THE GROSSMONT HOSPITAL
Physician

SEPTEMBER/OCTOBER 2008
ISSUE NO. 67

Robotic-Assisted Surgery to Debut at Grossmont

Say hello to the new bot in town. With the arrival of the da Vinci® S HD™ Surgical System on June 27, 2008 – and with the first surgeon granted privileges to use it – Grossmont Hospital will soon introduce robotically assisted, minimally invasive surgery to East County patients.

The first procedure is expected to be a prostatectomy by urologist Roger Sur, MD, a newcomer to the Grossmont medical staff who will start seeing patients on Sept. 15, 2008 (see "Roger Sur, MD, Poised to Launch Grossmont's New da Vinci Robot into Action" on Page 2).

Three additional members of the medical staff are trained to use the da Vinci system and are in the process of obtaining privileges to do so at Grossmont: urologist Julian Anthony, MD, gynecologic oncologist Kris Ghosh, MD, and cardiothoracic surgeon Yuan Lin, MD. Other surgeons on the Grossmont medical staff have requested training in the da Vinci system and are expected to follow suit in the coming months.

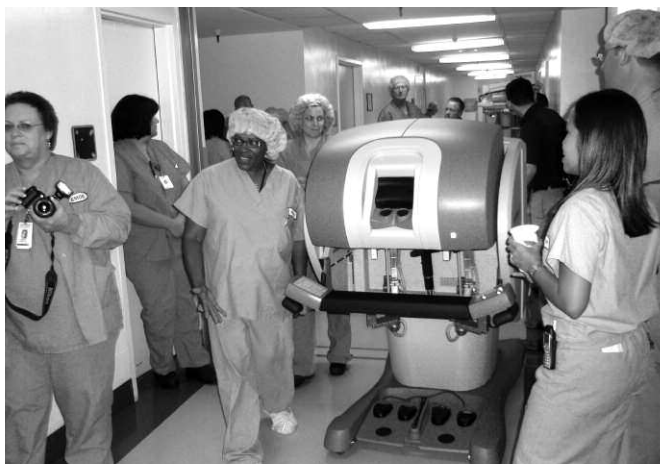

Photo by Bruce Hartman

The robotic surgical equipment arrived at Grossmont Hospital on June 27, 2008. Shown in foreground is the surgeon's viewing and control console, one of the main components of the da Vinci® S HD™ Surgical System with 3-D, high-definition vision.

Check out a demonstration of the **da Vinci robotic surgical equipment** at the Nov. 1 gala (see Page 3).

The da Vinci Steering Committee, which held its first meeting in August 2008, is working to develop a multispecialty program of minimally invasive surgery at Grossmont Hospital and promote it among East County residents, said Susan Werner, RN, Director of Surgical Services at Grossmont Hospital. Specialties will include urology, cardiac surgery and gynecologic oncology.

Campaign to raise $2 million continues

"Grossmont Hospital Foundation is in the midst of a $2-million fund-raising campaign for the minimally invasive surgical robotics program," said Elizabeth Morgante, Vice President/Chief Development Officer, Grossmont Hospital Foundation, at the end of August 2008. "$560,000 has been donated so far, with another million dollars or so currently

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Roger Sur, MD, Poised to Launch Grossmont's New da Vinci Robot into Action

As the first surgeon granted privileges to use the da Vinci S HD Surgical System at Grossmont Hospital (see cover story), Roger L. Sur, MD, is poised to launch the new high-tech robotic equipment into action. He'll soon be joined by other specialists who plan to participate in the new multispecialty program of minimally invasive, robotic-assisted surgery at Grossmont.

Roger L. Sur, MD

"Developing better minimally invasive surgery is an inevitable consequence of our continual pursuit of improvements in three areas," observed Dr. Sur. These are:

- Improving surgical outcomes – such as cancer control, incontinence and sexual function in prostate cancer surgery.
- Lowering the total economic impact of surgery, including "direct costs," such as shorter length of stay in the hospital and less inpatient ancillary care, and the "indirect costs," such as lost days of work and post-op recovery care.
- Improving the cosmetic effect of surgery.

"This pursuit will always come at an initial immense financial cost to health care institutions," Dr. Sur continued. "However, the return on investment is seen over time just as any financial market investment is realized over time – i.e., the initial principal is burdensome, but the long-term effect of compound interest is always impressive. Health care institutions that have plans for long-term success appreciate this concept and make financial decisions based on these principles."

Though new to Grossmont – Dr. Sur joined the medical staff on July 16, 2008, and will begin seeing patients on Sept. 15 – his experience, education and insight should stand him in good stead here. Prior to his arrival in San Diego, Dr. Sur served as a Navy urologist and as an Assistant Professor of Surgery in the Uniformed Services University of the Health Sciences (USUHS) in Bethesda, Maryland. A Diplomate of the American Board of Urology, he has also worked as a staff urologist at the National Cancer Institute, Urologic Oncology Branch, Bethesda; Walter Reed Army Medical Center, Washington, DC; National Naval Medical Center ("President's Hospital"), Bethesda; Duke University Medical Center; Department of Veterans Affairs, Durham, North Carolina; and Durham Regional Hospital.

His educational tour of duty included a medical degree from Eastern Virginia Medical School in Norfolk, Virginia, a surgery internship and urology residency at the Naval Medical Center San Diego, and an endourology/laparoscopy fellowship at Duke University Medical Center, Durham, North Carolina.

Dr. Sur sees the robotics program at Grossmont as "a defining moment for the hospital" with the potential to eventually "catapult" Grossmont Hospital into a medical leadership position locally and possibly in the Southwest U.S.

Hail and Farewell

Grossmont Hospital welcomes the following physicians who were appointed to the provisional medical staff by the Grossmont Hospital Corporation Board of Directors, as recommended by the Medical Executive Committee in July and August 2008. If the new physician's application listed a covering physician, the covering physician's name appears in parentheses: **Amarpal Arora, MD,** Orthopaedic Surgery (*Tasto*); **Joseph Baran, MD,** Infectious Disease (*Miradi*); **Brook Beall, MD,** Emergency Medicine; **John Brady, MD,** Orthopaedic Surgery (*Tasto*); **James Hsiao, MD,** Emergency Medicine; **Gus Kefapoulos, MD,** Anesthesiology; **Keeran Kumar, MD,** Anesthesiology; **Brian Leek, MD,** Orthopaedic Surgery (*Tasto*); **Walter Nahm, MD,** Dermatology (*Coughlin*); **Kenneth Ott, MD,** Neurosurgery (*Altenau*); **Salam Petros, MD,** Hospitalist; **Julie Phillips, MD,** Emergency Medicine; **Ralph Rynning, MD,** Orthopaedic Surgery (*Finkenberg*); **Mark Schwab, MD,** Emergency Medicine; **Gioi Smith-Nguyen, MD,** Obstetrics-Gynecology (*Missanelli*); **Roger Sur, MD,** Urology (*Gaylis*); **Hung Vu, MD,** Emergency Medicine; **Jenny Wong, MD,** Family Medicine (*Grossmont Family Medical Group*).

Farewell to departing physicians

Farewell to the following physicians who resigned from the medical staff: Thomas Sulllivan, MD, Surgery, and Orthopaedic Surgery Fellows Gregory Carolan, MD, Anthony Festa, MD, Joshua Landau, MD, and Sean Tracy, MD.

Lesley Bradley, CPMSM, Manager, Medical Staff Services

Nov. 1 Gala to Benefit Robotics Program

Come experience a night of masks, music and mystery at the "Carnivale di Venezia Gala" on Saturday, Nov. 1.

Ann Goldberg and Connie Conard, 2008 Gala Co-Chairs, invite you to enjoy an evening of fine dining, amazing auction items and fabulous entertainment by Bill Green's Society Beat Orchestra.

To get into the spirit of a Venetian-style "Carnivale," participants are encouraged to wear masks. Masks will be available for those who don't bring their own, but attendees are welcome to enjoy the evening mask-free as well.

Festivities will begin at 6 p.m. at the Sheraton San Diego Hotel & Marina, 1380 Harbor Island Drive in San Diego. Emcee for the evening will be Kimberly Hunt, anchor for KGTV Channel 10 News.

See robotics up close at demonstration

Proceeds will benefit the minimally invasive surgical robotics program at Grossmont Hospital (see article on Page 1 of this edition). Intuitive Surgical® Inc. will provide a demonstration of Grossmont's new robotics equipment, the da Vinci® S HD™ Surgical System, during the gala.

Bill Green's Society Beat Orchestra will keep dancers whirling at Grossmont's benefit gala on Nov. 1.

Gala sponsors to date include Superstar Sponsor Grossmont Hospital Medical Staff.

Tickets are $250 per person. Sponsorship opportunities start at $2,500. Other sponsorship levels are available. For more information, contact Bill Navrides, Grossmont Hospital Foundation, at 619-740-4200 or *bill.navrides@sharp.com.*

Robotic-Assisted Surgery to Debut at Grossmont CONTINUED FROM PAGE 1

in negotiations. Proceeds from the Nov. 1 gala will benefit the da Vinci campaign."

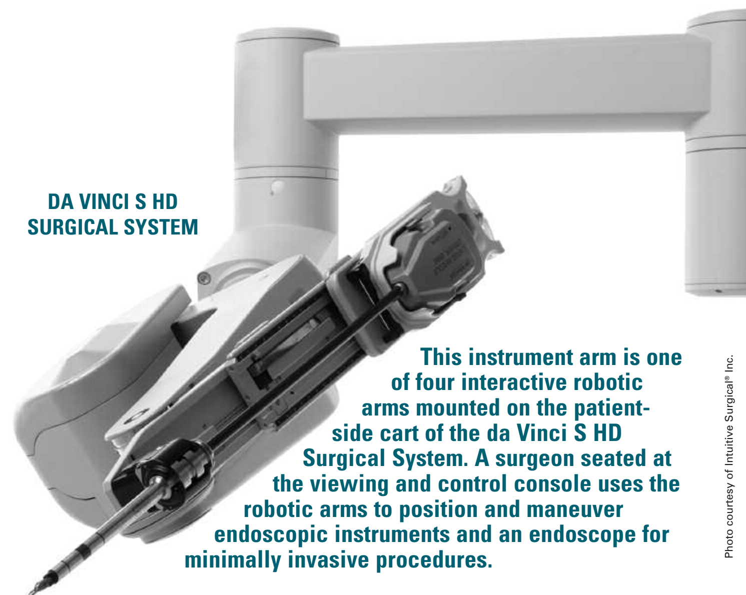
The state-of-the-art equipment accounts for $1.7 million of the total, while shipping, training, marketing and other costs account for the other $300,000, Morgante noted.

The da Vinci equipment is designed for fast setup and will be used in various rooms in the main OR at Grossmont Hospital, said Werner. Made by Intuitive Surgical® Inc., the da Vinci S HD Surgical System includes a viewing and control console with 3-D, high-definition endoscopy and a patient-side cart mounted with four interactive robotic instrument arms. It translates the surgeon's hand movements into extremely precise movements within the operative site and enables the surgeon to see in greater clarity and detail.

Potentially better outcomes, faster recovery

The benefits of minimally invasive, robotic-assisted surgery for patients include potentially better outcomes, faster recovery and return to normal activities, less pain, less scarring and shorter hospital stays.

Sharp Memorial Hospital was the first to bring a robotic-assisted da Vinci Surgical System to San Diego in 2005. Since then, Sharp Memorial-affiliated physicians have performed nearly 300 prostate, gynecologic and heart surgeries – more than any other hospital in San Diego. Competing institutions subsequently acquired da Vinci systems and have been vying for East County patients.



DA VINCI S HD SURGICAL SYSTEM

This instrument arm is one of four interactive robotic arms mounted on the patient-side cart of the da Vinci S HD Surgical System. A surgeon seated at the viewing and control console uses the robotic arms to position and maneuver endoscopic instruments and an endoscope for minimally invasive procedures.

Photo courtesy of Intuitive Surgical® Inc.

For more information about Grossmont's da Vinci S HD Surgical System, visit Intuitive Surgical at *www.intuitivesurgical.com/products* and click on "da Vinci S Surgical System." For more information about robotic-assisted surgery at Sharp Memorial Hospital, visit *www.sharp.com/services* and click on "Robotic-Assisted Surgery."

THE SHARP EXPERIENCE

SHARP GROSSMONT HOSPITAL PHYSICIAN SATISFACTION UPDATE

SEPTEMBER / OCTOBER 2008 ISSUE NO. 34

CEO Column: Charting a New Course

Although Sharp Grossmont Hospital has experienced favorable market growth, operations have fallen short of budgeted expectations due to fluctuations in the payer mix and an increase in unfunded and underfunded patients. The current fiscal year (FY08), which ends Sept. 30, 2008, is projected to end at $5.9 million in net operating income compared with the budget of $8.4 million.

Michele Tarbet

Management has worked diligently to develop a FY09 budget that improves profitability to support the ongoing programs, services and capital needs of the hospital. FY09 budgeted net operating income totals $7.2 million compared with the $5.9 million projected for FY08, an increase of $1.4 million. Budgeted net revenue totals $447.1 million, an increase of 7.5% over FY08 and budgeted operating expenses are $439.9 million, an increase of 7.3% over FY08.

Delivery of patient care remains strong

Overall, staffing is budgeted to decrease by 8.9 total FTEs (full-time equivalent positions) from projected FY08. We eliminated various positions to achieve an overall reduction of 50.7 FTEs. This reduction was offset by a 5.2 FTE increase that is volume related, 15.6 FTEs for new positions to support new programs, 11.0 new positions to support existing programs and services, and 10.0 FTEs for projected FY08 open positions that are currently open, but will be filled by the start of FY09.

Programs that were eliminated included the Pulmonary Rehab Maintenance program and the Lymphedema Program. Staffing was reduced in several other programs and services, but will not impact the direct delivery of patient care.

FY09 acute inpatient discharges are expected to increase by 1.1%. FY08 projected growth was 1.3% and FY07 growth was 2.3%. Overall outpatient visits are expected to increase 3.0%. Emergency visits are budgeted to average 224 patients per day compared with the projected FY08 volume of 218 patients per day, an overall increase of 2.3%. Other budgeted increases include 1.1% for surgical cases and 1.0% for cath lab cases.

Key initiatives to meet health care needs

Key initiatives will address the challenges facing SGH, including: patient throughput and bed management to meet high census demands; appropriate utilization of resources for the increasing unfunded and underfunded patient population; and staffing to meet the increasing acuity and volume of patients.

Through the timely management of resources, SGH will continue to provide excellent programs, services and an infrastructure that are responsive to the current and future health care needs of East County.

The capital budget for FY09 totals $26.9 million, which includes new projects and capital requests of $22.5 million. These projects include equipment and furnishings for the Emergency and Critical Care Center, design fees for the third cardiac catheterization lab, additional seismic building upgrades and routine equipment. Additionally, $4.4 million is budgeted for projects that are in process: design fees for the inpatient 64-slice CT scanner project, opening of OR #8 to increase surgical capacity, and other miscellaneous projects.

The hospital is very fortunate to have the support of the Foundation. Next fiscal year, the Foundation will contribute $2.6 million toward capital projects, including the da Vinci robotic surgical system (see cover story), the purchase of new sterilizers and cart washers for the Sterile Processing Department, and funding for other routine medical equipment. The Foundation will also contribute $784,000 toward operations for Sharp HospiceCare, LakeView Home and the new ParkView Home, and other patient care programs, including nurse education scholarships and senior programs.

Michele Tarbet, Chief Executive Officer, Sharp Grossmont Hospital

Take 15 Minutes to Speak Up for Your Satisfaction

A random sampling of medical staff members recently received the 2008 Physician Satisfaction Survey via a letter in the mail and e-mail. If you are one of the few who received the annual survey, your feedback is important. Administration uses the information to help ensure that Sharp Grossmont Hospital is the best place to practice medicine and provide patient care. The survey only takes 15 minutes to complete, so if you received it, make sure your voice is heard. Return the survey today.

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Physician in the Spotlight

Kelly Doyle DeWitt, MD: Light from Darkness

Radiation oncologist Kelly Doyle DeWitt, MD, sees hope where others see doom. She finds a path where others find a wall. She deals with cancer every day and thrives in her quest to cure, to relieve, to comfort. And she preserves the milieu of her patients' being while eliminating the unwanted guest. She does not destroy in order to save.

She sprang from the union of a professor of American history (Dad) and an administrator at Vanderbilt University Hospital (Mom) in Nashville, Tennessee. From middle America (Illinois) by way of Vanderbilt University, Harvard Medical School as research assistant, and then back to Quillen College of Medicine in Johnson City, Tennessee.

Photo by Nicole Quiroz

Kelly DeWitt, MD

Why? Because her college exposure to molecular biology ignited a desire to challenge oncology even before her formal medical training. But the blaze began with a radiation oncology rotation in medical school year four. At that point it became clear that newer imaging techniques such as CT and MRI were going to determine the nature of future cancer therapy and that the field of radiation oncology was poised to harness these technologies.

Why not medical oncology? A different spectrum of cancers, but recognition also that often the radiation, medical and surgical oncology modes are complementary. And so she was drawn to the David and Donna Long Center for Cancer Treatment at Grossmont, where these approaches coalesce, the connection made during her residency at University of California, San Francisco (2000-2004).

She appreciates especially the unique availability of TomoTherapy® at Grossmont and some of the newer additions to the department such as stereotactic radiosurgery and high-dose-rate brachytherapy, and virtually glows with enthusiasm when discussing these resources.

Early training in chemistry and physics is invaluable in quantifying the risks and side effects before "turning on the beam."

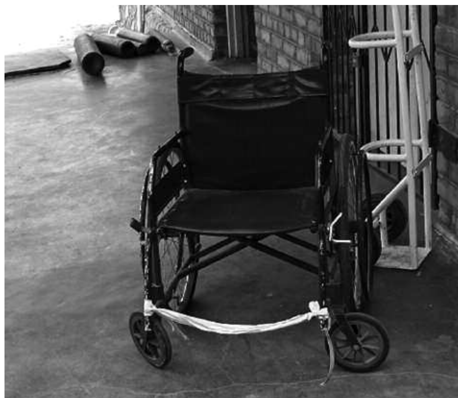
Life planning includes her husband of six years, Ned, the vice president of sales at Borrego Solar in San Diego, and their two children, Jackson, 4, and Caroline, 2. Leisure time includes outdoor sports, travel and photography.

Dr. DeWitt shines the light on her patients. Her inspiration shows as the light in her eyes.

Michael G. Marenchic, MD, Ph.D., Emergency Medicine

RODEO Roundup: The Zimbabwe Connection

EDITOR'S NOTE: Yes, Virginia, there is a "post-doc" life. It exists as certainly as generosity and creativity and determination abound in Grossmont physicians who have forged new paths in their retirement years. Some convene periodically under a modest aegis best suited for cowpokes, yet these "**R**etired **O**ld **D**octors **E**ating **O**ut" can inspire today's toiling medical staff members to reach for their own visions now and in the "post-doc" years to come. The "RODEO Roundup" will offer periodic glimpses at what engages their time and interests.



Lindani Sibanda, RN, right, has been gathering medical supplies, medicine, equipment and donations since 2004 to help "resuscitate" Mtshabezi Hospital in southwest Zimbabwe. Four nurses and a few support staff kept the hospital running for seven years without a physician until the recent arrival of Hlezikuhle Nyoni-Nkala, MD, shown with Sibanda during a May 2008 visit. Views of the hospital's laboratory (center photo) and this wheelchair show why donations of any usable medical equipment and supplies – even items that would otherwise be close to being discarded – are welcome. For more photos, visit *mtshabezi.org*.

Bill Pogue, MD, has found more ways to serve his fellow human beings during retirement than some people manage to fit into full-time careers (see "His So-Called 'Retirement' Provides Comic Relief" in the September/October 2007 *Grossmont Hospital Physician*). So when the retired nuclear radiologist and 30-year (1968-1998) member of the Grossmont medical staff sat next to Lindani Sibanda, RN, at a district assembly of Rotary clubs in 2006, he did more than turn a sympathetic ear to her plea for medical supplies, medications, equipment and donations to Mtshabezi Hospital, her birthplace in southwest Zimbabwe. First he arranged for Sibanda – a bone marrow transplant nurse at UCSD's Thornton Hospital and an honorary member of the La Jolla Rotary Club – to share her story with his La Mesa Sunrise Rotary Club.

"Then I scrounged 12 blood pressure cuffs from the Grossmont Thrift Shop donations and gave them to her. She took them to the hospital in Zimbabwe, and they were grateful, as they had no others," said Dr. Pogue. "I have been in contact with her many times over the past two years and I would like our doctors at Grossmont Hospital to be aware of what this fine woman is trying to do for a community hospital in the middle of an AIDS epidemic with no funds, no meds and no equipment."

Motivated by a wish "to give back to the village what my village gave to me," Sibanda began ferrying equipment, medications and money to Mtshabezi Hospital in 2004 to ease the plight of the people in Mtshabezi, a community of over 50,000. "I had no intention of starting a charity organization," she said. But growing donations spurred her and her co-workers to apply for 501(c)(3) status for Nursing Charity Organisation for the Philippines and Zimbabwe Inc. (NCOPZ), so that contributions to Hope for Mtshabezi, an affiliate of NCOPZ, will soon be tax deductible.

"As the founder of Hope for Mtshabezi, I have been privileged to visit the hospital every year to check its books and verify that the equipment we donated is in place," Sibanda said. "The hospital needs laboratory equipment, dental equipment, operating room equipment, oxygen monitoring equipment and most of all, the hospital needs medications to keep people alive."

For more information, contact Lindani Sibanda at 760-295-5407 or *lindanihsibanda@yahoo.com* or write to her at 107 Madison St., Oceanside, CA 92057.

When to Consider Hospice Care Services for Your Patients

Chronic illnesses are now the most common causes of death. For many patients, medical care can slow the course of the illness and improve quality of life. But as illness advances, continued life-prolonging interventions can impose increasing burdens and offer diminishing returns.

Despite the inherent uncertainty of identifying when precisely patients are approaching life's end, physicians must provide care that meets recognized clinical standards and responds to the needs of patients. Caring for people approaching death will always draw on the art and humanity of the practitioner.

Moving from clinical diagnosis to a prognosis of a terminal or incurable illness expected to end in death – including a prediction of the remaining course of illness and life expectancy – is an exercise in uncertainty, but not futility.

Photo by Linda Van Fulpen

Grand opening events for ParkView Home (inset photo) on July 22-23, 2008, attracted more than 150 guests, including Trung ("Andy") Dang, MD, left, a team physician with Sharp HospiceCare and hospitalist at Sharp Memorial Hospital; Daniel Hoefer, MD, Associate Medical Director of Sharp HospiceCare; and other Sharp-affiliated physicians, donors, community members, board members, volunteers and employees. ParkView, located in Del Cerro, is Sharp HospiceCare's second home for end-of-life care. It will begin accepting patients once the licensing process is completed.

Specially trained to provide end-of-life care

Earlier recognition of an incurable disease where life-sustaining measures would not be effective should facilitate an earlier referral to hospice. Clinical outcomes at end of life, such as effective management of symptoms – including pain, agitation, shortness of breath, confusion, nausea and fatigue – are best managed by those specially trained in the care of the chronically ill and dying. Hospice care improves quality of life, utilizing aggressive, state-of-the-art care focusing on comfort, symptom management and palliation of symptoms.

The hospice interdisciplinary team, including the physician, encompasses an approach to care for the dying based on clinical, social and spiritual principles, and utilizes clinical standards to achieve evidence-based outcomes.

Exception to six-month limit for hospice benefit

The Medicare Hospice Benefit provides hospice services to those patients having a life expectancy of six months or less, assuming the normal course of the disease. The hospice medical director and the patient's primary care physician must certify the six-month prognosis. However, patients may stay eligible for hospice beyond the six months as long as the patient continues to show decline in health status.

Clinical guidelines – or local medical determination guidelines developed by the Centers for Medicare and Medicaid Services (CMS) – can be a useful tool to assist physicians in determining eligibility for hospice. When considering a referral to hospice – and in addition to using the clinical guidelines – it would be useful for a physician to ask, "Would I be surprised if death occurred within six months?" If the answer is, "No, it wouldn't surprise me," then a referral to hospice is appropriate.

Sharp HospiceCare also provides ethics consultations for patients, families, physicians and other health care providers when requested. An ethics consultation can help clarify goals of care and facilitate advanced health care and long-term care planning.

David Bodkin, MD, serves as the Medical Director of Sharp HospiceCare and Margaret Elizondo, MD, is a team physician with Sharp HospiceCare.

For further information about hospice, please contact Sharp HospiceCare at 619-667-1900.

Suzi Johnson, Vice President, David Bodkin, MD, Medical Director, and Margaret Elizondo, MD, Team Physician, Sharp HospiceCare

Chief of Staff Column: "What We Need Is Medicare For All..."

Some say that the best way to fix health care in America would be to have a "Medicare For All" system. I always find this idea odd, especially when put forward by physicians. Why do I find it odd? Because much of what people hate most about our current system – that it doesn't support primary care and prevention; that it's too procedure-driven; that it doesn't support cognitive physician services – all these are the result of the rules of the game set up and enforced by … yep … Medicare!

Marc Kobernick, MD

The other argument I often hear from the "Medicare for All" crowd is the myth that administrative costs are somehow lower for the government than for private insurers. The argument goes like this: Medicare only spends 4% of its dollars per beneficiary on administration, while private insurers spend 14% per member on administration – a big difference. It's also completely misleading.

Medicare beneficiaries are over the age of 65, while most members of private commercial insurance plans are under the age of 65. A Medicare beneficiary spends almost three times more on health care than does the typical private commercial insurance member. If a Medicare beneficiary typically spends an average of $900 per month on health care, and 4% is spent on administration, that's $36 per month. If the private commercial insurance member typically spends an average of $300 per month on health care, and 14% is spent on administration, that's $42 per month, a smaller difference.But we're not finished yet.

Since Medicare is part of the federal government, its capital costs (e.g., buildings, information technology) and cost of benefits (e.g., health insurance and pension benefits) are funded elsewhere in the federal budget, not in the Medicare administrative budget. Private insurers have to pay for these items themselves. How much is that worth? Maybe $5 to $7 per member per month? So we're just about even now.

Lastly, Medicare doesn't actually process and pay claims. Medicare contracts with – yes – private insurance carriers (intermediaries) to process and pay claims. So that's also not in Medicare's administrative number. Medicare is actually administered by the same companies that are constantly condemned by the socialized medicine crowd.

One could more accurately argue that Medicare is simply a bureaucratic layer added to the top of the private insurance system, which means that it "adds" rather than reduces administrative costs. And to top it off, in typical government agency fashion, Medicare has erected a series of obstacles to prevent analysts from calculating its true administrative overhead. The bottom line: Administrative costs of government-run health care are no lower than those of the private insurance industry. Just another myth promulgated by the single-payer evangelists.

On the payment side of things, private plans, on average, pay somewhere between 120% and 125% of what Medicare pays for hospital and physician services. In other words, private plans pay "more" than Medicare pays. If people want "Medicare For All," they need to be prepared to either drastically raise Medicare rates and payments (and therefore Medicare costs) by 20% to 25% or, the more likely scenario, pay hospitals and physicians significantly less.

What will that look like for physicians in California? More like a "MediCal For All."

Marc Kobernick, MD, Chief of Staff

SHARP Grossmont Hospital

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