News for the Medical Staff

suttermedicalcenter.org

Sutter Medical Center, Sacramento

A Sutter Health Affiliate

SMCS Physician

Message from Tom Gagen, CEO

May 2009

Medical Office Building/Outpatient Surgery Center Receives New, Official Name

For the past few years, we have temporarily called the medical office building that is being constructed on 28th Street between Capitol Avenue and L Street the "Sutter Medical Foundation Building." It received that interim moniker because the third and fourth floors of the facility will house up to 39 doctor's offices – all of them Sutter Medical Group specialists.

However, that name is a misnomer and, in hindsight, created much confusion for the entire staff and medical community. I hope a new, official name can clear up that confusion. So, it is with much pleasure that I announce to the medical staff the new name of this multi-use medical facility – **the Sutter Capitol Pavilion.** It is fitting because the building sits on Capitol Avenue on the south side. It also emphasizes our reputation as being the capital city's locally grown, premier hospital system, and our location just up the street from the California State Capitol.

In reality, the Sutter Capitol Pavilion will be as much – if not more – a Sutter Medical Center, Sacramento facility as it is a Sutter Medical Foundation office building. The first floor of the building, scheduled to open early next year, will house the SMCS Cardiac and Pulmonary Rehabilitation Center, being relocated from the Sutter Memorial Hospital campus, as well as a Diagnostic Imaging Center, a lab and room for a small restaurant.

The entire second floor will be the Sutter Outpatient Surgery Center, which will have six ORs, four gastroenterology suites, three interventional radiology suites, 28 pre-operative rooms, a 15-room post-anesthesia care unit, and a sterile processing department. The north end of the second floor will be dedicated to pediatric outpatient surgery and will include a view of Sutter's Fort for our young patients. The Outpatient Surgery Center is for the use of all surgeons on the staff of SMCS, not just SMG physicians.

On the lower level is the new Energy Center, which will supply all the emergency power, as well as the heating and air conditioning for our entire midtown medical center, including the upcoming addition of the Anderson Lucchetti Women's and Children's Center. The lower level also includes two stories for MOB parking.

Please help us brand the new name by referring to the facility as the Sutter Capitol Pavilion in all your communications. And, I hope you will join us as we celebrate the Sutter Capitol Pavilion's opening in 2010.

Meanwhile, the first forum we set up for surgeons to discuss the Sutter Capitol Pavilion's Outpatient Surgery Center went very well, and I hope it provided the answers to some important questions and concerns. We do want to hear from our surgeons and the rest of the medical staff on the Surgery Center. A second forum is scheduled from 7-8 a.m. Thursday, May 21, at Sutter Memorial Hospital in the Right Auditorium on the seventh floor. Interested surgeons and physicians are invited to attend.

Get a Behind-the-Scenes Tour of Expansion Projects

Cindy Banta, director of Patient Care Planning, reports that the monthly Hard Hat Tours have been well-received. "Participants really seem to enjoy seeing where the medical center's Outpatient Surgery Center is located on the second floor of the Sutter Medical Office Building, and also the Energy Center that will power the entire campus," Banta said. "I can't seem to get them out of the basement of the Medical Office Building. They love the Energy Center."

The Master Site tours of the midtown expansion project include the Sutter Capitol Pavilion, Sutter General Hospital/Ose Adams Medical Pavilion, and the Anderson Lucchetti Women's and Children's Center. The Hard Hat Tours are held the third Thursday of each month from 4–5:30 p.m. You can register by going to suttermedicalcenter.org/expansion.

SMCS Welcomes New Medical Staff Members

Adam C. Braithwaite, M.D.
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Specialty: Radiology, Diagnostic

Douglas A. Hague, D.P.M.
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3800 J St., Suite 200
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Specialty: Surgery, Podiatry

Anne H. Sholes, M.D.
5055 Business Center Drive,
Suite 108
Fairfield, CA 94534
(916) 733-8247
Specialty: Surgery, Neurological

Ramya Srinivasan, M.D.
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Sacramento, CA 95819
(916) 733-6050
Specialty: Pediatric, Critical Care,
Pediatrics

How to Get Articles Through the Medical Library

Save the articles you want from your search results in the "Clipboard".

Go to Clipboard page, from there click on 'send to' pull-down and select e-mail function:

SMCSLIBRARY@sutterhealth.org

Include your name and e-mail address in the 'comments' section so we will know who the request is from.

OR e-mail the search results to yourself. Forward this e-mail to the library.

You can always just call the library and request any information or articles you need. Theresa Johnson is your medical librarian, 916-733-3880.

SHSSR Announces 2008 Financial Results

In April, the Sutter Health Sacramento Sierra Region announced its 2008 operating income was $139 million for its hospitals and physician care centers. However, net assets were decreased by $39 million due to unrealized losses in the investment portfolio resulting from the challenging economic environment and volatility in the financial markets.

SHSSR also reported contributions of $137 million to the Sutter Health employee retirement plan. Across the system, Sutter Health invested a half billion dollars during the last three months of 2008 to ensure the retirement security of its employees in this economic downturn. Affiliates throughout SHSSR brought in $1.7 billion in revenue last year, up from $1.6 billion the prior year.

Sarah Krevans, president, Sutter Health Sacramento Sierra Region, said Sutter Health reinvests earnings back into the communities to enhance the health care available to residents. This includes new buildings and medical equipment, and care for the poor and uninsured. "We are seeing an increased need for our services from those who are uninsured or underinsured because of the economic recession," she said. "More than ever people need access to efficient affordable health care in a high quality setting. A positive operating margin ensures that our services are always available to residents regardless of their ability to pay."

During 2008, SHSSR provided more than $109 million in services for the poor and underserved and on benefits for the broader community. Sutter also continued its mission to make health care more accessible and affordable by offering free or substantial financial discounts to all uninsured patients regardless of their financial status. Sutter-affiliated hospitals have always provided free charity care to low-income patients and continue to offer substantial discounts to all patients who don't have insurance.

Krevans added that Sutter has a history of making substantial capital investments in the region – as evidenced by the numerous project milestones in 2008 – and she is optimistic about the network's continued ability to make critical capital investments over the long term. She added, however, that Sutter Health leadership is reevaluating and reprioritizing capital projects given the current economic environment. Within in the Sacramento Sierra Region, renovation continues this year on Sutter Auburn Faith Hospitals' operating rooms and patient rooms, as well as construction at Sutter Medical Center, Sacramento. The City of Elk Grove approved the construction of an ambulatory surgery center and a future 68-bed community hospital, and Sutter Health has funded this project through the design phase.

Medical Library Offers New Way to Search Pubmed

You can now search Pubmed and have the Sutter Resource Library journal holdings displayed in your search results. To do this, you have to link to Pubmed through the Sutter Resource Library Web site. Both the SMCS and SMF Intranet home pages have a link to Library in "Quick Links." From the library home page, select the Pubmed link on the left side. After you do a search in Pubmed, select "Abstract" from the pull-down DISPLAY results feature. The default display is "Summary."

Articles that are purchased by the Sutter Resource Library will have our logo on them. Some will be print format only. Others will be electronically linked and you can simply click on that link and be directed to the full-text article.

Allowing Natural Death Vs. 'Do Not Resuscitate'

By Cecilia M. Hernandez, M.D.
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When should we speak to patients about the end of life? And how? These questions seem to be coming up more frequently lately, maybe because hospitalized patients are sicker than ever. In any case, it seems that society is more comfortable as a whole with the idea that physicians can and should facilitate one's death even as they strive to save lives. Tough place to be no doubt, but not impossible. Perhaps we need to talk about it amongst ourselves, as we don't seem to be as consistent in our approach as patients and caregivers need us to be.

This issue first came to my attention about a month ago as one of the chaplains expressed her concern that families are not being given options that include end-of-life care. She saw how one family in particular suffered with the guilt of continuing what they believed to be futile efforts while their physician kept telling them and the patient that it was too soon to discuss palliative care. The patient did, in fact, die during that hospital stay, but the patient and the family never had the option of preparing for death with the support of hospice. The family was plagued with guilt at not honoring their family member's need for a peaceful death at home.

I understand that as we push the envelope of science that we are able to bring back people from the brink of death despite horrific odds and despite utter and complete debilitation, but shouldn't the patient and family be the ones to decide just how horrific and how compromised they are willing to go? Aren't we obligated to give them the support they need in order to tolerate the suffering that goes along with hovering over that brink for longer and longer periods of time? Perhaps the best way to mitigate the conflict between giving up completely and pushing through months of pain and suffering is to partner with our colleagues best equipped to navigate the end of life – our palliative care team and chaplains. At the very least, they can have the conversations these patients and their families need about meaning and purpose as they choose to face down death. Further, they can help patients and families individualize their end points and define how they want their final days and weeks to be when that time comes. That time will inevitably come, whether it is weeks or years down the road.

As a physician, I understand my physician colleagues' need to gird oneself with resolve in the face of the impossible. It is ultimately what saves lives. The challenge is to remember that life belongs to someone else and we are only really here to serve that person. There comes a time in every life when the best medicine is to care and to support, not to push and to force. The excellent healer is the one who has a big and varied toolkit to serve his patients. We must all strive to develop the skills that heal the soul as well as the body. In the end, the best we can do is to continue to serve and to not abandon, to be present as a human being and as a witness to the most profound transformation a human being can experience. Furthermore, we must empower family members to do the same, to lovingly ease the way as they acknowledge what their family member meant to them and to the world, to thank him and honor him by not making his departure a failure on his part, and to reassure him that all is well. Even in death there can be healing. In fact, I would say that in death there must be healing if we are to be of the utmost service to our patients.

Is it possible that physicians avoid end-of-life discussions because the language currently available to us denies our need to save lives?

Recently, Adam Burroso, one of our nurses on 5 South, asked me to read an article suggesting we reshape our end-of-life conversations to "allow natural death" instead of "do not resuscitate." The article posits that "'Do-not-resuscitate' sounds cold, cruel – as though the health care team has given up. … 'Allow-natural-death' sounds softer, more comforting, warmer – even though it contains a form of 'the D word.' It says that the team cares and will continue to care for the family member."

This appears to be supported by a study conducted in 2004 at the University of Houston-Victoria in Texas and included 687 participants. The article, " 'Allow natural death' vs. 'do not resuscitate': three words that can change a life," can be found in the Journal of Medical Ethics 2008;34:2-6. The conclusion of the study is that framing the conversation in the context of allowing natural death increases appropriate end-of-life care.

Maybe that is a place for us to start.