The Patient Communication Consult Service: Facilitating Communications for All Clinicians
“Good catch!”

That term may remind you of snagging a fly ball on the baseball diamond, or saving a fragile item from a potentially disastrous plunge to the floor.

When it comes to hospital safety, a “good catch” can take many forms—from an idea that makes a routine process safer to the spotting of an inadvertent error regarding a patient’s care. All contribute to making MedStar Washington Hospital Center a high reliability organization (HRO), one that strives to avoid catastrophic incidents, despite the inherent risks and operational complexities of our work environment.

Due to the talents of its physicians and staff, and protocols that are continually evaluated and refined, we already have the building blocks of an HRO culture. Yet there is always room for improvement, because people—regardless of their training or experience—make mistakes.

Last year, we received about 8,000 RL Solutions patient safety event (PSE) reports, of which only a very small percentage were recorded as having resulted in harm to patients. Regardless of circumstances or severity, each report is investigated, analyzed and acted upon, as appropriate. The PSE review process is not intended to point fingers or damage reputations. We want to fully understand the “how” and “why” of each incident, and more importantly, what can be done to prevent it from reoccurring.

While every PSE report that leads to improvement is beneficial, our “good catches” are particularly worthy of celebration. Here are some examples from the past year:

• During a dietitian’s visit for nutrition risk screening, a patient remarked that she had experienced headaches; the result, she thought, of not having received her home antihypertensive medications since admission. When the patient reached into her purse for her medicine bottles, the dietitian politely asked her to wait until her physicians had reviewed and ordered her medications, as home medications are sometimes temporarily discontinued during a hospital stay. The dietitian notified the unit’s Patient Care Manager and the patient’s nurse, so that they could promptly follow up.

• An elderly patient was admitted for exacerbation of congestive heart failure. The pharmacist received a paper order for Argatroban Protocol Warfarin Conversion. Reviewing the medication profile, the pharmacist found no indication for Argatroban, and immediately paged the physician to verify the order. The physician responded that the patient should not be on Argatroban or Warfarin; the order had been written for the wrong patient. The order was corrected.

• A hospital transporter noticed that an oncology patient with a left ventricular assist device (LVAD) had been admitted to the oncology unit, 5E, which is not specifically designated to care for LVAD patients. The transporter informed the patient’s nurse of the situation, and arrangements were made to have the patient transferred to 3NW, a MedStar Heart & Vascular Institute unit capable of providing LVAD care. The LVAD team and staffs of 5E and 3NW worked together, to create and carry out a unique plan of care for the patient.

These and other incidents from across the hospital have two things in common—someone took the time to log into StarPort, and enter the incident into RL Solutions, our Patient Safety Event System, and the incident was investigated. The third example became the basis for the December Safety Pearl, used to broadly educate the hospital community about LVADs.

We realize that every physician’s time is precious, and that s/he may question whether entering a safety event report is a worthwhile use of that time. I believe that it is. Let me again assure you that each PSE report does receive attention, and that what we learn does make a difference. Please help us to progress on our HRO journey. Enter PSE reports, and make our hospital an ever safer place.

Karen L. Jerome, MD, FACP, is vice president, Quality, Safety & Risk Management. She can be contacted at 202-877-6127.
The recent December holidays were extra-special for Barbara Lott. For the first time in several years, the 68-year-old Washington, D.C., resident cooked dinner and pies for her family and friends, free of the osteoarthritis pain in her knees that had kept her from standing unassisted even for short periods.

Mrs. Lott’s pain-free celebrations were the result of a simultaneous total knee arthroplasty for bilateral osteoarthritis and windswept deformities, performed a few months earlier by Savyasachi C. Thakkar, MD, a specialist in hip and knee reconstruction surgery at MedStar Washington Hospital Center.

During the past 14 years, right knee pain that Mrs. Lott had originally attributed to simply “being on my feet a lot” had worsened. Over-the-counter medication, physical therapy and cortisone injections had failed to provide sufficient pain relief, and the condition eventually spread to her left knee as well.

Although Mrs. Lott wanted to stay active and do as much as she could, the spring of 2017 found her with both knees now deformed by pain. Dependent on a rolling walker to get around her house, she began to have doubts whether her condition would improve—to the point where she considered skipping her appointment with Dr. Thakkar.

But it’s a good thing she went. Dr. Thakkar conducted a physical exam and X-rays to determine the extent of knee deformation, and range of mobility.

“The initial results, plus her overall good health, made Mrs. Lott a potential candidate for a bilateral simultaneous total knee arthroplasty,” Dr. Thakkar explains. “But, we still needed to confirm that her knees had retained adequate strength to make the procedure viable.”

Three months of prescribed physical therapy confirmed that both knees were strong enough for the surgery. That’s when Dr. Thakkar recommended performing the arthroplasty on both knees in the same surgical setting.

He explains that the approach, though uncommon, offers many advantages over sequential procedures for a select group of people with significant deformities.

“Along with reducing risks of infection and multiple exposures to anesthesia, a simultaneous procedure allows patients to get a head-start on their recovery program, and regain their mobility sooner,” Dr. Thakkar says.

Mrs. Lott underwent radiographic templating to determine the desired amount of correction for each knee, and guide the arthroplasty surgery, which lasted approximately three hours. No issues or unexpected conditions were encountered during the procedure. Indeed, the most surprised person was Mrs. Lott herself, who awoke from anesthesia with minimal post-operative pain, and was delighted to see that her knees were no longer deformed.

Mrs. Lott’s recovery unfolded exactly as planned.

“Within six weeks of her surgery, Mrs. Lott could walk short distances without a walker,” Dr. Thakkar says. “Three months post-surgery, she could walk unassisted. Her overall health also improved along the way.”

Though pleased with Mrs. Lott’s outcome, Dr. Thakkar says bilateral knee osteoarthritis is best treated as early as possible to alleviate pain and preserve as much mobility as possible.

“Although it is not always possible to prevent advanced conditions resulting in deformed knees,” he adds, “there are surgical options that, in many situations, can fully alleviate the pain and other symptoms that accompany osteoarthritis.”
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A care mistake was made. Your patient was harmed. You know you should respond in a timely, empathetic, patient-centered manner, but you’re not sure about the best way to disclose the information to the patient and family.

The Patient Communication Consult Service is ready to help you.

“Apologizing about a complication is not admitting guilt, that you did something wrong, and it is not inviting a lawsuit,” says Karen Jerome, MD, FACP, vice president, Quality, Safety & Risk Management at MedStar Washington Hospital Center.

“Traditionally, physicians may not have been as transparent as we should have been about unanticipated outcomes, but with the PCCS, we now have a way to teach clinicians the ‘right way’ to share information and apologize, and to answer questions from the patient and family.”

A cohort of 18 physicians began training last fall, to learn how to set the tone for and conduct disclosure meetings, and to become mentors for other members of the Medical & Dental Staff. The PCCS training included actors, who took the cohort through set scenarios. The actors provided a wide variety of reactions that providers might encounter during a real disclosure session, says Dr. Jerome. “That way, we were able to frame the follow-up discussion, and really get into how to approach a delicate and potentially tricky conversation.”

One of the participants was Alex Pratt, MD, who serves as PCCS champion. As a critical care provider, she often has to disclose difficult information to families. Dr. Pratt has found that “a lot of reaction depends on how you deliver the information. You can’t change the outcome of what happened, but you can change the way that people process it.”

“How you present—your body language and tone of voice—are more important than the words you use,” she adds. “The way you stand and speak can elicit defensiveness, hostility and anger, or it can demonstrate to the family that you are being open and honest, and are sincerely sorry for what happened.”

The most common reason for the failure of a disclosure is a lack of planning, states Melanie Osley, RN, MBA, director, Patient Safety & Risk Management. “Doctors should discuss the situation with everyone who was involved, and agree on...
“A lot of reaction depends on how you deliver the information. You can’t change the outcome of what happened, but you can change the way that people process it.”

all the facts. You should identify the main communicator for your team, and solicit views from the other members of your team. They can help anticipate questions that may come up, such as ‘who is to blame’ and ‘who is going to pay for this’? And everyone should agree that the goal of the conversation is to help the patient and family.”

Osley cites a case she was involved in at another hospital:

A cardiac patient was having a treadmill stress test. The treadmill malfunctioned, throwing the patient to the floor. She began to have chest pain, and was transported to the Emergency Department. Her chest pain was determined to be benign, but her ankle was badly fractured.

During the subsequent hospital investigation of the incident, it was found that the treadmill had not been properly serviced to maintain correct performance, and that it had malfunctioned at other times. The patient was given the results of the investigation, and received an apology from the hospital. Her bills were waived. The hospital provided at-home physical therapy and the proper equipment for her exercises, and she was given transportation to and from follow-up visits to the hospital.

“The patient said she didn’t want what had happened to her, to happen to anyone else,” Osley states. “But the way the hospital handled her case made a difference: she didn’t file a malpractice suit, and the hospital didn’t incur litigation expenses. While the hospital did pay for the patient’s care, physical therapy and transportation, the resolution was faster and more cost-effective than litigation, which could have dragged on for years.”

While physicians can expect an emotional response to disclosure—crying, anger, denial, fear—physicians should resist any urge to “fix” the situation, and remember to document the disclosure when it’s completed. “If the situation becomes abusive or violent, it should immediately stop, and everyone should regroup,” says Rachel Miller, MHA, CPHQ, quality project manager, Infection Prevention & Patient Safety. “It’s good to remember that one of the physicians on the PCCS is always on call and available to help, either by phone or in person.”

Another training session with a new cohort is planned for the spring, Miller says. Dr. Jerome adds that she’s heard from chief residents that they would be interested in providing disclosure training to residents. “We hope to provide training sessions on a regular basis, working to make as many providers as possible comfortable with performing excellent disclosures, learning the process,” Dr. Jerome says.

The PCCS has also developed a brochure that’s available for all providers. It shares details about situations in which disclosures are appropriate, and provides a basic framework for disclosures. It also explains how providers can reach a PCCS member for advice, support and whatever help is needed for planning and carrying out a disclosure.

While not the main goal for the PCCS, Dr. Jerome says a properly handled disclosure can lessen a patient’s intent to sue. “Patients and families often cite the perception that the truth was hidden from them. Providing them with truthful information, emotional support, an apology and a follow-up—which may or may not include compensation—makes this a much better process for our patients and our physicians. It’s the right thing to do.”
Why Providers Get the Second Degree

The Intersection Between Medicine and Business

As health care increasingly becomes a commodity in the marketplace, many clinicians have recognized the value of a business degree. So despite their busy schedules, they have carved out time to pursue a Master’s degree in Business Administration, Public Health or Healthcare Administration.

Why did they feel the need for an additional degree?

“I always thought that having a better grounding in understanding the business of medicine would be helpful for the job,” says Jeffrey Dubin, MD, MBA. He completed his MBA in Medical Services Management in 2010, as part of a Johns Hopkins program offered in D.C. Dr. Dubin is now chair, Emergency Medicine.

“I wanted something broader, a bigger picture, not just from the patient’s point of view,” says Jessica N. Fields, MD, MBA, MHA. She completed a joint MBA/MHA at the University of Maryland in 2013. Once a hospitalist in Cardiology, she is now a physician advisor, part of the Clinical Resource Management team and Medical Affairs.

“I felt woefully inadequate in my understanding of business, especially as health care delivery became more complex,” says David Song, MD, MBA. He completed an MBA program at the University of Chicago in 2009, where he worked before joining MedStar a year ago. Dr. Song now serves as Washington Regional Chief of Plastic Surgery.

“I thought a lot about policy direction throughout my training and career, and I was interested in adding it as a component to my clinical training,” says Brian Lee, MD, MBA. He also completed the Johns Hopkins program in 2010. He is a Surgical Critical Care attending, and led efforts to transition an Intermediate Care Unit to a new Intensive Care Unit, and then develop a NeuroICU.

“I wanted to move from a purely clinical position to an administrative position as I got older, and I was interested in management and process improvement,” says Kristen Nelson, ACNP, MBA. After finishing the Johns Hopkins program in 2010, she became the chief Advanced Practice Clinician in Surgical Critical Care.

What specifically does an MBA or related degree add?

Leadership

All have assumed greater leadership roles since they got their degrees, both in their clinical fields and on various hospital committees. Dr. Lee made the transition from individual responsibility to team responsibility, using leadership skills
Dr. Song touts the ability to empower every individual on a team. “We follow the Toyota® example, empowering everyone on the team to ‘pull the cord’ to stop the process whenever something has gone awry.”

Process Improvement
As physician advisor to the administration, Dr. Fields spends her days working to reduce lengths of stay, improve throughput and optimize billing. She has been in her current position since May 2015, and finds her MBA invaluable in every aspect of her job. “I act as a consultant, to help determine the best way to abide by healthcare regulations and enhance hospital operations, while improving patient care and our financial outcomes.”

Dr. Song notes that health care has been traditionally slow to adopt process improvement. “It used to be thought that doctors knew best. During the last couple of decades, health care delivery has become not too different from other processes. The patient comes through the outpatient clinic, and then goes on to surgery and inpatient care. We need to understand each component to monitor the flow.”

Communication
APC Nelson finds that her ability to synthesize and present information, courtesy of her MBA training, has been invaluable. “The business training helps me in planning and preparing for change. I know how to do all the background work that is needed, and then put together a thorough, clear presentation,” she says.

Financial Know-how
Knowledge of accounts receivables has helped Dr. Dubin manage Emergency Medicine more efficiently. “We have to fight for reimbursements. I know what the revenue cycle means, and why it’s important.”

Dr. Song has found that an awareness of costs impacts utilization. “If I give you a MasterCard® and say go grocery shopping, you won’t be price shopping. It’s the same thing in health care. If you don’t have ownership about what you use, coupled with an ignorance of what something costs, there is tremendous waste.”

Dr. Lee calls this process “seeing the financial realities from 30,000 feet.”

Time Management
If these clinicians didn’t have good time management skills before completing their business degrees, they certainly had it afterwards. All continued their full-time clinical duties while attending classes. Each had to shuffle their clinical schedule to accommodate class time. And then, there was the reading and homework between classes to squeeze in.

“The program moved at a quick pace,” Dr. Dubin says. “There was definitely a time management issue.”

Dr. Song brought those time management skills to bear in his own practice. He noticed that his patients were randomly assigned to open slots in the schedule, regardless of the reason for their visits. By changing his practice to see return visits at the start of the day, he was able to significantly reduce wait times throughout the day while still seeing the same total number of patients. “You eliminate the domino effect when you run late,” he says.

Would they recommend business school to others?
Dr. Dubin gives a qualified yes. “If you want to move into management, it does help.

The trade-off is the time and expense. You can’t predict the return on investment, but it does give you more job opportunities.”

Dr. Fields states, “If your interest is in taking care of patients, it may not be for you. If you’re interested in the global aspect of medicine, this is for you. I can make a difference of a different scale.”

“If you want to become learners in health care, business school ‘makes you think differently,’” Dr. Song notes.

Dr. Lee presents the final word. “I think the one thing in common between me and my classmates is that what we did with the MBA didn’t matter. We all felt we were cogs in a much bigger machine. It’s nice to know how we fit, and why we do what we do. Unless you know what’s going on, you can’t make changes.”
Busy Residents Still Find Time to Volunteer

With long work weeks and often unpredictable schedules, residents may feel they have few hours to themselves, much less time to give to others. But two residents at MedStar Washington Hospital Center have carved out time to volunteer in the community.

Nam Tran, DPM, has a volunteer’s heart. From college on, he has found opportunities to give back to the Asian American community. By volunteering, he honors his Vietnamese heritage, and encourages young people to follow their dreams.

“Growing up as an Asian American, I didn’t have many outlets to explore my culture,” Dr. Tran says. Now a second-year resident in Podiatric Surgery, he is active in Asian American Youth/Leadership Empowerment and Development. AALEAD is an organization that supports low-income and underserved Asian Pacific American youth with educational empowerment, identity development and leadership opportunities through and after school, summer and mentoring programs. AALEAD is primarily a mentorship program, but Dr. Tran serves the organization by setting up events that focus on empowerment.

“My main focus is to make sure that no matter what background young people come from, they can achieve whatever dreams they aspire to,” he says. “I go to after-school programs and talk to students. Right now, I’m setting up a talk on cultivating a successful mind set for the future. I want to help them to feel empowered to chase after their dreams.”

While still in college, Dr. Tran volunteered at a children’s hospital. In medical school, he volunteered at the Vietnam Heritage Center in New York, working at events that targeted the Asian community. Now he finds time to volunteer whenever he can, despite his busy hospital schedule. During his first year of residency, he had no time to spare, but this year, he has found opportunities. “It depends on the rotation, how much spare time I have,” he says.

Throughout his career, he has also volunteered at health screening events, particularly those that target underserved populations. But he saves most of his spare time for non-medical volunteerism. “I get a different sense of fulfillment from volunteering outside of medicine,” he states. “For my career, I am doing something to make my own aspirations come true, but I am serving myself.”

“The only way to get a true sense of fulfillment is from serving others,” he continues. Still, it has its benefits on the career side, too. “I’m more empathetic with patients, as a result of volunteering.”
Lindsey DeGeorge, MD, is busy as a third-year resident in Emergency Medicine, but she still squeezes in time to serve others outside the hospital. Most times that volunteer work occurs in Miriam’s Kitchen, a soup kitchen in Foggy Bottom, near where she lives. But other times, it takes her as far away as Africa.

“When I started my internship, I wanted to volunteer,” she remembers. “I needed an organization with a flexible schedule.” Miriam’s Kitchen filled the bill, and now she works a three-hour shift once a month preparing food for the District’s neediest citizens.

“I've really enjoyed it,” Dr. DeGeorge says. “I see a lot of people I don’t usually see. And sometimes I even see someone who has been my patient.”

Her volunteerism works both ways, as she sometimes recommends Miriam’s Kitchen to a patient in need. “One time, I had a patient whose only complaint was that he was hungry. I knew where to send him for a good meal.”

She likes the immediate gratification of volunteerism. “Sometimes in the hospital, patients don’t seem very appreciative of the services they receive,” she says. “At Miriam’s Kitchen, I can see the impact of what I do right away. It reinforces why I like my job; we get to help people. It also makes me a little more empathetic with patients who don’t have resources available to them.”

Dr. DeGeorge spent November in Zambia, working at a missionary-run hospital in a small village. The program is sponsored by the hospital’s emergency residency program, which sends one resident a year to the village.

“Basically, I did a little bit of everything,” she says, “covering inpatient wards and outpatient visits. It was an incredible experience, and a big contrast to the way we practice medicine here. Some days we couldn’t get lab work done, and we routinely ran out of medicines we needed, including antibiotics.”

Her experience was well worth it, she says. “Patients had no expectations; everything you do is beyond their expectations. They were incredibly grateful.”

At times, it was also frustrating. “I knew what I would do for patients in the U.S., but it wasn’t available in Africa.”

Dr. DeGeorge highly recommends volunteering to other residents. She grew up volunteering with her family, church and school. She urges others to find time in their schedules to support a cause they believe in. “It’s a great opportunity to make an impact. You learn a lot, and help serve a huge need.”

“‘I can see the impact of what I do right away. It reinforces why I like my job; we get to help people.’

Lindsey DeGeorge, MD, recently volunteered at Mwami Adventist Hospital in a small village in Zambia.
If you’re searching for “Dr. Hampton” in the MedStar directory, you need to be sure you know which Dr. Hampton. There are two of them, and they have similar names—Daniel Hampton, MD, and David Hampton, MD. Both specialize in Orthopaedic Surgery, and both graduated from Georgetown University’s School of Medicine.

And oh yes, they’re brothers.

But the similarities end there. At least, they think so.

“Some people say we look exactly alike,” says Dr. David Hampton, the younger sibling by three years, and an attending orthopaedic surgeon at MedStar Washington Hospital Center. “Others say, not at all.”

Part of the discrepancy is likely due to the younger Dr. Hampton being 6’8” tall, while his older brother self-deprecatingly claims to be “six feet on a good day.”

Along with birth order, though, Dr. Daniel Hampton has the edge when it comes to professional titles. He chairs both the Surgery and Orthopaedic Surgery departments at MedStar Southern Maryland Hospital Center. He’s also part of MedStar Orthopaedic Institute’s sports medicine team, and the chief medical officer/team physician for D.C. United.

Dr. David Hampton, who joined the Hospital Center’s staff last year, focuses on Orthopaedic Trauma cases.

To answer that question, it helps to learn a little about the brothers themselves.

Both describe their sibling relationship as being fairly typical. While their age difference placed them in different school classes and peer groups, backyard games of basketball and other sports occasionally took on a competitive air. Older brother Dan usually came out on top, but that changed when he went off to college at UC San Diego.

“About the time I got physically able to compete, he was gone,” David says, adding that he also experienced a multi-inch growth spurt.

Dan counters that up to that point, he had prevailed mainly because David perceived himself the physical runner-up.

“It was a sad day when he realized that wasn’t the case,” he says with a laugh.

A visit to Georgetown University led Dan to begin his medical studies in the Nation’s Capital, staying on for an orthopaedic residency at MedStar Georgetown University Hospital. David didn’t intend to follow his brother East, having opted to attend medical school closer to home after graduating from UCLA.

But an 11th hour selection on MedStar Georgetown’s wait list changed his mind.

“We were both married at the time, and our wives were friends, and liked the area,” explains David, who has since divorced. “Since Dan’s residency would coincide with my training, it really seemed like the best thing to do.”

David admits that his brother had a little more influence on his choice of specialty. Intrigued by sports medicine during his third year of medical school, Dan went on to complete a fellowship specializing in sports medicine/knee and shoulder surgery at Brigham & Women’s Hospital in Boston. While there, he also taught Harvard University orthopaedic residents and medical students.

For David, pediatrics initially appeared to be an attractive career destination.

“We saw each other weekly during my third-year rotations,” he recalls, “Dan talked about his orthopaedic residency, which did sound interesting. But here I was, trying to be thoughtful about this life-altering choice, and he says he decided after thinking about it for only a couple of weeks!”

While Dan recalls sharing his enthusiasm for orthopaedics, he credits his brother for figuring things out on his own.

“He saw that I liked it, and probably found it interesting,” he says,
“but he didn’t follow me just because I was doing it.”

Indeed, David says the orthopaedic surgery rotations were the clincher.

“It was exciting,” he says. “I knew right then that this was what I wanted to do.”

David went on to complete his residency at Albert Einstein Medical Center in Philadelphia, and then a fellowship at Cedars-Sinai Medical Center in Los Angeles. Meanwhile, Dan returned to the D.C. area to join a private practice, which joined MedStar a few years ago.

The brothers hadn’t planned on yet another D.C.-area reunion, but Dan encouraged David to apply for an opening at the Hospital Center. “I interviewed, and felt that the program here was a good fit,” David says, adding that the possibility of Sunday night dinners with his brother’s family was a good incentive, as well.

Although their respective specialties and locations leave few opportunities for the brothers to cross paths professionally, they do consult with each other from time to time.

“Dan will send a patient to me with a more involved fracture, or we’ll ask each other about certain conditions we’re seeing,” David says.

Both agree that since he is single, David enjoys a more varied social life.

“I have four kids,” Dan says. “Any spare time I get is usually spent wishing I could have more of it.”

Still, the brothers do manage to get together whenever possible, to enjoy outdoor activities, such as a weekly meet-up for indoor climbing.

“There’s a fair amount of shop talk when we get together, because we both know the same people,” Dan adds, noting that it’s just as well to have some degree of separation from his “little” brother.

“We’re in different offices,” he says, “which, knowing how we are, is probably a good thing!”
MEDSTAR CONFERENCE HIGHLIGHT

Breast Cancer Coordinated Care (BC3)
March 1-3 | Grand Hyatt | Washington, D.C.
Conference Co-Chairs: Shawna C. Willey, MD | David H. Song, MD, MBA

This three-day symposium will evaluate and discuss different models for coordination of breast cancer care from major centers across the United States. The meeting’s intent is not only to educate the faculty and attendees about the wide range of options available for breast cancer coordinated care, but also to encourage the development of more standardized treatment strategies and protocols for the local treatment of breast cancer.

For more information and to register, visit www.BC3conference.com

UPCOMING CME EVENTS

Diabetic Limb Salvage Conference
April 5-7 | JW Marriott | Washington, D.C. | www.DLSconference.com
Course Chairman: Christopher E. Attinger, MD | John S. Steinberg, DPM
Course Co-Directors: Cameron M. Akbari, MD, MBA | Nelson L. Bernardo, MD | Karen F. Kim Evans, MD | J.P. Hong, MD, PhD, MBA | Paul J. Kim, DPM, MS | David H. Song, MD, MBA

Adult Congenital Heart Disease in the 21st Century
April 13-14 | College Park Marriott | Hyattsville, Md. | cme.medstarhealth.org/ACHD
Course Co-Directors: Anitha John, MD | Melissa Fries, MD

Frontline Cardiology: Cardiovascular Care in the Community
April 21 | College Park Marriott | Hyattsville, Md. | cme.medstarhealth.org/FRONTLINE
Course Directors: Allen Taylor, MD | Carolina Valdiviezo, MD | Sriram Padmanabhan, MD | James C. Welsh, MD, MBA, MPH
Course Co-Director: James C. Welsh, MD, MBA, MPH

Prostate Cancer 2018
April 28 | Omni Shoreham Hotel | Washington, D.C. | cme.medstarhealth.org/PROSTATE
Course Co-Directors: George K. Philips, MD, MBBS, MPH | Ross E. Krasnow, MD, MPH

The 13th Annual Georgetown Meeting on Gastrointestinal Endoscopy & Pancreatobiliary Surgery
May 5 | The Ritz-Carlton | Washington, D.C. | cme.medstarhealth.org/GIDISEASE
Course Co-Directors: John E. Carroll, MD | Thomas M. Fishbein, MD | Nadim G. Haddad, MD

MedStar Georgetown Transplant Institute Symposium
May 19 | Bethesda Pooks Hill Marriott | Bethesda, Md. | cme.medstarhealth.org/MGTI
Course Co-Directors: Thomas Fishbein, MD | Matthew Cooper, MD | Basit Javad, MD, MS | Stuart Kaufman, MD | Rohit Satoskar, MD

Abdominal Wall Reconstruction Conference
June 7-9 | Grand Hyatt | Washington, D.C. | www.AWRconference.com
Course Director: Parag Bhanot, MD

For more information regarding MedStar Health conferences, please visit cme.medstarhealth.org

CME Transcripts are Available Online
You can download, print or e-mail your CME transcript. Visit cme.medstarhealth.org and click on “View Your CME Transcript” for complete instructions.
What would you come up with? Cancer? Heart attacks? Diabetes? These are all good answers, but what if I told you that you were missing one of the most important diseases in America?

The disease I’m talking about is traumatic injury. And chances are, you didn’t mention it, because you don’t think of it as a disease. Most of us are accustomed to thinking of injury as something that just happens…an event. Because we think of it as somehow separate from other health issues, it tends to get left behind when we prioritize health problems in America. This happens when families consider their biggest health risks, and it also happens when lawmakers decide which diseases need funding.

Medical experts used to think this way, too. But around the 1970s, physicians realized that trauma followed all the rules of other diseases. For example, there are predictable risk factors. Just as smoking is a clear risk factor for lung cancer, alcohol abuse is a risk factor for injury. After injury occurs and is treated in the hospital, there is a risk that it will recur, just like a cancer that has been removed.

And, like someone with diabetes, injury doesn’t just kill, it changes the life of those who survive, affecting school, work, relationships and happiness. Disability among brain injury survivors costs society $77 billion per year, according to the Centers for Disease Control. The overall cost of injury each year in America is closer to $450 billion. Most importantly, like other diseases, injury can often be prevented with a combination of smart life choices and good public health.

How important is trauma? To start with, it’s the biggest killer of people younger than 45 years of age. More young Americans die from injury than cancer, heart disease, congenital defects or infection. Think of people in your life who tragically passed away at a painfully early age. Many of them were likely victims of injury. The fact that trauma often happens to young people has important consequences in public health. It means that more years of life are usually lost when someone dies from injury than from, say, heart disease. If you add up all the years of life lost in America due to traumatic injury, it’s more than any other disease, including heart disease and cancer.

Around the world, the problem is even worse. About five million—yes, that’s right—five million people die each year from injuries. That’s one every five seconds, and that’s more than malaria, tuberculosis and HIV/AIDS combined.

I think part of the problem is that the word “trauma” is a bit confusing. Many of us think of “trauma” as having to do with emotionally difficult events, or really anything bad that happens to us. Technically, “trauma” (or “traumatic injury”) refers to any instance where an external force causes damage to the tissues of the body. I think “injury” often does a better job as a label, but I think for now, we are stuck to the words we have.

There’s no reason we need to accept these numbers. As long as there are wars and cars and stairs and tall buildings, people will likely die from injury. But we can do far better. Compared to other diseases with far less impact, trauma is underfunded at local, state, and national levels. We need more research on preventing injury, surviving it when it happens, and rehabilitating the victims. There is room to do more education, too. Every American should understand the basics of bleeding control, just like they should know CPR. The American College of Surgeons’ STOP THE BLEED program is a great example of this type of education.

We at MedStar are always working to fix broken bodies and also to raise public and legislative awareness of this problem. The next time you are thinking of what disease to tell your kids about, or what to write a letter to your representative, or where to focus your family’s charitable contributions, don’t ignore what just may be the most important one of all: trauma.
Sometimes in life, even when we know what we’re capable of, it takes another person calling us “chicken” to propel ourselves forward toward greatness.

At least, that’s the loving reminder that Meghan MacCleary, DO, gets from a family friend every holiday. And Dr. MacCleary, now chief resident for Obstetrics & Gynecology, doesn’t disagree.

“It was the motivation I needed,” she says with a laugh, remembering a “tough love” conversation she had about attending medical school with her best friend’s mom, who is a nurse. “I wanted to go, but I was afraid of the MCAT. She knew I was up for the challenge.”

Deep down, Dr. MacCleary knew she was indeed up for the challenge. In fact, she’s always been attracted toward a challenge—whether in sports or life. Given her interest in sports, she studied physical therapy at Arizona State University, and entered Arizona College of Osteopathic Medicine at Midwestern University, thinking she might pursue orthopaedic surgery.

But in year three of medical school, she had an Obstetrics/Gynecology rotation—and knew it was the right path for her.

“I fell in love with the fact that you get to treat a patient and follow that patient, and have the honor of being present on the most important day of somebody’s life,” Dr. MacCleary says. “Not only do you get to deliver babies, but you also become a part of patients’ families through office visits.”

Dr. MacCleary knew she was ready for a change of scenery and a bigger challenge when she applied for residency, since she was raised in Phoenix, and stayed in Arizona for both college and medical school.

“I wanted to participate in a program that would challenge me every day, and mold me into the kind of independent doctor to whom I’d want to refer my own family,” she said. After some research, MedStar Washington Hospital Center was the obvious choice.

Now, about halfway through her chief year, Dr. MacCleary notes that it’s been a roller coaster ride, but a fun one. “I’m probably one of those people who would say, overall, I enjoy residency,” she laughs. “I like the challenge and pace of every day, and the people and patients are amazing. I’m really lucky.”

“To go from the role of learning procedures and mastering them, to being able to teach the procedure to younger residents—for me, that’s been very humbling,” adds Dr. MacCleary, who notes that, on most days, she’s just paying it forward. “Every day, I think of the chiefs I’ve had. My chiefs took the time to explain things, and give me opportunities.”

During her residency, Dr. MacCleary went on several mission trips, including two to Honduras. “What struck me about how great the trip was, was it really allowed me to reconnect with why I went into medicine. We got to truly help people who needed care and surgery, and they were incredibly grateful and amazingly strong. They never complained about post-op pain, and were up walking immediately. Everyone on the team did whatever job needed to be done, to provide care, including wiping down the room for turnover, moving patients and packing cleaning supplies.”

As Dr. MacCleary plans for life beyond residency, she has her eye on an attending role at a large tertiary care facility. Again, she credits incredible role models at Hospital Center for showing her the way. “Our attendings let us challenge ourselves and struggle. As a chief, I now realize that watching others struggle requires more patience. That’s one thing I’m learning to do and hopefully, someday, I’ll be as good as our attendings.”
Within a hospital, patient care is often delicately balanced between two critical roles—doctor and nurse. They weave together the bedside and the clinical, the curative and the holistic. For Shannon Burton, ACNP, marrying those two schools of thought into her role as a nurse practitioner has offered her the opportunity to take the best from both specialties—for the benefit of her patients.

“The nurse practitioner role really merges medicine and nursing—medicine’s curative care with nursing’s holistic care,” says Burton, who joined MedStar Washington Hospital Center’s Comprehensive Stroke Center nearly four years ago, after spending a decade as a neuro-intensive care unit nurse. “I can offer appropriate medical management, but I’m still putting on my nursing hat, and remembering how to care for the patient.”

For Burton, putting on her nursing hat might mean ensuring that other teams are involved in the patient’s care, beyond the medical next steps. Her ten years at the bedside also means she’s not shy about showing a nurse how to do an assessment.

“I loved the bedside,” Burton says. “So being able to still increase my skill set, but also keep those fundamental skills that you learn as a nurse—the caring part—has been critical. Sometimes you need to draw blood, and to still be able to do that and gain advanced assessment skills has helped merge both worlds together, which I love.”

Burton has spent her entire career working in neurological intensive care. A choice of specialty, she says, comes down to the unique challenge offered by neurology. “No one patient is ever the same,” she says of her patients.

“With a stroke, everything happens in an instant. One minute they’re fine, and the next they can’t speak,” says Burton, who speaks of a family history of strokes—her own personal connection to her specialty. “But you also see people who are devastated by stroke, and then you see them come back and say hello, and they’re walking and talking.”

Burton says that, in addition to taking on the additional responsibilities of nurse practitioner, arriving at Hospital Center almost four years ago felt like the culmination of all of her training. “Working in a hospital outside of MedStar, other nurses used to tell me, you’re not really a real nurse until you work at the Hospital Center.” In part, it was that call for a challenge that drew her to the Hospital Center, and the lore did not disappoint her, she states.

“We take care of some of the sickest of the sick, and some of the most underserved,” Burton says. “That’s what touches my heart the most. For me, this truly was the next level of nursing. We have a comprehensive stroke center, more advanced technologies and therapies, cutting-edge research and an entire team working together to make that patient better.”

Burton is effusive about her team and the leadership of Dr. Amie Hsia and Dr. Richard Benson. “We are a dynamic group of people who really want to do the best in stroke care for our patients,” she says. “And our team is here 24-7.”

But when Burton gets some time away from the hospital, she follows her love of traveling, and a love for baking. Her most recent trip was to Abu Dhabi, United Arab Emirates, “which was fun,” and she plans on expanding her list of destinations to visit.

For her culinary efforts, she’s perfected a “chocolate on chocolate cake,” thanks to her colleagues, who serve as her focus group—“my guinea pigs”—for any improvements. Cake decorating classes are next on her baking agenda, but she’s not yet ready to take orders from others at the hospital.
Physician’s Perspective

From the Desk of...

Stuart F. Seides, MD
Physician Executive Director, MedStar Heart & Vascular Institute

MedStar Heart & Vascular Institute (MHVI) has grown tremendously since its inception in 2011, far exceeding our expectations in every area. We’re one of the busiest cardiac programs in the nation, nationally ranked by U.S. News & World Report, with more than 2,300 open heart surgeries each year, more cardiac catheterizations than any other heart center in the area, an extended cardiac electrophysiology network and a host of other highly specialized services.

This is one of the great successes in developing “systemness,” integrating the care process across the MedStar system with shared protocols and expertise and an uncompromising focus on quality and safety. Our highly regarded cardiology and cardiac surgery departments consist of physicians who were both in private practice as well as employed faculty. Our first task was to sew all these pieces together under one roof. Initially, this included physicians and facilities in the Washington, D.C. hospitals, but has grown to include the Baltimore region as well.

An important catalyst was the formation of our clinical and research alliance with the Cleveland Clinic, which brought together two of the nation’s premier heart programs. The incorporation of our highly energized Vascular Surgery program has been a natural fit. More recently, the cardiovascular providers within MedStar Medical Group came under our umbrella, advancing the goal of a true Distributed Care Delivery Network for our specialties.

To use our resources wisely, we’ve concentrated many of our advanced imaging, surgery and interventional cardiology services at MedStar Washington Hospital Center. However, we are also working to integrate and further expand advanced services at MedStar Union Memorial Hospital, as our cardiovascular hub for the Baltimore community.

Any center is only as good as its people, and we’ve continued to recruit the best and brightest physicians, APCs, RNs and technologists in every discipline. Robust educational and research activities remain critical to our goal of remaining on the “cutting edge” of clinical and academic medicine.

Our collaboration and willingness in coming together under MHVI has allowed us to build strength upon strength. MHVI is working to optimally position ourselves as health care moves from volume to value, and remain both the “go-to” cardiovascular resource in our region and a major thought leader across the globe. For more information, please call my office, 202-877-2851.