoa.com/publishers/
PubMed Central Quality Requirements: http://www.ncbi.nlm.nih.gov/pmc/pub/addjournal/#sci-quality
MedKnow journal distribution: http://www.medknow.com/jrnldistribution.asp
Medline Citation Counts (% U.S.): https://www.nlm.nih.gov/bsd/medline_cit_counts_yr_pub.html
Medknow Search Interface: http://www.medknow.com/journals.asp
PubMed Central (PMC) Search Interface: http://www.ncbi.nlm.nih.gov/pmc/advanced/
Directory of Open Access Journals (DOAJ): https://doaj.org/

Massive Transfusion: It's not just for Trauma Patients

Amal K Obaid, MD | FACS

A Massive Transfusion Policy was initially developed at Huntington Hospital in 2010 to assist with the timely and efficient delivery of large amounts of blood products to exsanguinating trauma patients. Since then however the policy has been adopted house wide and can be activated by any attending physician, anesthesiologist or chief resident.

What is the massive transfusion policy and how is it activated?

The Massive Transfusion Policy is a protocol that allows for automatic preparation of blood and blood components during a massive bleeding setting. After the decision is made that a patient is bleeding and it is anticipated that large amounts of blood products will be needed (>10 Units), a phone call to the blood bank is made and this sets of a series of events which ultimately lead to the timely and uninterrupted delivery of blood products to patients at jeopardy of exsanguinating hemorrhage. The actual loss of this much blood does not necessarily have to occur before the judgment is made that this much loss if imminent.

Here is how it works!

Once the call is made and the policy is activated, an initial order of 10 U of packed red blood cells (PRBCs), 10 U of thawed plasma, and 1 platelet-pheresis will be prepared by the blood bank. Studies have shown that a 1:1:1 ratio of PRBCs, FFP, and platelets is the most physiologic. Until the policy is deactivated (the need for ongoing transfusion ends), an uninterrupted flow of products will be available.

Advantages of Using the Massive Transfusion Policy

One of the distinct advantages of using the Massive Transfusion Policy vs. ordering blood "stat" is TIME! Initially uncross matched blood will be used that is already available in the blood bank until the crossmatch results are available. Exsanguinating hemorrhage can lead to an irreversible coagulopathy if coordinated and prompt delivery cannot be achieved.

So the next time you are dealing with a patient with severe bleeding (whether it is a bleeding trauma patient, a ruptured aneurysm or an obstetrical emergency) remember that this policy is available and has proven success and can potentially save your patients life.

One word of caution

Do not forget to deactivate the policy once the patient has been stabilized and the bleeding has been stopped. Blood products are a precious resource and waste of products is something we want to avoid. Return unused products to the blood bank as soon as possible in order to avoid waste.

For further information on the policy, you may visit the SharePoint site at the hospitals homepage and review the entire policy.

Observation Priviledges

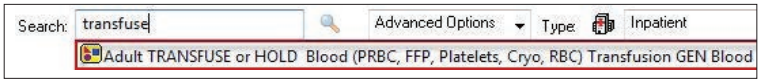
All visitors who are interested in observing clinical care in the hospital setting must be pre-approved prior to visiting the campus. Please allow at least 72 hours for the process.

- Physicians: Medical Staff members may call the Medical Staff Office when requesting observation privileges for a colleague. **626-397-3767**
- Non-physicians: Contact Lynette Dahlman at **626-397-2374** or via email Lynette.Dahlman@huntingtonhospital.com.

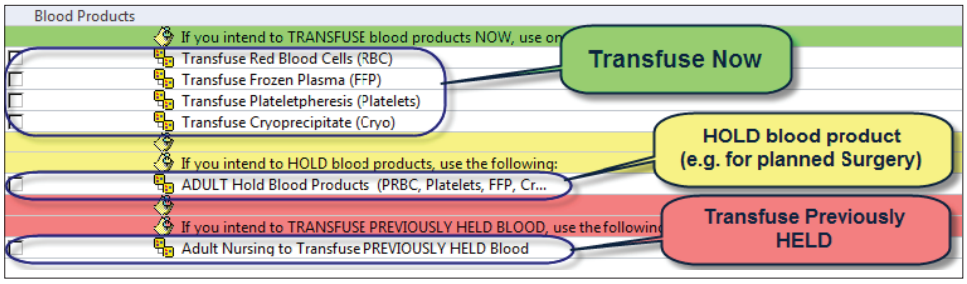
New Blood Products Transfusion PowerPlan

Coming soon in June 2016

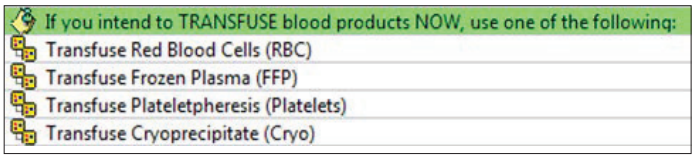
"GEN Blood Products/Transfusion – Adult" changed to → "Adult TRANSFUSE or HOLD Blood"



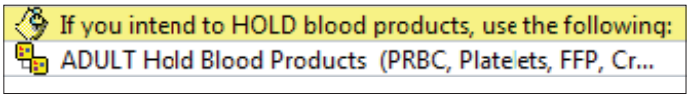
Blood products and transfusion orders are coupled in sub-phases within the one PowerPlan



- ***To <u>transfusion</u> now*** (or at a determined time)
  e.g. RBC transfusion for low Hb, or FFP transfusion
  i. Order the relevant "TRANSFUSE" sub-phase

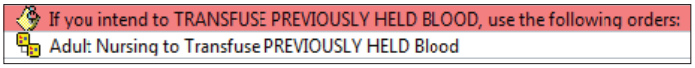


- ***To <u>HOLD</u> blood products,*** e.g. for planned surgery, or hold for possible future transfusion
  i. Order the "ADULT Hold blood products" sub-phase



  ii. For holding blood for planned surgery
    1. Select "Surgery" in "Intended For" field
    2. Specify the date of the planned surgery

- ***To <u>transfuse previously held</u>*** blood products
  i. Order the "Adult Nursing to Transfuse PREVIOUSLY HELD Blood"



NOTE:

- Initiating Massive Blood Transfusion needs to be directly communicated to the nurse who will call the Blood bank for initiating the protocol.
- No changes are made to the "NICU/PEDS Transfuse blood products" or the "Plasmapheresis/Plasma Exchange"

For assistance, please contact the Physician Support Services office at (626) 397-2500

Medical staff meetings

Calendar

JUNE 2016

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
		1 Noon Plastic Surg Sect. CR-10 12:15 p.m. OB/GYN Peer WT 5/6	**2** Noon Medicine Committee N/S Noon Trauma Services WT 5/6	**3** 7 a.m. Ortho Sect WT 5/6 Newsletter submission
6 12:15 p.m. OB/GYN Dept CR 5/6 5:30 p.m. MEC Board Room	**7** 8 a.m. QM Pre-Agenda CR C	**8**	**9** Noon QM Committee East Room	**10**
13	**14** 7:30 a.m. EP Subsection Cardio Conf. Room	**15** Noon Credentials Committee CR C	**16** 6:30 a.m. Anesthesia Peer Cr-7 8 a.m. Neurology Sect WT 8 Noon PT&D Committee CR 5/6 6 p.m. Bioethics CR 5/6	**17**
20	**21** 12:15 p.m. Infection Control CR – Research Hall 5:30 p.m. Surgery Committee WT 5/6	**22**	**23** Noon Pediatric Committee East Room	**24**
27	**28**	**29**	**30** Noon IM Peer Review WT 5/6	

Continuing medical education

Calendar

JUNE 2016

MONDAY		**6** **OB/GYN Dept. Mtg** **12:15 - 1:15 p.m.** **CR 5/6** ***Topic:***	**13** **Second Monday** **12 - 1 p.m.** **RSH** ***Topic: New Drugs for CHF***	**20**	**27**
TUESDAY		**7** **MKSAP** 7:30 - 8:30 a.m. Wingate Doctors' Lounge **General MDisc Cancer Conf.** 12 - 1 p.m. Conf. Room 11 **HMRI Lecture Series** **4 - 5 p.m.** **RSH**	**14** **MKSAP** 7:30 - 8:30 a.m. Wingate Doctors' Lounge **General MDisc Cancer Conf.** 12 - 1 p.m. Conf. Room 11 **HMRI Lecture Series** **4 - 5 p.m.** **RSH**	**21** **MKSAP** 7:30 - 8:30 a.m. Wingate Doctors' Lounge **General MDisc Cancer Conf.** 12 - 1 p.m. Conf. Room 11 **HMRI Lecture Series** **4 - 5 p.m.** **RSH**	**28** **MKSAP** 7:30 - 8:30 a.m. Wingate Doctors' Lounge **General MDisc Cancer Conf.** 12 - 1 p.m. Conf. Room 11 **HMRI Lecture Series** **4 - 5 p.m.** **RSH**
WEDNESDAY	**1** **Genitourinary Cancer** 12 - 1 p.m. Conf. Room 11 **Radiology Teaching Files** 12 - 1 p.m. MRI Conf. Room	**8** **Radiology Teaching Files** 12 - 1 p.m. MRI Conf. Room	**15** **Genitourinary Cancer** 12 - 1 p.m. Conf. Room 11 **Radiology Teaching Files** 12 - 1 p.m. MRI Conf. Room	**22** **Radiology Teaching Files** 12 - 1 p.m. MRI Conf. Room	**29** **Cardiac Cath Conf.,** 7:30 - 8:30 p.m. Cardiology Conference Room **Radiology Teaching Files** 12 - 1 p.m. MRI Conf. Room
THURSDAY	**2** **Trauma Walk** 7 - 8 a.m. Conf. Room B **Surgery M&M** 8 - 9 a.m. Conf. Room B **Thoracic Cancer Conf.** 12 - 1 p.m. Conf. Room 11	**9** **Trauma M&M** 8 - 9 a.m. Conf. Room B	**16** **Trauma Walk** 7 - 8 a.m. Conf. Room B **Surgery M&M** 8 - 9 a.m. Conf. Room B **Thoracic Cancer Conf.** 12 - 1 p.m. Conf. Room 11	**23** **Surgery M&M** 8 - 9 a.m. Conf. Room B	**30** **Trauma Walk** 7 - 8 a.m. Conf. Room B **Surgery M&M** 8 - 9 a.m. Conf. Room B
FRIDAY	**3** **Neurosurgery Grand Rounds** 7:30 - 9 a.m. Conf. Room 11 **Medical Grand Rounds** **12 - 1 p.m.** **RSH** ***Topic: DVT*** 12 - 1 p.m. Conf. Room 11 **MDisc Breast Cancer Conf.** 12 - 1 p.m. Conf. Room 11	**10** **Neurosurgery Grand Rounds** 7:30 - 9 a.m. Conf. Room 11 **MDisc Breast Cancer Conf.** 12 - 1 p.m. Conf. Room 11	**17** **Neurosurgery Grand Rounds** 7:30 - 9 a.m. Conf. Room 11 **MDisc Breast Cancer Conf.** 12 - 1 p.m. Conf. Room 11	**24** **Neurosurgery Grand Rounds** 7:30 - 9 a.m. Conf. Room 11 **MDisc Breast Cancer Conf.** 12 - 1 p.m. Conf. Room 11	

Huntington Hospital

Medical Staff Administration
100 W California Boulevard
P.O. Box 7013
Pasadena, CA 91109-7013

ADDRESS SERVICE REQUESTED

Medical Staff Leadership

James Shankwiler, MD | President
Christopher Hedley, MD | President Elect
Harry Bowles, MD | Secretary/Treasurer
Thomas Vander Laan, MD | Chair, Credentials Committee
Gregory Giesler, MD | Chair, Quality Management Committee
Peter Rosenberg, MD | Chair, Medicine Department
Jonathan Tam, MD | Chair, OB/GYN Department
Mark Powell, MD | Chair, Pediatrics Department
Steven Battaglia, MD | Chair, Surgery Department

Glenn D. Littenberg, MD | Newsletter Editor-in-Chief

2015-2016
Best Hospitals Report

BEST REGIONAL HOSPITALS U.S.News LOS ANGELES, CA RECOGNIZED IN 9 SPECIALTIES 2015-16

#7 Hospital in the
Los Angeles Metro Area

#18 Hospital in California

Recognized in 9 specialties:
- Diabetes & Endocrinology
- Gastroenterology & GI Surgery
- Geriatrics
- Gynecology
- Nephrology
- Neurology & Neurosurgery
- Orthopedics
- Pulmonology
- Urology