

# MEDICAL STAFF

Huntington Hospital NEWSLETTER

VOLUME 50, NUMBER 7 July 2012

## From The President



*A nickel ain't worth a dime anymore.*

–Yogi Berra

*The older I grow the more I distrust the familiar doctrine that age brings wisdom.*

– H.L. Mencken

Obstetrics, from the Latin obstare, “to stand by,” is the medical specialty dealing with the care of women’s reproductive tracts and their children during pregnancy, childbirth and the postnatal period. Gynecology comes from the ancient Greek, gyne, “woman,” and is the medical practice dealing with the health of the female reproductive system.

The Kahun Gynaecologic Papyrus (c. 1800 BC) is the oldest known medical text of any kind. It deals with women’s complaints, including disease, fertility, pregnancy and contraception. The womb is at times seen as the source of complaints manifesting themselves in other body parts.

The Hippocratic Corpus contains several gynecological treatises dating to the fifth century BC; included were descriptions of normal birth and instrument delivery, the latter restricted to stillborn babies, and involved the use of hooks, destructive instruments or compression forceps. Instrumentation carried a high maternal mortality. The gynecologic writings of Soranus of Ephesus, c. first century AD, are extant to this day. He described antenatal care, labor, and management of malpresentation by internal version

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## Summary of the Minutes for MEC

### Executive Committee Meeting

As provided by the Bylaws of the Governing Body and as the designated sub-committee of the Governing Board the following items were presented and approved by the Medical Executive Committee of June 4, 2012 and by the Governing Board on June 28, 2012.

#### ADMINISTRATIVE REPORTS

##### **PRESIDENT’S REPORT**

Dr. James Buese, Medical Staff President, presented the following item:

##### Event Report

There were six event reports for the months of April and May. All six incidents involved patient complaints. Five of the six incidents have been closed and one remains pending.

##### Report from the President/ Chief Executive Officer

Mr. Steve Ralph, President/CEO, presented the following items:

- New Compliance Officer  
The hospital has hired a new Compliance Officer, Mr. Terrence Ou.

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# Summary of the Minutes

## Executive Committee Meeting

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### • Clinical Integration Update

Discussions continue regarding the possibility of a Medicare Accountable Care Organization (ACO). Approximately fifty primary care physicians were invited to attend a meeting on June 14<sup>th</sup> to discuss the potential interest on the part of the physicians.

### • Healthcare Partners

He reported that Healthcare Partners has sold to DaVita (e.g. <http://online.wsj.com/article/BT-CO-20120521-711284.html>)

### Report from Director of Healthcare Services

Ms. Gloria Gomez, CPMSM reported on the following items:

### • Meeting Attendance Rewards

Mr. Ralph was selected to draw the raffle tickets for the May meeting attendance rewards, as follows:

- ▶ Ernie Maldonado, MD – Quality Management Committee
- ▶ Brandon Lew, DO – Trauma Committee

### • Happy Hour

The Medical Staff leadership hosted a “Happy Hour” event on June 8<sup>th</sup> at Mijares, which was geared encourage relationships amongst the Medical Staff. The event was well received and was represented by a variety of different specialties. The Medical Staff was treated with appetizers, liquid refreshments and a chance to win ten spectacular gifts, one of which included a 32” flat screen television. Mark your calendar for the next Happy Hour event scheduled for September 28<sup>th</sup> 2012.

### *Congratulations to all raffle winners:*

- Jim Blitz – Ipod Nano
- Harry Bowles – Apple TV
- Paul Gilbert – Apple TV
- Stephanie Johnson – 32” flat screen television
- Richard Nickowitz – Kindle Fire

- Gregory Northrop – Dr. Dre Beats headphones
- Arbi Ohanian – Blue Ray/DVD player
- Mark Powell – \$100 gift certificate to Parkway Grill
- Laura Sirott – Dr. Dre Beats headphones
- Ian Ross – Ihome



Dr. Bowles



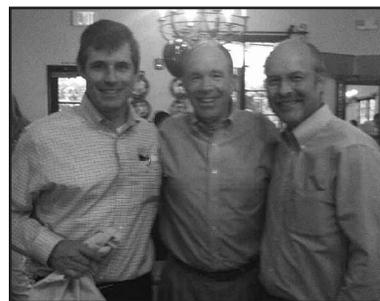
Dr. Johnson



Dr. Northrop



Dr. Sirott



Drs. Northrop and Gilbert with Steve Ralph

Please go to SharePoint -> Medical Staff Services -> Board Approved Items -> 2012 and select June to see:

### Clinical/Administrative Policies and Procedures

### Departmental Policies and Procedures and Order Sets

### Standardized Procedures

### Nursing/Ancillary Department Specific Policies and Procedures

# Summary of the Minutes

## Executive Committee Meeting

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### MEDICAL STAFF APPOINTMENTS



**Patrick Alix, MD**  
**Hospice and Palliative Medicine**  
1377 South Grand Avenue  
Glendora, CA 91740  
626-857-2501 (office)



**Sevag Balikian, MD**  
**Internal Medicine**  
100 West California Boulevard  
Pasadena, CA 91105  
HealthCare Partners  
626-405-7260 (office)



**James Kennedy, MD**  
**Plastic Surgery (Fellow) –**  
Effective 08/01/2012  
1510 San Pablo Street, Suite 415  
Los Angeles, CA 90033  
323-442-7903 (office)



**Andrew Lai, MD**  
**Infectious Disease**  
959 East Walnut Street, Suite 120  
Pasadena, CA 91106  
626-304-0782 (office)



**Donald Nicell, MD**  
**Diagnostic Radiology**  
11995 Singletree Lane, Suite 500  
Eden Prairie, MN 55344  
952-595-1100 (office)



**Michael Nuzzo, MD**  
**Orthopedic Surgery (Fellow) –**  
Effective 08/01/2012  
800 South Raymond Avenue, 2<sup>nd</sup> Floor  
Pasadena, CA 91105  
626-795-8051 (office)



**Perry Stevens, MD**  
**Diagnostic Radiology**  
1745 Cole Boulevard, Suite 150  
Lakewood, CO 80401  
303-914-8800 (office)



**Michelle Tyson, MD**  
**Family Medicine**  
2661 East Washington Boulevard  
Pasadena, CA 91107  
626-798-4952 (office)



**George Wang, DO**  
**Family Medicine**  
2603 Via Campo  
Montebello Urgent Care Center  
Montebello, CA 90640  
323-720-1144 (office)



**Sharon Yee, MD**  
**Hematology/Oncology**  
622 West Duarte Road, Suite 202  
Arcadia, CA 91007  
626-446-4461 (office)

### ALLIED HEALTH PROFESSIONAL APPOINTMENTS

- Sylvia Lagerstrom, RN – 5150 Status
- Walter Parker, CCP – Perfusionist

### MEDICAL STAFF RESIGNATIONS

- Timothy Davis, MD – Internal Medicine
- Khalida Pathan, MD – Internal Medicine
- Stefani Takahashi, MD – Dermatology
- Neil Tomaneng, MD – Emergency Medicine
- Maria Torrone, MD – Diagnostic Radiology

### ALLIED HEALTH PROFESSIONAL RESIGNATIONS:

- A. Louise Capellupo, PA-C – Physician Assistant
- Lawrence A. Flynn, MFT – Marriage, Family Therapist
- Anne M. Girard, PA-C – Physician Assistant
- Sharon Kirchheimer, NP – Nurse Practitioner
- Anne P. Odell, NP – Nurse Practitioner
- Marjott Ticsay, RN – RN Research Coordinator
- Hopey Witherby, RN – 5150 Status

**James Shankwiler, MD**  
*Secretary/Treasurer, Medical Staff*



## From *The President* continued from page 1

and breech extraction. He advised a laboring woman be nursed in bed until delivery was imminent, then moved to a birthing chair. Soranus' writings were formed into a manuscript in the sixth century AD, and little was added to obstetrical knowledge until the invention of the printing press some nine hundred years later. More recently, J. Marion Sims (1813-1883) is considered the father of American gynecology, despite the historical fact that he developed many of his techniques by operating on slaves, some without the benefit of anesthesia.

The earliest birth attendants were women. In ancient mythology, goddesses, but not gods, were present at deliveries. A laboring woman was accompanied by her mother or other female relative. Prehistoric figures and ancient Egyptian drawings show women giving birth in a sitting or squatting position. Birthing stools and midwives are mentioned in the Old Testament.

In ancient Greek Society, male dominance extended to childbirth. Greek medicine cast man as the bringer of sanity and health to the biologically defective, subservient woman through intercourse, which was believed to relieve the buildup of menstrual blood around the heart. Men received full credit for conception, since the womb was seen as a receptacle for sperm. Infanticide, particularly female newborns, was widely practiced. Greek women practiced birth control with little interference from religious or political authorities; a precise knowledge of medicinal plants was passed through female generations.

The history of obstetrics is inextricably linked to the history of midwifery. *Obstetrix*, Latin for "midwife;" *Mid*, "with," and *wyf*, "woman," from the Anglo-Saxon.

During the Renaissance, the first obstetrical writings were printed in Latin or German in the late fifteenth century. Eucharius Rosslin and Jacob Rueff published textbooks that were thought to be similar to Soranus' teachings. Midwives attended the vast majority of

births, while the physician was only summoned if complications arose. For over ten centuries, obstetricians managed obstructed labor by converting the presentation to a footling breech and delivering the baby by traction. In the long era before c-section, the main risk of obstructed labor was the death of the mother. The obstetrician would only be called once the midwife realized that problems were developing, and often by that stage, the baby was dead.

It has been suggested that the popularity of Rosslin's and Rueff's texts led to tension between doctors and midwives because physicians, barred as men from attending normal childbirth, could now learn midwifery from the printed page. The immediate effect of these texts was the dissemination of midwifery teachings. The French military surgeon, Ambrose Paré (1510-90), founded a school for midwives in Paris. One of Paré's pupils attended the French Court and delivered a baby girl named Henrietta Maria, who subsequently became Queen of England at age sixteen when she married King Charles I in 1625.

Male midwives, known as "accoucheurs," became fashionable in seventeenth century France. Most famous was Francois Mauriceau (1637-1709), best known for the so-called "Mauriceau-Smellie-Velt Maneuver" for dealing with a breech delivery. He also pioneered the suturing of the perineum after delivery, and introduced the practice of delivering women in bed rather than on a stool. He remained opposed to the c-section on grounds that it invariably was fatal to the mother. The British male midwifery family, the Chamberlain's, developed obstetrical forceps, which famously remained a family secret for the better part of a century. Of note, it was a Chamberlain who attended the above-mentioned Henrietta Maria in childbirth as the Queen of England.

Subsequent Chamberlains became obstetricians. The use of forceps remained controversial, and were mainly

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## From *The President* continued from page 4

used by male midwives who lived near the Chamberlains. William Smellie (1697-1763) improved the forceps design and adapted the 'English Lock,' which allowed separate insertion of the two blades and then brought together. As was the custom, the field of normal labor was the prerogative of female midwives. Even for Royal births, an obstetrician would attend by staying outside the room while a midwife attended the Queen.

Not all Royal Pregnancies ended well. In 1817, at age 21, Princess Charlotte, George IV's only child, went into labor with her first baby, afterward found to be a boy weighing nine pounds. Labor began two weeks post dates, and lasted fifty hours. The baby was stillborn, the placenta was removed with difficulty, and six hours later Charlotte died. The obstetrician, Sir Richard Croft, was widely criticized; he shot himself several days later. King George was left without an heir, and the throne first passed to his brother, then to his niece, who became Queen Victoria.

The threat of maternal mortality loomed large over obstetrics well into the twentieth century. Among the poor, rickets caused pelvic deformities. The maternal death rate 150 years ago was 1/200 pregnancies. In maternity hospitals, the death rate was ten times higher, due to epidemics of puerperal fever. Oliver Wendell Holmes (1809-94) and Ignaz Semmelweiss (1818-65) observed that doctors were vectors of infection. Semmelweiss met stiff resistance and disbelief from physicians, despite his ability to greatly reduce the incidence of puerperal fever by enforcing hand washing among his physician attendants.

James Young Simpson (1811-70) refined the OB forceps and experimented with vacuum extraction; as well, he introduced chloroform anesthesia to obstetrical practice. This was met by strong opposition from medicine and clergy, who quoted Genesis: "In sorrow shalt thou bring forth the children." In 1853, John Snow administered chloroform to Queen Victoria during birth of her eighth child. Joseph Lister's (1827-1912) work in Glasgow, Scotland resulted in

a spectacular reduction in death from sepsis. By 1900, modern aseptic technique (sterile gloves and steam sterilized instruments) had replaced the Listerian spray of carbolic acid, while several countries introduced the regulation of midwife training and certification.

Development of aseptic technique and anesthesia allowed the successful performance of c-sections in the nineteenth century. The term caesarian is not derived from Julius Caesar, as evidenced by the fact that his mother was alive during his life. Rather, the term derives from the Latin, caedere, "to cut." Roman Law, Lex Caesare, stated that a woman who died in late pregnancy should be delivered soon after her death, and if the baby died, they should be buried separately. By the 1880's, c-section was refined with a "classical vertical hysterotomy" on the upper uterus. This incision healed poorly, and in 1906, the modern, "lower segment," operation was introduced, which lessened the risk of subsequent rupture.

By the twentieth century, obstetrics had expanded from just childbirth to include antenatal care. Improvements in instrument delivery occurred with the introduction of rotational forceps and vacuum extractors. Up to the 1930's, the death rate from puerperal fever, in the hospital setting, was a staggering 25%, despite aseptic techniques. A tremendous breakthrough was accomplished by Germany's Bayer Pharmaceutical: based on the theory and systematic search for a substance that would be active against bacteria, Bayer scientists looked at dyes which strongly adhered to organic matter. Gerhardt Domagk (1895-1964) tested Prontosil, a red azo dye sulphanomide, which showed bactericidal activity. He was awarded the Nobel prize in medicine in 1939, and belatedly accepted it in 1947. Sulfas, followed by the penicillins, greatly reduced the incidence and mortality of puerperal fever. These milestones were followed by development of safe blood transfusions, which were pioneered during WWII. The use of epidural, rather than general, anesthesia also contributed to better

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## From the Health Science Library

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According to studies by the National Center for Health Statistics **Nutrition Examination Survey (NHANES)** study in 2011:

- The use of dietary supplements is common among the U.S. adult population. Over 40% used supplements in 1988–1994, and over one-half in 2003–2006.
- Multivitamins/multiminerals are the most commonly used dietary supplements, with approximately 40% of men and women reporting use during 2003–2006.

Since so many people are taking herbs and supplements, it is important to that they are included among the medications listed by patients, so one can be sure that they are not interfering with prescription drug so, many people would like advice on how effective these herbs and supplements are for different indications.

The Health Science Library offers a resource on its SharePoint site that is evidence based and, more than any other resource offers information on alternative therapies, whether they be foods, herbals, supplements or body manipulations, such as yoga, acupuncture or tai chi. It is called **Natural Standard (NS)** <http://huntington.naturalstandard.com/>. It offers overviews of various alternative therapies, including an effectiveness rating score according to the clinical studies the reviewers have used.

**NS** includes an **interactions tool** for measuring any number of food/herb/supplement interactions with prescription drugs or food/herb/supplement - food/herb/supplement-interactions.

When searching a substance or technique, the **Bottom Line** monograph is suitable for handing to patients; the **Professional Monograph** is aimed at health professionals. The **Clinical/Bottom Line** section grades the effectiveness of the substance for various indications and the **Evidence Table** tells you what articles were read to arrive at the ratings score.

Don't forget this valuable resource when dealing with any patient using integrative medicine substances or techniques.

To learn more about searching Natural Standard, take one of their free online webinars. Dates and times are listed in the Library Calendar at: <http://hhsp/sites/library/Lists/Calendar/calendar.aspx>

## From The President

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outcomes, as well as the use of uterotonics, steroids for lung maturation, and use of anti-D immune globulin to prevent Rh allomunization.

In developing countries, maternal mortality is still as high as one percent. The main contributors are sepsis, hemorrhage, hypertensive disease, and unsafe abortion; the same causes as in Western countries seventy years ago.

In the developed world, the recent emphasis has been on the fetus. Fetal monitoring and scalp blood gases were developed in the 1960's, along with ultrasound technology. The first OB patients examined by ultrasound were required to be in a tank of water; thankfully, ultrasound gel was discovered. Despite improvements in safety, it is estimated that childbirth is still one hundred times riskier for the baby than for the mother. This is partially reflected in growing c-section rates (of note, the c-section rate in Rio de Janeiro is 90%! ). A notable transformation is now occurring in OB/GYN: the gender difference between obstetricians and midwives, present since the time of Hippocrates, is about to disappear, with the predominance (70%) of female OB/GYN residents in the U.S.

**Jim Buese, MD**  
*President Medical Staff*



# From Physician Informatics

## Don't Go Quietly Into the Night

*By Rebecca Armato, Executive Director  
Physician and Interoperability Services*

**R**ather than face the 'Perfect Storm' of healthcare challenges such as decreasing reimbursement, increasing costs, legislative mandates and penalties around care reporting, technology adoption and information exchange – an alarming number of physicians are quietly making the decision to retire early from practice.

For some, as much as 10 years earlier than they had anticipated – or hoped. As far as I'm concerned, ending it one day early is too soon. Rather than consider change, some physicians are mentally placing a DNR on their practice, delaying or saying 'no' to investing in tools necessary to efficiently and effectively manage their business (electronic medical record, upgrading outdated computer hardware, telephone systems, printers). Not quite willing to pull the plug on their practice, some physicians provide just enough 'nourishment' to keep a faint pulse on their business - not willing to attempt what they consider 'heroic' life-saving measures. But what is the difference between 'heroic' vs. 'reasonable'? Is an electronic medical record 'experimental treatment'? What quality of life should your practice have at this point in your business' life?

You, as physicians, are trained to make decisions – not ask questions (except of patients). You are expected to be able to answer any questions your patients' ask. That same wonderful personality that gives you the noble confidence to heal, also causes you to feel you have to appear all knowing and all seeing on all topics. Many physicians are not comfortable publically sharing their questions about their practice, technology, or the business of healthcare – fearing that it will expose their ignorance in topics their peers have already all the answers.

If you experience an adverse outcome to the surgery or treatment you performed, unless you're a resident or behind closed doors during peer review, you aren't

encouraged to 'expose' the issue so you can brainstorm with your peers to improve your clinical decision-making thus reducing a similar adverse outcome in the future. For fear of retribution by attorneys representing patients or grieving families, you have been trained to 'suffer in silence', and guess at what might have happened and/or what you might do differently next time. Unfortunately, many of you are applying that same learned response to the business of your practice. Rather than openly discuss your questions, concerns, your thought process as you evaluate your technology options, your innate fear of change, or your lack of confidence in your ability to learn software, computers or smart-phones your grandchildren appear to come out of the womb skilled at – you'd rather withhold 'sustenance' and let your practice quietly flat line.

You (Physicians) are somewhere between a national treasure and a natural resource – and unfortunately becoming an endangered species. Fewer physicians are encouraging their children to go into medicine – unsure of the future reward for all the risk. Physicians are deciding to retire early, earlier than they really want, unwilling to learn something new, unsure they can. Don't underestimate yourself. Don't go quietly into the night. Your patients need you. We need you. Our community needs you. Hospitals have a license to house patients, physicians have the license to treat them – it is only by working together that we can continue to provide care to our community.

Don't end your practice pre-maturely because you fear the unknown. Don't be afraid to speak to your peers or reach out to us – most likely the person you are speaking to has the same questions, feels the same uncertainty and confusion about the future that you do. You are not alone.

If you are considering retiring within the next 3-4 years, perhaps investing in a full-blown EMR is not the best choice, but there are other options. Or are you considering an Electronic health record but

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## From Physician Informatics continued from page 7

fearing you're not sure of the value or investment in your practice? Not sure how to start looking, what to ask the vendors, what bells and whistles are really important (getting value vs. 'Wow factor' features)? Huntington Hospital has invested in resources to help you. We can come out and conduct a readiness assessment, helping you with the questions you should be asking yourself and how to look at your practice to determine what you should be considering. We are providing software you can use today, at no cost, that can assist you in improving patient care outcomes and efficiencies – such as HuntingtonRx (medication history, electronic prescribing, medication contraindications) and Huntington Health eConnect (physician portal, in-box of your patients' clinical results, securely communicate with other physicians, community virtual patient record combining inpatient and outpatient care). You don't need an electronic medical record to receive your patients' results via Huntington Health eConnect or eprescribe using HuntingtonRx. Adopting technology for your practice doesn't have to be considered a 'heroic' investigational treatment or extreme measure. There are well documented improvements to outcomes, practice expenses & efficiencies attributed to adopting the right technology, for the right reasons, in the right way and at the right time - including value from upgrading your business operations to the emerging tools available to you.

Huntington Hospital has invested in supporting you and our community by implementing a variety of services, resources and technology designed to leverage your own technology investments, as well as embarking on upgrading our own hospital electronic medical record from Meditech to Cerner to improve quality, outcomes and cost of care, and to better integrate with Huntington Health eConnect.

Don't go quietly into the night – without a fight. **Fight, with the same attitude & strength you ask and expect of your patients** when they are facing health issues you have confidence you can treat. You, above all others, have seen the real life power of attitude and action over health conditions and disease.

You've also seen how the highest quality care and treatment can be impacted by patients' negative attitude.

Just as you don't expect patients to fight alone and are right there with them, we are here so you don't have to face healthcare's 'perfect storm' alone. We have staff that can help you figure out how to use your new ipad, or iphone to access your patient's records in our hospital; we can perform a 'readiness assessment' of your practice and give you insight into questions you need to ask yourself when considering purchasing electronic health records, what features are important to improve the efficiency and treatment of your patients. As we implement our new hospital systems, we will be working closely with you to figure out the best workflows to leverage your practice's technology and bridge patient care across all technologies and locations of care in support of the highest quality and best care outcomes.

Do we have all the answers? We don't even know all the questions. No one has a crystal ball. But I do know that more heads are better than one – and by working together, sharing questions, concerns, challenges, success stories, and accepting the fact that it's OK to *not* have all the answers today, we can begin the journey together to improve care outcomes, cost and practice viability. Together we see 11,000 patients a day, 10,000 of those are seen in your private offices. If we can convince each of you to stay in practice just 1 more day, in that one day 10,000 lives will be touched, treated, healed. Who knows, among those 11,000 might be someone who saves the planet, becomes the next Gandhi, Mother Teresa, Da Vinci, Einstein, President of the United States, or hopefully, someone who grows up to become a physician who goes on to save/heal 11,000 more lives. You are not alone. Call us. Physician Informatics: 626-395-2500.

**Physician Informatics Office:**  
626-397-2500 or email:

Becky Pangburn: [becky.pangburn@huntingtonhospital.com](mailto:becky.pangburn@huntingtonhospital.com);  
Vera Ma: [vera.ma@huntingtonhospital.com](mailto:vera.ma@huntingtonhospital.com);  
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# Technology User Group Meeting



**D**o you use a smartphone, ebook reader or tablet computer? Perhaps you have thought about buying one but don't know which one or how it might be useful? If you are interested in mobile technologies, come join us for the first HMH Technology User Group meeting sponsored by the Health Sciences Library. Our aim is to bring hospital employees together to discuss, experiment and learn together about mobile technology.

Each meeting will focus on one mobile app with time to download and test it out. After the demo, there will be time to ask questions and exchange information with other attendees. Whether you consider yourself “in the know”, “want to know” or “don't know”, bring your lunch and come join us!

- WHAT:** Technology User Group Meeting  
**WHEN:** Wednesday, July 11, 11:30 a.m. – 12:30 p.m.  
**WHO:** Huntington Hospital employees and affiliated physicians  
**WHERE:** Conference Room C (Wingate 1<sup>st</sup> Floor, across from the library)  
**DEMO:** MDConsult/FirstConsult  
**BRING:** Your device(s) (if you have one)  
**RSVP:** Email: [library@huntingtonhospital.com](mailto:library@huntingtonhospital.com)  
**Phone:** 626-397-5161  
**SMS/text:** 626-344-0542 – please include your full name

*If you cannot attend the first meeting, but are interested in attending future meetings, please let us know so that you will be notified as to dates and times.*

## Carbs: in with the CCD, out with the ADA

**A** new Food & Nutrition Services policy will introduce a term new to physicians in place of the traditional “ADA diet” for patients with diabetes. The hospital will utilize the Consistent Carbohydrate Meal Planning System for all hospitalized patients requiring a therapeutic diet for glucose control. This system will replace the “calorie level ADA (American Diabetes Association) diets” (Exchange List System) and spread carbohydrate intake evenly throughout the day for more flexibility, improved acceptance, and ease of patient education. The change has been widely implemented at other institutions.

- The amount of carbohydrate offered at each meal is consistent, instead of specific calorie levels – hence CCD or Consistent Carbohydrate Diet.

- The focus is on the total amount of carb in the meal instead of on the type of carb served; thus for example some sucrose containing foods can be included as part of the total carbohydrate allowance.

When ordering a diet, even if a physician still orders, for example, a 1600 cal ADA diet, during data entry the computer will display the old ADA terminology alongside the CCD terminology, and if a physician looks up “current diet” in the care trend section of Meditech, both terms will still appear until we're all familiar with the new terminology.

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# Carbs: in with the CCD, out with the ADA continued from page 9

## PROCEDURE

1. The table below will be used to define the Consistent Carbohydrate Diets (CCD's) and the appropriate conversions to be made when a diet order utilizing the Exchange System is ordered. If a physician orders a diet using the "ADA" diet ordering system, an automatic translation to the appropriate Consistent Carbohydrate Diet will be made.
2. If the doctor does not specify a carbohydrate level, the Medium CCD will be ordered. Dietitians will make recommendations for change in carbohydrate limit as needed upon nutrition assessment.
3. If the doctor does not want to restrict total carbohydrates, a Regular diet with sugar substitute can be ordered. Meal plans such as "no concentrated sweets" are no longer appropriate and unnecessarily restrict sucrose.
4. Patients on liquid diets will generally receive ~ 200 grams of carbohydrate throughout the day. To ensure adequate carbohydrate and caloric intake and minimize risks of hypoglycemia, sugar-free drinks will not be provided (water, of course, excepted).
5. Between meal snacks and HS snacks will not be routinely provided (except in the case of gestational diabetes and pediatrics) and can either be ordered by the physician or requested by the patient. Meal plans will be adjusted to maintain consistent carbohydrate count.
6. Gestational Diabetes:
  - a. Gestational Diabetic meal plans are individualized and will be adjusted to provide between meal snacks; total carbohydrate amount per meal will differ from the chart below.
7. Pediatric and Teenage Patients:
  - a. Pediatric meal plans are individualized and will be prescribed by the physician and the RD will provide a meal plan based on the prescribed carbohydrate count.
  - b. For Pediatric or Teenage patients: if the calorie levels exceed 2400, then the RD will calculate the gram carbohydrates needed for the day.

**Mary-Jeanne Der Avedissian**  
*Clinical Nutrition Manager*  
 mary-jeanne.der\_avedissian@huntingtonhospital.com

**Glenn Littenberg, MD**  
*Nutrition Support Subcommittee (of PTD)*

<b>"ADA" Calorie Diet Order</b>	<b>Consistent Carbohydrate Diet Translation</b>	<b>Provides</b>
1200 ADA – 1600 ADA	Consistent Low Carbohydrate Diet (CCD Low)	~ 60 gram carbohydrate per meal/ ~ 4 servings of carbohydrate per meal
1800 ADA – 2000 ADA	Consistent Medium Carbohydrate Diet (CCD Medium)	~75 gram carbohydrate per meal/ ~ 5 servings of carbohydrate per meal
2100 ADA – 2300 ADA	Consistent High Carbohydrate Diet (CCD High)	~90 gram carbohydrate per meal/ ~6 servings of carbohydrate per meal
2400 ADA +	Consistent Very High Carbohydrate Diet (CCD Very High)	~105 grams carbohydrate per meal/ ~ 7 servings of carbohydrate per meal.

# Life History of Creighton Clark Horton, MD

September 11, 1918 – May 31, 2012

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**C**reighton Clark Horton was born in Salt Lake City, Utah on September 11, 1918, the first of two sons born to Mead Howard Horton and Chelta McMurrin Horton. When he was a very young boy, his family moved from Utah to Los Angeles, where his father worked as an agent for the New York Life Insurance Company. When he was six years old, his younger brother and only sibling, Howard, was born.

When Dad reached high school age, he decided he wanted to go to military school, and so he attended boarding school at the San Diego Army & Navy Academy in Carlsbad, California. Afterwards, he attended college at UCLA, where he obtained his pre-med degree. His decision to study medicine was strongly influenced by his uncle, Drew Chipman, himself a doctor.

After completing his undergraduate studies at UCLA, he was admitted to Jefferson Medical School in Philadelphia, where he started his medical studies. After successfully completing his first semester, he fell ill with a severe case of amoebic dysentery and had to drop out of medical school. When he got home he was extremely weak, having lost a great deal of weight.

After a slow recovery the following year, he improved enough that he wanted to resume his medical studies. He applied to USC Medical School but was at first rejected because of his still questionable health. He was told that he should pursue a less rigorous course of study and career, but by this time he was sure he wanted to be a doctor. Because of his persistence, a trait he inherited from his father, he persuaded school officials that he was up to the rigors of medical school, and he was admitted. He thrived in his studies and graduated from USC Medical School in 1947. He went on to pursue a residency in Internal Medicine at the Los Angeles County General Hospital from 1948 to 1951, and in 1955 became board-certified in Internal Medicine.

Dad absolutely loved being a doctor and caring for his patients. After completing his residency at the County Hospital, he joined the medical group of "Williams, Edmeads, Horton and Merrill," with offices in the Thatcher Medical Building on Green Street in Pasadena. A few years later, he left the group to open his own office at 624 S. Pasadena Avenue

near the Huntington Hospital, where he practiced for over 50 years. He was the quintessential "old fashioned doctor" who regularly made house calls and developed enduring personal relationships with his patients. He was the kind of doctor everybody wants to have, and the best interests of his patients was always his guiding principle.

Dad continued to practice long after most of his contemporaries retired. He thought about retiring in 2003 and even sent out an announcement to his patients to that effect, but after thinking it over and being told by countless patients that they couldn't imagine not having him as their doctor, he changed his mind. With his characteristic humor, he sent out a letter to his patients, saying, "Well, you are not going to believe this, but due to changing circumstances in the call schedule, and a few thinly veiled threats from patients, I have decided to continue my practice of medicine." He was 85.

Even after he did retire, he kept up on the latest developments in medicine, and observed the daily routine of going to the Medical Library at the Huntington Hospital and reading medical journals. He also continued to treat LDS missionaries in the area, an activity he was involved in for several years.

Dad remained mentally sharp and current on medical issues to the end of his life, and we in the family often called him when we had medical issues and problems. He always gave us good advice, and when his advice was different from what we were told by our own physicians, we generally went with Dad's advice, and he didn't steer us wrong.

After Mom died in 2008, Dad continued to live at 1545 Pasqualito Drive in San Marino, our family home since 1952. He was able to do that thanks to the support of our sister Joan, who lived with him. He continued driving until his 93<sup>rd</sup> birthday, and he enjoyed his life and his daily routine. People who met him had no idea that he was over 90, as he always seemed much younger than his years.

Dad lived a wonderful life and left a wonderful legacy, but it is hard to imagine life without him. He leaves behind countless people who love him, including friends, relatives, former patients, and his immediate family – his four children, 16 grandchildren and 23 great-grandchildren. While we will all miss him so very much, we are comforted to know that he and Mom are together again.



**Huntington Hospital**

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# MEDICAL STAFF

N E W S L E T T E R

July, 2012

## *CME Corner*



**Please note:** First Thursday conference is **moving** to a new date and time. Beginning in September the new date will be 2<sup>nd</sup> Monday at noon. In honor of the move, the July and August conference have been cancelled. Please mark your calendar.

The next activities will be held on:

### **Second Monday**

**Date:** September 10, 2012

**Time:** Noon – 1 p.m.

**Location:** Research Conference Center

### **Medical Grand Rounds**

**Date:** September 7, 2012

**Time:** Noon – 1 p.m.

**Location:** Research Conference Center

If you have any questions please contact Maricela Alvarez, CME Coordinator at 626-397-3770 or via e-mail at [maricela.alvarez@huntingtonhospital.com](mailto:maricela.alvarez@huntingtonhospital.com).