For three weeks in January, all members of the Medical & Dental Staff had access to a nine-question electronic communications preference survey. We asked for your feedback on the best ways to get messages to you. More than 370 of you provided thoughtful insights on how we can communicate with you during a busy day.

You told us:
- 50 percent of you check your MedStar email throughout the day, when you’re on campus
- 75 percent of you read emails marked “From Dr. Argyros” when they appear in your inbox
- Almost everyone immediately reads emails from your physician leader
- The top three ways you receive information include:
  - A text or email from your direct physician leader
  - STAT Update, our Friday morning e-newsletter
  - Your colleagues

You wanted:
- Fewer emails, and to receive only emails specifically designated for the Medical & Dental Staff, not the entire hospital
- Shorter emails, without attachments to open and read
- More advance notice about a department meeting with me, and the town halls for the entire Medical & Dental Staff
- Improved WiFi throughout campus
- A HIPAA-compliant app, to make it easier to check MedStar email when off-campus

Here’s the first set of actions:
- Before the malware incident last year, the Medical & Dental Staff Board had approved requiring all physicians and APCs, both employed and private practice, to only use MedStar email for hospital business. We are now working on setting up a MedStar email address for every member of the Medical & Dental Staff, and putting all the addresses into one group. Once we do that, we can remove your addresses from the hospital-wide distribution group.

While this means you will not receive emails that are associate-directed, we can always add the Medical & Dental Staff group to a hospital-wide communication. For example, if there is a communication from President John Sullivan that affects everyone on campus, we will make sure you receive that email.

- We are working with IS to determine the feasibility of a MedStar HIPAA-compliant, system-wide app that everyone will be able to use. One app is currently in trial; if it becomes available throughout MedStar, we will make sure all of you have access to it.

- We are discussing what can be done, given the 1950s building, to improve WiFi access, especially in the Ground and Basement floors.

Please remember that the primary written way I communicate with you is through STAT Update every Friday, which is emailed to you at 6:30 a.m. As I’ve said in town halls, my expectation is that you are reading STAT every week. Each STAT includes messaging from me, updates from Chief Medical Informatics Officer Peter Hill, clinical and other hospital news, and upcoming CME information. There is also a list of department town halls and Medical & Dental Staff meetings for the month.

However, the best way for us to communicate is face-to-face. Please attend your department’s meeting when I’m there, and also, try to come to the Medical & Dental Staff town halls.

- At your department meeting, I will always give a brief update on hospital news and issues. Please feel free to ask any questions about policies and procedures that affect you and your colleagues.

- At the Medical & Dental Staff town halls, both M&D President Scooter West and I are available for any hospital-wide concerns you want to discuss. Those meetings are in the early evening, 5:30 to 7 p.m. in True Auditorium, and we provide a boxed meal for those who attend.

Finally, if you know you cannot attend either a department meeting or the M&D town hall, please send me an email with your question or concern. I’ll send you a written response, and also address it at the next meeting.

With better communication, our Medical & Dental Staff can be more effective, efficient and engaged. We can ensure that we have communication transparency throughout the Hospital Center. And, we can all know that we’re on the same page, to provide the best experience with the safest quality care for all our patients and their families.

Gregory J. Argyros, MD, MACP, FCCP is sr. vice president, Medical Affairs/Chief Medical Officer and Designated Institutional Official at MedStar Washington Hospital Center. Contact him at 202-877-6038 or gregory.j.argyros@medstar.net.
Upcoming CME Conferences

MEDSTAR CONFERENCE HIGHLIGHT

2017 Comprehensive Stroke Symposium: Continuum of Care: Acute Management to Rehabilitation
May 19-20 | Renaissance Washington, DC Dupont Circle Hotel | Washington, D.C.
Course Directors - Richard T. Benson, MD, PhD and Rocco A. Armonda, MD

MedStar Washington Hospital Center is pleased to announce the upcoming Spring conference: Comprehensive Stroke Symposium: Continuum of Care: Acute Management to Rehabilitation, taking place May 19-20, 2017 at the Renaissance Washington, DC Dupont Circle Hotel. This one and a half day symposium will equip health care providers with practical, evidence-based knowledge for early stroke identification, evaluation, treatment, transport, and management. Through lectures, interactive sessions, and open discussions, this conference will explore the critical issues surrounding the assessment and management of stroke patients. Additionally the course will review recent AHA/ASA acute ischemic stroke guidelines, cutting-edge interventions, treatment recommendations, and research. For more information and to register, please visit cme.medstarhealth.org/STROKE

UPCOMING CME EVENTS

2017 Inflammatory Bowel Diseases and Other Inflammatory Pathologies of the GI Tract
April 29 | Ritz-Carlton | Washington D.C.
Course Co-Directors: Aline Charabaty, MD; Mark C. Mattar, MD
cme.medstarhealth.org/IBD

Frontline Cardiology: Cardiovascular Care in the Community
May 6 | College Park Marriott Hotel & Conference Center | College Park, Maryland
Course Co-Directors: Sriam Padmanabhan, MD; Allen J. Taylor, MD; and Carolina I. Valdiviezo, MD
cme.medstarhealth.org/Frontline

Pediatric and Adolescent Gynecology for the Primary Care Provider
October 6 | Hyatt Regency Bethesda | Bethesda, MD
Course Directors: Veronica Gomez-Lobo, MD; Course Co-Director: Lauren Damle, MD
cme.medstarhealth.org/pedgyn

Current Issues in the Care of Dialysis and Transplant Patients
October 7 | Georgetown University Hotel and Conference Center | Washington, DC
Course Directors: Matthew Cooper, MD and Basit Javid, MD, MS
cme.medstarhealth.org/transplant

2017 Update on the Treatment of Heart and Vascular Disease
October 14 | MGM National Harbor | Oxon Hill, MD
Course Directors: Mun K. Hong, MD and Frederick Beavers, MD
cme.medstarhealth.org/uthvd

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.
If bigger is better, few things can be more heartening than the fact that on this coming June 4, more people than ever will celebrate National Cancer Survivors Day. According to a report released last year by the American Cancer Society and the National Cancer Institute, there are 15.5 million cancer survivors in the U.S. today. By 2026, that number will grow to more than 20 million.

But as every cancer patient and physician knows well, undergoing treatment for cancer is an intense, life-changing experience, one that doesn’t end with remission or keeping the disease at bay.

That’s why leading cancer care institutions, including MedStar Washington Hospital Center, are complementing their cutting-edge diagnosis and treatment services with survivorship programs, which provide patients with guidance and resources aimed at supporting their physical, emotional and lifestyle needs. Survivorship also aims to help empower patients and their loved ones make informed decisions as they transition into a new phase of life, and any uncertainty that may accompany it.

“For many patients, survivorship begins at diagnosis,” says Christopher Gallagher, MD, medical director of Cancer Services at the Hospital Center. “There is a sprint toward being cured, after which we look at the long-term journey of recovery and surveillance. For those patients with non-curable forms of the disease, it is sometimes more of a marathon that will present its own set of challenges.”

While Cancer services and MedStar’s network of hospitals have long offered a wide range of services to cancer survivors, there’s been a nationwide movement in recent years to foster a more coordinated patient-centered approach. Last year, the Commission on Cancer of the American College of Surgeons issued new accreditation standards, requiring cancer hospitals to provide patients completing active care with a personalized roadmap that lays out future care needs, and ways they can continue improving their quality of life.

Dr. Gallagher says refining the requirements for survivorship makes sense, particularly given how cancer treatment has evolved.

“Before cancer centers, patients went to different places for treatment, follow-up and so forth,” he explains, “with no single source of care or information. By receiving cancer treatment in a single cancer center, survivorship services are patient-centered, to bring all that guidance together in a way that truly benefits the patient.”

Marc Boisvert, MD, director of the MedStar Breast Health Program at the Hospital Center, adds that the nature of cancer demands this higher level of post-treatment support.

“We want survivors engaged for life,” he says, “both for their general health, and also to be alert to any signs of recurrence.”

That’s also why survivorship care plans are designed to better engage primary care physicians in a patient’s long-term care, from handling side effects of various medications to scheduling routine screenings, such as colonoscopies.

“Before, it was pretty much just sharing standard medical records,” observes Eric Wisotzky, MD, director of Cancer Rehabilitation at MedStar National Rehabilitation Hospital. “The survivorship care plans are more succinct, and focused on the specific steps for transitioning the patient to wellness.”

The care plans provide a summary of the treatment received to date: details on medication, including type, dosage and potential side effects; surveillance methods, such as frequency of follow-up visits and recommended tests; and nutritional and exercise needs.

Dr. Wisotzky adds that while certain physical effects of cancer are universal, others are more
specific to the diagnosis and individual. For that reason, the care plans provide detailed guidance for monitoring conditions, including lymphedema associated with breast, melanoma and gynecological cancer; or speech and swallowing issues that accompany head and neck cancers.

Radiation oncology can be part of a treatment plan for patients, with radiotherapy treatments given during typically a finite period, often on outpatient status. Radiation Oncologist Adedamola Omogbehin, MD, says, “We often have to dispel the myth that radiation treatments accelerate a patient’s demise. The long-term effects of radiotherapy treatments are often overplayed, likely stemming from the fact that the side effects—skin darkening or thickening—are a constant visual reminder, whereas patients are more willing to overlook a scar from surgery, or hair changes from chemotherapy.”

Managing post-surgery rehabilitation is also a key issue in cancer care plans.

“Fatigue is the most common functional symptom associated with cancer,” Dr. Wisotzky says, “so the care plan can help a patient deal with energy levels, and how to gradually return to daily activities.”

Likewise, adds Dr. Boisvert, “a breast cancer patient may want to explore plastic surgery, or how to deal with abdominal bulges and hernias that can sometimes occur during treatment.”

Care plans also help patients understand where they can turn, as they restore and maintain their health.

“A big advantage of our survivorship program is that it’s multidisciplinary,” Dr. Gallagher says. “All the services beyond surgery, radiation and chemotherapy are here—rehabilitation, plastic and reconstructive surgery, genetic counseling, nutritional counseling, support groups and more.”

The survivorship program seeks to involve families and loved ones, as their support is critical to coping with the cancer experience. In addition to involving them in all aspects of the educational and post-treatment programs, they are also offered genetic counseling, and guidance for dealing with caregiver fatigue.

“We encourage patients and their family members or caregivers to ask us questions, and we can reinforce what has been said during earlier visits,” says Dr. Omogbehin. “We also encourage them to take notes during consultations, and with the patient’s permission, tell them to reach back to us with any other questions or concerns that may arise at other points of treatment, or later.”

“The Hospital Center has been really forward-thinking on survivorship,” Dr. Wisotzky says. “We have been meeting with physicians, nurse navigators and individual care disciplines on this for several years.”

Dr. Boisvert adds that while the care plan templates are in place, implementation remains a challenge.

“In many ways, our survivorship program is still in its infancy,” Dr. Boisvert agrees. “But we are catching up. A particular challenge is getting in contact with patients who have already completed their treatment, and making sure they have this information.”

Dr. Gallagher notes that in many ways, the survivorship program conveys many of the same messages and guidance patients have received throughout their treatment regimen.

“We’re not telling them anything they haven’t heard from the initial diagnosis,” he says. “This is a means by which we can educate them about what they need to do in the next phase of their lives, and provide the needed support every step of the way.”

And acknowledgement of treatment milestones are encouraged, adds Dr. Omogbehin. “Our department has a cowbell outside of every treatment room. On the day of final treatment, we insist that every patient who is able, go ring the bell as hard and loudly as they can, with pictures or videos taken by their families and caregivers, to celebrate this moment in their survivorship journey.”
Joel Patton was the quintessential “picture of health,” boasting a strong body and mind.

An IT professional working on his PhD, the 33-year-old is a personal trainer on his off hours. So this past May, when his left foot began to hurt, he chalked it up to an overworked muscle. But when the simple pain lapsed into numbness and tingling, and his co-workers told him of a noticeable difference in his walk, Joel thought his foot might require a professional’s point of view.

Several doctor visits reaped little in the way of a diagnosis, until one alert physician recognized that something was gravely wrong, and quickly referred Joel to Rajesh K. Malik, MD, RPVI, FACS, a vascular surgeon at MedStar Heart & Vascular Institute at MedStar Washington Hospital Center.

“By the time I saw Mr. Patton in the clinic, his left foot was ischemic—rubric, red and cold to the touch,” says Dr. Malik. “I knew without any testing that we had to admit him and start treatment right away.”

“I was the youngest person in the waiting room, and I was just thinking it was something relatively simple,” Joel remembers. “When Dr. Malik sat me down and told me I needed to be hospitalized immediately, I was in shock. And when he started to explain my situation, described the blood clot and noted that amputation was a possibility, it was a horror story coming true.”

Rare and Dangerous Thrombosis

A thrombosis of this severity is rare in a young person, Dr. Malik explains. While the cause was not yet clear, the resulting damage to his leg was catastrophic. “We started him on a heparin drip immediately, and conducted a series of diagnosis tests. A CT-angiogram confirmed extensive thrombosis at the left popliteal artery. Blood flow was restricted from the knee to his foot.”

“The timely care that Mr. Patton received is an excellent example of the multidisciplinary care we offer at MedStar Heart & Vascular Institute,” says Edward Woo, MD, director, MedStar Vascular Program. “Mr. Patton was able to be admitted, diagnosed and treated in an expeditious manner.”

The angiogram also indicated that the thrombosis was so extensive and had been left
untreated for so long, that finding option for bypass was difficult.

“...I was honest with Mr. Patton about the situation. Endovascular/minimally invasive surgery wasn’t possible—and open surgery was risky,” says Dr. Malik. “In an open procedure, we might have been able to take a piece of vein from above the popliteal artery, remove the clot and create a bypass, but the risk of failure was great.”

With a condition this complex, which is fraught with so much risk, the collective knowledge of an experienced team of vascular surgical experts is paramount, says Dr. Malik. “We gathered the team together to discuss the options,” he says. “As you can imagine, there were a variety of opinions. And in a situation like this I had to make the hard decision.”

Tackling Tough Choices

This is when Dr. Malik’s years of diagnosing and treating some of the most complex vascular disorders gave Joel a critical edge. “Some other surgeons might have opted to bypass,” he says. “But I thought in Mr. Patton’s case, we should sit tight and watch.”

Within a matter of days, some feeling had returned to Joel’s foot. “I was ready for whatever was going to happen—bypass or amputation. I just became resolved to it,” says Joel. “Then Dr. Malik tested the pulse in my foot again, and he heard something. When he looked at me he had a big grin on his face.”

“There was some improvement—the blood thinner was doing its job,” says Dr. Malik. “But we still didn’t know what had initially caused the clot. Then we did a complete work up, including a MRI. What we discovered was a rare condition called popliteal artery entrapment syndrome.”

Dr. Woo adds, “This is a great example of where Dr. Malik’s experience and expertise not only was critical for the presenting problem, but also for recognizing a potential future issue, as well.”

In Joel’s case, the muscle and tendons near the knee were positioned so that they compressed the popliteal artery. Over time, that compression restricted blood flow to his lower leg.

“The muscle band was not in the correct position, and we knew that because it was a birth anomaly, it would also be present in his right leg,” Dr. Malik notes. The fact that Mr. Patton was an athlete increased his risk. The condition is most often seen in young athletic patients with no other vascular problems. Exercise and training increase the size of the calf muscle, and results in compression of the artery.

Correcting a Birth Anomaly

Fortunately, Dr. Malik was optimistic that corrective surgery to release the entrapped muscle would provide a cure for Joel.

“During the procedure, I entered through the back of the knee, and resected the muscle band. We then performed an angiogram to visualize blood flow, and immediately saw tremendous improvement, from just 20 percent to 80 percent. A month later, I performed the same procedure on the right leg.”

While Joel will need to take blood thinning medication for some time, Dr. Malik is very encouraged by his progress. “We continue to monitor his blood flow, which is returning to normal.”

Because this condition and procedure is not common, Dr. Malik presented this case with a video, at a national professional meeting. “Most vascular surgeons never get to see this, and the video was a very useful teaching tool,” he says.

Months after surgery, Joel is navigating his way back to his active life. He is back to work remotely, and has started to exercise.

“I’m working out smarter now,” he says. “At this point, my knees talk to me! I’m not running and not doing squats, but I’m ready to start intensive physical therapy. There is no question, this whole experience has been an eye opener for me. I’m grateful I put my confidence in Dr. Malik. He saved my leg.”

“We are all very happy for Mr. Patton’s recovery,” states Dr. Woo. “This is the level of care and expertise we offer all patients in the MedStar Vascular Program.”
Attorney Sarah Pheasant, a recent transplant to Washington, D.C., was happy building her new life, juggling work, friends and family. Tennis—one of Sarah’s long-time favorite activities—became an important way for her to de-stress. One day last June, she reached for a shot, and pulled a muscle in her left calf. It was a backhand that nearly proved fatal.

“I went limping off the court,” Sarah remembers. The pain put a damper on her busy schedule, and visits to an urgent care center, use of an orthopaedic boot and physical therapy weren’t helping. She stayed off her feet for a time, and went home to Pennsylvania for a little parental pampering. Back to work, but not back to speed, the pain continued.

Early one morning, she grew concerned when her breathing became labored. She was sweating and felt tightness in her chest. Sarah dialed 911. When she opened her eyes four days later she was in the ICU at MedStar Washington Hospital Center. “I looked across the room and saw my family and asked ‘what happened?’

Skill, Experience, Timing
What happened to Sarah was the worst-case, rare consequence of a simple athletic injury: the combined expertise of a team of very skilled and experienced medical specialists; and perhaps, a bit of fate, faith and luck.

When Sarah arrived in the ED, Ethan Booker, MD, knew only what he could see. “We had a patient who was very sick, and couldn’t speak, due to respiratory distress. She had low oxygen saturation, and my job was to stabilize her,” he says. Twice, Sarah arrested, and twice, Dr. Booker and his team, including Emergency Medicine resident Travis Thompson, MD, revived her.

“The sudden onset of symptoms like these in a healthy young patient strongly suggests pulmonary embolism (PE),” he says. Sarah was intubated, and a bedside echo supported the diagnosis. “She had a dilated right ventricle, the result of increased pulmonary artery pressure, which is classic in a massive PE. We administered tPA (tissue plasminogen activator) in the CT suite, but prior to CT, after her second cardiac arrest,” he adds.

“It was serendipity that I was in the ED checking on another patient,” says Matthew Schreiber, MD, pulmonologist and associate director of the medical ICU. “I stopped in, while she was being scanned. The image clearly showed bilateral pulmonary embolism.”

Why would a healthy young women present with a dangerous bilateral PE? Dr. Schreiber soon unraveled the mystery, after Dr. Booker’s call to Sarah’s dad provided critical information. The pulled muscle had rendered Sarah relatively immobile for weeks. Blood began to pool from the inflammation, and a clot grew in her popliteal vein.

“Left long enough without treatment, many clots will break off, and travel via the femoral vein to the lung,” Dr. Schreiber explains. “Very often, this embolism will prove fatal. It’s true that if Sarah hadn’t gotten to the ED when she did, the outcome would have been very different.”

Advanced Technology Put to Work
Minutes following that definitive scan, the ED team hustled Sarah to interventional radiology, where Emil Cohen, MD, assessed her condition. He made a critical decision to perform a thrombectomy using the Indigo system—an advanced clot removal tool not available in many hospitals.

“I was impressed with how well our team of technologists and nurses sensed the urgency of the situation. Within minutes of her rapid arrival to our department, we had her in the procedural room. Technologists and nurses from other rooms who were not busy with patients came to help set her up for the procedure in just a few minutes,” he says.

“Sarah had already coded, and taking a ‘wait and see’ approach with blood thinners infused directly to her lung would have been too dangerous,” Dr. Cohen explains. “We needed to approach the problem more aggressively. The thrombectomy system rapidly breaks up and sucks out clots. We routinely use this system in other parts of the body, and we decided it was the right tool to use in this situation. We threaded the catheter through the vessel in the leg, and into the pulmonary artery. There were several clots, and we were able to clear them from

The Pheasant family at the luncheon: brother David, mother Linda, Sarah and father, Dr. Thomas Pheasant.
her left lung and restore blood flow. Sarah responded immediately.”

“At that time, we couldn’t determine if there had been damage to her brain. But it was our job to keep her oxygen levels where they needed to be, and keep her sedated," Dr. Cohen says.

While in the ICU, the small skin poke in her leg began to bleed—the result of the heavy doses of blood thinners. “We had to put pressure on the bleed,” says Dr. Schreiber. For several hours, he and a resident took turns holding gauze on the wound with a single finger until the bleeding stopped. By then, Sarah’s parents were on their way to the hospital.

Retired Vitreoretinal Surgeon Thomas Pheasant and his wife Linda now call the experience “miraculous.” They spent days in the ICU, watching and waiting. As a father and a physician, Dr. Pheasant was impressed with what he saw.

“Every member of the team was so kind to us. They went out of their way to make us comfortable, and the care Sarah received was quite remarkable,” Dr. Pheasant says. “The practices and the culture of caring were so impressive. When I was told that the ICU had had no central line infections in more than a year, I knew they paid attention not only to the small things but the critical things, too. The hospital staff displayed a combination of kindness and competence. And I know that for a very bad random event the outcome is amazing.”

After five days in the ICU, Sarah had stabilized and was moved to a regular unit, where she spent several weeks. Then Sarah spent a week at MedStar National Rehabilitation Hospital for cardiac rehab, before returning home to rebuild her active life.

Gratitude and Generosity

Today, Sarah is back to work, and back to walking in her neighborhood. Tennis, she says, is next on her “to do” list. “My family and I are so appreciative to the hospital and the entire team. When I talked to my Dad, he said he wanted to make some kind of gift, to say thank you,” Sarah explains.

“My wife and I know that Sarah is alive, because she had the right doctors with the right skill set, doing their job well,” states Dr. Pheasant. “I wanted to give a gift to the staff, because they made it possible for my entire family to celebrate the holidays together. My wife and I directed that the donation be used to fund educational efforts for the hospital staff.”

“We are extremely grateful to the Pheasants for their generous gift,” says Richard Kief, senior vice president and Chief Philanthropy Officer. “Their contribution recognizes the incredible skill and clinical expertise of our physicians, nurses and techs. It will help us continue to offer our staff rich continuing educational experiences, which are vital to providing a high level of quality care at the Hospital Center.”

Last fall, Sarah, her family and the team that saved her life met once again at a luncheon.

“I had the good fortune to be present when she came to the hospital. And it was absolutely wonderful to go to the luncheon and see her,” Dr. Booker says. “In 15 years as an emergency physician, I have never later met with someone who had arrested and I had revived. It’s nice to consider all the things Sarah may do in her life, and it’s a privilege to have helped make that happen.”

Emil Cohen, MD, Interventional Radiology; Sarah; Matthew Schreiber, MD, Critical Care Medicine and Ethan Booker, MD, Emergency Medicine, celebrated Sarah’s recovery.
The John J. Lynch, MD Center for Ethics

Difficult Decisions helped by Clinical Ethicists

Every day, physicians encounter ethical conflicts that need to be resolved. When does life-saving become death prolonging? Who is the true surrogate decision-maker in a divided family? Is the patient competent to make decisions about his or her care? What should be done, when team members disagree about treatment?

Fortunately for physicians at MedStar Washington Hospital Center, a team of highly-trained clinical ethicists is available 24/7, to help with those difficult decisions. The Center for Ethics developed from the bioethics committee spearheaded by John J. Lynch, MD, an oncologist who recognized the need for this unusual kind of resource at a high-volume, high-acuity hospital such as the Hospital Center. The Center is now named the “John J. Lynch, MD, Center for Ethics” in honor of its beloved founder and medical director, who died in January 2016.

The Center was one of the first of its kind, and remains one of the most recognized voices in the bioethics community. Under the leadership of its new director, Norine McGrath, MD, it is poised to expand its influence.

In addition to her duties as the Center’s director, Dr. McGrath is also an attending physician in the hospital’s Emergency Department. After completing her residency in Emergency Medicine at the University of Chicago, she pursued a fellowship in Clinical Ethics.

All hospitals must have a bioethics committee, mandated by The Joint Commission. The Center’s staff participates in the hospital’s monthly bioethics committee, to discuss specific cases and address general issues. It also collaborates with Palliative Care, Social Work, Psychiatry and Spiritual Care, to offer patients and families well-rounded support.

But the Center takes The Joint Commission mandate forward dramatically, undertaking a wide range of ethics activities.

Consults. Every year, the Center’s ethicists participate in some 350 consults, nearly one each day. A consult can be called by a physician, other team member, patient or family member. The purpose can be to help families make end-of-life decisions, to assist team members to settle differences or to settle another challenge.

“Physicians have the primary relationship with patients and families, and a lot of times, these decisions are straightforward,” Dr. McGrath says. “We get involved when the situation is more complex—a patient can’t make decisions, the family is contentious, there’s disagreement among the treating team—when decision-making or the decision-maker is not clear cut. Sometimes, these situations are ethically challenging, and there are no great answers.”

Dr. McGrath stresses that physicians remain the most important voice. “We expect doctors to be medical experts, not experts in ethics. We are there to assist and answer, or to facilitate a family meeting. By default, we become the experts in communication. We want to be there as an asset and consultant.”

Rounds. Clinical ethicists participate in rounds on units that see the most ethical dilemmas—medical and surgical ICUs, NICU, Trauma, Burn and Advanced Heart Failure. The purpose is twofold: facilitate decision-making when appropriate, and expose residents to clinical ethics thinking.

Evan DeRenzo, PhD, joined the Center 18 years ago, and is now the senior clinical ethicist. “Participating in rounds is an important part of our mission at the hospital,” she says. “As each patient is discussed, we can weigh in as needed on decision-making, and can help identify any potential conflicts.

“We practice ethics here in a way that is consistent with the way physicians are trained,” Dr. DeRenzo adds. “We use a contextual, virtue-based approach that helps physicians make the best decisions for their patients. We work with the team to help everybody make the best decisions for the best outcomes that are medically reasonable, for patients and families.”

Education. The Center’s clinical ethicists play an important role as educators, conducting programs on such topics as Advance Directives and Informed Consent, and distributing information materials for patients and families. The Center offers training for...
residents in formal sessions about ethics, and informal sessions in which residents can discuss moral distress. A one-month clinical rotation in bioethics is offered to interested residents. The staff also conducts regional training for social workers, and has instituted an ethics support group for respiratory therapists.

The Center’s Clinical Ethics Immersion program, held biannually, is a four-day course in which participants round with senior clinical ethicists in intensive care units and respond to case consultation requests. They also engage in discussions with resident and guest faculty, on topics such as intensive and emergent care, law, moral philosophy, psychiatry and other subjects essential to the practice of clinical ethics. Participants take part in simulated consultations with trained actors, in MedStar’s Simulation & Training Environment Laboratory (SiTEL).

The Center also publishes the Journal of Hospital Ethics (JOHE), an educational tool for the hospital community. “JOHE is a vehicle for us to educate the community in the practical clinical application of ethics. It is a beacon out of this Center to the hospital ethics community, about taking care of patients and elevating the ethical climate from a virtue perspective,” Dr. DeRenzo explains.

Policy. The Center’s staff also works with the hospital administration on the development and implementation of any hospital policy that has an ethical component. This can include policies that address withdrawal of care, informed consent, advance directives, surrogacy, organ donation, patient restraints and patient rights.

The John J. Lynch, MD Moral Courage Awards recognize individuals at the hospital who have exemplified courage, when acting against difficult and ethically challenging circumstances. Established in 2010, these biennial awards have become a way in which hospital leaders can communicate about values they consider central to creating and sustaining an ethically sound climate.

“Physicians trust us to understand the practice of medicine and help them make the best decisions for their patients,” Dr. McGrath concludes. “We work with the team to help everybody make the best decisions for the best outcomes medically reasonable for patients and families. We support our clinicians in making that happen.”

For an ethics consult, call pager 202-801-1005.
TeleTriage in the ER: One-to-One, One to Many

The strength of telemedicine’s virtual patient encounter is being tested within MedStar Washington Hospital Center’s Emergency Department (ED). Initial results: Two thumbs up.

TeleTriage, a pilot program underway since fall 2015, is speeding care delivery and improving patient perception of their ED experience. It is specifically targeting patients in the mid-range of acuity, who might spend hours of wait time between triage and administration of doctor’s preliminary orders.

The TeleTriage program represents the natural progression of a system established in 2009, to decrease wait times for patients. “A physician was put in place in triage alongside the nurse and tech during the ED’s busiest times, between 12 and 9 p.m.,” explains Ethan Booker, MD, Emergency Medicine. This designated “Gold Team” physician serves multiple patients, moving between five intake rooms and the ambulance bay, and accessing one computer housed nearby to input orders for between 75 and 80 patients during peak time.

“Still, we thought we could improve the process, if we conducted the initial physician review remotely via computer,” Dr. Booker explains. “We began testing some off the shelf software. Then Dr. Smith connected us with a start-up technology company, which helped us develop a telemedicine portal and flow management system to meet our needs.”

Mark Smith, MD, director of MedStar Institute for Innovation (MI2) and former chair of Emergency Medicine at the Hospital Center, introduced Dr. Booker to Ed Barthell, MD, founder of EmOpti, a company that was developing a teletriage platform for emergency departments. It was an excellent fit, says Dr. Smith.

Efficient Virtual Encounters
“New information and communication technologies are transforming the patient-clinician encounter, and moving at least some of those encounters into the virtual world,” says Dr. Smith. “MI2’s role at MedStar is to catalyze change that advances health. Piloting TeleTriage in a busy ED like the Hospital Center is ideal. Can we decrease the time that patients wait to receive care? This pilot is demonstrating the virtual encounter works at multiple levels.”

In the pilot program, the remote physician is providing triage for both the Hospital Center and the lower volume ED at MedStar Good Samaritan Hospital in Baltimore. The physician sits in a command center, with three computer screens. One computer serves as the patient teleport; a second is dedicated to physician order entry; a third provides electronic medical records that document previous patient encounters and give historical information.

“It’s a better use of physician skills,” says Dr. Booker. “We are away from the distractions of a busy ED, that pull us from evaluating patients and placing orders. Remote triage allows physicians to be more efficient and give patients our undivided attention,” he explains.

In a typical encounter, patients are triaged by a nurse, who then contacts the remote physician and makes a short presentation summarizing the patient’s
condition. The physician speaks to the patient, makes a preliminary diagnosis and immediately places orders into the system. The patient doesn’t return to the outer waiting room, but moves to the internal waiting area for initial diagnostic testing.

Of the approximately 6,000 patients seen since the TeleTriage system was initiated, median wait time between the nurse’s request for a consult and the time the physician sees the patient on the screen is 43 seconds. The average length of time spent on screen with the patient is one minute, 30 seconds, and median door-to-doctor time is 30 minutes for these consults.

“During the consult, I can also check a patient’s previous medical history,” says Dr. Booker. “Patients who are referred to the ED are tagged in the system for pre-arrival, and I can contact the referring primary care doctor or specialist if needed. Downstream, when the patient is given a bed, the treating physician has more complete information.”

Expanding Expertise to Other EDs

Data for a single representative eight-hour shift shows that of a total of 104 patient consults, 96 were from the Hospital Center and nine from MedStar Good Samaritan.

“I think those numbers demonstrate one of the best reasons for this program. We can provide a flexible service to multiple sites to meet irregular demand,” says Dr. Booker. “It’s the shift from the one-to-one model to the one to many.”

“The system provides a unique opportunity to expand the program to other MedStar Health EDs,” says Jeffrey Dubin, MD, chair, Emergency Medicine at the Hospital Center. “TeleTriage is a very efficient way to staff less busy emergency rooms that have sporadic needs. The pilot has also shown that patients are in and out of triage faster with very little wait time to see a physician. And physicians write and initiate orders in a far more efficient way.”
Bilal Yousufzai, MD
Ophthalmology

There is one patient that Bilal Yousufzai, MD, will always remember.

The man spent much of his workday driving, until he was sidelined by worsening cataracts. With a simple surgery, Dr. Yousufzai—now chief resident, Ophthalmology—was able to restore that patient’s vision, getting him back to work and to a restored quality of life.

“That quality of life improvement is rewarding not just for the patient, but for me,” Dr. Yousufzai says.

Both of Dr. Yousufzai’s parents have a biomedical background. His father is a researcher, and his mother works in a hospital lab, so a career in medicine was always on his radar. But Ophthalmology found him, not the other way around: As an undergraduate, Dr. Yousufzai stumbled upon Ophthalmology while looking for research opportunities. The research position he secured focused on diabetic eye disease.

Years later, he now finds himself treating that same disease from a totally different angle. “Now, as a clinician, I treat it with an injection or laser, while my biomedical counterparts try to tackle the actual disease process.”

For Dr. Yousufzai, the decision to pursue Ophthalmology became clear, once he had a chance to explore specialties at the Medical College of Georgia, at Augusta University. He realized that Ophthalmology gave him the chance to treat patients both medically and surgically, and also, develop long-term relationships with them.

“What I love about this career—beyond the learning, the surgery, the medicine—is the interactions you make with your patients, just by virtue of being in a room, consulting or consoling,” Dr. Yousufzai says. “You are making a difference with your own personal interactions, and being able to do that on a daily basis is a really attractive thing.”

For Dr. Yousufzai, the area in which he’s grown the most has actually been in the “unlisted” responsibilities of the job—both on the resident and the patient side.

“I may not have all the answers, but I try to make sure to get them to the physicians who have the answers,” he says. “This experience has forced me to grow clinically, organizationally and as a mentor.”

After his year as chief, Dr. Yousufzai will be in a two-year retinal fellowship at the University of Pittsburgh, spending two years focusing on his very favorite part of Ophthalmology.

“I love looking at the retina the most,” he says. “It’s the ‘film’ of the eye; it processes the light and sends it to the brain, so without a good retina, you won’t get a good image. But you can also see inflammatory diseases or metabolic diseases. So many things that can present in the eye; it’s really a glimpse into the health of the body.”

He is most excited for the complex clinical cases and intellectual challenges that will surely come from that experience, which he begins in July.
Amanda Beirne, MSN, ACNP-BC
Cardiac Electrophysiology

Amanda Beirne, MSN, ACNP-BC, is a master at balancing her days, between her clinical duties as Chief Nurse Practitioner, and her strategic efforts as an administrator for Cardiac Electrophysiology (EP).

At MedStar Washington Hospital Center, Beirne “spends 100 percent of my time as a clinician, seeing patients.” The EP nurse practitioners at the Hospital Center are the frontline caregivers for the procedural area, the inpatient service and for rounding and doing consults.

In the outpatient area, “we are integral to the safety and throughput for each patient,” Beirne explains. “We take care of the history and physical and the intake of all other information. We may or may not change the treatment plan for the patient, depending on what clinical information we receive. We expedite the process for the periprocedural area for eight to 14 complex patients every day.”

For the inpatient service, the NPs manage care for anyone who has a procedure and then needs an overnight stay, and for patients transferred from another hospital, admitted from the Emergency Department or directly from home with primary arrhythmia problems.

When the NPs round and are called to consult, they see as many as 20 to 30 patients each day in the ED, OR, PACU, ICUs, clinics and other procedural areas, such as the Endoscopy Suite or Cardiac Cath Lab.

“These consults are for patients with any range of electrophysiologic complaint, such as syncope, bradyarrhythmias, tachyarrhythmias; device-related issues, such as battery depletions, lead fractures or device infections; evaluations for eligibility for pacemakers or defibrillators. They are going to be admitted, or who have already been seen by an attending physician who believes that Electrophysiology should come in, to assess the patient.”

The frontline evaluation and care that the NPs perform “frees up our attendings, who can then spend a full day in clinic and as a consultant for new patients,” Beirne explains.

But Beirne’s day includes much more than seeing patients. “All my administrative work is in between patients, and after seeing them for the day. In the ideal world, I’d like to spend one day a week at our clinics in Northern Virginia, MedStar Georgetown University Hospital and our other sites, to be a visible presence at all our locations, and get a better idea of how to help each one a little more.”

Beirne currently manages 13 EP nurse practitioners across multiple hospitals and clinics in Maryland, Virginia and the District of Columbia. She coordinates peer reviews, certification and regulation compliance, hires and on-boards new nurse practitioners, and advises the head of the department about nurse practitioner strategy.

Beirne began her career as a patient care technician in the Coronary ICU at Medical College of Virginia in Richmond before becoming a nurse, then a nurse coordinator and ultimately, a nurse practitioner. While she spent some time finding the perfect role, she notes that her field of choice was always cardiology, a decision she attributes to the sudden loss of her father from a heart attack, when she was a toddler. She joined the Hospital Center team in 2012, after working as a nurse practitioner in the Cath Lab and EP Lab in the University of Virginia Health System.

While Beirne admits the chief NP position is a balancing act, she feels it’s a great fit for her skills and talents. She prides herself on her ability to talk with anyone, and to relate to different people of all professional levels. And, say her colleagues, she has the rare combination of good bedside manner and great time management.

Beirne also loves the complexity of her role, figuring out the very different needs of different groups, and what they need to be successful.

“The Hospital Center’s needs are not the same as those in our Fairfax clinic,” she notes. “They have different patient volumes. Fairfax initially required significant focus on patient outreach, but now we have to balance where our providers are located on a day-to-day basis, in order to ensure patients are seen quickly and efficiently. It differs from the Hospital Center’s constant, high volume and high acuity patient population, which comes directly to us and is all under one roof. I like the challenge of all that, and the challenge of growing with our service line.”

Beirne says that joining the Chief Advanced Practice Clinician leadership team has been an insight into an incredibly dynamic peer group. “This group of chiefs is really top notch,” she states. “Everyone is smart, down-to-earth and charismatic. I truly look forward to meeting with them, and hearing their ideas”

Even with her busy days in the hospital, Beirne sometimes prefers to take the long way home. “When I’m not at work, I’m on my bike,” she confesses with a laugh, although she admits to taking some time away from the street during the dead of winter. Beirne races competitively in road cycling and mountain biking, and this past year, won the Mid-Atlantic Cyclocross Series for her competitive category.
The MedStar Heart & Vascular Institute (MHVI) cardiac catheterization lab at MedStar Washington Hospital Center (MWHC) is the home to one of the nation’s leading interventional cardiology programs. Our catheterization labs embrace change by remaining on the forefront of innovation. MHVI catheterization labs serve as an investigational site for the newest, most promising technologies.

The depth of our expertise is matched only by the breadth of our offerings. All interventional cardiologists at the MWHC cath lab are experienced operators, performing complex coronary interventions, including left main stenting, rotational atherectomy, coronary imaging (IVUS and OCT), brachytherapy, chronic total occlusions (CTO) and complex high-risk indicated patients (CHIP). Complex peripheral interventions, including thoracic and abdominal aortic endovascular repair, are performed routinely, as well as above and below knee angioplasty, with high success rates.

The MWHC catheterization lab is a national leader in structural heart and valve interventions. To ensure procedural accuracy, our cath lab is complemented with three state-of-the-art cardiac computed tomography (CT) scanners, operated with experts in cardiovascular structural imaging. For the last 10 years, we have been treating patients with severe aortic valve stenosis, using different transcatheter aortic valve replacement (TAVR) technologies. Currently, patients with high and intermediate-risk for surgical complications are candidates for TAVR. However, our cath lab offers TAVR for patients who are low-risk, as part of low-risk TAVR (LRT) trial.

To accommodate different types of mitral valve disease, our cath lab offers the MitraClip™ procedure for mitral valve regurgitation, total transcatheter mitral valve replacement, for patients with severe mitral stenosis due to degenerative disease or failing prosthetic surgical valve. We are also among the first to offer percutaneous tricuspid valve repair, using Tri-Align™ technology, and pulmonic valve replacement with the Melody™ valve.

With the recent development in left atrial appendage closure devices, our team offers options using WATCHMAN™ and Amulet™ devices. Atrial septal defects (ASD) and ventricular septal defects (VSD) are treated with the AMPLATZER™ device with high success rates.

Recognized nationwide, MedStar Heart & Vascular Institute interventional cardiologists provide comprehensive care of the highest quality, ensuring that patients receive the most advanced and up-to-date therapies. For any questions, please call 202-877-5975.

From the Desk of...

Lowell Satler, MD
Director, Cardiac Catheterization Lab at MedStar Washington Hospital Center