Highest Honors to Drs. Priebat & Peterson

Dennis Priebat, MD, director, Medical Oncology, and Stephen Peterson, MD, chair, Psychiatry, are the 2015 Gold-headed Cane Award winners.
The phrase isn’t just for your use when you see a security issue that should be reported to police or other officials. “See something, say something” should be acted on every day at MedStar Washington Hospital Center.

- We need to say something, any time we see a provider who is not following the “Clean In, Clean Out” policy.
- We need to say something, any time we see someone who did not wash his/her hands before or after seeing a patient.
- We need to say something, any time we see someone breaking sterile conditions near a patient with a central line.

If you’re on the receiving end of what should be a polite, professional encounter, please graciously accept the reminder that excellence in infection control is a hallmark of exceptional practitioners, and is a “patient first” effort. As we work towards being a High Reliability Organization, we need to understand and avoid areas of weakness as well as every unsafe condition.

We shouldn’t have to monitor each other, but daily, throughout the hospital:
- At the start of their shift, providers enter the building, wearing green scrubs.
- Providers are walking through the halls and even to the garage while wearing paper hats, masks and shoe covers.
- Providers are sitting in the hospital cafeteria, taking a break or meeting with colleagues, wearing paper products.

Strong infection control practices also help us, and keep us from spreading disease to each other, to our teams, to our families and to our patients.

Taking Action

Some departments have made patient and provider safety a priority. In the Endoscopy Suite, for example, providers must wear a barrier-proof gown during all endoscopic procedures. Gowns must be changed between procedures, and may not be worn outside of the procedure room.

Gastroenterology Section Director David Shocket, MD, reports that the Association for the Advancement of Medical Instrumentation, the American Society for Gastrointestinal Endoscopy and the Centers for Disease Control and Prevention all have published guidelines for use of personal protective equipment for endoscopic procedures.

“We enforce compliance with wearing a barrier-proof gown, and strongly recommend the use of masks and either eye protection or face shields,” he says. “Anyone who declines to follow the policy is referred to his/her respective department chair for appropriate disciplinary action.”

On the third floor of the hospital, Anesthesiology and Perioperative Services have worked hand-in-hand to make infection control top-of-mind for everyone involved in a surgical or procedural area.

“Numerous professional bodies have published guidelines for personal protective equipment in areas such as the operating rooms and procedure rooms, and we reviewed all of them,” states Greg Argyros, MD, MACP, FCCP, sr. vice president, Medical Affairs & Chief Medical Officer. He can be reached at 202-877-5053 or gregory.j argyros@medstar.net.

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Mary Tastaca, Gastroenterology Technician III, and Gastroenterology Section Director David Shocket, MD, demonstrate the proper personal protective equipment for the Gastroenterology suite.

CHIEF MEDICAL OFFICER

Your New Mantra:
See Something, Say Something™

PHYSICIAN | NOV/DEC 2015
Tears of the anterior cruciate ligament (ACL) in the knee are among the most common sports injuries. While surgical procedures have helped many athletes of all abilities resume their favorite activities, these methods are far from perfect. Research finds, only about 43 percent of high school and college football players who have undergone ACL surgery during the past 10 years have returned to play at their pre-injury level. Thirty percent don’t return at all.

“A conventional ACL repair is better than not doing anything, but there’s just no guarantee you’ll get back,” says Orthopaedic Surgeon Wiemi Douoguih, MD, director of Sports Medicine for Washington Region MedStar Orthopaedic Institute.

What’s more, many people who undergo conventional ACL reconstruction procedures begin to experience painful arthritis-like symptoms in their repaired knees, likely due to the inability of current techniques to completely eliminate rotational and translational laxity. Often, athletes are forced, over time, to give up sports that involve running and jumping.

Kaniya Brown might well have been one of them. Last fall, Kaniya injured her knee while playing for her high school soccer team. An MRI at the Hospital Center confirmed she had a torn ACL.

Dr. Douoguih suggested a new procedure for Kaniya’s knee. Unlike conventional tendon graft procedures, the new approach places FiberTape®, an ultra-high strength, braided suture coated with type 1 bovine collagen, through the repaired ligament to provide additional support. Functioning much like a knee brace, only located inside the joint, the innovative suture also helps patients recover faster.

“If procedure is successful, we’re actually repairing native ligament tissue, and using the FiberTape suture to strengthen and protect it as it heals,” Dr. Douoguih says. “That accelerates the recovery process, because you don’t have to wait for the cells in the tendon graft to die and regenerate.”

Dr. Douoguih adds that while comparisons of the new and conventional procedures are still ongoing, there seem to be few downsides to attempting an ACL repair using the suture in patients with all but the most severe ligament damage.

“In the worst case scenario, if the new procedure doesn’t work, you haven’t caused that much additional damage to the knee,” he says. “You have a good template upon which you can do a conventional ACL reconstruction.”

Two weeks after Dr. Douoguih performed the new procedure, Kaniya was walking and able to return to school. She began physical therapy the following week. A year later, it’s almost like the ACL injury never happened.

“I’m running and able to play soccer again,” reports Kaniya, now a freshman at the University of Maryland-Eastern Shore. “I’m also looking forward to being on the track team when the outdoor season begins in March.” Kaniya hopes to compete in the 200- and 400-meter dash events, and the 4x4 and 4x8 relay events.

She adds that the only injury-related pain she experiences now comes when there’s a change in the weather—a common side effect of many joint surgeries.

“My knee tells me when it’s going to rain,” she says with a laugh. “It’s pretty reliable.”
Stephen W. Peterson, MD

Stephen Peterson, MD, is chairman, Psychiatry at MedStar Washington Hospital Center. He is certified by the American Board of Psychiatry and Neurology in Psychiatry and in Psychosomatic Medicine. Dr. Peterson’s cum laude undergraduate degree is in Philosophy and Religion, and Psychology from the University of Tennessee. His medical degree is from the University of Tennessee Health Science Center. Dr. Peterson’s internship and residency in psychiatry were at St. Elizabeths Hospital, and he received additional advanced psychotherapy training at the Washington School of Psychiatry.

Dr. Peterson is a member of many professional societies and organizations, including the American Psychiatric Association, the Medical Society of the District of Columbia and the American Medical Association. Dr. Peterson has lectured to other healthcare professionals in the region about the impact of depression, violence, alcohol and drug abuse and ethical issues that arise for treating psychiatric patients.

Dennis A. Priebat, MD

Dennis Priebat, MD, is director, Medical Oncology, Washington Cancer Institute, and served as the previous program director for the Hematology/Oncology fellowship program. He is an associate professor of Medicine at George Washington University School of Medicine. Dr. Priebat earned his undergraduate and medical degrees from the State University of New York at Stony Brook. He completed his internship and residency in medicine at the Hospital Center, and completed a clinical and research fellowship in Hematology/Oncology at the University of Utah.

Dr. Priebat is an active teacher and clinical researcher who is involved in trials focusing on new therapies for patients with soft tissue and bone sarcomas, and gastrointestinal stromal tumors. In addition to being a member of the American Society of Clinical Oncology and American Society of Hematology, Dr. Priebat is a member of the Sarcoma Alliance for Research Through Collaboration (SARC) Group, and the Connective Tissue Oncology Society, where he presently serves on the board of directors. Dr. Priebat has continually been listed in Washingtonian and Checkbook magazines as a “Top Doctor,” and has been named a Washington Post magazine “Super Doctor” and a Castle Connolly regional top doctor.
Two long-serving physicians at MedStar Washington Hospital Center were honored with this year’s Gold-headed Cane Awards.

Stephen Peterson, MD, chair, Psychiatry, and Dennis Priebat, MD, director, Medical Oncology, received the awards at a dinner with their colleagues, family and friends.

Dr. Peterson said he was expecting something else when Robert Laureno, MD, chair, Neurology and chair, Gold-headed Cane Award committee, called him to meet.

“I thought Dr. Laureno might ask me to write a keynote speech for the Gold-headed Cane dinner,” said Dr. Peterson. “I didn’t know what to think at first. What an honor to be included with the group of past awardees. They are all high-caliber physicians with wonderful attributes. I will have to try very hard to live up to the ideals of the award, which are ‘devotion to patient care and duty.’ It was also a wonderful treat to receive the award with all of my family present.”

Dr. Peterson called the Hospital Center a “wonderful, miraculous place of healing.” He also thanked his colleagues for care he and his family have received at the hospital.

Dennis Priebat, MD, director, Medical Oncology, said he was very appreciative and surprised to receive the honor, and cited the strong teamwork that was necessary to treat patients with cancer. “We’re all dependent on one another, and we have a multidisciplinary sarcoma team that works closely for every patient.” It was an initial collaboration with retired physicians Martin Malawer, MD, Orthopaedic Oncology, and Barry Shmookler, MD, Pathology, that fostered his interest in sarcomas.

Dr. Priebat thanked the physicians who brought him to the Hospital Center—Drs. Werner Barth, James Curtin, Lawrence Pierce—his current colleagues, Drs. Vera Malkovska, Joseph Catlett, Aarthi Shenoy—and the multidisciplinary tumor group, Drs. Robert Henshaw, vice chair, Orthopaedic Surgery; James Jelinek, chair, Radiology and Dhruv Kumar, interim director, Anatomic Pathology—for their ongoing commitment, expertise and “patient first” approach at all times.
Every triathlete has a disaster story.
For Rocco Armonda, MD, Neurosurgery, it came during his first IRONMAN®. His Neurosurgery boards had interrupted his training, and during the opening 2.4-mile swim, he swallowed a lot of salt water and found himself essentially “trying not to drown.” He did not finish the race.

Nurse Midwife Ginny Lee, NP, was in the middle of a bike training run when a car hit her. She required three surgeries to repair her broken wrist.

The first Sprint Triathlon for Robert Golden, MD, Orthopaedic Surgery, took place in a torrential downpour. “It’s no fun when you’re getting wetter on the run than you are during the swim.”

For Scott Dziedzic, MD, Radiology, the embarrassment was worse than the pain. At the end of a 70-mile ride, just a mile from home, he flipped his bike. “I tried to hop back on, as if nothing had happened, but I couldn’t move my arm.” He had to call his wife to come pick him up.

Yet all four were back to training as soon as possible.

The origins of the triathlon are murky, but in America during the fitness craze of the 1970s, three-part races began popping up in California and Hawaii. The modern triathlon comes in many variations, but each features a swimming leg, followed by a biking leg and finishes with a run. The Olympic race includes an open water swim of just under one mile, a 25-mile bike ride, and a 6.2 mile run. The Ultra distance, commonly referred to as the IRONMAN, raises those standards to a 2.4-mile swim, a 110-mile ride, and a full 26.2-mile marathon run.

Before her accident, NP Lee had been competing happily at shorter distances for 10 years. The accident gave her the urge for a new challenge. Within three months of being hit, she signed up for her first IRONMAN. That began a three year period in which she was selected to compete in the “Best of the U.S.” competition, and qualified for the World Championships.

Now, NP Lee does it more for fun and fitness. “As you age, you have to realize that your days of personal bests are behind you.” But there are always new challenges to be found. This past summer, Lee trained with her older daughter to race in the 2015 Marine Corps Marathon. Her younger daughter competes for her high school cross country team. Both girls were pushed in baby joggers when they were little.

Dr. Dziedzic had always run to keep fit, but when a friend encouraged him to try a triathlon, he thought it would be nice to add some variety to his regimen. If all you do is run, he says, “you’ll break down faster.” In just three years of competing, the radiologist has finished more than 10 races, including two IRONMAN races.

Dr. Golden was also looking for a different way to keep in shape. A family history of Crohn’s disease led him to a group that was training for a fundraising triathlon. He was hooked. Once they begin training, he says, “everybody I know gets bitten by the bug.”

A self-described “newbie” amongst his colleagues, Dr. Golden has made it up to the half IRONMAN level. With two young children at home and a crowded work schedule as an orthopaedic surgeon, he struggles to find training time for
“As you age, you have to realize that your days of personal bests are behind you.” But there are always new challenges to be found.

Dr. Armonda is the one the others look up to. “A legend,” as one of his colleagues called him. But when he started training for his first race, it was primarily because the rigors of medical school and residency had caused his weight to balloon from 170 to 240 pounds. Since he began competing 20 years ago, Dr. Armonda has completed fifteen half-IRONMAN races, in addition to two full races. He has also run in seven marathons. Part of Dr. Armonda’s motivation is fundraising. He has competed on behalf of numerous organizations, including the Wounded Warrior Project® and the Bob Woodruff Foundation. His wife Heidi, also an avid triathlete, has raised more than $10,000 for the Woodruff Foundation.

In addition to the fitness benefits, Dr. Golden says a triathlon is fun, especially for type-A personalities who like to really dig into high tech gear and strategy. It is a complex race. “There is so much to focus on and tweak; an infinite amount of bike gear and computer programs.” His wife thinks part of his love for triathlon grows out the excuse it gives him to buy all those new toys, he says.

Dr. Dziedzic does have a high-tech bike, but says that you don’t need fancy equipment to get started. “The race comes in all sizes. Start small and don’t be intimidated.” He plans to scale back his competition schedule, so he might have more time to teach his young children how to play golf. But, he states, not before possibly competing in a 100-mile Ultra-Marathon next April.

Though he began training with the goal of keeping fit, Dr. Armonda now sees more mental and psychological benefits to his training than even the obvious physical ones. Training “sets your mind free to come up with novel solutions to problems.” He feels mentally sharper when he is regularly training. In fact, he feels cranky when he has to miss several days.

NP Lee also sees training as a valuable stress reduction tool, and it helps her speak to her patients about the importance of exercise and nutrition. “I’m not just talking the talk, I’m walking the walk.”
When the Department of Anesthesiology at MedStar Washington Hospital Center looked for a performance improvement project that would streamline and improve care for surgery patients, Anesthesiologist Susan Stasiewicz, MD, was eager to champion a proven way to improve outcomes and control costs. As Perioperative medical director, Dr. Stasiewicz was well-positioned to study patient flow, from pre-op assessment to post-op recovery.

Dr. Stasiewicz knew of a program that provides multimodal care pathways to reduce the patient’s stress response to surgery, support the physiologic function and accelerate the return to normal daily function. At the Hospital Center, the program is being called Ideal Recovery After Surgery, or IRAS.

These care pathways, explains Dr. Stasiewicz, “form an integrated continuum, as the patient moves from home through the perioperative phases of surgery and home again. Research demonstrates that IRAS leads to improvement in patient satisfaction, better outcomes, faster recovery, optimal pain management with narcotic-sparing and a structured, stabilized approach, leading to a decreased length of stay and fewer complications.”

The Mayo Clinic, Duke University Medical Center and the University of Virginia Medical Center are utilizing these types of protocols, with excellent results. A gynecologic oncology protocol at Mayo Clinic resulted in a five-day reduction in length of stay, as well as an 80 percent reduction in narcotic usage. AARP reported that a study of colorectal patients at the University of Virginia Medical Center, published in April in the Journal of the American College of Surgeons, used this process, and hospital stays were reduced by more than two days; the complication rate was decreased by 17 percent and patient satisfaction with pain control was increased by 55 percent.

Dr. Stasiewicz decided the program was ideal for the Hospital Center. Her first task was to get buy-in from other physicians, starting with her department. “Anesthesiologists are experts in working with patients from pre-op preparation to post-op recovery,” she notes.

Anesthesiology interim chair, Eileen Begin, MD, agrees. “Anesthesiology is in a perfect position to orchestrate this kind of program. We’re based in the hospital, and we can oversee this and tie it all together.” The resulting program is a global multidisciplinary effort among nursing and physicians involved in perioperative services, including Caren Lewis, MHSA, BSN, RN, vice president, Perioperative Services, and Khaled Salem, MD, director, acute pain, Anesthesiology, as well as Drs. Stasiewicz and Begin.

“As members of the clinical care team, we are delighted to partner with our patients in providing the opportunity for this enhanced postoperative experience,” says Lewis. “When a patient thinks about surgery and anesthesia, it is not often they visualize having an active role in their outcome. With IRAS, they certainly do. We look forward to hearing the positive results from this new collaborative approach.”

The next task was to put together a pilot program. Joint replacement was a logical choice, and James Tozzi, MD, chair, Orthopaedic Surgery, was a willing participant. Together, he and Dr. Stasiewicz analyzed patient flow, and devised ways to improve the process. The result was a multi-faceted approach that implements best practices at every opportunity and involves all the necessary disciplines, including Pharmacy, Physical Therapy and Nutrition.
“Patient selection is key to the success of the program,” Dr. Tozzi notes. “Patients have to understand the protocol to comply with it. We also need to adjust the protocol for patients with comorbidities and other special circumstances.”

**Scheduling.** When a patient is scheduled for joint surgery, it serves as a red flag to implement a pre-op protocol that will give the patient the best chance for optimal outcome and early discharge from the hospital. Patients who attend the pre-op clinic are given a list of instructions that specifies protein intake. For patients who attend the pre-op clinic, blood work provides information about glucose and hemoglobin so patients can be optimized for surgery. Smokers receive a prescription for nicotine withdrawal medication. Other patients are contacted and sent a checklist for surgery preparation.

IRAS calls for patients to drink fluids such as Gatorade® on their way to the hospital, up to two hours before surgery. This practice actually aids in recovery, Dr. Stasiwicz says.

**Pre-op holding area.** Drs. Stasiwicz and Tozzi developed a standardized list of pre-op medications to be administered to each joint replacement patient. The protocol includes a pain control cocktail, with such non-narcotic pain relief as TYLENOL®, LYRICA®, Neurontin and Celebrex®, in combination with oxycontin, which is administered to begin pain relief before surgery.

**Operating room.** The protocol extends to what analgesics work best to block pain in the OR. For joint replacement patients, spinal anesthesia and a regional block is the preferred modality during surgery, accompanied by a TORADOL® injection to begin pain relief before the patient wakes up. IRAS also works to optimize fluid management for a faster recovery.

**Recovery room.** “In the recovery room, patients are concerned about pain, nausea and people being nice to them,” Dr. Stasiwicz says. The pain management protocol is explained and patients receive chewing gum to relieve nausea. Physical therapy is started to aid the patient in early ambulation.

**Inpatient stay.** Joint replacement patients are started on a protocol that details ambulation goals, advancement of diet and pain management. Again, there is a focus on reducing the use of narcotics, as that can interfere with recovery by slowing bowel function, causing dizziness and inhibiting early ambulation.

A white board in each room tells patients and families what to expect. The protocol continues until the patient is discharged, when they leave with a set of instructions to follow at home.

Dr. Tozzi cautions that not every patient can benefit from the IRAS program. Key to its success is compliance before surgery, the patient’s willingness to follow the pain management regimen, and fast transfer to an inpatient unit that focuses on early ambulation. Also, the patient’s medical requirements may make it difficult.

Still, hopes are high for the program’s success. “We see a big opportunity here,” says Cassandra Lawrence, RN, administrative director, perioperative services. “When Dr. Stasiwicz brought this idea to us, and we heard how well it’s working at other hospitals, of course we wanted to try this here.”

It is still too early to have hard data about IRAS results at the Hospital Center. But, in other hospitals, length of stay, readmission rates and complications have been reduced dramatically and patient satisfaction has been enhanced significantly. Also, opiate use has been reduced dramatically.

“IRAS is a win-win situation,” Dr. Begin says. “For the hospital, it can decrease length of stay and for patients, it can increase patient satisfaction because their pain is better controlled.”

“All the mechanisms are in place for the right patient,” Dr. Tozzi says. “It’s not easy to achieve the well-oiled machine this program is designed for, but we’ll keep at it to overcome stumbling blocks and make progress.”

Dr. Stasiwicz is now working with the colorectal surgeons to implement a set of IRAS protocols customized to their needs. Other departments have also indicated an interest. She hopes to integrate the IRAS protocols with the MedConnect electronic chart, and is exploring the use of a special software program that works with tablets and smart phones, to prompt the patient through each step.

“My main role is to educate and spread the word about IRAS,” Dr. Stasiwicz concludes. “This program can achieve positive results throughout the Hospital Center. To integrate IRAS successfully, we need a structured, collaborative multidisciplinary approach, with education and awareness and team members, including nurses and physicians.”

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**IRAS Protocol Innovations**

**Nutrition counseling and carbohydrate loading before surgery**

Patients can eat solids up to six hours before surgery and drink clear liquids containing electrolytes and carbohydrates—such as Gatorade®—up to two hours before surgery to minimize protein loss and provide energy for a faster recovery.

**Pain management before, during and after surgery**

Analgesic pain medications are given before surgery along with non-narcotic pain relief delivered by catheter directly into the surgical site, with spinal anesthesia whenever possible. This is followed by a pain management protocol after surgery that aims to reduce the use of narcotics.

**Early ambulation after surgery**

Patients are encouraged to stand and walk as soon as possible after surgery, which helps prevent pneumonia and regain bowel function more quickly, leading to a shorter hospital stay.
When MedConnect III (MC3) comes to the department of Anesthesiology at MedStar Washington Hospital Center sometime in mid-2016, it will replace an assortment of patient charting methods currently in place. A team of anesthesiologists, anesthetists and IT specialists from six MedStar Hospitals is currently at work, customizing the product to meet clinical needs.

Anesthesia applications can be divided into three distinct areas: preoperative, intraoperative and postoperative. Anesthesiologists use multiple charting modalities to make sure they create a comprehensive patient care record. While they currently provide high quality patient care, it requires an array of tools and distinctly different mindsets to utilize each tool.

Fast forward to next year. The intent is for one tool to do it all: record the status of the preoperative patient, track the progress of the patient under anesthesia and record patient recovery in the PACU.

“Quality tracking has been our goal,” says Eric Skolnick, MD, director, Thoracic Anesthesia and director, Equipment and Technology for Anesthesiology. “Historically, we’ve had to use different tools to meet that goal. The intent of MC3 is to integrate these activities, to standardize throughout MedStar the same consistent, high level of care.”

The benefits are obvious. Less duplication of effort reduces errors and saves valuable time. But the biggest overall benefit is that anesthesiologists can create integrated, comprehensive documentation, which ultimately improves patient care.

At the heart of MC3 is Dynamic Documentation™, an interactive charting application that will allow anesthesiologists to automatically pre-populate the chart with an array of data, using tagging, smart templates and auto-text to create a comprehensive patient record. They will be able to create their own auto-text, which can populate key information automatically, while still allowing individual customization.

To better understand the benefits, look at the anesthesiologist’s role in the surgical suite, and compare the existing way of documentation to the implementation of the MC3 anesthesia application.

Preoperative Care

Before the patient goes into the operating room, the anesthesiologist performs an assessment to evaluate the patient’s history and condition, and then, based on this information, creates an anesthetic plan. It requires an overview of the patient’s history, an assessment of the patient’s current status, and a detailed look at what medications the patient has used historically, as well as received in the immediate preoperative period.

The existing MedConnect II electronic record provides a list of medications, but at times, is insufficient for a complete preoperative assessment. The anesthesiologist uses Microsoft® Amalga™ Unified Intelligence System (formerly known as Azyxxi) to record information about the patient history. For patients who have been previously hospitalized at the Hospital Center, the Medical Records Document Imaging (MRDI) can supply a PDF summary of previous anesthesia care. The anesthesiologist then makes handwritten notes that summarize the pertinent information. Subsequent anesthetics require the same process to be repeated, often with the challenge of interpreting a colleague’s penmanship.

MC3 will integrate all that information into a single, legible electronic record that can be used to pre-populate subsequent assessments. The system will be optimized for anesthesiologists’ needs. An extensive review of systems focused on anesthesia specific issues is united with test results, such as echocardiograms and stress tests, to create the final Dynamic Documentation.

MC3 will “let us view data from previous pre-op assessment and populate it into our current one with a few clicks, without
having to look through multiple data bases,” explains Dr. Skolnick. “It should decrease the time needed to perform a thorough pre-op assessment on repeat visits. For inpatients, it will pull data from other documents to highlight relevant medical history, rather than rely on manual chart review, to make sure we aren’t missing anything.”

**Intraoperative Care**

The patient’s vital signs, such as blood pressure and heart rate, will be automatically recorded electronically in real time. This replaces the manual ticks now used to track the patient’s status. The MC3 record will incorporate delivered medications and transmit the date to the pharmacy.

Today, the anesthesiologist team may spend the first 30 to 90 minutes of the case taking care of the patient, before turning to charting. This retrospective documentation includes pertinent facts about the patient’s condition throughout surgery, such as hemodynamic trends, ease or difficulty of intubation and special positioning. When MC3 goes live, hemodynamic data will be reduced to “point and click” on pre-built actions.

Currently, anesthesiologists make a post-op assessment either before PACU discharge or within 48 hours of surgery. “With MC3, the process will be the same. In both cases, we chart the patient’s status during the visit, and there is no retrospective assessment,” states Dr. Skolnick.

“The real power of the electronic record,” Dr. Skolnick says, is the ability to manipulate the tremendous amount of data not currently being captured. MC3 will change that. We can use it to improve patient care ultimately, because it allows us to spend more time with the patient.”

The application also will have monetary value. By recording what goes on during surgery, the most complete, accurate bill can be generated.

For shorter cases that are commonly performed—colonoscopy, for example—the anesthesiologist will be able to create set defaults. “Often, in these cases, we do the same thing every time,” Dr. Skolnick notes. “It expedites things if we use standard auto-text that is then easily edited if needed.”

**Postoperative Care**

Currently, a member of the anesthesia team reports to the PACU staff, where notes are taken on paper. “We describe key things that happen in each case, such as narcotics and fluids administered, blood loss and intubation difficulties,” Dr. Skolnick says.

With MC3, a standardized electronic document will be generated for handoff to the recovery room staff, containing prepopulated information. “This gives us a systematic way to share information about the patient,” Dr. Skolnick explains. “We plan to use the CORES tool, currently used by residents and fellows, for handoffs both in the PACU/ICU, as well as between clinicians intra-operatively. CORES will provide a summary of the case up until that time, by pulling data from the anesthesia record. Because it is a summary of intra-op data, its use will likely be limited to just the immediate post-op period in the PACU/ICU.”

With all the value that MC3 creates, it will require a steep learning curve. Plans are under development to make sure that all anesthesia staff—some 100 anesthesiologists, Certified Anesthesiologist Assistants, Certified Registered Nurse Anesthetists and 40 Student Registered Nurse Anesthetists (SRNA) and Student Anesthesiologist Assistants (AA-S)—will become proficient in its use. “This is an incredibly complex system with a lot of nuances,” Dr. Skolnick says. The standard training module requires 12 hours of classroom training, but he is working to leverage SiTEL to create a series of short online modules, so staff can learn the new system in bite-size chunks, capped off with a four-hour class.

When MC3 is in place, there will be a full month of co-charting using existing practices. Super users from each area—anesthesiologists, CRNAs, AAs and residents—will co-chart the system to build familiarity before paper charting goes away.

But all the effort will be worth it. “Once we become proficient with MC3, we’ll have a standardized way to create a comprehensive patient record that will ultimately improve patient care,” Dr. Skolnick concludes.
It’s 5:30 a.m. on a weekday morning, and Melissa Fries, MD, sits in a metal shed on her rural western Montgomery County farm, hand-milking Leaf, an Oberhasli milk goat. Moon, a LaMancha, waits her turn nearby. Once the milk has been collected, filtered and stored in the refrigerator, Dr. Fries will kiss her husband, Ronnie, goodbye and make her way to I-270 for the drive to MedStar Washington Hospital Center, where a busy day awaits her as chair of the Ob/Gyn Department.

There will be other farm chores to do when she gets back this evening—another round of milking, feeding a menagerie of agricultural animals, picking vegetables and taking care of whatever else can be done on the 25-acre spread, before bedtime at 9:30 p.m.

For now, however, Dr. Fries savors the early morning serenity, a quiet broken only by the rhythmic ring of new milk squirting in the pail, her reassurances to Leaf and the occasional cluck, baa and moo from the farm’s other “residents.”

“This is a very peaceful time of day,” says Dr. Fries, as she squeezes the last few drops from Leaf, who has nonchalantly been munching on grain. “The animal is giving you the blessing of her milk, while a new day is getting started around you. It couldn’t be better.”

Her colleagues at the Hospital Center would certainly agree, as they often get to share in the farm’s bounty—goats’ milk, cheeses and yogurt; eggs, courtesy of the farm’s free-range chickens; honey from a start-up beehive; and fresh vegetables from a garden that Dr. Fries laments, “went to weeds for the summer,” but vows will be back next spring.

Dr. Fries joined the Hospital Center in 2006 after a 26-year career as an Air Force Ob/Gyn. She and her husband had little collective farm experience to draw on when they purchased the property in Montgomery County’s Agricultural Reserve in 2013.

“I’d always loved growing things, and we did have a few chickens and sheep in Mississippi,” she says. “My husband grew up on Long Island near German communities, where growing and sharing crops was common. Working with animals was his dream, and it became mine, too.”

Fortunately, the couple had some time to get up to speed on their adopted lifestyle. They spent the first six months clearing portions of the property, and setting up fencing to make space for various animal enclosures, as well as a barn and other storage areas. The house was expanded, to include a shop and an industrial kitchen for processing and preparing everything from cheese to soap.

Meanwhile, they sought advice from the County Agricultural Extension service, which provided guidance on everything from soil testing for locating gardens, to identifying sources of farm animals.

“Once you find a person who sells a certain type of animal, they become a mentor to you,” Dr. Fries says. “We’ve also received a lot of help from area vets, who help with health assessments and illnesses. And, we’ve read books—a lot of books.”

Since the first animals began moving in last spring, the Fries farm’s zoological census has expanded to two cows, 11 goats, 11 turkeys, three pigs, two dogs, an indeterminate number of bees and 35 chickens, though that number fluctuates.

“The chickens are free-range, which means we occasionally lose one to a fox,” Dr. Fries says with a sigh.

Otherwise, the animals have their separate areas, with shelters and troughs for food and water. They’re fed twice a day, with Ronnie typically handling the other daytime chores during the week. This summer, however, he juggled the farm chores.

Dr. Fries and her husband, Ronnie, before the morning’s chores begin.
The Farming Life of Melissa Fries, MD

duties with his studies to become an Emergency Medical Technician.

When the weekend rolls around, there’s plenty of work to go around. On a recent summer Saturday, for example, Dr. Fries weeded the garden, made batches of goat milk cheese and tomato sauce, and milked the goats, while Ronnie mowed the property’s open areas and worked on restoring an old truck and a horse trailer.

“Every day, we’re doing something different,” Dr. Fries says. “There’s not much downtime, and no vacation in the summer. We have to plan our trips for the winter months when the animals are pregnant, but not ready to deliver, and we can get some help with the feeding.”

Dr. Fries says she and Ronnie have learned a great deal as part-time farmers, particularly the importance of fresh, non-processed food. “There’s no comparison between what you grow yourself or buy from a neighbor, and what’s available in the grocery store,” she says. “We really are what we eat, and so much of our health is affected by it.”

Dr. Fries has also gained a greater respect for those whose livelihoods depend on growing food. “It takes 20 tomatoes to make a quart of sauce,” she says, “so you can imagine how much someone has to produce to make an operation economically viable. And that’s on top of the inherent challenge of growing the crop.”

There are many other lessons yet to be learned, which is why Dr. Fries and her husband are “testing the waters” when it comes to breeding their animals and expanding their farm population. “If the turkeys do well, Ronnie has plans for more of them next year,” Dr. Fries says, admitting that most were fated to end up on holiday dinner tables. She is also contemplating getting a third milk goat, and erecting framing so that she can start growing hops next year.

Then, there’s coming up with new ways to use the approximately four quarts of goats’ milk Leaf and Moon produce each day. “We go through the milk pretty quick, but we can’t sell it because it’s not pasteurized,” Dr. Fries says, “We may be able to sell cheese, if I can get good at it.”

Asked if she doesn’t already feel her daily schedule is busy enough, Dr. Fries just smiles. “Everything we do here brings us joy,” she says. “Why not do more of it?”
As the only adult burn treatment center in the metropolitan Washington area, The Burn Center at MedStar Washington Hospital Center is understandably a busy place. Last year, The Burn Center admitted more than 400 acute burn-injured patients, and approximately the same number received outpatient care.

But there is far more to The Burn Center’s story than being a place for first-class, acute care in the event of an accident or injury. In addition to surgical services for treatment and skin reconstruction, The Burn Center is among the few facilities of its type in the nation to offer specialized long-term care services, with a dedicated, multidisciplinary team of nurses, rehabilitation therapists, dieticians, pharmacists and social workers.

“The breadth of our expertise and care is unique, which is important in serving an area as diverse as ours,” says Director Jeffrey Shupp, MD, who has been part of the Burn Center staff since 2008. Both Dr. Shupp and Burn Surgeon Laura Johnson, MD, agree that the provisioning of burn care could not happen without a functioning multidisciplinary team. “Fortunately, at the Hospital Center, our collective team experience is in hundreds of years,” states Dr. Shupp.

The Burn Center sees patients from locales as diverse as the city center and rural hamlets, with cases ranging from minor burns to large traumatic injuries, and those of skin loss due to immunological processes to profound drug reactions.

“We probably have one of the most diverse groups of patients,” adds Dr. Johnson. “In addition to area residents, we have treated students and visitors from all over the world. Anyone who needs help, we see without qualification.”

To accommodate this wide range of patients and treatment needs, The Burn Center features outpatient clinics for minor wounds, follow-up care and rehabilitation, as well as a burn step-down unit for both non-critical patients and those whose serious injuries have progressed to the post-acute phase. The Burn clinics and step-down unit share a common space in the hospital, with its own dedicated rehabilitation gym that supports a variety of rehabilitation needs.

When a Crisis Occurs

As with most of the Hospital Center’s other facilities, The Burn Center is prepared to handle major emergencies. During January’s Metrorail tunnel fire, for example, more than a dozen passengers were brought to The Burn Center to be treated for smoke inhalation. In July, seven adults injured in a flash fire aboard a boat at a Solomons Island, Md., marina were brought to the Hospital Center.

“We also have coordination plans with the city and other burn centers in our region, in the event of major incidents,” says Dr. Shupp. Regional cooperation is critical to a quick and organized response to disasters. In late September, The Burn Center hosted the Northeast Regional Burn Conference, the first time the conference has been offered in nearly five years.

“Our mentor, Dr. Marion Jordan, was instrumental in starting this conference decades ago, and we thought it would be a perfect time to resurrect the meeting in the District,” commented Dr. Johnson. “In fact,” adds, Dr. Shupp, “the meeting went off without a hitch, thanks in many ways to the work and support of Kathleen Hollowed, MSN, outreach education coordinator, and with our partnership with the D.C. Firefighters Burn Foundation.”

“Burn centers are a limited resource in this country, and we all need to communicate and share knowledge in order to provide state of the art care for patients,” says Hollowed. “Hosting the conference was a shared vision for Drs. Shupp and Johnson, and together, as a team, we hosted burn team members from throughout our region. We laughed, we cried, we shared ideas, but most importantly, we communicated and educated each other throughout the process. These are values brought to us by our leadership, which provided us the opportunity to share with our peers.”

Research is Crucial

In addition to patient care, The Burn Center staff participates in cutting-edge clinical, translational and basic science research. The Firefighters’ Burn and Surgical Research Laboratory opened in 2009, funded in large part by the D.C. Firefighters Burn Foundation and many local firefighters. The lab is equipped to support a variety of funded research projects aimed at gaining a
better understanding of the pathophysiology of burn injury at the systemic, molecular and cellular levels.

The research staff performs a wide array of investigations, and aims to facilitate “bench to bedside” exploration and innovation. Trials range from alternative skin grafting techniques, such as “spray on” skin to large, observational clinical trials, focusing on the coagulopathies associated with thermal injury.

With three participating residency programs, The Burn Center is also committed to providing clinical training to rising young physicians, in all phases of burn injury diagnosis, treatment and rehabilitation.

“There are not a lot of people trained in the treatment of burn injuries,” Dr. Johnson says, “so it’s important that we do this for the next generation of caregivers. Medical students from the Uniformed Services University of the Health Sciences, Georgetown University and students from as far away as Florida and Chicago have rotated on the service. Paramedic students from the area are also frequent visitors, and it’s always rewarding when we see paramedics bringing our patients into MedSTAR Trauma have applied what we teach them.

Dr. Shupp adds that the collaboration spanning The Burn Center’s staff and services is what helps the department be more than just the sum of its parts.

“We all truly enjoy what we do, and who we’re doing it with,” he says. “That’s particularly important since we’re caring for some of the sickest patients in the hospital. We want to be sure everyone can count on us–our Hospital Center colleagues and staff, and of course, our patients.”
The 12th Annual Georgetown Meeting on Gastrointestinal Endoscopy and Pancreatobiliary Surgery
March 12, 2016 | The Ritz-Carlton | Washington, D.C.
Course Directors: John E. Carroll, MD; Nadim Haddad, MD; and Lynt B. Johnson, MD
This one-day symposium will address state of the art management and care of difficult and complicated disorders, such as pancreatobiliary, esophageal and other gastrointestinal diseases. The optimum method to diagnose and treat these problems requires a multimodality approach. Perspectives from radiology, endoscopy, interventional radiology, pathology, surgery, medical oncology, radiation medicine, genetic assessment and counseling of “high-risk” patients will be presented.
For more information and to register, please visit: cme.medstarwashington.org/GIDISEASE

Update on Pediatric Solid Organ Transplantation 2016
March 18, 2016 | Georgetown University Hotel & Conference Center | Washington, DC
Course Directors: Thomas M. Fishbein, MD and Stuart S. Kaufman, MD
This one-day educational symposium hosted by the MedStar Georgetown Transplant Institute will address pediatric liver and intestinal disease with special emphasis on management of tumors including transplantation.
For more information and to register, please visit: cme.medstarwashington.org/PEDIATRICTRANSPLANT

14th International Congress on Targeted Anticancer Therapies
March 21-23, 2016 | Omni Shoreham Hotel | Washington, DC
Course Director: Giuseppe Giaccone, MD, PhD
The 14th Annual TAT Congress (TAT 2016) is the leading annual phase 1 meeting on promising new drugs and molecular and immunological targets for cancer therapy in early-phase clinical development. TAT Congress is a medium-sized meeting encompassing three days of plenary sessions, poster viewing sessions, special symposia, international faculty and excellent networking opportunities.
For more information, please visit: tatcongress.org

Advances in Liver Diseases and Transplantation 2016
April 9, 2016 | Bethesda North Marriott Hotel & Conference Center | Bethesda, MD
Course Directors: Thomas M. Faust, MD; Thomas W. Fishbein, MD; and Rohit S. Satoskar, MD
This one-day educational symposium hosted by the MedStar Georgetown Transplant Institute will educate the audience on advances in liver diseases and liver transplantation. This will include: the diagnosis and management of acute and chronic liver diseases, approach to and management of complications of chronic liver disease, and the diagnosis and management of viral hepatitis, liver-related malignancies, and liver transplantation.

CME Transcripts are Available Online
You can download, print or e-mail your CME transcript. Visit http://cme.medstarwashington.org and click on “View Your CME Transcript” for complete instructions.
**Thank You to Dr. St. André**

Physicians, nurses and many others touched by the 30+ year career of Arthur St. André, MD, gathered to celebrate his transition from the leadership role of Surgical Critical Care.

Dr. St. André examines the crystal commemorative award.

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**“The Doctor’s Lounge” for September**

Kevin Pho, MD, nationally-renowned speaker and KevinMD blogger, presented “Establishing, Managing and Protecting Your Online Reputation: A Social Media Guide for Physicians and Medical Practices” to the Medical & Dental Staff in September. Dr. Pho explained how providers can make a difference in health care, by using social media.

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**Dr. Huerta Honored At Johns Hopkins**

Elmer K Huerta, MD, MPH, director, Cancer Preventorium, Washington Cancer Institute, has received special recognition from the Johns Hopkins University Alumni Association, which honored his accomplishments as a graduate of the School of Public Health.

Dr. Huerta has educated Spanish-speaking audiences about the importance of cancer prevention and early detection. His radio and television programs are widely syndicated in the United States and Latin America, and he is a medical commentator on Univision, Telemundo, CNN en Español and CNN Radio Noticias.

Since he founded the Cancer Preventorium in 1994, Dr. Huerta has seen more than 33,000 patients, primarily poor and uninsured Latinos. President Bill Clinton appointed him in 1998 to the National Cancer Advisory Board. In 2007, Dr. Huerta was elected President of the American Cancer Society, becoming the first Latino to hold that office. Dr. Huerta’s other honors include the 2004 Innovations in Prevention Award from the Secretary of the U.S. Department of Health and Human Services, and the 2013 White House Public Health and Prevention Champion of Change Award.

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**Veterans Day Providers**

There are 317 former members of the United States Military now at MedStar Washington Hospital Center. To celebrate Veterans Day, some former military members of the Medical & Dental Staff gathered in the Samet Atrium.

Physician thanks you all for your service.


For Mallory Shasteen, MD, a former Division One athlete and member of the University of Notre Dame’s rowing team, the key to surviving those grueling, early-morning practices was just getting to the middle.

On the water often before sunrise, the cold wind whipping as her oar broke through the frigid waters of the St. Joseph River in northern Indiana, the varsity rower knew that if she could get to the middle of that workout—see the end in sight—she could also make it to the finish line, giving it everything she had.

Halfway through her year as Chief Resident of Emergency Medicine, Dr. Shasteen is hitting a similar stride. While she hasn’t spent time in a scull since college, she’s taken many of those lessons learned with her.

“Varsity crew definitely helped,” Dr. Shasteen says, of finding her footing as a resident, and now, chief resident. “It was physically, mentally and emotionally demanding.”

After graduating from Notre Dame, Dr. Shasteen headed to warmer weather for medical school, and attended the University of Florida College of Medicine. As a first-year medical student and a former college athlete, she set her sights on orthopaedics, assuming that would be her chosen specialty—until she started her Emergency Medicine rotation as a third-year.

“I loved Emergency Medicine,” Dr. Shasteen recalls. “You get to see every walk of life, from newborns to 100-year-olds, and you’re taking care of people when they are at their most vulnerable points.”

Now, as a chief resident, Dr. Shasteen also has the opportunity to see a different side of the emergency room. “It’s been eye-opening,” she says. “The hospital world behind the scenes is so complex—which I knew, but seeing it from this vantage point, you see what goes on behind the scenes, to make everything work.”

For Dr. Shasteen, part of that learning experience has been balancing individual support for residents, with learning how to support the program as a whole—advocating for both the individual and the program, which sounds a lot like her time on the crew team.

Once Dr. Shasteen gets to the finish line of her chief year, she hopes to return to those college athlete roots. She is applying to sports medicine fellowships for next year.

“It would take all of my passions and put them together,” she says. After the one-year program, her goal is to practice in an emergency room setting, and also be a team physician for a college team and run a sports clinic.

Maybe for the Fighting Irish?

“I love my Fighting Irish, and if Notre Dame were closer to family it would definitely be my dream job,” says Dr. Shasteen, whose family now lives in the south. “For now, I will dream of being a team physician for any college.”

It’s been several years since Dr. Shasteen has touched an oar to water. “After four years of brutal workouts, I’ve stayed away from it,” she laughs. But in her limited downtime, she enjoys traveling and spending time with her husband and family.
Daniel Stoltzfus, MD, FCCM
Critical Care

Daniel Stoltzfus, MD, FCCM, has trained as an anesthesiologist and a critical care specialist, and has worked in every medical setting, from the military to academia to private practice. But perhaps his most valuable lesson about critical care came not from those varied experiences, but from his father.

“My father taught me to respect everyone, and to work with people through the stressful events in their lives,” Dr. Stoltzfus says. His father, he says, taught him to be a calming presence for others.

“It’s been a good skillset in talking with families in end-of-life or stressful situations,” he says of that practiced calm. “There’s such a need to allay their anxiety in their time of need.”

During his fourth-year of medical school at the University of Texas Medical School at Houston, Dr. Stoltzfus had the chance to see what that type of bedside manner could look like: an attending physician who was triple-trained as a surgeon, anesthesiologist and critical care specialist took him under his wing, allowing Dr. Stoltzfus to shadow him during the nightly in-house calls.

“That was a turning point for me,” says Dr. Stoltzfus, who had, until then, planned to pursue oncology. “Seeing his approach to stressful situations, and the ability to take emergency situations and handle them in an orderly fashion prompted me to go into anesthesiology.” He saw the specialty as an opportunity “to provide life-saving treatment in life-saving scenarios,” and bring to those scenarios a demeanor to comfort patients.

Dr. Stoltzfus switched gears, pursuing anesthesiology and later, critical care, completing a portion of his fellowship at MedStar Washington Hospital Center more than 20 years ago.

Last spring, he returned to the Hospital Center, this time as a leader of the critical care team. He was intrigued by the opportunity to participate in the future development of a critical care department at the Hospital Center, bringing together all of the different critical care units into one comprehensive department.

That type of shift makes sense, as Dr. Stoltzfus sees it, because of the potential for collaboration and uniformity of practice standards for the future sub-specialization of critical care, a specialty at a crossroads, perhaps much like cardiology was a decade ago.

“Critical care is such a broad, diverse field, with a plethora of disease states,” he says.

For Dr. Stoltzfus, this transition to the Hospital Center has also been a meaningful one for his family, in many ways. He and his wife are now much closer to his daughter and two grandchildren in northern Virginia. His returning to a teaching hospital setting also overlaps with the start of his son’s first year of residency in anesthesiology.

“It’s an interesting crossing of paths,” he says, noting it has allowed him to see the challenges of medical residency from multiple vantage points: as a former resident himself, as a teacher, and now, as a father.

For Dr. Stoltzfus, nearly three decades working as an intensivist has taught him a measure of gratitude and perspective.

“You frequently experience just how suddenly and drastically someone’s life can change, and can’t help but take away from those experiences how valuable life is and how it can change at any one moment.”
Physicians’ Perspective

From the Desk of…

David Shocket, MD
Director, Gastroenterology

Fortunately for our patients, MedStar Health has established a regional program for gastroenterology, with more resources and a greater emphasis on patient satisfaction. This allows our department to add endoscopy rooms, continue to update our technology and add new physicians, so we can better tend to hospitalized patients, as well as perform outpatient procedures.

After 23 years in private practice, I assumed the department’s leadership position on September 1. My goal is to bring greater stability and a stronger focus on customer service to my new role. I am looking forward to working closely with my colleagues on the hospital staff and in private practice, to offer our patients the best care in a timely, professional manner.

To that end, we are adding three additional endoscopy rooms by the end of 2015. With four rooms already operating all day long, we are almost doubling our capacity. This will allow us to better accommodate inpatients who need endoscopy services, while still maintaining our busy outpatient endoscopy schedule, which accounts for 65 percent of our patient load.

Each endoscopy suite will be staffed with a nurse anesthetist, so we can offer monitored anesthesia care (MAC) with propofol, which provides faster sedation and faster recovery for patients. This is a better use of hospital resources, and is safer for patients when compared to conscious sedation.

In recent years, the division has been updating its technology, so we provide state-of-the-art endoscopy equipment to provide the best results. We also are adding new equipment for the diagnosis of motility disorders, and advanced technology for interventional endoscopy.

We now have four full-time gastroenterologists on staff, and have plans to add two more by next July. There is a tremendous backlog of patients in the clinic, and this will allow us to better accommodate those patients, as well as improve service for our other patients.

We are now serving as home base for a new, combined fellowship program, with fellows from MedStar Georgetown University Hospital, the Washington DC VA Medical Center, and the Hospital Center in one program. The program trains 18 fellows, with one third of them in the Hospital Center at any one time. For any additional information, please call me, at 202-877-5144.