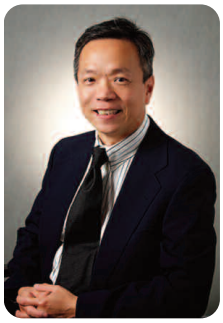
medical staff NEWSLETTER

September 2014 volume 52, issue 9

From the President



"When you locate good in yourself, approve of it with determination. When you locate evil in yourself, despise it as something detestable."

– Xun Zi (310-237 B.C.)

"When anger rises, think of the consequences."

- Confucius (551-479 B.C.)

Disruptive Physician Behavior – Part 1

According to the 2004 study by the American College of Physician Executives (ACPE), *Poll Results: Doctor's Disruptive Behavior Disturbs Physician Leaders* by David O. Weber, there were 1,600 survey respondents from different hospital executives and Chiefs of Staff addressing the problems with disruptive behaviors of physicians. Some of the problems included: refusal to complete tasks or carry out duties, physical abuse (including throwing items), and verbal abuse (insults, disrespect, yelling) amongst others. In this study, executive physician respondents revealed that disrespect was the most common type of disruptive behavior involving the same physician for a period of time. There were internal and external factors that influence the behaviors of some physicians turning them into a problem doctor. Examples of some of the internal factors include low emotional quotient and problems with drug and alcohol addiction while examples of some of the external factors include organizational bureaucracy, difficult patients, institutional financial crisis, excessive paper work, patient referral limitations, and cost-based instead of need-based diagnostic procedures.

The Institute of Safe Medication Practices (ISMP) did a study with nurses, pharmacists, and other hospital workers on disruptive physician behavior. Their result pointed towards the issue on nurses falling as the primary victims of a physician's disruptive behaviors contributing to rapid turnover of nurses at hospital settings and the superiority complex of physicians which contributes to

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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 Virtual Medical Executive Committee of July 24, 2014 and by the Governing Board on July 31, 2014.

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Inside this issue:

General Medical Staff meeting is Sept. 17, 2014

Huntington Hospital

Medical Staff Appointments

Patrick Alix, MD
Geriatrics
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Risser Orthopaedic Group
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HACC
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Orthopedic Surgery Fellow
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Ramya Swamy, MD
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Medical Staff Appointments

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626-254-9019 (fax)

Jesus Vazquez, MD
Electrophysiology
Foothill Cardiology
301 W. Huntington Drive
Arcadia, CA 91007
626-254-0074 (office)
626-254-0079 (fax)

Allied Health Professional Appointments

- Paul Cavazos – Clinical Research Coordinator
- Kyong-Jin Han, CCP – Perfusionist
- Lindsay Howard, NP – Nurse Practitioner
- Aaron LaRue, CCP – Perfusionist
- Rusty Samuel, CPO – Prosthetist/Orthotist
- Sean Stellar, CPO – Prosthetist/Orthotist

Medical Staff Resignations

- Anna Cuomo, MD – Orthopedic Surgery – effective 10/31/2014
- Graham Fedorak, MD – Orthopedic Surgery – effective 10/31/2014
- Susan Kay, MD – Plastic Surgery – effective 10/31/2014

Allied Health Resignations

- Jimmy Arms, Jr., PA-C – Physician Assistant – effective 09/30/2014
- Hilary Gibbins, PA-C – Physician Assistant – effective 09/30/2014
- Karen Meske, RN – RN 5150 Status – effective 09/30/2014
- Nicholas Stevenson, CCP – Perfusionist – effective 09/30/2014
- Pamela Weed – Oral/Maxillofacial Surgical Assistant – effective 09/30/2014

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.

35 Years (on staff 09/1979)
Steven J. Petit, MD – Gastroenterology

30 Years (on staff 09/1984)
Karen Morgan, MD – Ophthalmology

25 Years (on staff 09/1989)
Paul Gilbert, MD – Orthopedic Surgery
Heman Upadhyaya, MD – Pediatrics
Evon Cadogan, MD – Anesthesiology
John Legault, MD – Pediatrics

15 Years (on staff 09/1999)
Magdi Alexander, MD – General Surgery
Fred Weaver, MD – Vascular Surgery
Lori Wynstock, MD – Internal Medicine

10 Years (on staff 09/2004)
Joel Hutchinson, MD – Pain Management
Prema Kothandaraman, MD – Obstetrics & Gynecology
Henry Wang, MD – Hematology/Oncology
Jeremy Williams, MD – Emergency Medicine
Annie Yessaiain, MD – Gynecologic Oncology

From the **President** continued from page 1

the disruptive behavior. ISMP recommended ways to handle misbehavior of physicians in the healthcare setting through leadership by the institutionalization of codes of conduct and resolution strategies for disruptive behaviors involving all health care employees in its creation and implementation.

There is a strong need for physician leadership to evaluate how they proactively respond to the disruptive behaviors of their colleagues as a complement to the institutional policies, and the significance of listening and communication skills as important tools in getting the cooperation of the disruptive physicians and the entire organizational team. In addition, executive physicians are held accountable for the achievements and failures of their colleagues and staff. Executive physicians can help prevent disruptive behaviors by instilling respect as part of the organizational culture.

There should be institutional steps on how to resolve physician disruptive behavior. Sometimes, good and top performing physicians are the people involved in disruptive behavior thus it becomes harder for the harassed or the victims to complain and for the physician executives to take action against the misconduct of a well-respected colleague. Furthermore, disruptive physicians are known to file counter complaints against those who seek implementation of disciplinary action. There is equal importance of the procedural and legal steps in responding to physician disruptive behavior. Three simple steps should be taken to counter physician disruptive behavior with the use of collegial intervention, adoption of the organizational code of conduct, and documentation of the incidents and actions taken.

Alcohol and substance abuse can be another factor that affects physicians and the people around them. It is estimated that 1%-10% of the physician disruptive behavior in U.S. hospitals are linked to alcohol or substance abuse. There is a tendency for a disruptive physician's colleagues and even their families to tolerate their addiction which could result in an even graver problem. Longer periods of disease treatment and rehabilitation will then be required for these physicians to seek help. Therefore, it is very important for educating physicians on the proper avenues to disruptive behavior management.

The Joint Commission for Accreditation of Healthcare Organization (TJC) is an organization that established standards to assist medical staff in dealing with disruptive physicians to prevent severe consequences in healthcare such as fast turnover of nurses, compromised patient health, and recurrence of physician misbehavior leading to progression of abuse. TJC emphasizes on establishing standards that can provide a clear definition of roles of the leadership and non-leadership alike in the healthcare setting, while promoting an organized and respectful manner in dealing with disruptive physicians.

More time is being spent in figuring the causative factors contributing to disruptive behavior than in formulating appropriate and standard organizational policies and procedures in managing the problem. And if these problems aren't managed with prompt intervention it could complicate the problem even more leading to a breakdown in social relationships within the organization, directly or indirectly affect patient care or clinical performance, and it can impact the progression of the physician's illness.

In light of establishing standards and regulations in the health care organization,

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From the **President** continued from page 4

it is pertinent for a health care organization to have a common definition on what is considered disruptive behavior not only for the physicians but for all the employees. A formal behavior standard must be established in a consultative manner to get equal ideas and participation of all the health care employees and to educate everybody at the same time. At the most basic level, disruptive behavior is any behavior in the form of language, habits, or actions that can result in problems in patient care and in performing duties and responsibilities in the hospital.

Subsequently, legal measures should be in place in the organization but must be considered very carefully as it could create tension between the physician and hospital administration. Before resorting to legal measures a dialogue must be done amongst the disruptive physician, the complainants, and the physician executives and administration. Inconsiderate or overuse of legal action can do more harm to the organization and involved people as it creates tension and defensive mode from the physician in question.

According to the Huntington Medical Staff General Staff Rules and Regulations, Chapter 1.9, "disruptive behaviors" is defined as any conduct or behaviors including without limitation, sexual harassment or other forms of behavior which disrupts the operation of the hospital, affects the ability of others to get their jobs done, creates a "hostile work environment" for hospital employees or other physicians on the Medical Staff, or appears to interfere with physician's own ability to practice competently. There are three classes of severity of improper behavior and conduct in which class I is considered the most severe. Class I involves any physical violence or abuse directly at human beings; it includes sexual harassment involving physical contact. Class II behavior includes verbal abuse which is directed at human beings or physical violence or abuse directed in anger at an inanimate object. Examples of this are unwarranted yelling, swearing, cursing or making humiliating, demeaning, or otherwise inappropriate comments. Class III conduct is verbal abuse, which is directly at large, but is perceived by a witness to be disruptive.

Next month will look at the management of disruptive physicians.

Edmund Tse, MD
President of the Medical Staff

Save the DATE

Medical Staff Holiday Party

Date: Friday, December 5, 2014
Time: 6 p.m.
Location: The Langham Hotel

Formal Invitations to follow

From the **Health Science Library**

Full AccessMedicine Now Available

Good news! In addition to ClinicalKey, physicians will now have access to the full suite of medical textbooks and interactive tools available on AccessMedicine. Connect instantly to 80+ leading medical references, in the following specialties:

- Anesthesiology
- Basic Science
- Anatomy
- Biochemistry
- Epidemiology & Biostatistics
- Histology
- Microbiology
- Pathology
- Pathophysiology
- Pharmacology
- Physiology
- Behavioral Medicine
- Critical Care Medicine
- Dermatology
- Emergency Medicine
- Family Medicine
- Internal Medicine & Subspecialities
- Neurology
- Obstetrics & Gynecology
- Ophthalmology
- Pediatrics
- Psychiatry
- Radiology
- Surgery

For a complete list of references, visit the Readings tab within AccessMedicine.

Additional Interactive Features Include

- **Extensive Multimedia Library** – 250+ examination and procedural videos, patient safety modules, audio files, and animations.
- **Diagnosaurus® Differential Diagnosis Tool** – a downloadable tool that allows users to browse more than 1,000 differential diagnoses by symptom, disease, or organ system at the point of care.
- **Diagnostic Tests** – Select the right test for specific symptoms and accurately interpret findings easily with Pocket Guide to Diagnostic Tests.
- **Integrated Drug Database** – Look up dosing, indications, and adverse reactions through an updated drug database that includes thousands of generic and brand-name drugs – with printable patient handouts presented in English and Spanish.
- **Patient Education** – healthcare information for adults, pediatrics, medicines, & acute settings available in English, Chinese (Trad & Simp), French, Korean, Portuguese, Russian, Spanish, Tagalog & Vietnamese.
- **Cases** – evaluate real-world patient scenarios.
- **Self-Assessment** – prepare for exams with thousands of interactive questions.

Mobile Access – AccessMedicine mobile is optimized for viewing on iPhones and other PDAs. Register for a My AccessMedicine profile from any hospital computer. Then log on to the mobile site using your My AccessMedicine username and password using the same url: http://accessmedicine.mhmedical.com.

For Off-Site Access – Navigate to the library's webpage via Citrix/Connect or request a username/password from the library using the "Request Off-Site Access" form at the library's website.

Important URLs:

- Library website: http://huntingtonhospital.libguides.com/ (forms are under the ASK A LIBRARIAN box)
- Citrix/Connect Offsite Access to Library Resources Instructions: http://huntingtonhospital.libguides.com/physicianoffsiteaccess

For questions, troubleshooting and more information, contact the library by phone (626) 397-5161 or email library@huntingtonhospital.com

From **Physician Informatics**

The Medical Staff Task Forces have been busy working on HANK issues and making workflow improvements. Below is a summary of the major accomplishments in the past month:

- ✓ More than 50 PowerPlans have been updated.
- ✓ The Admit to Inpatient orders were updated to remove the anticipated length of stay field.
- ✓ Pharmacy-to-dose medications have been updated. These now appear on the Medication Reconciliation screen.
- ✓ The issue of code status order being discontinued after delivery has been resolved.
- ✓ The Discharge Patient Summary printout that is provided to patients upon discharge has been updated to make it more easily understood by our patients.
- ✓ In the discharge readiness screen, the two-day default follow up has been removed. Additionally, there is a predefined comment "Please call for appointment" available for providers to select.
- ✓ BMI has been added to the Patient Summary under vital signs.
- ✓ All temperature sources have been added to display on the Patient Summary.
- ✓ The issues with the Immunization Schedule have been resolved.
- ✓ All OB physicians have been added so that they can access Fetal Link remotely.
- ✓ Several OB PowerNotes have been revised and created.
- ✓ Message Center changes for the Medicine Task Force physicians have been completed.
- ✓ I&O changes for Nursery, NICU, PICU, and Pediatrics have been completed to assist with providing a concise, clear picture of the patient's I&O.
- ✓ A new Cardiology tab has been added under Results Review, which displays all Cardiology procedures.
- ✓ From this point forward, vascular studies will be found under Radiology Results.
- ✓ The issue with viewing Radiology priors has been resolved.

Printing Update

The other topic that is on everyone's mind is printing. This has unquestionably one of the biggest challenges that we have faced since the go live. In order to address this, we are going down two paths to address this issue.

First, we have selected and installed a new solution that is designed to address this issue including enable remote printing. In our initial testing, we have encountered issues, which are being addressed with the vendor. Once resolved, we will move into the pilot phase where a few physicians will use the solution and provide feedback prior to proceeding with a full rollout.

The second path is related to configuration of default printing in-house. Initially, Cerner conveyed to us that it wasn't possible to set up default printing. However, through contacts in the industry, we have found that it is possible to default some specific document types (ex: Patient List and Billing Worksheet). While about half of the devices have been configured, we are seeing inconsistencies in these defaults sticking, which we are continuing to work on. We also believe we may have discovered a way of defaulting the printer for Prescription printing, which we are doing further testing.

As more information is available, we will provide updates in the twice a month Medical Staff Task Force Memo's.

CME Corner

MEDICAL GRAND ROUNDS

Topic: Lung Cancer Screening: How should we do it?
Speaker: Robbin Cohen, MD
Date: September 5, 2014
Time: Noon - 1 p.m.
Place: Research Conference Hall
Objectives:

1. Know who should be screened for lung cancer.
2. Understand risks and benefits of screening.
3. Know what steps to take for a patient with a positive study.

Audience: Pulmonologists, Primary Care Physicians, Internal Medicine
Methods: Lecture
Credits: 1.0 *AMA PRA Category 1 Credits™*

SECOND MONDAY

Topic: Antiplatelet Therapy
Speakers: Gregory M. Giesler, MD, Azhil Durairaj, MD, & Gary L. Conrad, MD
Date: September 8, 2014
Time: Noon - 1 p.m.
Place: Research Conference Hall
Audience: Cardiologist, Primary Care Physicians, Internal Medicine
Methods: Lecture
Credits: 1.0 *AMA PRA Category 1 Credits™*

Upcoming Special Activities:

General Medical Staff Meeting

Please join us for our upcoming General Medical Staff Meeting with a CME approved guest lecture by Robert C. Reback, Esq.

Topic: Litigation: Dollars and Sense
Speaker: Robert C. Reback, Esq.
Date: September 17, 2014
Time: 5:30 – 7:30 p.m.
Objectives:

1. Your (their) role in the litigation process.
2. Developing trends in medical malpractice litigation.
3. The law of informed consent and informed refusal.
4. Limitations on coverage as to theories of liability alleged.
5. November initiative and its effect on MICRA and adequacy of coverage.

Audience: Primary Care & Specialties
Methods: Lecture
Credits: 1.0 *AMA PRA Category 1 Credits™*

Please RSVP by September 5, 2014 to Edmond Mouton at (626) 397-5913 or Edmond.Mouton@huntingtonhospital.com.

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CME Corner continued from page 8

Baby Friendly Hospital Designation

Interventions to Increase Breast Feeding Success

Huntington Hospital is in the final stages of achieving "Baby Friendly" Designation. It is required by the accreditation process that all medical staff providing obstetrical/newborn care complete a one-time 3-hour course in Lactation Management with receipt of a certificate of completion by September 30, 2014. This activity will fulfill the requirement.

Topic: Lactation Training
Speaker: Karen Bodnar, MD
Date: September 20, 2014
Time: 9 a.m. – Noon
Objectives:

1. Identify and employ practices that increase patients' breastfeeding success.
2. Identify common barriers to mothers meeting their breastfeeding goals.
3. Employ motivational interviewing to help promote increased breastfeeding exclusivity.
4. Help solve clinical breastfeeding problems.

Audience: Pediatricians, OB/GYN
Methods: Lecture
Credits: 3.0 *AMA PRA Category 1 Credits™*

Please RSVP by September 8, 2014 to Maureen Friesen, MSN, RNC, Perinatal CNS, at (626) 397-3514

Reminder:

If you have completed your training at another facility, please submit your certificate of completion to the Medical Staff Office as soon as possible.

Epilepsy Monitoring Unit Earns Laboratory Accreditation

The Epilepsy Monitoring Unit has earned accreditation by the Long-Term Monitoring Laboratory Accreditation Board of the American Board of Registration of Elec-troencephalographic and Evoked Potential Technologists (ABRET).

"ABRET accreditation means that our program has met strict standards and is recognized as a place where patients and physicians can have confidence they are receiving quality diagnostics," said William Sutherling, MD, medical director of the Epilepsy and Brain Mapping program. Under Dr. Sutherling's leadership, Huntington Hospital has become an international destination for the treatment of epilepsy.

From left to right are: Alison Birnie, RN; Yafa Minazad, DO; Tatiana Maleeva, MD; Denise Hua, RN; and William Sutherling, MD, medical director of the unit.

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Epilepsy Monitoring Unit continued

The hospital's Epilepsy and Brain Mapping Unit is recognized by the National Association of Epilepsy Centers as a Level IV Center, the highest obtainable level in epilepsy treatment. The designation recognizes programs that meet the highest standards for patient care.

ABRET is the credentialing board for EEG, Evoked Potential, Long-Term Monitoring, and Neurophysiologic Intraoperative Monitoring Technologists. ABRET was organized in 1964 through a joint effort by the American Society of Electroencephalographic Technologists and the American Clinical Neurophysiology Society (formerly American EEG Society). The Long-Term Monitoring Laboratory Accreditation program was initiated in 2012.

Medical Staff Services Corner

Woman Sues CA Hospital, Doctor After Prank Photo Snapped — While She Was Unconscious — Winds Up On Facebook

A woman whose anesthesiologist made a joke of her while she was unconscious, drawing a mustache on her lip and tears near her eyes, is suing the overseeing doctor and hospital, for violation of privacy and infliction of emotional distress.

The patient has taken the anesthesiologist and Torrance Memorial Medical Center, to Los Angeles County Superior Court over the incident.

The 36-year-old woman, who was undergoing surgery on her finger, has a history with the institution, as an administrator who worked there for 13 years.

"I thought she would think this is funny and she would appreciate it," the doctor said in court docs. An OR staff member said she took the photo, showed it and deleted it, but the image somehow wound up on Facebook, where the patient, through her attorney, said she was "ridiculed and humiliated while under anesthesia." In court papers, the patient said she "felt violated" and "in shock" over the incident.

The doctor was suspended by the hospital for two weeks in connection with the prank, and faced other "disciplinary action" as a result. Others, including the OR staff member, were also suspended in the incident, and had to attend patient privacy training before going back to their posts.

Rules & Regulations Revisions

Proposed revisions to the Medical Staff Rules & Regulations are scheduled for review and approval by the Governing Board on September 25, 2014. Copies of the revisions are available for review and comment. Please contact the Medical Staff Office at (626) 307-3767 to request a hard copy or an e-file. Responses are needed by September 19.

Bioethics Corner

By: Wendy Kohlhase, PhD

Los Angeles-area Advance Care Planning Group Statement

On May 20, 2014 the Advance Care Planning Group of Los Angeles, a coalition of Los Angeles-area healthcare providers (including Huntington Hospital) endorsed guidelines intended to assist healthcare professionals and community individuals with advance care planning, end-of-life decision-making, and access to palliative care. The main goal of the guidelines is to respect individual values and reduce unnecessary suffering at the end of life. It is also hoped that physicians will feel more comfortable having end-of-life conversations and making difficult treatment decisions because they will feel the support of major LA-area healthcare providers and institutions that have formally endorsed the guidelines.

About a year ago, a coalition of Los Angeles-area healthcare providers met to address the issue of inadequate communication among healthcare providers and patients/families on advance care planning, often resulting in the default of a full-court press of aggressive treatment because no one is talking to each other. Recent studies have indicated that poor communication about end-of-life treatment is impacting both patient quality-of-life and healthcare resources. A 2011 survey by the California Healthcare Foundation found that 80% of respondents said they definitely or probably would like to talk with a physician about end-of-life wishes, but that only 7% had done so. And, more than half of those respondents had also not communicated their wishes with their surrogate decision-maker. In 2013 the Dartmouth Atlas Study reported that healthcare dollars spent in the last two years of life was about $112,000 per patient in Los Angeles. These and other studies support the idea that advance care planning is extremely important and needs to be promoted in a way that makes both providers and community members approach advance care planning as a standard of care. Thus, this led the Los Angeles-area coalition to recommend specific guidelines that address advance care planning and end-of-life treatment issues.

The guidelines discuss the importance of advance care planning discussions and early access to palliative and other supportive services. They also recommend that physicians have discussions with patients and families about the burdens and benefits associated with specific aggressive treatments and whether or not such treatments "may deprive the person of life closure." In addition, the statement recommends that, although a shared decision-making model of physician-patient communication is optimal, when physicians believe treatment to be medically ineffective or non-beneficial there should be a hospital process that defines how potential conflicts are addressed between patients/families and physicians and that supports the idea that physicians are not obligated to provide such medically ineffective or non-beneficial treatment. Huntington Hospital has such a process in place outlined in Policy #8740.050 "Do Not Attempt Resuscitation (DNAR)/Allow Natural Death (AND) & Withholding and withdrawing of Life-Sustaining Treatment," section IV. Responding to Requests for Medically Ineffective Treatment. It is hoped that with the endorsement of the Advance Care Planning Group Statement, Los Angeles-area hospitals will feel more comfortable and confident with addressing end-of-life issues, specifically addressing treatment wishes prior to progressive illness. Huntington Hospital collaborated on and endorses this Statement.

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Bioethics Corner continued

The Advance Care Planning Statement in its entirety is the following:

Advance Care Planning Group Statement
The Advance Care Planning Group of Los Angeles

Medical treatment is intended to preserve life and improve its quality yet when misdirected it can lead to avoidable pain and suffering. Misdirected treatments near the end of life detract from dignity and reduce comfort at the time of death. In contrast, optimal health-care involves planning for all stages of life to ensure care is consistent with each patient's goals and values while adhering to medical standards and the goals of medicine. To promote our common goals of respecting individual values and reducing unnecessary suffering at the end of life, after extensive discussion our health systems are united in recommending:

1. All adults should engage in Advance Care Planning. Such planning involves discussing and documenting preferences that will help healthcare professionals and loved ones to ensure that future care is consistent with personal values, wishes and goals. Physicians and members of the healthcare team should encourage every patient with a terminal illness who does not yet have an advance directive to engage in Advance Care Planning without delay – regardless of age. Advance Care Planning should be considered standard medical care in our community.

2. Medical systems and healthcare providers should facilitate early access to palliative and other supportive services for all patients with chronic and progressive illnesses, when such services are available. Early education and timely access to hospice services are essential for easing the dying process for patients with terminal illness.

3. Physicians should advise patients and families as to how likely potential therapies would be to provide benefit consistent with a patient's known goals and values. These discussions should disclose whether any treatments under consideration may deprive the person of life closure (the ability to say "forgive me," "I love you" or "goodbye") or preclude a peaceful death.

4. Shared decision-making is fundamental to optimal quality of care at the end of life. Physicians caring for patients and assisting with decision making should engage in discussions with patients and families while understanding that they are not obliged to offer or provide medically non-beneficial treatment. When such care is requested, physicians should have access to an explicit process, provided by their medical staff or health system. This process, like that described by the California Medical Association should guide the response to requests for non-beneficial treatment from patients or their legally recognized agent. Such processes should respect all views and help guide the parties to a resolution.

From the **Clinical Documentation Specialists**

Documentation Tip of the Month – Anemia

Always document the **type** of "anemia" as a separate problem from its **cause**.

ACUTE BLOOD LOSS ANEMIA

Considerations include:

- Drop in H/H
- Increased monitoring of lab values
- Hypotension
- SOB
- Tachycardia
- Inability to participate in therapies
- PO or IV iron preparations
- Need for blood transfusions (transfusion is not required)
* Not identified as a complication of surgery unless specified in the documentation as a complication

Use expected or unrelated to procedure if not a complication of a procedure

ANEMIA:

Acuity: Acute or chronic
Type:

1. Nutritional (iron deficiency anemia, Pernicious anemia, etc)
2. Hemolytic (thalassemia, sickle cell, etc)
3. Aplastic

Etiology:

1. Post hemorrhagic
2. Drug induced
3. Chemotherapy induced
4. Malignancy
5. Manifestation of an adverse effect or poisoning

DOCUMENTATION EXAMPLES:

* Acute blood loss anemia due to GI hemorrhage
* Chronic blood loss anemia due to chronic ulcer
* Anemia of CKD/ESRD
* Anemia due to neoplastic disease
* Expected acute post operative blood loss anemia due to hip fracture
* Avoid using pathological descriptors to describe the anemia. For example, "Hypochromic microcytic anemia" does not the diagnosis of iron deficiency anemia.

Flu Season 2014: Vaccinate or Wear a Mask

From David Man, MD, Chair, Infection Control Committee

The Hospital's Influenza Vaccination Plan was designed in response to an advisory issued by the Pasadena Public Health Department under the authority of §120175 of the CA Health and Safety Code. In December 2013, the Director ordered the Hospital to implement a plan to prevent the transmission of influenza virus to patients including the provision of free flu vaccination to all healthcare workers, along with measures to be taken for those who decline to be vaccinated. The Plan requires healthcare workers who decline the vaccine wear a surgical mask when they are in within three (3) feet of patients during the influenza season. The definition of healthcare workers includes physicians and all healthcare providers who have direct contact with patients. The influenza season has been defined as November 1 – March 31. Medical Staff members must provide documentation of vaccination or will be offered flu vaccination at the hospital. Please watch for more information to come.

September 2014 **Medical Staff Meetings**

monday	tuesday	wednesday	thursday	friday
-1-	-2-	-3-	-4-	-5-
Labor Day Holiday		- 7:30 a.m. Medicine Dept. Cerner Task Force - CR 5&6 - Noon Plastic Surgery Section - CR-10 - Noon CME Committee - CR-8 - 12:15 p.m. OB/GYN Peer - CR 5&6 - 3 p.m. QMC Pre-agenda - CR C - 5:30 p.m. Pediatric Dept. Cerner Task Force - CR-8	- Noon Medicine Committee - North/South Room - Noon Trauma Services Committee - CR-5&6 - 12:15 p.m. Ob/Gyn Dept. Cerner Task Force - CR-10	- 7 a.m. Ortho Section - CR 5&6
-8-	-9-	-10-	-11-	-12-
- 12:15 p.m. OB/GYN Dept. - CR 5&6 - 5:30 p.m. Medical Executive - Board Room	- 7:30 a.m. EP Subsection - Cardiology Conf. Room - Noon Cerner Task Force Committee Meeting Dept. of Surgery - CR-C - 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 - Newsletter Submission -	- 6:30 a.m. Anesthesia Section - CR-7 - Noon QM Committee - East Room - 5:30 p.m. Neonatal/Pediatric Surgical Case Review - CR-10	
-15-	-16-	-17-	-18-	-19-
- 8 a.m. Emergency Medicine Section - ED Conf. Room	- 12:15 p.m. Credentials Committee - CR-C	- 7:30 a.m. Medicine Dept. Cerner Task Force - CR 5&6 - 7:30 a.m. Cardiology Section - Cardiology Conf. Room **- 5:30 p.m. - General Medical Staff Meeting - Topic: "Litigation - Dollars and Sense"**	- 6:30 a.m. Anesthesia Peer - CR-7 - Noon PT&D Committee - CR 5&6 - 1 p.m. Thoracic Surgery Section - CR-11 - 3 p.m. Neon QI - CR-10 - 6 p.m. Bioethics - CR 5&6	- 7:30 a.m. Spine Peer Review - Conf. Room 11
-22-	-23-	-24-	-25-	-26-
- Noon GME Committee - East Room	- 7:30 a.m. Interdisciplinary Practice - CR-C - Noon Pulmonary Sect. - CR-10 - Noon General Surgery Section - CR 5&6	- 12:15 Endovascular Committee - CR-5 - 5:30 p.m. Surgery Committee - CR 5&6	- 12:15 p.m. Pediatric Committee - East Room - Noon IM Peer Rev - CR-6 - 5:30 p.m. Metabolic & Bariatric Surgery Committee - CR-10	

September 2014 **CME Calendar**

monday	tuesday	wednesday	thursday	friday
-1-	-2-	-3-	-4-	-5-
Labor Day 	- 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. Neonatal/ Perinatal M&M, Conf. Room 10 - 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 - 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 Grand Rounds, RSH **Topic: Lung Cancer** - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-8-	-9-	-10-	-11-	-12-
- 12:15 - 1:15 p.m. OB/GYN Dept. Mtg, CR 5 & 6 **Topic: Vulvar Disease** - Noon - 1 p.m. Second Monday, RSH **Topic: Antiplatelet Therapy**	- 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	- 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
-15-	-16-	-17-	-18-	-19-
	- 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	- Noon - 1 p.m. Medical Case Conference, RSH - Noon - 1 p.m. MDisc Breast Cancer Conf., Conf. Room 11
-22-	-23-	-24-	-25-	-26-
	- 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	- 8 - 9 a.m. Surgery M&M, Conf. Room B	- 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
-29-	-30-			

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ADDRESS SERVICE REQUESTED

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 first Friday of every month.

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