

# medical staff NEWSLETTER

November 2013

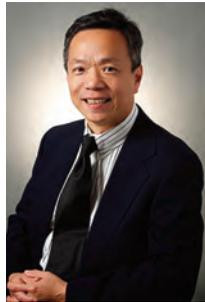
volume 51, issue 11



## From the **President**

***“You should examine yourself daily. If you find faults, you should correct them. When you find none, you should try even harder.”***

Xi Zhi (1130-1200)



### Hospitals and Care Systems In The Future (Part One)

We, the medical staff, are facing constant changes and challenges in the areas of health care requirements, restructuring, and reimbursement. This article, which is separated into two parts, will hopefully help us gain some insight on how to face future challenges and to engage in the change of hospital policy and procedure which could have significant impact on the medical staff.

### What to Expect from “The Hospital of the Future”

There are many factors that contribute to the change in how medical institutions and health care providers operate and do business. These factors include the ever changing and evolving needs of patients, changes in policies regarding health care reform, and the ever increasing need to provide quality services in spite of manpower shortages and increased costs. Thus, health care organizations need to perform certain changes in order to address the above concerns and be able to accommodate patients effectively despite these harsh economic times.

One of these changes, from volume based economics to value based economics may be a bit of a challenge, as proper research and timing are necessary in order to assess when a leap from one to the other is appropriate. Taking up the volume based

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## 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 October 7, 2013 and by the Governing Board on October 24, 2013.

## Administrative Reports

### Department/Section Rules and Regulations

#### Medical Staff Rules and Regulations

The following sections were recommended as additions to Chapter 6 (Committee Descriptions) of the Medical Staff Rules and Regulations:

#### Robotic Committee

##### Composition

The Robotic Committee shall consist of members from the Obstetrics and Gynecology Department and the Surgery Department involved in the performance of robotic surgery. The chair shall be appointed by the President of the Medical Staff and include representatives

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**Don't forget to get  
your flu shot!!**

## Robotic Committee *continued*

from Administration, Nursing and Quality Management.

### Duties

The Committee shall be responsible for:

1. The evaluation of quality improvement data related to robotic surgery;
2. Making recommendations to the appropriate Medical Staff Sections or Department regarding proposed privileging criteria and proctoring requirements for robotic surgery;
3. Review by the Committee Chair of all requests for robotic surgery privileges and forwarding privileging recommendations to the appropriate Section or Department Chair.

### Meetings

The Robotic Committee shall meet as often as necessary at the call of the chair but at least quarterly.

### Records and Reporting

Appropriate records of meetings will be kept. The Committee will report the quality improvement and peer review activities to the Quality Management Committee. The Committee will report privileging and proctoring recommendations to the appropriate Departmental Committee.

## Transfusion Subcommittee

### Composition

The Transfusion Subcommittee shall consist of Active Staff members and representatives from the Blood Bank and Quality Management Department. The Chairman is elected by the committee members for a term of two years. The primary focus of the Transfusion Subcommittee is the safe use of blood in the Hospital. The Transfusion Subcommittee shall develop, review and evaluate recommended policies and procedures concerning the administration of blood and blood components and shall take such action as may be necessary to maintain appropriate standards of quality transfusion practices.

### Duties and Responsibilities

The duties of the Transfusion Subcommittee relating to the transfusion of blood and blood components include:

1. Evaluating the sources, adequacy, quality and safety of the supply of blood and blood components used in the Hospital.
2. Reviewing data regarding transfusions and the adequacy of transfusion services to meet patient needs, and reviewing/making recommendations concerning policies governing such practices.
3. Reviewing all confirmed transfusion reactions, and making recommendations to improve transfusion procedures and practices.
4. Conducting intensive evaluations of any known or suspected problems in the use of blood or blood components, according to clinically valid criteria.
5. Reviewing data from the Blood Bank and medical records in order to:
  - a. Identify unnecessary waste due to unreasonable "hold" order or excessive "outdating" of blood.
  - b. Identify questionable ordering practices and use of blood or blood components.
  - c. Study all instances of transfusion transmissible diseases.

### Meetings

The Transfusion Subcommittee will meet quarterly.

### Records and Reporting

Meeting minutes will be maintained. The Committee reports to the Pharmacy, Therapeutics & Diet Committee.

## Cardiology Section Rules & Regulations:

The following section has been added to the Interventional Cardiology Panel Section:

### Failure to Respond Within 30 Minutes

All incidents involving the failure of a physician to respond to the Emergency Department within thirty (30) minutes while on the interventional

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Cardiology Section continued

cardiology panel will be referred for peer review. If two cases in any two-year reappointment period are given an assignment of "3" due to failure to respond within the required time periods, the physician will be suspended from all call panels (STEMI, Echo, EKG, unassigned, etc.) for a period of six months.

Privilege Delineation Forms

Revisions were approved to the following privilege delineation forms:

- Urology
- Pediatric Surgery

Please go to SharePoint → Medical Staff Services → Board Approved Items → 2013 and select October 2013 to see:

- Administrative/Clinical Policies and Procedures
- Order Sheets
- Formulary Management
- Departmental Policies and Procedures and Order Sets
- Ancillary/Nursing Policies and Procedures

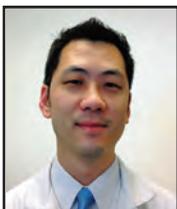
Medical Staff Appointments



**Farnam, Kevin, MD**  
**Allergy and Immunology**  
 Huntington Medical Foundation  
 55 East California Blvd.  
 Suite 204  
 Pasadena, CA 91105  
 626-397-8323 (office)  
 626-792-3611 (fax)



**Khatibi, Azadeh, MD**  
**Ophthalmology**  
 Children's Retina  
 7447 North Figueroa Street  
 Suite 200  
 Los Angeles, CA 90041  
 323-257-3937 (office)  
 877-579-4558 (fax)



**Ham, Sung Wan, MD**  
**Vascular Surgery**  
 USC Surgeons  
 1520 San Pablo Street  
 Suite 4300  
 Los Angeles, CA 90033  
 323-442-6835 (office)  
 323-442-5735 (fax)



**Martel, Cynthia, MD**  
**Hematology/Oncology**  
 Keck Medical Center of USC  
 625 South Fair Oaks Avenue  
 Suite 400  
 Pasadena, CA 91105  
 626-568-1622 (office)  
 323-865-9560 (fax)



**Heringer, Laura, MD**  
**Geriatrics**  
 Huntington Medical Foundation  
 375 Huntington Drive  
 Suite G  
 San Marino, CA 91108  
 626-441-4231 (office)  
 626-441-0282 (fax)



**Mnatsakanyan, Aristakes, DO**  
**Internal Medicine**  
 Health Care Partners  
 450 East Huntington Drive  
 Arcadia, CA 91007  
 626-462-1884 (office)

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## Medical Staff Appointments *continued*



**Nguyen, Mike, MD**  
**Urology**  
1441 Eastlake Avenue  
Suite 7416  
Los Angeles, CA 90089  
323-865-3700 (office)  
323-865-0120 (fax)



**Pataky, Morris, MD**  
**Emergency Medicine**  
100 West California Blvd.  
Emergency Department  
Pasadena, CA 91109



**Pathan, Khalida, MD**  
**Internal Medicine**  
1329 Maynard Drive  
Durarte, CA 91010  
626-716-6291 (office)  
801-681-5027 (fax)



**Philip, Rajiv, MD**  
**Pulmonary Disease**  
301 West Huntington Drive  
Suite 607  
Arcadia, CA 91007  
626-445-4558 (office)  
626-446-5807 (fax)

## Allied Health Professional Appointments

- Dubko, Judy, PA-C – Physician Assistant
- Fabian, Michael, RN – 5150 Status
- Kohlhase, Wendy, PhD – Bioethicist
- Lemert, Sara, PA-C – Physician Assistant
- McBirney, Ryan – Physician Assistant
- Wheeler, Breana, RN, NP – Nurse Practitioner
- Woolsey, Malia, RN, NP – Nurse Practitioner

## Resignations

### Medical Staff Resignations

- Aho, Christopher, MD –  
Neurosurgery – effective 10/31/13
- Brady, Wanda, MD –  
Obstetrics & Gynecology – effective 10/31/13
- Chang, Tsang-Hung, MD –  
Obstetrics & Gynecology – effective 9/16/13
- Cho, Jonathan, MD –  
Internal Medicine – effective 8/20/13
- Hamelin, Nicolas, MD –  
Plastic Surgery Fellow – effective 10/31/13
- Hammoudeh, Jeff, MD –  
Plastic Surgery – effective 10/31/13
- Jandial, Rajnish, MD –  
Internal Medicine – effective 10/31/13
- Kashanian, Albert, MD –  
Internal Medicine – effective 6/30/13
- Morales, Victor, MD –  
Obstetrics & Gynecology – effective 10/31/13
- Page, Michael, MD –  
Emergency Medicine – effective 11/30/13
- Pylko, Timothy, MD –  
Psychiatry – effective 9/3/13
- Rhee, Paul, MD –  
Emergency Medicine – effective 10/31/13
- Rose, Anya, MD –  
Obstetrics & Gynecology – effective 10/31/13
- Rosen, Barney, PhD –  
Psychology – effective 10/31/13
- Roth, Bradley, MD –  
General Surgery – effective 9/5/13
- Williams, Richard A., MD –  
Obstetrics & Gynecology – effective 11/30/13

### Allied Health Resignations

- Dinsay, Jocylane, NP –  
Nurse Practitioner – effective 11/30/13
- Wheaton, Rick, CCP –  
Perfusionist – effective 10/31/13
- Wiseman, Cori, NP –  
Nurse Practitioner – effective 11/30/13

## From the **President** continued from page 1

approach for too long may cause an institution to become deficient in its abilities to take the leap towards successful market transition; while rushing towards the value based approach too early may cause revenue to be not what is expected. Ideally, however, all health care systems are expected to reach value based economics, termed as the second curve shift, where multiple organizations share costs and revenues, as compared to the first curve paradigm where each essentially exists on its own.

With the vision of a hospital of the future in mind, experts predict that organizations will form networks and systems that will be integrated together to provide all services, big or small, within the scope of medical services. With this, these experts have taken into consideration current and future assumptions on perceived health care trends in order to formulate a series of elements that would help organizations take that critical leap towards that elusive second curve shift. In order to achieve this, both good strategic plans and the development of core competencies are required. As core competencies can be built with proper guidance, training, and leadership, strategic development and operational plans are equally, if not more, crucial and important in order to provide acceptable results on preset metrics to gauge the organization's success and effectiveness.

The four core strategies that should be formulated are; creating a network of competent physicians and health care providers, improving on quality of service using time tested practices, improving efficiency with regards to reducing costs while increasing productivity, and developing information systems that can manage data across all facets of the industry. These, aside from other strategic plans such as creating leaders and reinforcing finances, are crucial in ensuring success.

By adhering to these strategies, hospitals, physicians, and other health care systems can have measurable and attainable benefits. When preparing for a paradigm shift within the industry, it is thus important that proper strategic management, above all else, in addition to constant enhancement of competencies across all departments, are highly taken into consideration and marked as deeply essential and crucial to the growth of the organization and the health care industry as a whole.

### **Strategy #1: Aligning hospitals, physicians, and other providers across the continuum of care**

In a survey conducted in 2010, nearly 74% of hospital heads indicated they were planning to employ more physicians. But a more effective approach would be to communicate effectively with all parties involved in this system and make them realize the importance of their contribution that could curb unnecessary expenditure. This should also include apt remuneration and awards to those who work conscientiously towards helping to improve the overall setup.

The Wenatchee Valley Medical Center based in Washington realized that nearly 48% of the Medicare costs were due to ER visits and inpatient hospital charges. They began by involving the doctors and keeping an open ended discussion to reduce unnecessary ER visits and readmissions. This process took nearly three years to show results and finally they reduced the percentage to nearly 17.7 %, without compromising the quality of the services.

### **Strategy #2: Utilizing evidence-based practices to improve quality and patient safety**

Records show that Medicare spent nearly 20% of its payments on unplanned re-admissions during the period of one year. Methods were sought to provide quality services without

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## From the **President** continued from page 5

increasing the cost. Patient oriented care facilities were looked into and the satisfaction of the patients were recorded. Reviewing the results and making changes accordingly began to produce a positive result.

Flowers Hospital in Alabama worked towards identifying higher risk patients. A nurse reviewer identified the patients and monitored the progress thus avoiding future risks. Additionally, the authorities set up multidisciplinary teams to assess the failed reports and suggest improvements. This procedure improved the situation to help attain a 99.7% compliance rate with CMS core measures.

The Borgess-Lee Memorial Hospital in Dowagiac, MI was troubled with an increase in cases of urinary tract infections due to unnecessary provisions of urinary catheters. Keeping a record of the use of these catheters and appointing appropriate staff to monitor the usage helped to reduce the unwanted usage by 25%.

### **Strategy #3: Improving efficiency through productivity and financial management**

Today, medical service providers are working toward an increase of 29% in primary care workload along with a two to seven percent increase in the number of such providers by the year 2025. This calls for a highly efficient system in order to improve on the existing policies. Incorporating changes such as the Lean process design or Six Sigma would lead to redesigning the existing models accordingly. North Mississippi Medical Center is a part of the Northern Mississippi Health Services. Studies indicated that patients wasted too much time waiting in ED. Thus the challenge was to help patients feel more comfortable in ED and to increase standardization in purchasing. The authorities provided computers in ED to assist the doctors identify the past records of

the patients and increase the overall efficiency. Also, to ensure standardization in purchasing, this was done only after each supplier was analyzed over a trial period and feedback from physicians was considered before finalization. As a result of these attempts, the waiting time of patients reduced by nearly three hours and the annual supply costs reduced by almost three million dollars.

### **Strategy #4: Developing integrated information systems**

Using computers in health care is seen as one of the main methods to reduce cost within the medical system. In 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act within the American Recovery and Reinvestment Act (ARRA) provided monetary incentives for physicians and hospitals to adopt electronic health records. The need to educate the staff and doctors to utilize this technology to integrate their work and reduce any loss due to manual inefficiency was felt acutely by the government.

Piedmont Clinic in Atlanta, Georgia incorporated the use of computers in their working environment. They set up an indigenous Clinical Integration Trust (CIT), a single data warehouse. All reports based on population health analysis and statistics, Physician Quality Reporting Initiative (PQRI), billing, and other information regarding the hospital and physician records were fed into CIT. A daily update of these records made it easy to access and within a short span of nine months; CIT had improved the overall performance at the clinic by 11%.

### **Strategy #5: Joining and growing integrated provider networks and care systems**

Every hospital aims at expanding its reach to places and people beyond its immediate

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## From the **President** continued from page 6

vicinity. These expansions were undertaken in the form of mergers, acquisitions, strategic alliances, etc. This helped both parties involved in more ways than one. It improved the efficiency and led to both organizations inculcating a trusted name for among the people. Collaborations were also undertaken with community health, government organizations, and even the criminal justice systems, although such combinations require unique systems.

Hoag Hospital Newport Beach in Newport Beach, California was having a lot of problems managing its orthopedic cases. They set up a new Hoag Orthopedic Institute under joint management which helped conduct more and efficient operations in the next few months. This further helped to improve its financial status.

Johns Hopkins Medicine (JH) in Baltimore, Maryland and All Children's Hospital (AC) in St. Petersburg, Florida were having individual problems which got sorted out once JH acquired AC. This helped JH expand its operations outside the Baltimore-D.C. area, meanwhile AC was saved from decreased Medicaid payments and the resulting debts it had incurred.

It is believed that best practices by human resources and the workforce always proves to be advantageous for health care institutions and hospitals. The top health care experts often favor the 4 key work practices that lead to a great performance by the industry. The 4 best work practices may include:

- Staff acquisition with development
- Organizational engagement
- Leadership alignment and
- Frontline empowerment

Therefore, it is essential to provide comprehensive training to all the clinicians in order to prepare them to deliver supreme quality service in healthcare centers. Improvement in organizational design and culture result in delivery of better safety with higher quality at a lower ultimate cost.

**Edmund Tse, MD**  
*President*

## Celebrating Milestones

**The following physicians** hit a service milestone in the month of November. The Medical Staff would like to recognize the following physicians for their service and dedication to Huntington Hospital.

### 35 Years (on staff 11/1978)

Babatunde Eboreime, MD –  
Obstetrics & Gynecology  
K. Heiner Vogelbach, MD –  
Cardiovascular Disease

### 30 Years (on staff 11/1983)

Gordon Sasaki, MD – Plastic Surgery

### 25 Years (on staff 11/1988)

Bryan Jick, MD –  
Obstetrics & Gynecology

### 20 Years (on staff 11/1993)

Harout Balian, MD –  
Physical Medicine & Rehab  
Shaun Grady, MD –  
Obstetrics & Gynecology

### 15 Years (on staff 11/1998)

Troy LaMar, MD – General Surgery  
Toni Morrissey, MD –  
Obstetrics & Gynecology  
Paulette Saddler, MD –  
Internal Medicine

### 10 Years (on staff 11/2003)

Yee-Jean Chou, MD – Pediatrics  
Neil Doherty III, MD –  
Cardiovascular Disease  
Wei Huang-Lee, MD –  
Internal Medicine  
Marc Incerpi, MD –  
Maternal & Fetal Medicine  
Garry K. Kim, MD – Internal Medicine

## Physician's... You Are The Patients Experience!

### Communication Practices of Physicians With High Patient-Satisfaction Ratings

**How do primary care** physicians with outstanding patient-satisfaction ratings communicate with their patients? Which specific practices distinguish them from less effective communicators *on the basis of measured performance*? Based on research done at Kaiser Permanente facilities in Southern California and Hawaii, five major categories of practice emerged that described the behaviors that discriminated between High, Medium, and Low Group rated physicians.



#### 1. Focus on the Patient's Agenda

##### Rather than Focusing Primarily on Clinical Issues or Visit Management

- Low Group physicians frequently talked at length about clinical issues, managing time, limited resources, and problems with systems, computers, and uncooperative patients.
- Physicians from the Medium Group and, especially, High Group were focused much more on the patient. They attended fully to the patient's medical concerns, and also considered what the patient would need to move forward in the management of his/her condition(s). In effect, they helped the patient be an active participant in their care.

#### 2. Drawing Out the Story

##### Use Active Listening Responses During Patient Storytelling

- Listen to 3–5 uninterrupted patient sentences
- Give patients the opportunity to express fears and concerns
- Ask probing questions, especially regarding patient concerns
- Show caring

#### Great bedside manner – One patient's description

"I have always enjoyed his bedside manner – such a pleasure. He stops doing what he is doing and watches and listens. So many doctors ... may listen, but they are not really there. They are cold and indirect. He makes your day brighter ... He can help you with a lot without sending you to someone else. I think that is a big plus. Others send out for nurses to do bandages, etc ... He makes jokes ... to take your mind off things. He keeps you entertained ... He will listen to your jokes too, even if they are bad!"

#### 3. Demonstrate Understanding

- Investing a little effort to build a strong relationship with patients was typical among High Group physicians. There were three practices related to this concept: empathic responses, demonstrations of caring, and familiarity with patient's history.

#### 4. Provide Detailed Explanation

##### Explain What is Happening and Why

Medium Group and High Group physicians tended to offer more detailed explanation

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## Bioethics Corner

### Do You Want Us to Do Everything?

**Ms. T is an 89-year-old** woman who presented to the ER from a nursing facility with respiratory distress and sepsis. She had a history of chronic aspiration pneumonia and end-stage dementia with multiple hospitalizations within the past year. Ms. T lacked capacity and had been bed-bound for the past 2 years. The medical team believed that CPR would not be in her best interest. When the primary care physician met with Ms. T's family to discuss goals of care, he asked them, "Do you want us to do everything?" The family said "yes" and requested that Ms. T remain a full code. The case was eventually referred to Bioethics because the physician felt that the family was unrealistic and that they were requesting medically ineffective treatment.

Unfortunately, the case of Ms. T is very familiar to the Bioethics Committee and raises some important issues worth discussing. In the September 2013 Medical Staff Newsletter, Dr. Nathan Lewis, Bioethics Committee Chair, discussed the topic of medically ineffective treatment and responding to families who request (or even demand) it. As a reminder, the HH DNAR/Withdrawal and Withholding of Life-Sustaining Treatment policy outlines the procedure to follow with patients and families when such cases arise (refer to policy 8740.050, section IV). But I feel there are two other important issues that this raises that deserve discussion. The first issue has to do with the use of language and delivery style during medical decision-making discussions with patients and families. A second and related issue deals with whether or not "gentle paternalism" has a place in medical decision-making discussions.

A physician's choice of words, delivery style, and demeanor can have a tremendous impact on patients and families during medical decision-making discussions. The way these discussions are framed is very important and the physician recommendation itself has a significant influence on patient and family choices. In the case of Ms. T the physician offered "everything" when he knew that Ms. T's prognosis was very poor, giving the family hope

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### You Are The Patient's Experience *continued*

to patients *using simple language* than Low Group physicians.

- present options to the patient
- *using simple language*
- gave concrete suggestions
- provide the "personal touch."

## 5. Complete the Patient's Agenda

### Delivering what was Promised; Responding to Questions

- Some of the visits with Low Group physicians were incomplete with respect to the patient's agenda.
- High Group physicians generally overlooked fewer items in communication with the patients

## Discussion

The findings suggest an approach to improving physician communication with patients. The general theme emerging from this research is the importance of the patient's agenda.

- Identifying the patient's agenda
- Allowing the patient time to describe their concern(s) and to express their fears
- Ask the patient questions
- Using empathic statements and showing familiarity with the patient's history
- Return to the patient with details to normalize or explain the reasons for the problem and how it might be addressed.
- Physician explains any options for managing the problems.
- Physician verifies that the items in the patient's agenda were addressed or negotiated to a future visit.

Perm J. 2007 Winter; 11(1): 19-29. Published online Winter 2007

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3061374/>

### Bioethics Corner *continued*

that something could make her better. Most patients and families are not knowledgeable enough to know when medical treatment may be non-beneficial or ineffective, so when a physician offers “everything,” the patient or family may not think to question it. Maybe a better choice of words in the case of Ms. T might have been something like, “We will be very aggressive in managing your loved one’s symptoms of pain and discomfort, but if things get so bad that her heart stops or she stops breathing, I would like to make her comfortable, but I would not recommend CPR or any other aggressive measures. What are your thoughts about this?” Thus, the physician takes a more “guiding” and “informing” approach with the family, rather than simply asking them what they want to do. This is especially important when the physician believes a particular treatment or procedure would have little benefit to the patient’s overall prognosis. That said, the use of graphic language in order to scare patients and families into agreeing to certain procedures, such as talking about “breaking bones” and “jamming tubes down throats” when trying to convince someone to agree to a DNAR, may raise ethical concerns of its own, as it couches the recommendation in a coercive manner. It is important to remember that families do not want their loved ones to suffer, but they just may not want to be the ones making the decision. Therefore, I suggest a shared approach to medical decision-making that involves more “guiding” than it does “asking.”

Integral to this discussion is the second and related issue having to do with whether gentle paternalism has a place in medical decision-making and its delicate balance with patient autonomy. The Hippocratic Oath never directed the physician to educate patients or empower them to make decisions. Patients were not to be informed; rather, they were to be persuaded. Beneficence was equated with the physician deciding what he/she felt was in the best interests

of the patient. This strong paternalism began to wane during the 1970s and 80s and in 1990 the Patient Self Determination Act was passed, which affirmed the right of adult persons with capacity to make their own decisions about medical treatment, including completing an advance directive of their treatment wishes and naming an agent to uphold these wishes when they lack capacity or when they autonomously choose not to be involved in their medical decision-making process. Beneficence became equated with being fully informed to make autonomous decisions about one’s medical treatment. The practice of deciding for patients underwent a dramatic shift and physicians began to deflect patient and family questions of “What do you think I should do?” with answers such as “Unfortunately, I can’t decide for you” or “This is your decision to make, not mine.” Patient autonomy quickly grew to be viewed as the most important principle in bioethics. Paternalism became a bad word. However, frequently we see (certainly when it reaches the point of bioethics involvement) that patients and families can be overwhelmed with the burden of choices, especially when they lack the contextual information they need in order to best evaluate their alternatives. I suggest that the use of gentle paternalism can be helpful in these circumstances and has a place in the decision-making process, especially when it is clear that the burdens of a particular treatment far outweigh any potential benefit and would only prolong the dying process. In fact, perhaps a physician-patient communication style that attempts to blend patient autonomy with gentle paternalism in a shared decision-making approach could result in more satisfied patients and families, lower burnout in physicians, and fewer dollars spent on medically ineffective treatment.

### **Wendy Kohlhase, Ph.D.**

*Bioethics Consultant*  
626-823-1103

## Getting to Know Your Medical Staff Leaders

**Waleed Shindy, MD, MPH**, has been a member of the Medical Staff since November 2004. He is a member of the Department of Medicine specializing in Gastroenterology. Currently, Dr. Shindy is the Chair of the Gastroenterology Section for the 2013-2014 term.



Dr. Shindy was born in Northern California and raised in Southern California. He obtained his bachelors and Masters of Public Health (MPH) in Epidemiology degrees from the University of California, Los Angeles. He went on to earn his medical degree from the David Geffen School of Medicine and completed six years of postgraduate and specialty training at the UCLA San Fernando program. Dr. Shindy is board certified by the American Board of Internal Medicine and holds certifications in both Gastroenterology and Internal Medicine. Additionally, he serves on the Public Health Committee for the County of Los Angeles which evaluates and discusses the public health programs throughout the county.

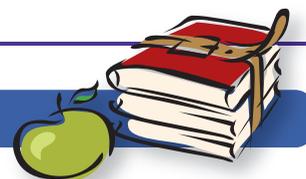
Dr. Shindy is the proud father of four children, two daughters and two sons, whose ages are 15, 13, 11, and 8. He enjoys coaching his sons' soccer teams and watching his daughters' volleyball games. In his spare time, Dr. Shindy enjoys cycling, snorkeling, sailing, travel, and participating in the occasional triathlon.

## From the Health Science Library

### Earn 4 Free CME Credits @ the Library

**Need a few extra** Continuing Medical Education (CME) credits? Huntington Hospital affiliated physicians can now earn 4 CME credits by completing the library's online learning tutorials on the **Become a Journal Articles/eBooks Power Searcher on OvidSP** webpage. It's free and it's easy! Visit the library's website to download the course objectives, course outline and a checklist. To receive credit, all the tutorials must be viewed and a quiz submitted for each level – Rookie, Intermediate, Expert and Super User. The videos are divided up into segments so that they can be viewed separately, at your convenience, rather than having to complete the whole course in one sitting. When all four levels have been successfully completed, a confirmation email from the library will be sent to you and the CME department will be notified of your completion. The CME Coordinator will email participants their *Certificate of CME Completion* and update the EEDs record. It's that simple!

The **Become a Journal Articles/eBooks Power Searcher on OvidSP** webpage can be accessed directly at: <http://huntingtonhospital.libguides.com/powersearcher> or via the **SUBJECT GUIDES** tab off the main library website. For more information, contact the library at extension 5161, [library@huntingtonhospital.com](mailto:library@huntingtonhospital.com) or text us at 626-344-0542.



## CME Corner

### Medical Grand Rounds

Topic: Winter Infections  
Speakers: Kevin B. Lake, MD & Kimberly A. Shriner, MD  
Date: November 11, 2013  
Time: Noon – 1 p.m.  
Place: Research Conference Hall  
Audience: Primary Care Physicians  
Methods: Lecture  
Credit: 1.0 AMA PRA Category 1 Credits™

### Did you know?

#### High-Density Lipoprotein

Research has found that people from South Asia have a higher risk of low levels of high-density lipoprotein. High-density lipoprotein levels have been linked to coronary artery disease. Nationwide mortality rates of coronary artery disease have been decreasing but the rates have actually increased in immigrants from South Asia. Although, further research is needed to determine what other risk factors are increasing the rates of coronary artery disease.

Dodani, S. Excess coronary artery disease risk in South Asian immigrants: Can dysfunctional high-density lipoprotein explain increased risk? *Vasc Health Risk Manag.* 2008;4(5): 953–961. PubMed PMID: 19183743

#### Subclinical Hypothyroidism

Research has demonstrated that postmenopausal women who have subclinical hyperthyroidism are at higher risk for loss of bone mass. However, there are very few studies that suggest treatment of subclinical hyperthyroidism will result in bone benefit.

Donangelo, I, Braunstein, GD. Update on Subclinical Hyperthyroidism. *American Family Physician.* 2011;83(8):933-938.

### Second Monday

Topic: Disaster: Are you Ready?  
Speaker: Amal K. Obaid, MD  
Date: November 1, 2013  
Time: Noon – 1 p.m.  
Place: Research Conference Hall  
Objectives: 1. Understand overall disaster plan.  
2. Understand physician role in disaster response.  
3. Review hazard vulnerability.  
4. Identify factors required for personal preparedness.  
Audience: Internal Medicine and all other interested specialties  
Methods: Lecture  
Credit: 1.0 AMA PRA Category 1 Credits™

## National Medical Staff Services Week November 3 – 9, 2013

**In 1992, President** George Bush issued a proclamation designating the first week of November as “National Medical Staff Services Awareness Week,” to acknowledge and thank medical services professionals (MSPs) for playing “an important role in our nation’s health-care system.” When you visit a hospital, you see the doctors, the nurses, and other medical personnel. What you don’t see are the people behind the scenes who make certain the credentials of all practitioners who are caring for you are correct and have been verified. MSPs are experts in provider credentialing and privileging, medical staff organization, accreditation and regulatory compliance, and provider relations in the diverse healthcare industry. They credential and monitor ongoing competence of the physicians and other practitioners who provide patient care services in hospitals, managed care organizations, and other healthcare settings. MSPs are a vital part in making certain that all patients receive care from practitioners who are properly educated, licensed and trained in their specialty.

**Happy Medical Staff Services Week to our Medical Staff Professionals!**

**From the Department of Radiology**

*By: Christopher Hedley, MD, Chairman, Radiology Section*

**In an effort to increase patient safety**, allocate our valuable resources appropriately, and prioritize the case load at Huntington Hospital, the Medicine Committee has recently recommended that the following high risk interventional radiology (IR) procedures require physician to physician communication. To contact the radiology department between 8 a.m to 5 p.m. please call 626-397-5185, for after hours call 626-397-5139 or the hospital operator.

**The following list of interventional radiology (IR) procedures will require physician to physician communication:**

Procedures Requiring Communication	Procedures <b>Not</b> Requiring Communication
TIPS	IVC filter placement
Genito urinary IR procedures	Dialysis catheter insertion (both temporary and tunneled)
Biliary IR procedures	Dialysis access procedures
Arterial angiographic procedures	PICC line insertion
All "STAT" procedures and all cases where the exam needs to be performed on the same day	CT/UN guided biopsy
CT/US guided aspiration and drainage of abdominal abscesses/lung abscess	CT/US guided placement of pleural drainage catheter
Percutaneous gastrostomy/gastrojejunostomy	CT/US guided paracentesis
All embolization IR procedures	CT/US guided thoracentesis
Chest tube placement for PTX	Port placement
US guided thrombin injection of pseudoaneurysm	

If you have any questions or concerns please contact me at extension 3894.

*Save the date*

**Medical Staff Holiday Party**

Date: December 6, 2013 

Time: 6 – 11 p.m.

Location: The Langham Hotel

*Invitations will be mailed*




## November 2013 Medical Staff Meetings

monday	tuesday	wednesday	thursday	friday
				-1-
				- 7 a.m. Ortho Section - CR 5 & 6
-4-	-5-	-6-	-7-	-8-
- 12:15 p.m. OB/GYN Dept - CR 5 & 6 - 5:30 p.m. Medical Executive - Board Room		- Noon Plastic Surgery Section - CR-10 - Noon CME Comm – CR-5? - 12:15 p.m. OB/GYN Peer Review - CR 5 & 6 - 3 p.m. QMC Pre-agenda - CR C	- Noon Trauma Services - CR 5 & 6	
-11-	-12-	-13-	-14-	-15-
- Noon Transfusion Subcommittee - N/S Room  - Newsletter Submission -	- Noon Critical Care Section - CR 5 & 6	- 10 a.m. PICU/Peds QI- CR 2 - 12:15 p.m. OB/GYN Committee - CR 5 & 6 - 5:30 p.m. Physician Disaster Task Force - North/South	- 6:30 a.m. Anesthesia Section - CR-7 - Noon QM Committee - East Room - 5:30 p.m. Neonatal/Pediatric Surgical Case Review - CR-10	- 7:30 a.m. Spine Committee - CR-11
-18-	-19-	-20-	-21-	-22-
- 8 a.m. Emergency Medicine Section - ED Conf. Room - Noon GME Committee - East Room	- 7:30 a.m. Interdisciplinary Practice - CR-C - 12:15 p.m. Infection Control Ctte: WT 10 ? - 12:15 p.m. Credentials Comm. - CR C	- 7:30 a.m. Cardiology Section - Cardiology Conf. Room - 5:30 p.m. Surgery Committee - CR 5&6	- 6:30 a.m. Anesthesia Peer Rev - CR-10 - 8 a.m. Neurology - CR 5 - Noon PT&D Comm - CR 5 & 6 - 3 p.m. Neon QI - WT CR 10 - 6 p.m. Bioethics - CR 5 & 6	
-25-	-26-	-27-	-28-	-29-
- Noon Radiology/Nuclear Med Section: CR-11	- Noon Pulmonary Sect. - CR-10 - Noon General Surgery Section – CR 5 & 6 - 5 p.m. Robotic Committee - CR 5&6	- 12:15 p.m. Endovascular - CR 10		

November 2013 CME Calendar

monday	tuesday	wednesday	thursday	friday
				-1--
				- 7:30 – 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11 - Noon – 1 p.m. Medical Grand Rounds, RSH <b>Topic: Disaster Management</b> - Noon – 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-4-	-5-	-6-	-7-	-8-
-12:15 – 1:15 p.m. OB/GYN Dept. Mtg, CR 5 & 6 <b>Topic: Wound Care</b>	- 7:30 – 8:30 a.m. MKSAP, Conf. Room A - Noon – 1 p.m. General MDisc Cancer Conf., Conf. Room 11	- Noon – 1 p.m. Genitourinary Cancer Conf., Conf. Room 11 - Noon – 1 p.m. Radiology Teaching Files, MRI Conf. Room	- 7 – 10 a.m. Trauma M&M, Conf. Room B - 7:30 – 8:30 a.m. Neonatal/ Perinatal M&M, Conf. Rm. 4 - Noon – 1 p.m. Thoracic Cancer Conf, Conf. Room 11	- 7:30 – 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11 - Noon – 1 p.m. Medical Case Conference, RSH - Noon – 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-11-	-12-	-13-	-14-	-15-
<b>VETERAN'S DAY</b> - Noon – 1 p.m. Second Monday, RSH <b>Topic: Winter Infections</b>	-7:30 – 8:30 a.m. MKSAP, Conf. Room A - Noon – 1 p.m. General MDisc Cancer Conf, Conf. Room 11	- Noon – 1 p.m. Radiology Teaching Files, MRI Conf. Room	- 8 – 9 a.m. Surgery M&M, Conf. Room B	- Noon – 1 p.m. Medical Case Conference, RSH - Noon – 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-18-	-19-	-20-	-21-	-22-
	- 7:30 – 8:30 a.m. MKSAP, Conf. Room A - Noon – 1 p.m. General MDisc Cancer Conf., Conf. Room 11	- Noon – 1 p.m. Genitourinary Cancer Conf., Conf. Room 11 - Noon – 1 p.m. Radiology Teaching Files, MRI Conf. Room	- 7 – 8 a.m. Trauma Walk Rounds, Conf. Room B - 8 – 9 a.m. Surgery M&M, Conf. Room B - Noon – 1 p.m. Thoracic Cancer Conf, Conf. Room 11	- 7:30 – 9 a.m. Neurosurgery Grand Rounds, Conf. Room 11 - Noon – 1 p.m. Medical Case Conference, RSH - Noon – 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-25-	-26-	-27-	-28-	-29-
- Noon – 1 p.m. Pelvic Floor Clinical Conf., Conf. Room 11	- 7:30 – 8:30 a.m. MKSAP, Conf. Room A - Noon – 1 p.m. General MDisc Cancer Conf., Conf. Room 11	- 7:30 – 8:30 a.m. Cardiac Cath Conf., Cardiology Conf. Room - Noon – 1 p.m. Radiology Teaching Files, MRI Conf. Room	<b>THANKSGIVING DAY</b>	



# Huntington Hospital

## Medical Staff Administration

100 West California Boulevard  
P.O. Box 7013  
Pasadena, CA 91109-7013

ADDRESS SERVICE REQUESTED

### Medical Staff Leadership

- K. Edmund Tse, MD, President
- James Shankwiler, MD, President-Elect
- Kalman Edelman, MD, Secretary/Treasurer
- James Recabaren, MD, Credentials Committee
- William Coburn, DO, Quality Management
- Peter Rosenberg, MD, Medicine Department
- Laura Sirott, MD, OB/GYN Department
- Ernie Maldonado, MD, Pediatrics Department
- Harry Bowles, MD, Surgery Department

**Newsletter Editor-in-Chief – Glenn Littenberg, MD**

If you would like to submit an article to be published in the Medical Staff Newsletter please contact Bianca Irizarry at 626-397-3776. Articles must be submitted no later than the 13<sup>th</sup> of every month.

## Medical Staff Demographic Changes

### Joanne Asuncion, MD Pediatrics

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626-544-6995 (fax)

### Cindy Collo, MD Pediatrics

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### Edward Barton, MD Neurology

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626-598-3770 (office)  
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### Allison Yim, MD Pediatrics

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626-544-6995 (fax)

Please notify the Medical Staff Office via email if there is a change in your demographic information.



- 2013 – 2014 Best Hospitals Report
- # 5 Hospital in the Los Angeles metro area
- # 10 Hospital in California
- # 33 Nationally in Orthopedics
- # 44 Nationally in Urology