Leaders for the EP retreat included Zayd Eldadah, MD, PhD, MedStar Heart & Vascular Institute director, Electrophysiology; Lynn Orosco, Organizational Effectiveness, MedStar Health; Glenn Meininger, MD, FACC, director, Electrophysiology and associate chief, Cardiology at MedStar Franklin Square Medical Center; and standing, David Strouse, MD, Electrophysiology, Northern Virginia offices; Susan O’Donoghue, MD, Electrophysiology, MedStar Washington Hospital Center.

Cardiac Electrophysiology
Fostering Teamwork Through Creativity
All providers can have a decided impact on the success of this year’s hospital goals and objectives. There are four specific areas where we can direct our focus and daily efforts:

- Interdisciplinary Model of Care (IMOC)
- Length of stay (LOS) and throughput
- Hospital acquired infections (HAI)
- Advances in Quality and Safety (Q&S)

**IMOC, LOS and Throughput**

IMOC is a MedStar-wide process that requires daily rounds, spending at least five minutes with each patient with the bedside nurse. There should be discussions with the patient and family/friends about treatment plans, and when to expect the patient will go home. Our focus this year is to discharge patients before 11 a.m. We can drop our case mix index-adjusted LOS and the number of Emergency Department boarding hours, by having appropriate lengths of stay for every patient.

**Here’s what you can do:**

- Round daily, to identify when a patient can go home, and start the discharge process at the first appropriate opportunity.
- Write discharge orders by 9 a.m., so patients can leave at 11 a.m.
- If family members say they cannot pick up the patient in the morning, explain that the patient will not wait in a bed, but will be discharged, and wait for his/her ride in our Discharge Hospitality Center.
- Discuss your ideas for better throughput and discharge with your unit team, and your Medical Director/Nursing Director dyad.

**Hospital Acquired Infections**

Each of the HAI interdisciplinary teams has a sponsor who meets monthly with the MD/ND dyad leaders. I am the sponsor for central line-associated bloodstream infections (CLABSIs); here are the others:

- Surgical Site Infections (SSI), Sue Eckert, MSN, RN, NEA-BC, CENP, Chief Nursing Executive
- Clostridium difficile (C.diff), Karen Jerome, MD, vice president, Quality, Safety & Risk Management
- Catheter-associated urinary tract infections (CAUTI), Mark Marino, MSN, RN, CPPS, interim director, Nursing Quality, Safety and Education
- Sepsis, Dr. Argyros, Dr. Jerome and CNE Eckert
- Hand hygiene, Dr. Jerome

**Advances in Quality & Safety**

We want to demonstrate improvements in our quality of patient care, and in patient and associate safety, through metric improvements in serious safety events, the number of hospital acquired pressure injuries, associate percutaneous injury, the mortality ratio and improvements in our just culture. When we examined the FY 17 serious safety events (SSEs), our analysis found the primary cause was failing to apply our high reliability organization (HRO) safety tools, particularly the “stop, think, validate and verify” tool.

**Here’s what you can do:**

- Work to prevent safety events and near misses, and use the Patient Safety Event (PSE) reporting system to record events that do occur. Don’t assume someone else will report them.
- Take part in the new hospital-wide mortality review conference, which should begin this fall.
- Take part in your department’s action plans for a non-punitive response to errors.

The Greek philosopher Plato is quoted as saying, “The beginning is the most important part of the work.” Our beginnings for these goals are important, but equally important is the work we will do to reach our goals, and sustain them past the end of this fiscal year.

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.
Listening to music on the Metro was a routine part of Lauren Kotwicki’s daily commute, a way to relax after a busy day at her job with the U.S. Department of Health and Human Services.

Arriving home one evening this past February, however, Lauren took off her headphones and discovered she couldn’t hear anything in her right ear.

What Lauren initially shrugged off as simply being part of a cold became much worse overnight, as she began experiencing severe nausea and vertigo. By morning, she could barely make it to a nearby urgent care center, where she was told she had a labyrinthitis, a serious inner ear infection that is usually caused by a virus.

“They gave me some medication for the nausea, and sent me home,” Lauren recalls. “I hoped that would be it.”

It wasn’t. Lauren’s symptoms persisted, rendering her unable to go to work or eat, which added to her anxiety, as she is a Type 1 diabetic. Yet, visits to other health care providers proved fruitless and frustrating. She couldn’t eat, and couldn’t hear in her right ear.

The answer came when Lauren finally was able to see Selena Briggs, MD, PhD, FACS, MBA, an otologist, neurotologist and skull base surgeon at MedStar Washington Hospital Center. Dr. Briggs diagnosed Lauren’s condition as sudden sensorineural hearing loss (SSHL), the cause of which can be difficult to pinpoint, but can range from infections to skull base tumors.

Within the United States, up to 100,000 people experience SSHL each year, typically presenting with sudden decrease in hearing in one ear, or both ears, ringing in the ear(s), and/or a sensation of plugging. Vertigo and dizziness may also accompany the symptoms. Of those individuals affected, about one-third recover most of their hearing spontaneously, usually within the first few weeks from onset. Up to two thirds of individuals remain with some degree of residual hearing loss after the initial incident. According to Dr. Briggs, the condition should be treated as an emergency, as delay in intervention can result in permanent hearing loss.

“If we see patients immediately—within the first week of onset—treatment options typically produce better outcomes.” One commonly used option is steroid therapy, either oral, as an intratympanic steroid injection, or in combination.

Although imaging and other tests indicated no presence of a tumor, Lauren faced long odds of recovery, since her onset of SSHL was more than two months earlier. Still, Dr. Briggs felt it might be possible to restore at least some of her right-ear hearing.

“She was very honest, yet also encouraging about my chances,” Lauren says, adding that Dr. Briggs also cautioned her that taking shots in the ear would sting for a few seconds.

As uncomfortable as that treatment may sound, it’s still a far cry from how SSHL used to be handled, says veteran Hospital Center Otolaryngologist Ziad E. Deeb, MD.

“Up until about 20 years ago, a patient with unilateral hearing loss would be admitted to the hospital,” he says. “We didn’t want the patient moving around very much, so we’d prescribe bed rest and treatment with diuretics to decrease the build-up of pressure in the ear.”

Dr. Deeb adds that because of SSHL’s mysterious origins, “a patient might be examined for everything from a microvascular event in the ear or brain stem, to syphilis.”

Although the average age of onset for SSHL is 40s to 50s, SSHL can occur at any age, as in Lauren’s case, at age 30.

It’s important for patients and providers to have SSHL on their radar. “Often when patients experience sudden hearing loss, they just assume it is something temporary, like congestion or ear wax,” Dr. Briggs says. “A primary healthcare provider can easily determine whether the patient simply has a buildup of wax or fluid in the ear.”

If not, the patient should undergo a hearing test, and get a referral to an otolaryngologist.

Five months after her odyssey with SSHL began, Lauren reports she has yet to regain full hearing in her right ear, and is undergoing physical therapy to help deal with the vertigo. Yet she’s also heartened by Dr. Briggs’ assessments of her periodic hearing tests.

“I had seen so many people, and she was the only one willing to try something,” Lauren says.

Even if her hearing loss is permanent, Lauren is determined to make sure none of her friends relive her experience.

“I told a friend who was having hearing issues to get to a specialist immediately,” she says. “Just because urgent care can see you right away doesn’t mean they’re 100 percent right. Do the follow-up, and get other opinions.”
During the past several years, the Section of Cardiac Electrophysiology in MedStar Heart & Vascular Institute (MHVI) has rapidly become one of the largest and busiest practices of its type in the country. In addition to performing thousands of EP procedures annually, and providing a variety of other diagnostic and treatment services at multiple locations, the EP staff is widely recognized for cutting-edge research programs and technology resources.

One might assume that these and other attributes would mean few worries for Zayd Eldadah, MD, PhD, MHVI’s director of Cardiac Electrophysiology. Dr. Eldadah wondered whether a good program could be made even better. He also worried that his section’s accelerated expansion in both size and geography had inadvertently created barriers to effective collaboration, which could hamper operational efficiency and patient care.

Cardiac Electrophysiology had grown from three physicians and a small staff, to an 80-person team at hospitals and clinics throughout the region.

Strengthening Relationships

“We felt the need to reinvigorate the noble, common mission that all members of our team share, and to further that mission by strengthening our relationships with one another,” Dr. Eldadah says. “It is essential for our patients, and for us, to remember that our patients’ well-being is our fundamental focus, and that we must function in a way that is as compassionate, consistent and coordinated as we possibly can be across the entire organization.”

After consulting MedStar’s corporate Human Resources department, Dr. Eldadah worked with Lynn Orosco, an organizational effectiveness consultant and facilitator, who has helped other MedStar groups tackle issues related to team-building, leadership development and change management.

Orosco approached the EP Lab’s issues in the same way a physician treats a patient—gathering information about the department and its people, in order to formulate the most appropriate strategy for affecting positive change. “We learned about how they work as a team: internally, as part of the EP Lab organization and within MedStar.”

Based on responses to interviews and group sessions conducted with EP staff in Washington, Baltimore, Southern Maryland and Northern Virginia, Orosco discovered that while the team shared many attributes and goals, its members really didn’t know each other outside of their immediate work groups.

Priority: Team-Building

Those insights formed the foundation of the strategy’s centerpiece event, a two-day retreat at Kent Island, Md., that blended team-building exercises, didactic sessions, technology workshops and, perhaps most importantly, social interaction among every staff position from the geographically-dispersed offices.

Although the setting was selected to provide a relaxing, open environment for interaction, Orosco wanted to ensure participants didn’t instinctually gravitate toward familiar faces. She divided them into four groups, with given names taking the place of titles. Leading up to the retreat, EP staff members were asked to take an online assessment, which provided insights on how they learned and approached projects and problems.

“It’s human nature for each of us to have different approaches to learning,” Orosco explains. “Unless it’s recognized, however, it can lead to miscommunication and conflicts. Each person was categorized into one of the four learning styles: accommodating, converging, assimilating and diverging. Different versions of
teams, some with all the same style and others with all styles represented, were created for the exercises.”

The exercises ranged from visualization practices to help focus group thinking, to drawing and sharing images that symbolized each person’s discovery of something important in their lives. There were also conversations where participants discussed their interest in choosing health care as a career, and what they found most fulfilling about their work.

“We are a group of committed professionals, each essential to the other, with a common mission,” Dr. Eldadah says. “And our time together allowed rich interaction, often with people we did not previously know.”

Marshmallow Challenge

The retreat culminated with an 18-minute creative exercise, the “Marshmallow Challenge.” Reorganized into new, more diverse teams, the groups were tasked with building a free-standing structure out of sticks of spaghetti, tape, string and one marshmallow, which had to be placed on top.

“The marshmallow symbolizes an organization’s goal, which should be the most important thing it has,” Oroso says. “But most teams focused on building structure, then putting marshmallow on top at the end.” Such an approach, she says, illustrates how groups lose sight of the organization’s overall goal, concentrating instead on the minutiae of methods.

Exceeded Expectations

By the time the participants said their farewells, it was clear that the retreat had more than exceeded expectations. “It blew me away,” says Glenn Meininger, MD, FACC, director of Electrophysiology and associate chief of Cardiology at MedStar Franklin Square Medical Center. “As reluctant as we were to give up a Saturday, we all walked away amazed at how big we are as a group, and what resources are accessible to us.”

For example, Dr. Meininger says he wasn’t fully up to speed on MedStar’s genetic counseling services when he came to the retreat. “Since then, I’ve referred several patients to that service,” he says. “Knowing it’s available is helpful to all of us.”

David Strouse, MD, who is based at MHVI’s Virginia offices, found the insights about the different problem-solving approaches particularly valuable. “It’s a reminder that each of us has different skills and roles to play,” he says. “We’ll be better able to work together to fulfill those roles.”

Susan O’Donoghue, MD, who practices at the Nancy and Harold Zirkin Heart & Vascular Hospital at MedStar Washington Hospital Center, adds that having greater cohesion across the EP team will have a direct benefit on patient care. “Patients can sense when people treating them know each other well, and respect each other’s abilities,” she says.

Result: Success

Oroso believes the retreat was successful because the participants met and interacted with each other as equals. “We requested that everyone be open-minded, patient and curious,” she says, “and they all were.”

Oroso is helping the EP section’s leadership ensure that the retreat’s lessons endure and flourish. Along with additional sessions at the individual locations, there will be a book of materials that captured the retreat’s activities and revelations, for use as a staff reference and an orientation guide for new associates.

Dr. Eldadah believes other departments and sections could benefit from similar experiences of their own. “Coming together in such a respectful, creative and uplifting way allowed us to emerge as better colleagues and better caregivers,” he says. “We spend so much professional time together. We owe it to our patients and to ourselves to give our mission—and each other—our best.”

Dr. Meininger agrees. “I think we already knew we have a good program, with a lot of good skill sets blended together,” he says. “But we have so much going on, that it’s hard to take time and do things that help us work better together. Without the retreat, I’m not sure we would have done this at all.”
It has been more than 30 years—nearly half her life—since Loraine Green has been in good health. A team of medical specialists, all members of the Medical & Dental Staff at MedStar Washington Hospital Center, has been instrumental in keeping her alive and providing a decent quality of life, demonstrating the value of expertise and teamwork.

Now 66, the D.C. resident began her medical odyssey, with a diagnosis of Type II diabetes. Soon to follow was a diagnosis of hypertension. For each condition, she followed a strict medical regimen and struggled to lose weight, keeping up with her job as a librarian at the Library of Congress. But in 2004, her kidneys failed, putting her in need of dialysis.

Enter Gilberto Vera, MD, a nephrologist, who began seeing Mrs. Green regularly to manage her three-times-a-week dialysis. “She was very unstable at the beginning,” he now remembers. “And along the way, she has had serious complications.”

Maintaining a viable vascular access point proved a challenge. Mrs. Green’s daughter, Toelithia, estimates that her mother had some 25 surgeries to change access points.

Enter Tareq Massimi, MD, a vascular surgeon, who moved the dialysis access point from arm to arm. “Many long-time dialysis patients develop clots and infections in their grafts,” he acknowledges. “Most grafts are placed in an arm, so when there is a blocked vein in the chest, the grafts keep clotting. The next option is a tunnel catheter, which makes the patient susceptible to infections.”

Enter Jesse Garcia, MD, another vascular surgeon. “We had exhausted access graft options in her arms,” he says. “She was a good candidate for a HeRO Graft that goes straight to the heart. This gives her better dialysis access and because it’s under the skin, it decreases infections.” There are only a few surgeons in the area who place the HeRO Graft, and Mrs. Green underwent the procedure in 2015.

Around the same time, she began experiencing severe back pain. Multiple tests failed to determine the cause or source of her pain. After many doctor and emergency room visits, a culture finally showed a staph infection.

Enter a whole team of other specialists. With Dr. Vera as the main point of contact, the medical team swung into action. First, the infection needed to be controlled. Maria Elena Ruiz, MD, an infectious diseases doctor, started Mrs. Green on intravenous antibiotics. Cardiologist Bernard Wagman, MD, determined that she had endocarditis that had badly damaged her aortic valve. Jennifer Ellis, MD, a cardiac surgeon, was called in to evaluate her for valve replacement surgery.

In February 2016, Mrs. Green was scheduled for aortic valve replacement surgery. “When an infection shows up in the aortic valve, it can be hard to treat medically, especially given her diabetes and renal disease. Once the valve is destroyed, we are pretty aggressive at replacing it,” Dr. Ellis says.

After that, Mrs. Green endured multiple courses of antibiotics, outpatient and inpatient, to keep the infection at bay. But the pain persisted, and her
quality of life was severely compromised. It became clear that the staph infection had also severely damaged her spine.

Enter orthopaedic fellowship-trained spine surgeons James Tozzi, MD, and Oliver Tannous, MD. They agreed that a two-part procedure was the best option. First, Dr. Tozzi scheduled an L2 corpectomy for December 2016. “The infection had eaten into the bone, and we had to get the vertebra out,” he says. With Dr. Massimi’s assistance accessing the surgical site, Dr. Tozzi worked from an anterior approach, removing the infected collapsed lumbar vertebra and installing an expandable cage, to correct the resulting deformity and align the vertebra correctly.

Meanwhile, Dr. Ruiz worked to control an infection that had developed in the tissue valve to stabilize Mrs. Green for the second surgery. “We didn’t want to delay the surgery because every day that passed was bad for the spine,” she says. And the infection needed to be controlled, as a second aortic valve surgery was too high risk.

Dr. Tannous performed the second spine surgery five days after Dr. Tozzi’s procedure, using a minimally invasive posterior approach to install screws that stabilized her spine from the back. “We combined the best of two approaches to relieve her pain and stabilize her spine,” he says.

The end result was dramatic pain relief and finally the infection cleared. Now the team had to help her get back on her feet.

Enter Andrew Gordon, MD, PhD, a physiatrist at MedStar National Rehabilitation Hospital, where she went after discharge from the Hospital Center. “When Mrs. Green came to us, her stated goal was to ‘Beat this thing, do lots of physical therapy and walk without assistance.’ After two weeks here, with lots of help from our excellent nurses and therapists, she was able to leave, walking 500 feet with a rolling walker.”

All the doctors are very pleased with her progress. “This was a very complicated case and there was a lot of coordination involved,” Dr. Vera notes. “Hospital Center surgeons are the best of the best.”

“This is an example of a collaborative effort in a tertiary care hospital,” Dr. Tozzi adds. “We have the resources to give her an improved quality of life.”

Mrs. Green and her daughter Toelithia are even more pleased. “This is the first time in two years that I’ve been pain-free. I’m just like a motorcycle on the road now. I use my walker with confidence,” Mrs. Green says.

“The doctors are truly amazing,” her daughter adds. “The odds were against them as much as they were against her. But they took a personal interest and wanted to help her. We really appreciate each and every one of them.”
Should Birth Control Pills Be Offered Over-the-Counter?

Two obstetrician/gynecologists at MedStar Washington Hospital Center answer a resounding “yes” to this important question. The evidence is compelling.

Many countries around the world—including rapid-growth population centers, such as China and India—make birth control pills easily available to women.

In fact, the American College of Obstetrics and Gynecology (ACOG) went on record in 2012 that birth control pills should be available over-the-counter (OTC). The American Medical Association (AMA) and the American Academy of Family Physicians (AAFP) agree that the practice is safe.

Veronica Lobo-Gomez, MD
“With the former president of the North American Society for Pediatric and Adolescent Gynecology, I attended an ACOG meeting that convened all the stakeholders. There was a lot of discussion about adolescents’ access to over-the-counter contraception. They presented some very interesting data.

The first piece of data dealt with the availability of condoms. When condoms started to become widely available, there was a corresponding decrease in unplanned pregnancies.

Second, wider availability to birth control pills did not decrease women’s doctor visits. The data showed that women still went to their doctors for regular screenings. So making access to birth control easier did not necessarily decrease women’s seeking the health care they needed. That was reassuring.

Third, the small risks associated with birth control pills did not seem to merit limiting women’s access to them. After all, TYLENOL® use has a much higher incidence of health risks than birth control pills, and TYLENOL has long been over-the-counter. And pregnancy is far riskier than birth control pills.

The conclusions support the FDA’s efforts to change birth control pills to over-the-counter.

Simply put, all methods of birth control are better than nothing. Birth control pills are a great bridge until women are ready to commit to longer-lasting methods such as IUDs or implants.

When I went into that meeting, I was very skeptical. Now I think more access is better. The point is to reduce unwanted pregnancies.”

Pamela Lotke, MD
““I’m very much in favor of over-the-counter access to birth control pills. Unplanned pregnancy remains a big problem. Any way to increase access to contraception is a good thing.

In general, there is very low risk associated with birth control pills. It’s hard to overdose, and they’re not addictive. And birth control pills are far safer than being pregnant.

Still, it makes sense to develop a questionnaire or checklist for women to review about risk factors associated with birth control pills. The pharmacist could review the questionnaire and take their blood pressure to reduce risks even more.

The arguments people have against over-the-counter access aren’t valid. They worry that women won’t get routine screenings, but what we know now is that women still do go to their doctors for screenings.

For people paying out-of-pocket for health care, requiring a doctor’s visit for birth control pills is hampering access. Unplanned pregnancies are even worse for the budget.

All this is especially true for teens. Medically, economically and educationally, they face large barriers to health care. This is a group who could be very well served by over-the-counter access to birth control pills.”

DATA:
• In 2011, the unplanned pregnancy rate was 45 percent. (Guttmacher)
• Among women aged 19 years and younger, more than 4 out of 5 pregnancies were unintended. (CDC)
• The proportion of pregnancies that were unintended was highest among teens younger than age 15 years, at 98 percent. (CDC)
• Large increases in unintended pregnancy rates were found among women with lower education, low income and cohabiting women. (CDC)
In the spring 2013 Connections, three new residents—Jason Chen, MD, Surgery; Guillermo Rivell, MD, Internal Medicine; and Alex Shuster, MD, Emergency Medicine—shared their expectations for their residencies. We checked in with them in 2014, 2015 and again in 2016, when both Drs. Rivell and Shuster graduated.

Dr. Chen spent last year in a fellowship at MedStar Washington Hospital Center’s Firefighters’ Burn and Surgical Research Laboratory, under the mentorship of Jeffrey Shupp, MD, director, Burn Center. He has two more years of his surgical residency, and agreed to once again reflect on his past year and his goals for the future.

Burn Research
While the hours were more regular during this research year, the work was still demanding, says Dr. Chen. “As a surgical resident, you are an apprentice working directly with an expert surgeon, who tells you to ‘Do as I do,’ and that is how you learn. In research, you often learn on your own by trial and error. You figure things out, sometimes reinventing the wheel.”

In addition to having state-of-the-art equipment, there are subtle but critical nuances to set up an experiment for success, which cannot be found in another paper or book. But it’s been a good year for Dr. Chen. Under Dr. Shupp’s mentorship, Dr. Chen has won awards for his work in wound healing and health disparities at five competitions:

• From the American College of Surgeons (ACS) Committee on Trauma, both the local and regional research competition
• American Burn Association’s Carl A. Moyer Resident Award
• ACS DC Chapter All Surgeons Day
• MedStar Health Research Symposium

The year has helped to mold Dr. Chen’s future. “When I rotated on the burn unit as a second year resident, the operations were hot and long,” he recalls. “I did not love it.”

But after attending multiple burn conferences and meeting other surgeons and patients, he feels his calling in burn care. “There is a huge need in the nation and globally for burn surgeons,” he says. “Furthermore, there is a life-long gratifying relationship with burn patients. I also love the emphasis on the interdisciplinary model of care that The Burn Center has exemplified at this hospital. It is wonderful seeing physical therapists, pharmacists, nutritionists and nurses giving their input during rounds. They are a real team.”

Year Four
“I look forward to operating more and taking on greater responsibility,” he says. “I still encourage incoming interns to learn to be efficient team players.”

World View
During his four years here, Dr. Chen continues to believe in nationalized medicine, and that doctors should take an active role in politics. “It takes a village to raise a child,” he says. “It is a failure of society—state and country—not just an individual, when someone falls victim to addiction, obesity or cardiovascular disease. I hate to hear people say they don’t want to pay for someone else’s health care. It represents an ignorance toward the need for public health.”

Life Outside the Hospital
On a more personal note, Dr. Chen met his wife as a new resident: “You can find love as a resident!” They married last September, and have enjoyed their time while he worked “normal” hours in research. Their favorite restaurant is Izakaya Seki, and they enjoy their free time exploring the gardens at Dumbarton Oaks and the National Arboretum.
Fighting Antibiotic Resistance: An Effort for All Providers

by Glenn Wortmann, MD, director, Infectious Diseases

Every week, there seems to be a new story about emerging bacteria that is resistant to antibiotics, and therefore, a potential danger to the public. At MedStar Washington Hospital Center, we’ve heeded the call for more prudent use of antibiotics for several years now. So when The Joint Commission implemented its mandate to combat antimicrobial resistance in January, we already had a program in place.

According to the World Health Organization, “Antimicrobial resistance threatens the effective prevention and treatment of an ever-increasing range of infections caused by bacteria, parasites, viruses and fungi.” One simple reason for this is when a bacterium is exposed to antimicrobials, it mutates and becomes resistant.

Still, antibiotic use is rampant. The Centers for Disease Control reports that 20 to 50 percent of all antibiotics prescribed at acute care hospitals in the U.S. are either unnecessary or inappropriate.

Clearly, healthcare professionals must make an effort to curb inappropriate use of antibiotics. Here is what we’re doing at the Hospital Center:

Teamwork
We’ve established a multidisciplinary team of professionals to focus on antimicrobial stewardship. Consisting of representatives from infectious diseases, pharmacy, information technology and pathology, we are establishing guidelines for use, and are tracking adherence to these guidelines.

Guidebook
Working with the hospital’s pharmacists, we’ve developed a 20-page pocket-size guidebook that details appropriate antibiotic use. The book is organized alphabetically by diagnosis, and lists which antibiotics should be used for specific infections. To date, we’ve distributed about 1,000 of these guidebooks to clinicians throughout the hospital, and plan to distribute more to our new residents and fellows.

Clinician education
We’re educating clinicians about antimicrobial resistance and appropriate stewardship practices. We’ve developed a SITEL module, required for all clinicians, nurses and pharmacists, which details appropriate antimicrobial use. Additionally, we participate in Grand Rounds and other educational sessions, to drive home the importance of judicious use.

Patient education
Equally important, we are doing what we can to educate patients and families about the problems associated with overuse of antibiotics. For example, we have created posters for display in exam rooms in our ambulatory care clinics and in the Emergency Department, to serve as teaching aids.

It has been, and will continue to be, an arduous journey to reduce the over-prescription of antibiotics. That’s why we are asking all providers to educate themselves, and especially their patients, about the dangers inherent in overuse, and to consult the guidebook for information about proper use. Antibiotics have changed the face of medicine, and are life-saving when used appropriately. Let’s all work to keep that option open for everyone.

Causes of Antibiotic Resistance Crisis

- Overuse
- Inappropriate prescribing
- Extensive agricultural use
- Availability of few new antibiotics
- Regulatory barriers
Caring for the Wounded in a War Zone: Orthopaedic Oncologist on a Mission

Orthopaedic oncologist Brock Adams, MD, has taken surgical mission trips to Kenya, Ethiopia, Jamaica and Zimbabwe. But those trips didn’t quite prepare him for the surgeries he had to perform in Iraq, in a mobile hospital on the border of Iraq.

Dr. Adams, along with three general surgeons, traveled to Iraq as part of a trip with Samaritan’s Purse®, an international Christian relief organization. For three weeks this spring, he cared for a wide variety of patients as a member of the disaster assistance relief team for Samaritan’s Purse.

“Some patients were military personnel—fighters allied with the Iraqi force and some ISIS fighters, and others were civilians—men, women and children. All suffered large open wounds, caused by mortar fire, sniper fire and IEDs (improvised explosive devices),” Dr. Adams explains.

Picture large tents, set up like a Mobile Army Surgical Hospital unit. One tent is the Emergency Room, and two are designated operating rooms. There is a separate recovery tent for women, and another for children, alongside a tent for men. Surrounding the tents are large concrete walls for blast protection, and there’s a big gravel area around the blast wall. Enclosing it all is a big berm with razor wire, and Kurdish security guards are on patrol, ready to protect the mobile hospital.

Now envision the surgical theater, inside the tent. The equipment differs from an American hospital operating room, and there aren’t as many supplies as Dr. Adams would like. For example, the supply of external fixators he needs for orthopaedic surgeries was depleted on his second day in Iraq. Solution? An Iraqi surgeon found some at a local bazaar, and paid $25 for each one.

“There were other improvisations,” Dr. Brock says. “We fixed long bone fractures with nails, using the Surgical Implant Generation Network (SIGN) system. We frequently used Ketamine for sedation. We were short on pain relief medication, relying primarily on Fentanyl, Tramadol and TYLENOL®, even for children. It would have been nice to have had more pain medications, especially for those patients who needed amputations, but we found that most of our patients were incredibly stoic about pain.”

Details about the incoming wounded were often inadequate for the surgical teams to prepare for their patients. “We could be told that there were four patients coming in one ambulance in about an hour,” Dr. Adams recalls. “But when patients came, there might be eight of them, hours later than the time we anticipated their arrival, and we would finish 8 to 10 surgeries each day.”

The World Health Organization coordinated the ambulances, transporting most of the patients from Mozul, in northern Iraq. “Most of our patients arrived between 1 and 10 p.m. We tried to group the surgeries during that time period, and the process was more organized than I anticipated it would be, even though we were dealing with war injuries,” says Dr. Adams.

Having had other mission experiences as well as this particular one in a war zone, Dr. Adams would still recommend a mission trip for all types of healthcare providers. “Mission organizations are always looking for clinicians—surgeons, anesthesiologists, surgical assistants, nurses. They will call, based on what’s needed in any situation.”

Why does he take time away from his busy practice to volunteer his surgical skills?

“I do it because I enjoy it. I also like the fact that it’s easy to make an impact beyond delivering basic medical care.”
MEDSTAR CONFERENCE HIGHLIGHT
27th Annual Controversies in Cardiac Arrhythmias
October 20 | The Cosmos Club | Washington, D.C.
Course Director - Edward V. Platia, MD

According to the American Heart Association, cardiac arrhythmias have an estimated prevalence of 14.4 million patients in the United States, and they account for more than 40,000 deaths annually. New developments and advances in the management of cardiac arrhythmias afford benefits to patients who suffer from these conditions. Novel analytical approaches and important clinical trials challenge the practicing physician to implement translation of those discoveries into his clinical practice.

This one-day program is designed to provide clinicians with a review of selected topics in present day management of patients with cardiac arrhythmias, emphasizing new advances in the field and incorporating current guidelines and evidence-based principles of practice. The format will incorporate didactic lectures as well as case management studies and panel discussions with experts in the field.

For more information, please visit cme.medstarhealth.org/CICA

UPCOMING CME EVENTS
Gastric Soft Tissue Neoplasms 2017
September 23 | Park Hyatt | Washington, D.C.
cme.medstarhealth.org/GSTN2017

Pediatric and Adolescent Gynecology for the Primary Care Provider 2017
October 6 | Hyatt Regency | Bethesda, Md.
cme.medstarhealth.org/PedGyn

Current Issues in the Care of Dialysis and Transplant Patients
October 7 | Georgetown University Hotel and Conference Center | Washington, D.C.
cme.medstarhealth.org/Transplant

Update on the Treatment of Heart and Vascular Disease
October 14 | MGM National Harbor | Oxon Hill, Md.
cme.medstarhealth.org/uthvd

Lung Cancer 2017: Progress and Future Directions
November 4 | Renaissance Dupont Circle Hotel | Washington, D.C.
cme.medstarhealth.org/lungcancer

Advances in Gastroenterology for Primary Care Provider
November 11 | The Ritz Carlton | Washington, D.C.
cme.medstarhealth.org/GIPCP

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

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Welcome to New Members of the Medical & Dental Staff

Kathryn Beaudoin, CRNP  Cardiovascular Medicine
Damon Licari, PA-C  Cardiovascular Medicine
Sarah Thomas, PA-C  Cardiovascular Medicine
Molly Ambler, CRNP  Cardiovascular Surgery
Nicole Jacona, PA-C  Critical Care Medicine
Adeline Kranzburg, PA-C  Critical Care Medicine
Jessica Thurn, CRNP  Critical Care Medicine
Wesley Cook, CRNP  Hospitalist Service
Kristal Gardiner, CRNP  Hospitalist Service
Makeda Haileselassie, CRNP  Hospitalist Service
Alfonsine Mofor, CRNP  Hospitalist Service
Jordana Fein, MD  Ophthalmology
Helen Sax, MD  Radiology
Michael Schwartz, MD  Radiology
Richard Young, MD  Radiology
Leslie Cnossen, CRNP  Plastic Surgery
Gretchen Edwards, PA-C  Plastic Surgery
Anuj Prashar, DO  Surgery

 Welcoming New Residents and Fellows

MedStar Health welcomed 420 new residents and fellows during the two day, system-wide orientation, “Foundations in Educational Excellence.” Of that number, 137 new housestaff came to the Hospital Center. Among the topics included in orientation were patient safety, quality care, when to call an attending and how to care for themselves, as they start this part of their lives.

Congratulations to Dr. Burman

Kenneth Burman, MD, MACP, Endocrinology, received the Citation of Merit Award from the University of Missouri Medical School, the highest honor for alumni who have performed outstanding work in their fields. Dr. Burman currently leads the Integrated Endocrine Fellow Training Program for MedStar Washington Hospital Center and MedStar Georgetown University Hospital; and is a professor of the Department of Medicine at Georgetown University and at the Uniformed Services University of the Health Sciences. Dr. Burman has been participating in both clinical and translational thyroid research for nearly 30 years, and has produced more than 250 publications.
Afnan Mossaad, MD, learned at an early age what kind of doctor she didn’t want to be. At age 9, she saw patient care through the eyes of her 10-year-old sister, who was suffering from a brain tumor.

A specific memory is seared into Dr. Mossaad’s memory: Her sister’s physician entered the Texas hospital room, and matter-of-factly told her mother: “Your daughter only has a couple of months to live, and isn’t going to make it.”

That abrupt revelation, and the way in which the doctor delivered his prognosis—which ended up being incorrect—had a severe effect on her mother, who was already coping with the potential loss of her child, Dr. Mossaad recalls. It also had a lasting effect on Dr. Mossaad: It made her want to be a doctor, but a very different kind of doctor than the one she’d observed.

“It was a life-changing experience,” Dr. Mossaad says, of both the eventual loss of her sister, and the family’s interaction with her medical team.

Now as one of the chief residents for Internal Medicine at MedStar Washington Hospital Center, Dr. Mossaad says her family’s experience profoundly shaped her approach to working with patients.

“I try to be a doctor who treats patients and their families with empathy and respect, and seeks to understand what they’re going through.”

In part, it was that desire to build trust and empathy with patients that led her to Internal Medicine. “As an internist,” she says, “you’re the center of care for the patient, who really needs that one physician to coordinate health care and educate the patient on the disease processes and management.”

As Dr. Mossaad embarks on her year as chief, she says she is most excited to teach younger residents. “The chief year gives me the privilege of now focusing on teaching others, and helping to create an environment that is conducive to the success of our medical students and residents.”

After her year as chief, Dr. Mossaad hopes to stay in the world of teaching residents, working as an academic hospitalist. “I think it keeps you up to date,” she states. “When you’re around residents and medical students, they tend to challenge you, and force you to recognize what you don’t know and continuously build on your knowledge base.”

When she’s outside of the Hospital Center, Dr. Mossaad tries to challenge herself physically. An avid runner since her time as an undergraduate at the University of Texas at Austin, she’s recently added kickboxing to her weekly regimen. “There’s something about punching a bag,” she says. “It’s not only a great stress reliever, but also very empowering.”

Her long-term goal has always been to run a marathon, and even though she says she’s not there yet, she scoffs at the idea of postponing that goal during her chief year. “Hopefully not! I hope I can find time to keep doing the things I love.”

Dr. Mossaad grew up in Austin, Texas, and comes from a long line of Longhorns. And while her father has a doctorate in electrical engineering, she’s the only medical doctor in her extended family. “It’s an annoying thing,” she says with a mock laugh. “They expect me to know all the answers! But hopefully I’m making my parents proud—they have always been my motivation.”
Saumil Doshi, MD
Infectious Diseases

As a medical student at Temple University in Philadelphia, Saumil Doshi, MD, volunteered at Prevention Point, a non-profit that sought to stop the spread of HIV and Hepatitis C, through, among other strategies, a needle exchange program.

But the program, says Dr. Doshi, was always about more than just getting dirty needles off the street.

“It provided a point of contact, for an underserved population who had a distrust of health care,” says Dr. Doshi. “We were able to say ‘Look, we’re here to help,’ and offer a non-judgmental way of gaining access to care.”

For Dr. Doshi, the new director for the MedStar Washington Hospital Center Infectious Diseases Fellowship, it was a formative intersection between the clinical world of medicine and public health, and one that has shaped his philosophy as an educator.

During his residency at Bellevue Hospital Center in New York City, Dr. Doshi served on the “virology” rotation—the name given to the HIV rotation, to reduce stigma—for all three years. “The patients were sicker, and took a lot more time,” Dr. Doshi says, “but to me, they were also the most interesting and rewarding.”

The combination of experiences in medical school and residency prompted Dr. Doshi to apply for the Epidemic Intelligence Service fellowship with the Centers for Disease Control in Atlanta, a role that Dr. Doshi says is jokingly referred to as a “disease detective.” He joined the CDC at the height of the 2009 influenza pandemic, and played a central role in those investigations, but eventually found himself missing the clinical side of the work.

The delicate balance between the public health and clinical dimensions of infectious disease are paramount for Dr. Doshi, as he assumes his new role as fellowship director.

“For example, with infection control and antimicrobial stewardship, you have to have your feet on both sides,” he says, noting the limitations of many ID fellowships that struggle to incorporate a public health lens. “The typical fellowship model is based on clinical training, seeing patients and learning in lecture format, and that doesn’t quite translate to some of the other skills critical to this specialty.”

“Many antimicrobial stewardship programs are still in their infancy, and we’re still learning the best ways to implement them,” he says. And yet, fellows are still asked to assume a level of expertise in these developing areas. “I’ve had graduating fellows who—Day One out of their fellowship—are in charge of not just running a stewardship program, but creating one. So there has to be room to fit that training into a fellowship.”

Dr. Doshi, who joined the Hospital Center team after working in a clinical educator role at Howard University, is also a member of the D.C. Cohort, a longitudinal research project that collects clinical data on consenting HIV-infected District residents. That role, Dr. Doshi says, has allowed him to continue to pursue and bolster his passion for the public health side of this work, while still working as a clinician.

As he dives into the work of running the fellowship program, he says he’s excited to take an already stellar program and put his own stamp on it. “Every step I’ve taken, I’ve always been involved in the education of trainees,” he says.

In envisioning his value add, Dr. Doshi says top-of-mind for him is incorporating some of those pragmatic and public-health oriented pieces that are not typically part of an infectious diseases curriculum. “Let’s make sure you’re not only a well trained infectious diseases physician, but you have the skills to go out and do your job better. You’re not just going out and seeing patients, but taking on leadership and administrative roles in infection control, antimicrobial stewardship or clinic management.”

When he’s away from the hospital, Dr. Doshi is teaching in a different way. He is instilling a love for the outdoors in his two children, ages 3 and 7. They go hiking, biking or camping whenever they get a chance. For the future, Dr. Doshi is looking forward to a full-fledged backpacking trip with them, somewhere in the backcountry.
Interdisciplinary care is a mainstay in many specialty areas of medicine, but we believe the MedStar Pituitary Center showcases the best interdisciplinary model of care anywhere. Each member of our team is an expert in their field, and together, we strive to offer patients the best approach to treat their pituitary conditions.

Pituitary disease is a complex, multifaceted condition, often first suspected in the internist’s office. A specialty consult is necessary to determine the precise diagnosis and identify the optimal treatment plan. Our neuro-endocrinologist, Susmeeeta Sharma, MD, evaluates the patient’s hormonal balance, using dynamic blood testing to examine blood samples at specified intervals. Our neuro-ophthalmologist, Martin Kolsky, MD, examines the optic nerve, to identify possible pituitary infringement. An on-site neuroradiologist performs CT or MRI imaging, to precisely visualize the pituitary tumor, followed by a neurosurgery consult.

At the MedStar Pituitary Center, we perform minimally invasive surgery for optimal results. Our otolaryngologist, Stanley Chia, MD, surgically navigates the nasal passage to access the tumor, and then I take over the neurosurgical portion of the procedure, using computer-assisted technology to remove the tumor. Brainlab technology in the operating room provides detailed, high-resolution image guidance for precise results, accurate to less than 1mm. We have the flexibility to use a transsphenoidal approach, neuroendoscopic approach or craniotomy, depending on the unique needs of each patient.

For a residual or recurrent pituitary tumor, radiosurgery may be used to destroy the remaining tumor tissue. We have The EDGE™ Radiosurgery Suite, a fully integrated dedicated system, which uses new real-time tumor tracking technology and motion management capabilities for superior results.

Research is another priority so we can stay at the forefront of treatment for pituitary disorders. Joseph Verbalis, MD, is an internationally recognized leader in pituitary tumor research, currently conducting molecular study of pituitary tumors to predict the patient’s prognosis and determine if future treatment will be needed. We also offer access to clinical trials and other treatment advances.

Working together synergistically, our team offers patients throughout the region the best approach to treatment for any pituitary condition, from the most common to the most rare. If you would like to refer a patient, or discuss treatments we provide, please call us at 202-877-DOCS.