



Sutter Medical Center,
Sacramento

A Sutter Health Affiliate

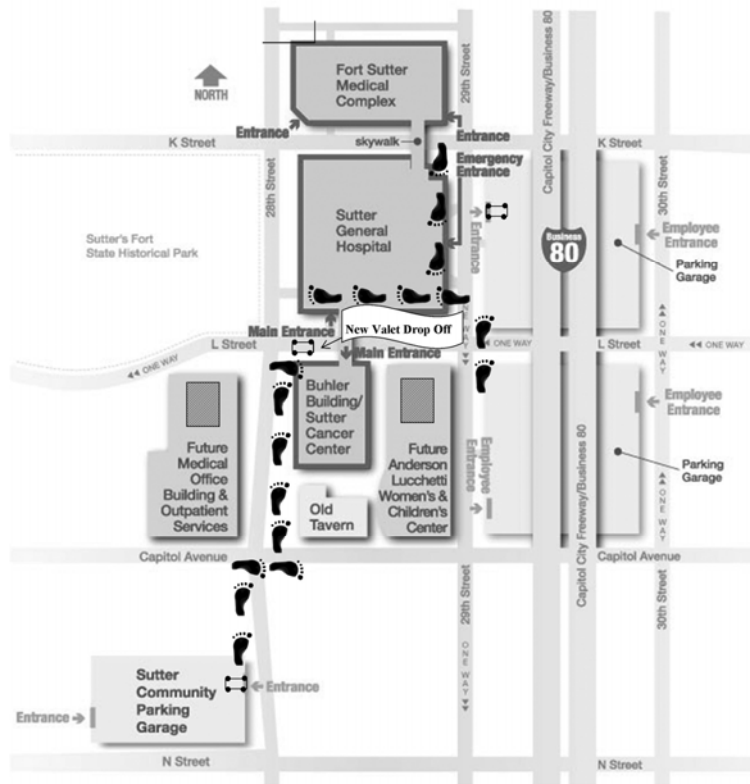
SMCS Physician

Message from Tom Gagen, CEO

June 2009

With the moving of the Sutter Cancer Center/Buhler Building valet parking to L Street this month, construction for the Anderson Lucchetti Women's and Children's Center will really start to heat up, and traveling to and around the midtown medical center will become more challenging.

"After many years of anticipation, this is an exciting time for all of us at Sutter Medical Center, Sacramento and throughout the region," said Larry Maas, assistant administrator for the midtown construction project. "I hope we can all work together to make this transition run smoothly for everyone, especially our patients and visitors."



Physician parking is still in the same location in the North Parking Lot, where we have 90 parking spaces dedicated for our medical staff. However, staff and others who park in the South Parking Lot are now having to walk farther to get to the Buhler Building. The sidewalk on L Street leading from the South Parking Lot has been blocked for the remainder of construction. Foot traffic from that parking lot must cross over L Street to the north sidewalk and either enter Sutter General and cross over the second-story bridge to Buhler, or walk down to 28th Street to cross at the crosswalk and backtrack to the main entrance. (Do not jay-walk across L Street; this is dangerous and illegal.) Most patients, staff and visitors coming to the Buhler Building will enter the main doors facing L Street, although the single side door for the disabled will be accessible.

Construction will also impact 29th Street traffic lanes and sidewalk. Traffic lanes were shifted to the east to run adjacent to the South Parking Lot. There will be barricades with fencing surrounding the construction site, and the 29th Street sidewalk will be closed from L Street to Capitol Avenue. Staff walking to and

from Sutter General Hospital or the Buhler Building must enter and exit the South Lot at L Street, not Capitol Avenue.

It will make more sense for many staff and visitors to park in the Sutter Community Garage at 28th and N streets and walk to the Buhler Building. The Sutter Community Garage accepts employee and medical staff name badge swipes the same as in the parking lots under the Capital City Freeway. Those heading north on Capital City Freeway can exit at N Street, make an immediate left, and very quickly and easily hit the Sutter Community Garage. If heading south on Capital City Freeway, it is probably quicker to take the P Street exit and turn right on 28th Street. The garage has seven floors, and it is far from being filled. "Plus, there's another bonus," Maas says. "Every space in the Community Garage except on the roof is covered, providing shade during these hot summer days."

For more information, and to sign up for a Hard Hat Tour of the entire construction project, visit <http://www.suttermedicalcenter.org/expansion>.

SMCS Welcomes New Medical Staff Members

Thanhmy N. Bui, M.D.
1020 29th St., Suite 480
Sacramento, CA 95816
(916) 733-3777
Specialty: Internal Medicine

Jonathan A. Eandi, M.D.
2801 K St., Suite 205
Sacramento, CA 95816
(916) 733-5005
Specialty: Surgery, Urology

David E. Massil, M.D.
1 Medical Plaza Drive
Roseville, CA 95661
(916) 781-1000
Specialty: Internal Medicine

Christopher J. Wilson, M.D.
1201 Alhambra Blvd., Suite 410
Sacramento, CA 95816
(916) 457-4263
Specialty: Surgery, Hand

Physician Appreciation Event Set for June 30

The next SMCS Physician Appreciation event is Tuesday, June 30, from 6 to 7:30 p.m. at Buonarroti Ristorante, 2627 Town & Country Place (behind William Glen in Town & Country Village). For more information, contact Grange Fife, medical staff services secretary, at (916) 733-3097 or e-mail her at fifek@sutterhealth.org.

Continuing Medical Education Calendar Is Online

Don't forget to go to <http://suttermedicalcenter.org/forourphysicians> to access the entire June CME Calendar. There are several case conferences scheduled throughout the month.

Transfer Summary of Current Orders Available

What is it? A new function of our pharmacy software that enables us to print the current list of medications the patient is on in the hospital.

What is the purpose? To decrease transcription errors and save physicians the time it takes to manually write out all the patient's medications on the Transfer to SNF form.

Where will I find this? The software icon is on every computer. All case managers and assistants have been trained and have access to it.

Who can I give feedback to or ask a question? Barbara Quinn, Clinical Nurse Specialist, 733-3075 ext 80264 or BB# 832-6003.

Medical Library Services for SMCS Physicians

The library is on the sixth floor of the Sutter Cancer Center/Buhler Building. SMCS physicians have access to the library 24/7 with door code 5150. If you have questions about library services, call the library at (916) 733-3880 or e-mail Theresa Johnson at johnsoMT@sutterhealth.org.

Electronic Resources: The Library subscribes to online journals and e-books, as well as Natural Standard Database and PubMed. You can access them at <http://suttermedicalcenter.org/library>

Medical Textbooks and Journals: The library has many of the latest textbooks and journals. You can visit the library and photocopy anything. Many of our texts can be checked out.

Research: Let us help you find the information you need. We will research any medical topic for you.

Document Delivery: If the journal you want is not online or in our library, we will order your article(s) from another medical library. E-mail Sharon Babcock at babcocsw@sutterhealth.org.

Classes: Need a PubMed Refresher? Call the library and we can schedule a class. We teach classes on other databases too. Just ask.

Tables of Contents: Too busy to read the latest journals? We send you the tables of contents of selected journals and you can pick the articles you want to read.

SMCS Authors: Have you published an article? The library's front page has links to local physician authors. Please tell us what you have published so we can add your name to our growing list.

New Vitamin K Administration Recommendations

Oral administration recommended over subcutaneous administration. (Grade 1A – strong recommendation with high-quality evidence). Subcutaneous administration is less predictable and sometimes delayed.

1. Oral administration is safe, convenient and predictably effective.
2. Administer vitamin K in effective dose to lower INR safely and avoid causing resistance. Recommended vitamin K doses for elevated INR *and no significant bleeding*:
 - INR 5 to 9 : 1 to 2.5 mg
 - INR \geq 9 : 2.5 to 5 mg (For patients with serious bleeding – vitamin K 10 mg by slow infusion)
 - High dose vitamin K may lead to resistance to Warfarin for more than one week
 - Low doses and slow infusion rates recommended for IV administration
 - Anaphylaxis may still occur even with slow infusion rates (may also occur with non-IV routes)

Allowing Natural Death Vs. ‘Do Not Resuscitate’

EDITOR’S NOTE: Due to the importance of this topic, Dr. Hernandez is reprinting this article from last month.

By Cecilia M. Hernandez, M.D.
SMCS Director of Medical Affairs
hernanc@sutterhealth.org

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.