

medical staff NEWSLETTER

September 2013

volume 51, issue 9



From the **President**

“All existing things are really one. We regard those that are beautiful and rare as valuable, and those that are ugly as foul and rotten. The foul and rotten may come to be transformed into what is rare and valuable, and the rare and valuable into what is foul and rotten”

– Zhuangzi, 369 BC to 286 BC

[Part II Commentary on The American College of Physicians Ethics Manual](#)

Emergency Treatment and DNR Orders

Patients whom some perceive to be responsible for their own illness (such as those who suffer from alcohol abuse, drug abuse, or the acquired immunodeficiency syndrome [AIDS]) must be treated with the same care and according to the same ethical considerations as others (Fisher, 2007). Withholding or Withdrawing Certain Types of Life-Sustaining Interventions Orders Not to Resuscitate (DNR Orders): the goal of DNR orders is to provide optimum quality care to patients. A decision to withhold cardiopulmonary resuscitation (CPR) does not imply that other aggressive therapies should be withheld or withdrawn, and a DNR order should not affect any other aspects of the patient's care (Caldicott & Danis, 2009; Emanuel, 2012).

The unique clinical feature of CPR is that it is an emergency treatment that must be applied immediately to be successful (Huish, 2009; Emanuel, 2012). Because

there is limited time during the crisis for deliberation and decision-making, all decisions about the use or with-holding of CPR should be determined in advance of the clinical crisis. When it is agreed that CPR should be done, physicians and nurses should not carry out half-hearted efforts (so-called "slow codes"). When appropriate procedural safeguards exist, including proper documentation so that members of the health-care team are aware of the decisions, DNR orders and other decisions about withholding life-sustaining therapies have been widely accepted as reasonable standards of clinical practice (Carmack, 2010; Emanuel, 2012).

The The Joint Commission requires that institutions develop DNR policies which ensure that patients' rights are respected, provide procedures for resolving conflicts, make the physician responsible for writing the DNR order, and require that the DNR order be documented in the patient's medical record (Fisher, 2008). The two guiding principles that should determine whether a DNR order is written for a competent patient are the medical indications and the patient's preferences. Ideally, these considerations are discussed by the



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**General Medical Staff Meeting is
September 18, 2013
at 5 PM.**

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 **Huntington Hospital**

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 Virtual meeting of August 1, 2013 and by the Governing Board on August 1, 2013.

Medical Staff Appointments



Mark Brinckman, MD
Diagnostic Radiology

Diversified Radiology
1746 Cole Boulevard
Suite 150
Lakewood, CO 80401
303-914-8800 (office)
303-716-3777 (fax)



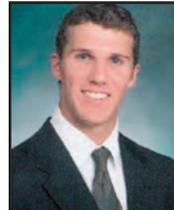
Niall Harty, MD
Urology Fellow

City of Hope
1500 East Duarte Road
Urology Department
Duarte, CA 91010
626-471-7100 (office)
626-301-8285 (fax)



Laura Chang, MD
Dermatology

HealthCare Partners
50 Bellefontaine Street
Suite 104
Pasadena, CA 91105
626-304-6300 (office)
626-304-6373 (fax)



Timothy Jackson, MD
Orthopaedic Sports Medicine

Congress Medical Associates
800 South Raymond Avenue
2nd Floor
Pasadena, CA 91105
626-795-8051 (office)
626-795-0356 (fax)



David Costantino, MD
Diagnostic Radiology

Diversified Radiology
1746 Cole Boulevard
Suite 150
Lakewood, CO 80401
303-716-3787 (office)
303-716-3777 (fax)



Barbara Janetzke, PhD
Psychology

One West California Boulevard
Suite 321
Pasadena, CA 91105
626-255-7512 (office)
626-628-3177 (fax)



Eric Frechette, MD
Neurology

665 West Naomi
Suite 201
Arcadia, CA 91007
626-445-8481 (office)
626-574-9669 (fax)



Spencer Kozinn, MD
Urology Fellow

City of Hope
1500 East Duarte Road
Urology Department
Duarte, CA 91010
626-471-7100 (office)
626-301-8285 (fax)



Nicholas Greco, MD
Emergency Medicine

100 West California Blvd.
Emergency Department
Pasadena, CA 91109
626-397-5116 (office)
626-397-2981 (fax)



Manon Kwon, MD
Emergency Medicine

100 West California Blvd.
Emergency Department
Pasadena, CA 91109
626-397-5116 (office)
626-397-2981 (fax)

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Medical Staff Appointments continued



Steven Lin, MD
Orthopedic Surgery
 Congress Medical Associates
 301 West Huntington Drive
 Suite 408
 Arcadia, CA 91007
 626-821-0707 (office)
 626-821-0239 (fax)



Scott Tobis, MD
Urology Fellow
 City of Hope
 1500 East Duarte Road
 Urology Department
 Duarte, CA 91010
 626-471-7100 (office)
 626-301-8285 (fax)



Charles Niesen, MD
Pediatric Neurology
 960 East Green Street
 Suite L-11
 Pasadena, CA 91106
 626-599-7600 (office)
 626-599-7601 (fax)



Clayton Vandergriff, MD
Diagnostic Radiology
 Diversified Radiology
 1746 Cole Boulevard
 Suite 150
 Lakewood, CO 80401
 303-716-3787 (office)
 303-716-3777 (fax)



Elizabeth Raab, MD
Neonatology
 Pediatrix Medical Group
 100 West California Boulevard
 Neonatology Department
 Pasadena, CA 91109
 626-397-3826 (office)
 626-397-2181 (fax)



John Wendel, MD
Diagnostic Radiology
 Diversified Radiology
 1746 Cole Boulevard
 Suite 150
 Lakewood, CO 80401
 303-716-3787 (office)
 303-716-3777 (fax)



Joseph Rosenthal, MD
**Pediatric Hematology/
 Oncology**
 City of Hope
 1500 East Duarte Road
 Pediatrics Department
 Pasadena, CA 91010
 626-359-8111 (office)
 626-256-8723 (fax)



Sharon Yegiaian, MD
Neurology
 625 South Fair Oaks Avenue
 Suite 325
 Pasadena, CA 91105
 626-535-9344 (office)
 626-535-9387 (fax)

ALLIED HEALTH PROFESSIONAL APPOINTMENTS

- Marianne Haines, NP – Nurse Practitioner (Supervisor: Jamie Powers, MD)
- Ashkhan Kaviani, PA – Physician Assistant (Supervisor: Stanley Kalter, MD)
- Caroline Oh, NP – Nurse Practitioner (Supervisor: Stanley Kalter, MD)
- Kylie Smith, PA-C – Physician Assistant (Supervisor: William Caton, MD)

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Resignations

Medical Staff Resignations

- Kamal Bijanpour, MD – Psychiatry – effective 7/16/13
- Thomas Chu, MD – Ophthalmology – effective 9/30/13
- Sylvia Del Castillo, MD – Pediatric Critical Care – effective 6/26/13
- Dong Ha, MD – Plastic Surgery – effective 9/30/13
- Tracy Grikscheit, MD – General Surgery – effective 6/25/13
- Chester Koh, MD – Urology – effective 6/30/13
- Andrew Lai, MD – Internal Medicine – effective 6/21/13
- Stephen Liu, MD – Hematology/Oncology – effective 6/30/13
- Cynthia Martel, MD – Hematology/Oncology – effective 9/30/13
- Lara Nelson, MD – Pediatrics – effective 9/30/13
- Michael Nuzzo, MD – Orthopedic Surgery – effective 7/31/13
- Sarah Rubin, MD – Pediatric Critical Care – effective 6/26/13

Allied Health Resignations

- Adrian Krueger, PA-C – Physician Assistant (Supervisor: Stanley Kalter, MD)
- Martin Szyleyko, RN – 5150 Status (Supervisor: Christian Rutland, MD)
- Timothy Thompson, LPT – 5150 Status (Supervisor: Christian Rutland, MD)

From the President continued from page 1

patient and physician, and they reach a joint and acceptable decision. Discussions of a DNR order can be initiated either by the physician or the patient at any time but are essential in clinical situations where a cardio-respiratory arrest is likely (Thompson, 2006). Such discussions that have occurred when patients are relatively stable often provide physicians with guidelines for developing a comprehensive treatment plan for the patient. When treatment is judged useless, or when CPR would only prolong the dying process, then, if the patient agrees with the plan, an order not to resuscitate such a patient is ethical. In cases of conflict between the competent patient and the physician, the patient's wishes should prevail. For reasons of conscience, the physician may elect to withdraw from the case (Winland-Brown & Dobrin, 2009; Emanuel, 2012). A DNR order should

not be discussed with a competent patient's family unless the patient authorizes such a discussion. If the patient signifies his preference for a DNR order, this preference becomes the paramount consideration.

A DNR decision for an incompetent patient or for a patient who lacks decision-making capacity raises the same issues discussed earlier in this section regarding incompetent patients. For persons who have been declared legally incapacitated, DNR orders must never be written solely on the basis of the mental condition but for the same reasons as for competent patients. Family members and friends often serve as representatives of the patient's moral community and frequently are most knowledgeable about the patient's values and preferences (Jonsen, 2006). Physicians should work closely

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From the President continued from page 4

with family and friends of incompetent persons to determine the patient's preferences. Legally, the physician would be well advised to recommend to the patient's family that they have one member of the family appointed as the patient's guardian so that the physician will have a person to deal with who has the legal authority to make all treatment decisions for the patient.

Other life-sustaining interventions, the general rules developed for competent and incompetent patients, and their specification regarding DNR decisions, apply also to decisions about other complex and simple life-sustaining interventions such as ventilators, dialysis, transfusion of blood products, and antibiotic administration. When possible, physicians should work with their patients in advance of a clinical crisis to develop a mutually agreeable, general-care plan that considers which, if any, life-sustaining interventions should be withheld or withdrawn in various clinical circumstances.

The most difficult situation involves a non-terminally ill, permanently unconscious patient whose previous wishes are not known (Levy, 2005). In such cases, some hold that there is no obligation to provide fluids and nutrition because the burdens of even such simple interventions exceed the limited benefits of sustaining organic life in a person who will never recover cognitive function (Lyon & Mirivel, 2011; Emanuel, 2012). Another viewpoint cautions that in withholding simple interventions like fluids and nutrition, physicians may be contributing to the death of non-terminally ill persons, and that such a policy may be dangerous for various groups of vulnerable patients. In deciding between these two positions, the physician must exercise his or her own judgment about what is morally permissible and should seek guidance

concerning the law in his or her locale (McDaniel, 2010; Emanuel, 2012).

Because patients can and do change their minds, both oral conversations and written directives should be updated periodically so that choices made by the patient are contemporary with the progress of treatment, and thus carry greater weight. Quality-of-life considerations are important for individuals to reach decisions about their care. By contrast, when quality-of-life standards are used by parties other than the patient to reach a clinical decision, decision-makers must be aware of the personal and subjective values that may influence such quality-of-life evaluations.

Communication

Ethical guidelines for public announcement are indistinct because it is unfamiliar terrain for most scientists. Thus, some caveats may prove useful: The risk/ benefit ratio of the event must be carefully contemplated, cautious assurance must be given that conclusions are justified from data (which have satisfied rigorous scientific methodology), and carefully chosen language must be incorporated into all decisions about public pronouncements. Initiating and foregoing life-sustaining treatment considerations arise most frequently in patients who are severely and critically ill, terminally ill, permanently unconscious, or who suffer from irreversible cognitive or physical impairment.

These cases (about which the law varies from state to state) frequently present perplexing clinical and ethical challenges to patients, physicians, and families. The challenges include life and death matters, certain types of decisions (for example, do-not-resuscitate [DNR] issues) arise more frequently, patients are often not

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From the **President** continued from page 5

“capable of participating in the decision-making process and may never regain decision-making capacity, and there is frequent need to involve decision makers other than the patient (Emanuel, 2012).

Institutional protocols must be in place to assure this. Advances in medical knowledge and technology can occur rapidly. Often it is possible for the clinical application of such progress to proceed swiftly, even before the medical community has had an opportunity to establish guidelines for appropriate and ethical use. It is the responsibility of the medical profession to ensure verification of the safety and efficacy of new technologies and treatment. Medical consensus development should be open to public scrutiny.

When a nurse believes a physician's order is contrary to his or her personal values or to usual medical and nursing practice, the nurse must share this opinion with the physician so that the matter can be discussed. Conflict-of-opinion policies and procedures in hospitals should be developed to further guide the resolution of such conflicts (Emanuel, 2012). Medical capability has not always progressed hand-in-hand with medical availability. The unevenness and disparity in patient-to-physician ratios across the country have been factors in the remarkable increase in non-physician practitioners who represent a broad spectrum of educational background, training, experience, and skill. Limits imposed by licensure for non-physician practitioners vary (Emanuel, 2012). The relationship of the physician to the news media could make patients become vulnerable in the public eye either because physicians may seek public acclaim and attention through their work, or involve in events beyond their control.

Society has identified the physician as possessing the necessary training to undertake this responsibility, and such responsibility is implied in the relationship between patient and physician. Physicians and nurses both strive to serve the patient (Emanuel, 2012). The lines of communication between physicians and nurses must always be open, and communication must always be characterized by mutual respect. The physician should act as an advocate and coordinator of care for the patient and should assume appropriate responsibility, especially when utilizing the help of other health professionals. The physician should collaborate only with competent health professionals when sharing the care of the patient.

Conclusion

The sixth edition of the American College of Physicians' (ACP's) Ethics Manual addresses ethical decisions in clinical practice, teaching, and medical research, as well as the underlying principles and the physician's role in society and with colleagues. Similar to previous editions, the current update of the ACP's manual covers surrogate decision-making and end-of-life care, use of complementary and alternative medicine, physician-assisted suicide, relationship between physicians and industry, genetic testing, and research ethics. While exploring these topics in greater depth, the new edition also highlights the patient-physician relationship during health catastrophes, culturally sensitive care, research use of human biologic materials, social media and online professionalism, and industry-sponsored research. Therefore, I recommend our medical staff to be familiar with this manual for their practice.

Edmund Tse, MD

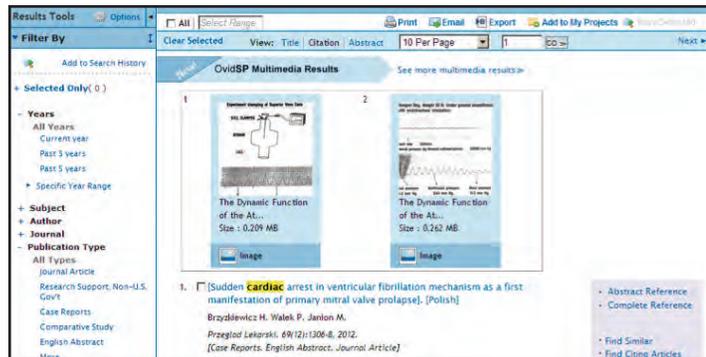
President

From the **Health Science Library**

**NEW FEATURE ON OVIDSP –
Multimedia now easily available**

On July 23, videos and images were made available on OvidSP. You now have institutional access to the multimedia assets belonging to the journals and books you currently subscribe to!

You now have access to videos of procedures, expert interviews, diagnosis and treatment techniques, lectures and article discussions, as well as images for visual diagnosis, education, presentations and more. All available multimedia assets will be identifiable in your search results. Browse all related video and images while still maintaining access to your full-text content results. You can filter multimedia search results by media type, duration of video, subject matter and other criteria – and print, export, download, and email results to colleagues.



First conduct your search. If multimedia are available they will appear at the top of the Results list as seen below. Note the link to “See more multimedia results.” Click on that link to see all multimedia available from your search results.

Need a Break? Stop by the Library & Curl up with or Take a Book

This is to remind you that the library has an area in the alcove at the back for recreational reading books. Feel free to “Bring One...Take One...Or Both.” There are mysteries, suspense, fantasies, and other novels, as well as some non-fiction (mostly sports-related).



To check out some of the titles, go to the libraries SharePoint site to “SUBJECT GUIDES -> All Subject Guides...” on the left. Scroll down to “Recreational Reading.” Or go directly to the following URL: <http://huntingtonhospital.libguides.com/recreading>. This will give you an idea of the books in the collection. Be sure to check back later, as books are being added all the time.

No need to sign them out, just take what looks interesting to you. When you finish reading one, we’d appreciate your returning it so that others will have a chance at it, but that’s optional.

Whatever your into for recreational reading, there is probably a book there for you! Take some time to escape. There’s a reason it’s called recreation – it will help you re-create and refresh yourself.

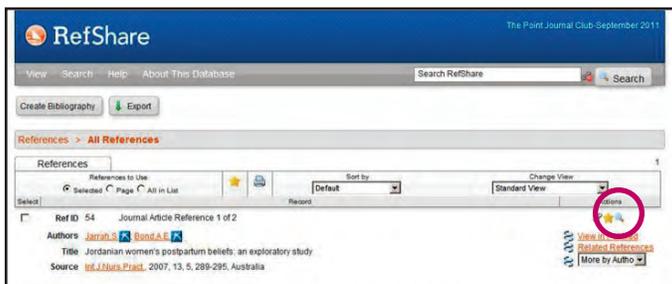
From the Health Science Library

ABOG 3rd Quarter Articles

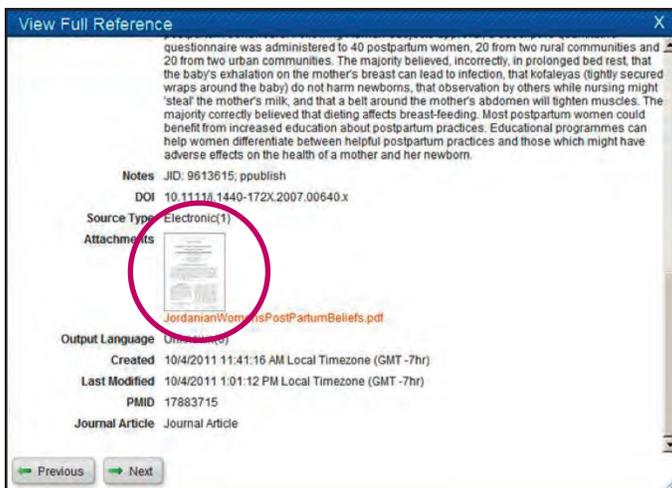
The 3rd quarter articles for the ABOG General and Subspecialties lists are now available on the Library's SharePoint site. Go the Library's SharePoint site to "READING LISTS" on the right to find the 3rd Qtr lists. Click on **General** or **Subspecialties** to get to the list with the full text articles. The below instructions will show you how to download the articles.

Instructions for Downloading Articles from RefShare

1. Click on the magnifying glass icon next to the citation



2. A new screen will pop up, scroll all the way to the end of this screen and click on the document under the attachments section to open.



If you have any difficulties accessing any of the articles, please email library@huntingtonhospital.com or phone 626-397-5161.

Happy Hour Recap

On July 19, 2013, Edmund Tse, MD, President of the Medical Staff, hosted a happy hour event. The event, which was geared toward encouraging relationships among the Medical Staff, was attended by a variety of different specialties. Those who attended were treated to appetizers, refreshments, and a chance to socialize among colleagues. In addition, a raffle was held where physicians were given ten tickets and were allowed to select which prize or prizes they wanted to try and win. Congratulations to the following raffle winners:

- Movie night basket – Sharon Yegiaian, MD
- Keurig coffee maker – Priscilla Songsanand, MD
- Movie tickets – George Matsuda, MD and Azhil Durairaj, MD
- Magic Mountain basket – Kay Durairaj, MD
- Dodger tickets – Syeda Ali, MD
- Helicopter ride around Los Angeles – Marlowe Majoewsky, MD
- Mini iPad – Beth Julian-Wang, MD
- Wine basket – Geronimo Rodriguez, MD



Dr. Songsanand



Dr. Rodriguez

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

A monthly communication to assist physicians in patient engagement and the patient experience.

Reviewed by: Shant Kazazian, MD

The question patients are asked to rate on a scale of 1-5 (very poor – very good) is:

“Physician’s concern for your questions and worries”

Question Definition

In varying degrees, patients expect physicians to share in their uneasiness, trepidation or worry about a condition, procedure or symptom, rather than dismissing them outright. Patients respond positively to physicians who are able to put aside the medical agenda and encourage the patient to disclose their feelings. They also respond positively to physicians who elicit and respect all of their concerns, who acknowledge the patient's fears, and who do not avoid unpleasant subjects. Patients respond negatively to physicians who ignore or seem uncomfortable with patients' emotional expressions

Tools for success:

1. Encourage the patient and/or family to write down questions they have for the physician ahead of time. When arriving in their room, our patients are given a pencil and notepad titled "Questions for My Caregivers" for this purpose.
2. Allow the patient to "tell the story" without interruption. The average amount of time that a physician allows a patient to speak before interrupting with a question or observation is only approximately 20 seconds. Patients do not feel this is an

adequate amount of time to fully explain their story. Actively listening to the patient allowing them their full voice actually doesn't take any additional time (in fact, it may actually take less time, in the long run).

3. Provide answers in understandable, nontechnical language.
4. It only takes a second to pat a hand or smile. Listen. Prove you care about what the patient has to say. Do not answer questions with more questions. Put yourself in a patient's circumstances. Be empathetic.

Job Well Done!

“My OB/GYN has a wonderful bedside demeanor and is a remarkable physician. We could not be happier with our doctor.”

“My Resident was great – concerned, compassionate, and helpful.”

Improvement Opportunities

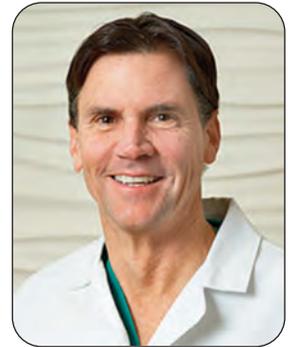
“My physician has no bedside manner. The physician did not seem to care at all about my concern. The physician didn’t clearly explain procedures to me. I will never use this physician again!”

“The physician treated my concerns as if they were routine, maybe they are to the physician, but not to me. The physician was dismissive with my questions and concern.”

All comments are from the Press Ganey satisfaction survey.

Getting to Know Your Medical Staff Leaders

Christopher Hedley, MD has been a member of the Medical Staff since August 1990. He is a member of the Department of Medicine specializing in Diagnostic as well as Vascular and Interventional Radiology. Dr. Hedley received his medical degree from Baylor College of Medicine and completed both his Diagnostic Radiology residency and Body Imaging and Interventional Radiology fellowship at the LAC/USC Medical Center. He is board certified in Diagnostic Radiology and Vascular and Interventional Radiology. Currently, Dr. Hedley is the Medical Director of the Department of Radiology and has served as Chairman of the Radiology/Nuclear Medicine Section since 2009. He is active in medical staff affairs and is a member of the Medicine, Quality Management, and Cancer Committees.

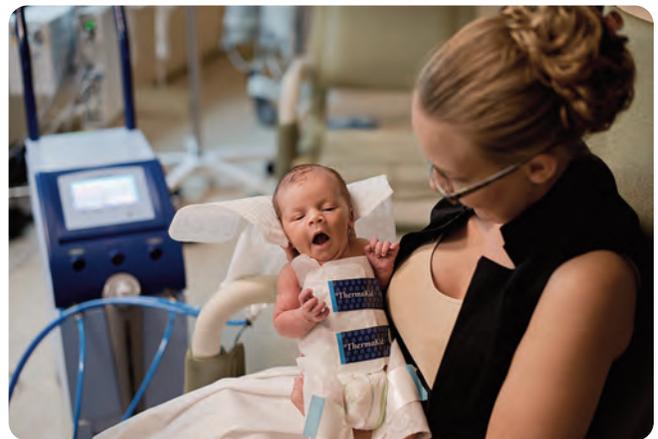


He is currently the President of the Hill Medical Corporation, the California Medical Business Services, LLC, and a newly formed radiology group, Radiant Imaging, Inc. Additionally, Dr. Hedley is on the Board of Strategic Radiology, LLC. Strategic Radiology is comprised of large clinically advanced radiology groups across the United States. Strategic Radiology has created a formal Patient Safety Organization, and Dr. Hedley is excited that this facilitated exchange of information will result in higher quality and increased patient safety for patients at Huntington.

In his spare time, Dr. Hedley enjoys snow skiing and mountain biking. On weekends when he is not covering Huntington you can find him throughout the Southwest at his daughter's volleyball games or at Mammoth Mountain watching his son ski race.

CureWrap Blankets in NICU

Huntington Hospital has become the first hospital in California to acquire wrap-around cooling blankets for use with babies at risk of brain damage. The blankets are used to induce hypothermia, a treatment that may prevent or minimize the long-term consequences of brain injury in newborns. These new blankets allow parents to hold their babies during treatment, which couldn't be done in prior treatments.



Bioethics Corner

Letter to the Chief:

Thank you for opening the door to a subject worthy of ongoing discussion. Many questions were raised in your last article referencing the 6th edition of The American College of Physicians Ethics Manual.

Let me start by saying there are usually more questions raised in this arena than answers provided. Furthermore, the answers suitable in one case scenario can be totally inappropriate or inadequate in another case even with the exact set of circumstances.

So where does one start in formulating their *ethos* in the practice of medicine in general and specifically here at Huntington Hospital? It may help to reflect on why we chose this profession in the first place. At the top of the list stands the word "principle." In all likelihood there were guiding principles in formulating your opinion in selecting medicine as a livelihood. The obvious was that you love working with people. Or some life experience gave you a desire to contribute to the relief of pain and suffering. And a part of that goal may have also been that you wanted to join the search for cures: cancer, heart disease, diabetes, seizure disorder, and schizophrenia to name a few. Within the framework of your quest you acquired several character traits that would assist you in decision-making. These include honor, respect, trustworthiness and a sense of "rightness." Combining your principles, character and acquired skill set, as a practitioner, has brought value to you as a physician, to your colleagues, to the hospital and to patients along with their families. Never lose site of this sacred value while navigating through this emerging morass of best practices, core measures, quality indicators and last but not least, cost-containment protocols. These interjections in the practice of medicine can at times be viewed as burdensome but may also improve outcomes.

Somehow when it comes to "end of life" decisions, we may lose site of the aforementioned. So let's consider a strategy for approaching this issue. The most important and vital participant in this process is the primary or

treating physician. This person sets the tone from the onset and provides the bridge for understanding the medical condition. Therefore it is vital that very early, open communication, trust and heartfelt care is established with the patient and family members. Next, let's separate the "clear cut" areas from the "gray" areas. "Clear cut" areas are those that are 100% fatal and further treatment beyond comfort care would be "non-beneficial." Examples would be carcinomatosis with impending respiratory arrest, cardiogenic shock with multiorgan failure, massive intracerebral hemorrhage with herniation, etc. "Gray" areas are any area outside of "clear cut." With respect to "clear cut" areas physicians are protected when refusing to provide non-beneficial treatments. *California law contains broad immunities for physicians and health care institutions who decline requests for such treatment. Under California statute, when acting in good faith and in accordance with generally accepted health care standards, a physician or health care institution who declines to give treatment that is medically ineffective or non-beneficial is immune from civil or criminal liability and disciplinary action. (CA Probate Code 4740 quoted from CMA ON-CALL Document #0403).* Therefore an approach in addressing these "clear cut" cases with patient and families should be more informative. Avoid asking for a decision regarding resuscitation but rather invite their participation in understanding and being involved in the end of life care. Be sensitive to family concerns and desires where feasible.

Remember policies and manuals should guide not dictate your decisions. Do not be afraid to remove yourself from a situation or case that goes against your ethical principles or sense of rightness. The Bioethics Program can assist you in these most sensitive areas.

Watch for further discussions in the Bioethics Corner.

Nathan L. Lewis, MD
Chair, Bioethics Committee

New Hospital Vice President

The Medical Staff

would like to announce that Nancy Greengold, MD, MBA has been named Vice President of Clinical Integration. In this role, Dr. Greengold will be responsible for helping to drive operational excellence in all of the hospital's clinical areas, promote care integration and effective practice management across independent physicians, and serve as the clinical lead for the operations of the Huntington ACO.



Second da Vinci Robot Acquired

Huntington Hospital has acquired its second da Vinci surgical robot. Since 2000 over 1,600 of these systems have been installed at more than 1,200 hospitals worldwide.



CELEBRATING MILESTONES

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

45 Years (on staff 09/1968)

In Chang Kim, MD – Rheumatology

30 Years (on staff 09/1983)

Ruby Batin, MD – Pediatrics
Jean Lauricella, MD – Pediatrics
Brian O'Connor, MD – Rheumatology
Kathleen Smith, MD – Pediatrics

25 Years (on staff 09/1988)

Richard B. Williams, MD –
Internal Medicine
Steven Hartford, MD –
Obstetrics & Gynecology

20 Years (on staff 09/1993)

Andre Ettinger, MD – Internal Medicine
Anchel Furman, MD – Internal Medicine

10 Years (on staff 09/2003)

Frederic Bushnell, MD – Anesthesiology
Anthony Chang, MD – Anesthesiology
Thomas Coates, MD –
Pediatric Hematology/Oncology
Nayiri Doudikian-Scaff, MD –
Plastic Surgery
Hillel Naon, MD –
Pediatric Gastroenterology
Daniel Rowady, MD – Internal Medicine
Kevin Ruhge, MD – Plastic Surgery
Yasmeen Ruhge, MD –
Cardiovascular Disease
George Tang, MD – Orthopedic Surgery
Babak Tashakkor, MD – Electrophysiology
Dan Thomas, MD –
Pediatric Gastroenterology

CME Corner

Medical Grand Rounds

Topic: Adventure in Therapeutic Discovery
 Speakers: Robert J. Hickey, Ph.D. & Linda H. Malkas, Ph.D.
 Date: September 6, 2013
 Time: Noon – 1 p.m.
 Place: Research Conference Hall
 Objectives: 1. A mechanism for generating DNA mutations in human cells.
 2. Discovery of a biomarker for the detection of cancer.
 3. Discovery and development of a novel molecular target for cancer chemotherapy.
 Audience: Oncologists
 Methods: Lecture
 Credit: 1.0 AMA PRA Category 1 Credits™

Second Monday

Topic: Subclinical Hyperthyroidism
 Speaker: Charles F. Sharp, MD
 Date: September 9, 2013
 Time: Noon – 1 p.m.
 Place: Research Conference Hall
 Objectives: 1. Interpret TSH levels in the context of the clinical state.
 2. Identify cases of “subclinical” (mild) thyrotoxicosis.
 3. Recite the differential diagnosis of thyrotoxicosis.
 4. Appreciate when/which therapy should be considered.
 Audience: Internal Medicine, Primary Care Physicians
 Methods: Lecture
 Credit: 1.0 AMA PRA Category 1 Credits™

General Medical Staff Meeting

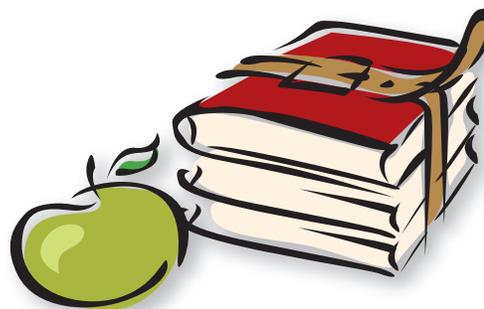
This year the General Medical Staff Meeting will focus on disaster preparedness. Dr. Zoraster will give a one hour presentation on Mass Casualty Care; attendees will receive 1.0 AMA PRA Category 1 Credits™.

Topic: Mass Casualty Care
 Speaker: Richard Zoraster, MD, MPH
 Date: September 18, 2013
 Time: 5 – 6:30 p.m.
 Place: Braun Auditorium
 Audience: Primary Care & Internal Medicine
 Methods: Lecture
 Credit: 1.0 AMA PRA Category 1 Credits™

Please RSVP with Pamela Ha by September 13, 2013.

Phone: 626-397-5913
 or email:

Pamela.Ha@huntingtonhospital.com



MEDICAL STAFF HANK COMPUTER TRAINING CLASSES

DESIGNED FOR YOUR SPECIALTY!

To register for training you can either call 626-397-5913 or complete the registration form and return it to the Medical Staff either via fax, 626-397-2917, or email, pamela.ha@huntingtonhospital.com.

[CORE physicians: Internal Med, Family Med, Allergy, Derm, Endocrinology, Geriatrics, Hospice/Palliative, Infectious Dis, Rheumatology]

[Surgery: All Surgical Specialties]

Sunday, Sept 15	Mon, Sept 16	Tues, Sept 17	Wed, Sept 18	Thur, Sept 19	Fri, Sept 20	Sat, Sept 21
						IT10: 7:30a-11:30a Residents
						IT10: 12p-4pm CORE
				IT10: 5pm - 9pm Core	IT10: 5pm - 9pm Residents	IT10: 5pm - 9pm Hospitalists
Sunday, Sept 22	Mon, Sept 23	Tues, Sept 24	Wed, Sept 25	Thur, Sept 26	Fri, Sept 27	Sat, Sept 28
						(IT8) 7:30a-11:30a Emergency Dept
	(IS1) 7:30a-11:30a Core				(IS1) 7:30a-11:30a Core	(IT12) 7:30a-11:30a Pediatrics
	(IS1) 12p-4pm Core				(IS1) 12p-4pm Core	(IT10) 7:30a-11:30a Core
	(IT12) 5p - 9p Core	(IT12) 5p - 9p Core	(IT12) 5p - 9p Core	(IT12) 5p - 9p Core	(IT12) 5p - 9p NICU	(IT10) 12p-4pm Core
	(IS1) 5p - 9p Hospitalists	(IT8) 5p - 9p Hospitalists	(IT8) 5p - 9p Surgery	(IT8) 5p - 9p Surgery	(IT10) 5p - 9p Pediatrics	(IT12) 12p-4pm Hospitalists
	(IT8) 5p - 9p Surgery	(IT10) 5p - 9p OB/Gyn	(IT10) 5p - 9p OB/Gyn	(IT10) 5p - 9p OB/Gyn	(IT8) 5p - 9p OB/Gyn	(IT10) 5p - 9p Core
Sunday, Sept 29	Mon, Sept 30	Tues, Oct 1	Wed, Oct 2	Thur, Oct 3	Fri, Oct 4	Sat, Oct 5
						(IT8) 7:30a-11:30a NICU
						(RC11) 7:30a-11:30a Neuro/Sleep
(IT8) 7:30a-11:30a Core						(IT12) 7:30a-11:30a Pulmonary/CC
(IT8) 12p-4pm Core						(IT10) 7:30a-11:30a Surgery
(IT8) 5p-9p Core		(IS1) 7:30a-11:30a Hospitalists				(RC11) 12p-4pm Neuro/Sleep
(IT12) 7:30a-11:30a Pediatrics		(IS1) 12p-4pm Core				(IT8) 12p-4pm Core
(IT12) 12p-4pm Pediatrics		(IS1) 5p - 9p Core				(IT12) 12p-4pm Pulmonary/CC
(IT10) 7:30a-11:30a Surgery	(RC11) 5p - 9p Surgery	(RC11) 5p - 9p NICU	(RC11) 5p - 9p OB/GYN	(RC11) 5p - 9p Emergency Dept	(RC11) 5p - 9p OB/Gyn	(IT10) 12p-4p OB/GYN
(IT10) 12p-4p Surgery	(IT8) 5p - 9p Emergency Dept	(IT8) 5p - 9p Emergency Dept	(IT8) 5p - 9p Psychiatry	(IT12) 5p - 9p Hospitalists	(IT8) 5p - 9p Hospitalists	(IT10) 5p-9p OB/GYN
(IT10) 5p-9p Surgery	(IT10) 5p - 9p Core	(IT10) 5p - 9p Pediatrics	(IT10) 5p - 9p Core	(IT10) 5p - 9p Core	(IT10) 5p - 9p Core	(RC11) 5p-9p Emergency Dept
(IT12) 5p-9p Cardiology/EP	(IT12) 5p - 9p OB/Gyn	(IT12) 5p - 9p Neuro/Sleep	(IT12) 5p - 9p Neuro/Sleep	(IT8) 5p - 9p Neuro/Sleep	(IT12) 5p - 9p Surgery	(IT8) 5p-9p Core
						(IT12) 5p-9p Pulmonary/CC

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[Surgery: All Surgical Specialties]

Sunday, Oct 6	Mon, Oct 7	Tues, Oct 8	Wed, Oct 9	Thur, Oct 10	Fri, Oct 11	Sat, Oct 12
(RC11) 7:30a-11:30a Core						
(RC11) 12p-4pm Core						
(RC11) 5p-9p Core						
(IT8) 7:30a-11:30a NICU						(IT8) 7:30a-11:30a Surgery
(IT8) 12p-4pm Emergency Dept						(IT8) 12p-4pm Surgery
(IT8) 5p-9p Pulmonary/CC						(IT8) 5p-9p Surgery
(IT12) 7:30a-11:30a Hospitalists			(IS1) 7:30a-11:30a Cardiology/EP			(IT12) 7:30a-11:30a Emergency Dept
(IT12) 12p-4pm Hospitalists			(IS1) 12p-4pm Core			(IT12) 12p-4pm Core
(IT10) 7:30a-11:30a Surgery			(IS1) 5p - 9p Emergency Dept			(IT10) 7:30a-11:30a OB/GYN
(IT10) 12p-4p Surgery		(IT8) 5p - 9p Cardiology/EP	(IT8) 5p - 9p Surgery	(IT8) 5p - 9p Emergency Dept	(IT8) 5p - 9p OB/GYN	(IT10) 12p-4p OB/GYN
(IT12) 5p-9p OB/GYN	(IT8) 5p - 9p Psychiatry	(IT12) 5p - 9p Core	(IT12) 5p - 9p NICU	(IT12) 5p - 9p Core	(IT12) 5p - 9p Core	(IT12) 5p-9p Core
(IT10) 5p-9p Surgery	(IT12) 5p - 9p Core	(IT10) 5p - 9p OB/GYN	(IT10) 5p - 9p Psychiatry	(IT10) 5p - 9p Neurology/Sleep	(IT10) 5p - 9p Pediatrics	(IT10) 5p-9p Pediatrics
Sunday, Oct 13	Mon, Oct 14	Tues, Oct 15	Wed, Oct 16	Thur, Oct 17	Fri, Oct 18	Sat, Oct 19
	6:30 am - 6pm FAVORITE FAIRS 1:1 with Drs	(RC11) 7:30a-11:30a FAVORITE FAIR				
	Patient Lists & Favorite Folders	(RC11) 12p-4pm FAVORITE FAIR				
						(RC11) 5p-9p FAVORITE FAIR
						(IS2) 7:30a-11:30a Surgery
(IT8) 7:30a-11:30a FAVORITE FAIR						(IS2) 12p-4pm Cardiology/EP
(IT8) 12p-4pm FAVORITE FAIR						(IS2) 5p - 9p Core
(IT8) 5p-9p Core				(IS1) 7:30a-11:30a Pediatrics		(IT8) 7:30a-11:30a Pulmonary/CC
(IT12) 7:30a-11:30a Pulmonary/CC				(IS1) 12p-4pm Cardiology/EP		(IT8) 12p-4pm Cardiology/EP
(IT12) 12p-4pm Hospitalist				(IS1) 5p - 9p OB/GYN		(IT8) 5p-9p OB/GYN
(IT10) 7:30a-11:30a OB/GYN	(RC11) 5p - 9p Core	(IT12) 7:30a-11:30a Hospitalists				
(IT10) 12p-4p Surgery	(IT8) 5p - 9p Emergency Dept	(IT8) 5p - 9p Cardiology/EP	(IT8) 5p - 9p Hospitalists	(IT8) 5p - 9p Cardiology/EP	(IT8) 5p - 9p Hospitalists	(IT12) 12p-4pm Hospitalists
(IT12) 5p-9p Surgery	(IT12) 5p - 9p Anesthesia	(IT12) 5p - 9p Pulmonary/CC	(IT10) 7:30a-11:30a Core			
(IT10) 5p-9p Emergency Dept	(IT10) 5p - 9p Cardiology/EP	(IT10) 5p - 9p Pediatrics	(IT10) 5p - 9p Emergency Dept	(IT10) 5p - 9p Neurology/Sleep	(IT10) 5p - 9p OB/GYN	(IT10) 12p-4p Surgery
						(IT12) 5p-9p Hospitalists
						(IT10) 5p-9p Psychiatry

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[Surgery: All Surgical Specialties]

Sunday, Oct 20	Mon, Oct 21	Tues, Oct 22	Wed, Oct 23	Thur, Oct 24	Fri, Oct 25	Sat, Oct 26
(RC11) 7:30a-11:30a FAVORITE FAIR	6:30 am - 6pm FAVORITE FAIRS	(RC11) 7:30a-11:30a FAVORITE FAIR				
(RC11) 12p-4pm FAVORITE FAIR	1:1 with Drs	(RC11) 12p-4pm FAVORITE FAIR				
(RC11) 5p-9p FAVORITE FAIR	Patient Lists & Favorite Folders'	(RC11) 5p-9p FAVORITE FAIR				
(IT8) 7:30a-11:30a Core						(IT8) 7:30a-11:30a Pediatrics
(IT8) 12p-4pm Pediatrics						(IT8) 12p-4pm Core
(IT8) 5p-9p Core						(IT8) 5p-9p Core
(IT12) 7:30a-11:30a Cardiology/EP						(IT12) 7:30a-11:30a Cardiology/EP
(IT12) 12p-4pm Surgery						(IT12) 12p-4pm Cardiology/EP
(IT10) 7:30a-11:30a OB/GYN						(IT10) 7:30a-11:30a Psychiatry
(IT10) 12p-4p OB/GYN						(IT10) 12p-4p OB/GYN
(IT12) 5p-9p Pulmonary/CC					(IS1) 7:30a-11:30a Hospitalists	(IT12) 5p-9p Surgery
(IT10) 5p-9p Surgery					(IS1) 12p-4pm Core	(IT10) 5p-9p Pulmonary/CC
Sunday, Oct 27	Mon, Oct 28	Tues, Oct 29	Wed, Oct 30	Thur, Oct 31	Fri, Nov 1	Sat, Nov 2
6:30 am - 10pm FAVORITE FAIRS	6:30 am - 10pm FAVORITE FAIRS	6:30 am - 10pm FAVORITE FAIRS	6:30 am - 10pm FAVORITE FAIRS	6:30 am - 10pm FAVORITE FAIRS		
1:1 with Drs	1:1 with Drs	1:1 with Drs	1:1 with Drs	1:1 with Drs		
Patient Lists & Favorite Folders'	Patient Lists & Favorite Folders'	Patient Lists & Favorite Folders'	Patient Lists & Favorite Folders'	Patient Lists & Favorite Folders'		
					GO LIVE	

NEW DICTATION TEMPLATES READY FOR PHYSICIAN USE

To improve communication and collaboration around patient care - HMH has expanded the documentation templates available TODAY. All you need do is select the worktypes listed below when you call to dictate! These will also be available when HANK goes live. While Turn Around Time contracted is 2 hours, physicians have seen much faster turn around times.

Once signed, all these documents are sent to your office/staff in your Huntington Health eConnect (HHeC) in-box, eliminating your need to print out copies to take to your office! When you utilize Front End Templates (pDOCs) in Meditech - once signed, they are immediately available in HHeC.

Dictate Inside Hospital: ext 2585

****Enter Following When Prompted:

1. **Physician ID** Number; Followed by #
2. **Work Type** (listed below), followed by #
3. **V (Visit) Number**, Followed by #

BACK END TRANSCRIPTION

Work Type	Traditional Back End Dictation Transcribed Reports	Turn Around Time (24x7)
9	Preop H&P For Next Day Surgery	2 hours
1	History & Physical; Psychiatric H&P	3 hours
2	Consult	12 hours
21	Hematology/ Oncology Consult	12 hours
22	Cardiothoracic Consult	12 hours
23	Neurology Consult	12 hours
3	Operative Report	12 hours
31	Procedure Report	12 hours
33	Interoperative Neuromonitoring Report	12 hours
4	Pulmonary Reports	24 hours
44	GI Procedure Reports	12 hours
5	Discharge Summary	24 hours
6	Cardiac Cath	12 hours
7	Coronary Angiogram	12 hours
12	Ophthalmology History & Physical	3 hours
13	Parturition Summaries	12 hours
14	Geriatric Assessment	12 hours
15	PICU Progress Note	2 hours
16	ECHO - Adult	12 hours
17	ECHO - Pediatric	12 hours
18	Holter	12 hours
19	EKG	24 hours
20	Stress Test	12 hours
34	ECT Procedure Note	2 hours
72	ED Report (STAT < 2 Hours)	12 hours
77	Sleep Study	12 hours
85	Brainstem Auditory Evoked Potential	12 hours
86	Somatosensory Evoked Potential	12 hours

FRONT END TEMPLATES in Meditech

Work Type	pDOC Templates in Meditech	Turn Around Time
NA	Cardiology Progress Note	Immediate
NA	CDRC Initial Treatment Plan	Immediate
NA	Central Line Insertion Monitor	Immediate
NA	Discharge Day Note/Summary (AHMG)	Immediate
NA	Discharge Summary	Immediate
NA	Emergency Department Visit (ED2) Report	Immediate
NA	History & Physical	Immediate
NA	History & Physical (Long)	Immediate
NA	History & Physical (Short)	Immediate
NA	IM Resident Progress Note	Immediate
NA	Inpt Rehab 24 Med Func Update	Immediate

Calling from Outside Hospital: (626) 397-2585

For All Notes: REMEMBER to Say: '**DATE OF SERVICE**'

BACK END TRANSCRIPTION

Work Type	Traditional Back End Dictation Transcribed Reports	Turn Around Time (24x7)
87	Visual Evoked Potential	12 hours
88	EEG	12 hours
89	EMG Nerve Conduction Study	12 hours
50	Critical Care Progress Note	2 hours
51	ENT Progress Note	2 hours
52	General Surgery Progress Note	2 hours
53	Hem/Oncology Progress Note	2 hours
54	Hospitalists Progress Note	2 hours
55	Neurology Progress Note	2 hours
56	Neurosurgical Progress Note	2 hours
57	OB/GYN Progress Note	2 hours
58	Orthopedic Progress Note	2 hours
59	Palliative Care Progress Note	2 hours
60	Pediatric Progress Note	2 hours
61	Thoracic Surgery Progress Note	2 hours
62	Trauma Progress Note	2 hours
63	Urology Progress Note	2 hours
64	Vascular Surgery Progress Note	2 hours
65	Pulmonary Progress Note	2 hours
66	Internal Medicine Progress Note	2 hours
67	Nephrology Progress Note	2 hours
68	Family Practice Progress Note	2 hours
69	Cardiology Progress Note	2 hours
70	Ophthalmology Progress Note	2 hours
73	PPR-HMH Psychiatric Progress Note	2 hours
73	PPR-HMH Psychiatric Progress Note	2 hours
74	Infectious Disease Progress Note	2 hours
75	GI Progress Note	2 hours

FRONT END TEMPLATES in Meditech

Work Type	pDOC Templates in Meditech	Turn Around Time
NA	Inpt Rehab Indiv Plan of Care	Immediate
NA	Inpt Rehab Pre Adm Screen	Immediate
NA	Internal Medicine Progress Note (AHMG)	Immediate
NA	Neonatologist L&D Attendance	Immediate
NA	OB Duramorph Paid Mgmt Note	Immediate
NA	Pain Mgmt Progress Note	Immediate
NA	Palliative Care Progress Note	Immediate
NA	Pediatric Discharge Summary	Immediate
NA	Pulm/Crit Care Progress Note	Immediate
NA	Trauma History & Physical	Immediate
NA	Trauma Progress Note	Immediate

September 2013 Medical Staff Meetings

monday	tuesday	wednesday	thursday	friday
-2-	-3-	-4-	-5-	-6-
		- Noon CME Comm – CR-8 - 12:15 pm OB/GYN Peer Review – CR 5&6 - 3 pm QMC Pre-agenda – CR-C	- Noon Medicine Committee – North/South Room - Noon Trauma Services Committee – CR 5-6	- 7 am Ortho Section – CR 5&6
-9-	-10-	-11-	-12-	-13-
- Noon Transfusion Subcomm – North/South Conf. Room - 12:15 pm OB/GYN Dept – CR 5&6 - 5:30 pm Medical Executive – Board Room	- 7:30 am EP Subsection – Cardiology Conf. Room - Noon Critical Care Section – CR 5&6	- 10 am PICU/Peds QI – CR 2 - 12:15 pm OB/GYN Committee – CR 5&6 - Newsletter Submission -	- 6:30 am Anesthesia Section – CR-7 - Noon QM Committee – East Room - 5:30 pm Neonatal/Pediatric Surgical Case Review – CR-10	
-16-	-17-	-18-	-19-	-20-
- 8 am Emergency Medicine Section – ED Conf. Room	- 12:15 pm Credentials Committee – CR-C	- 7:30 am Cardiology Section – Cardiology Conf Room	- 6:30 am Anesthesia Peer – CR-7 - Noon PT&D Comm – CR 5&6 - 1 pm Thoracic Surgery Section – CR-11 - 3 pm Neon QI CR-10 - 6 pm Bioethics – CR 5&6	- 7:30 am Spine Peer Review – Conf. Room 11
-23-	-24-	-25-	-26-	-27-
- Noon Graduate Medical Education – East Room	- 7:30 am Interdisciplinary Practice – CR-C - Noon Pulmonary Section – CR-10 - Noon General Surgery Section – CR-5	- 5:30 pm Surgery Committee – CR 5&6	- 12:15 pm Pediatric Committee – East Room - Noon IM Peer Rev – CR-6	

September 2013 CME Calendar

monday	tuesday	wednesday	thursday	friday
-2-	-3-	-4-	-5-	-6-
	- 7:30 – 8:30 am MKSAP, Conf. Room A - Noon – 1 pm General MDisc Cancer Conf, Conf. Room 11	- Noon – 1 pm Genitourinary Cancer Conf., Conf. Room 11 - Noon – 1 pm Radiology Teaching Files, MRI Conf. Room	- 7:00 – 10 am Trauma M&M, Conf. Room B - Noon – 1 pm Thoracic Cancer Conf, Conf. Room 11	- 7:30 – 9 am Neurosurgery Grand Rounds, Conf. Room 11 - Noon – 1 pm Medical Grand Rounds, RSH Topic: New Cancer Markers - Noon – 1 pm MDisc Breast Cancer Conf., Conf. Room 11
-9-	-10-	-11-	-12-	-13-
- 12:15 – 1:15 pm OB/GYN Dept. Mtg, CR 5 & 6 - Noon – 1 pm Second Monday, RSH Topic: Subclinical Hyperthyroidism	- 7:30 – 8:30 am MKSAP, Conf. Room A - Noon – 1 pm General MDisc Cancer Conf, Conf. Room 11	- Noon – 1 pm Radiology Teaching Files, MRI Conf. Room	- 8 – 9 am Surgery M&M, Conf. Room B	- 7:30 – 9 am Neurosurgery Grand Rounds, Conf. Room 11 - Noon – 1 pm Medical Case Conference, RSH - Noon – 1 pm MDisc Breast Cancer Conf., Conf. Room 11
-16-	-17-	-18-	-19-	-20-
	- 7:30 – 8:30 am MKSAP, Conf. Room A - Noon – 1 pm General MDisc Cancer Conf, Conf. Room 11	- Noon – 1 pm Genitourinary Cancer Conf., Conf. Room 11 - Noon – 1 pm Radiology Teaching Files, MRI Conf. Room	- 7 – 8 am Trauma Walk Rounds, Conf. Room B - 8 – 9 am Surgery M&M, Conf. Room B - Noon – 1 pm Thoracic Cancer Conf, Conf. Room 11	- Noon – 1 pm Medical Case Conference, RSH - Noon – 1 pm MDisc Breast Cancer Conf., Conf. Room 11
-23-	-24-	-25-	-26-	-27-
- Noon – 1 pm Pelvic Floor Clinical Conf., Conf. Room 11	- 7:30 – 8:30 am MKSAP, Conf. Rm. A - Noon – 1 pm General MDisc Cancer Conf, Conf. Room 11	- 7:30 – 8:30 am Cardiac Cath Conf., Cardiology Conf. Room - Noon – 1 pm Radiology Teaching Files, MRI Conf. Room	- 8 – 9 am Surgery M&M, Conf. Room B	- 7:30 – 9 am Neurosurgery Grand Rounds, Conf. Room 11 - Noon – 1 pm Medical Case Conference, RSH - Noon – 1 pm MDisc Breast Cancer Conf., Conf. Room 11

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 13th of every month.

Demographic Changes**Fadi Chahin, MD**

11550 Indian Hills Road
Suite 240
Mission Hills, CA 91345
310-274-2763 (office)
818-365-1189 (fax)

Joseph Chao, MD

1500 East Duarte Road
Building 51
Duarte, CA 91010
626-471-9200 (office)
626-301-8233 (fax)

Irma Gonzalez, MD

960 East Green Street
Suite L-12
Pasadena, CA 91106
626-795-8822 (office)
626-795-8823 (fax)

Karl Heiner Vogelbach, MD

900 South First Street
Suite E
Arcadia, CA 91006
626-247-9202 (office)
626-566-2704 (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