Setting the Trend: Critical Care Medicine
at MedStar Washington Hospital Center

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Regulatory Readiness is Right on Target

More than 50 visits.

That’s how many regulatory surveys we could expect in any given fiscal year. For a healthcare organization as large and complex as ours, we are always getting ready for either a hospital-wide survey or a service line-specific site visit.

To ensure that we stay on target, and are always ready for the next survey, under the direction of Dr. Karen Jerome, vice president for Quality, Safety and Risk Management, we have reorganized our department leadership.

Sally Gutierrez, MSN, RN, CPHQ, who served as interim director of Quality and Outcomes since November 2015, is now director, Regulatory Readiness. In this newly-created dedicated position, Sally will use her 17 years of experience in quality and safety (with eight of those years at the Hospital Center), to focus on the significant regulatory challenges faced by a hospital of our size.

Barb Mitchell, RN, is our new director, Quality and Outcomes. Barb was a member of the MedStar Washington Hospital Center Quality department from 2009 to 2013. For the past three years, she served at MedStar Health as director of High Reliability and Safety. We are fortunate Barb returned, as she has a corporate-wide knowledge of quality and safety initiatives and projects.

You’ll be receiving frequent quality and safety messaging from Dr. Jerome in our weekly e-newsletter, STAT Update. Please make sure you read it every Friday morning or during the weekend, so you’ll be up to date on what you’ll need to know for the upcoming week.

Up Next: TJC

We can expect The Joint Commission survey at any time during the next few months. Our regulatory readiness for a TJC visit includes these ongoing opportunities for improvement:

- Hand hygiene
- Personal protective equipment (PPE)
- Legible, timely documentation
- HIPAA/privacy concerns

These areas of focus were discussed during our recent D.C. Department of Health survey. Our quality and safety teams are now drilling down to amend some of our processes surrounding these issues, and we’ll send updates and reminders on a regular basis.

Singling Out Hand Hygiene

Our hand hygiene goal for this fiscal year is 95 percent or better, for each patient encounter. At a leadership meeting this past summer, we jokingly said that our theme for hand hygiene would be, “Wash Your D@#$ Hands!” But that thought should stick with you.

There used to be a time in America when no one used seatbelts. Today, putting on your seatbelt is second nature. Most people don’t consciously think about it when they get into their cars. Good hand hygiene is the most basic and important tool we have, to prevent the spread of hospital acquired infections (HAI) between patients and among caregivers. Hardwiring hand hygiene should be part of everyone’s daily routine.

Additional Items

Also to keep top-of-mind:

- The H&P completed prior to admission/procedure is acceptable, if done within 30 days of admission. There may be clinical, drug or other changes since the H&P was completed that could affect the outcome of the anesthesia, surgery or procedure. If the H&P is updated on the day of the admission/procedure, it should include the information that you reviewed the H&P, assessed the patient, concurred with the information, had no additional findings and determined the patient is still a candidate for the procedure. If you do have additional findings, they must be addressed.

- Informed consent allows your patients to fully participate in the decisions about care and treatment, and it involves completing three steps:
  - Procedure description written on the form
  - Witnessing the patient’s signature, attesting the patient has had an informed consent discussion with the treating provider
  - Final signature by the treating practitioner, attesting that an informed consent discussion occurred, as noted above; that the form was completed and the patient wishes to proceed.

The physician attestation statement on the consent form must be signed, dated and time before the procedure.

Regulatory readiness is an important part of quality and safety, “Above All, Patients First” approach to excellence in care. Please ensure that everyone on your team is aware of any work that needs to be completed, so that we are survey-ready at all times.

Gregory J. Argyros, MD, MACP, FCCP is senior vice president, Medical Affairs & Chief Medical Officer. He can be reached at 202-877-7202 or gregory.j argyros@medstar.net.
Douglas Quintanilla refused to give up on finding a solution for his obstructive sleep apnea. Despite having undergone four surgeries to help correct the serious sleep disorder, in which breathing repeatedly stops and starts, the 47-year-old program analyst was willing to try a new implantable technique that monitors breathing and delivers stimulation to airway muscles.

“It has been a positive life-changer for me,” says Quintanilla, who endured a mandibular advancement surgery, hyoid suspension, partial glossectomy and uvulopalatopharyngoplasty prior to having the new surgical procedure at MedStar Washington Hospital Center in March.

The system, called Inspire® Upper Airway Stimulation, is a neurostimulation device that uses implanted components to detect breathing patterns, in combination with an external remote that stimulates key airway muscles to maintain an open airway. The technology, approved by the U.S. Food and Drug Administration in 2014, gently moves the tongue and other soft tissues out of the airway, to prevent collapse and blockage of the upper airway during sleep.

Stanley Chia, MD, chair of the department of Otolaryngology at the Hospital Center, is trained in the new system, and performed the two-hour surgery on Quintanilla. “This is a great technology for the right patient,” he says.

The procedure involves three separate incisions, explains Dr. Chia. First, a pacemaker-like device is implanted on a patient’s right chest, just below the clavicle. A second, right-sided incision near the ribs is then made, with a wire extending from the generator to the intercostal muscles to sense breathing at night. Lastly, an incision on the neck allows a stimulation lead to wrap around the hypoglossal nerve, which controls tongue movement during breathing. After a 30-day waiting period, the device is activated.

Marc Schlosberg, MD, FAASM, a neurologist who specializes in sleep medicine and epilepsy, says after the initial activation, the device is titrated so that the tongue protrudes to the back of a patient’s incisor teeth, ensuring an open airway. Patients are then trained to use a remote, which activates the device before going to sleep, and also has a pause button if a person needs to awake during the night.

For Quintanilla, the device was a huge success. Prior to implantation, his Apnea Hypopnea Index (AHI) was 28—meaning he stopped breathing 28 times per hour. After the device was activated and calibrated, his AHI was 4.5.

“We want to see people having less than 20 episodes per hour and we initially try CPAP (Continuous Positive Airway Pressure) on everybody,” Dr. Schlosberg notes. “Unfortunately, approximately 50-60 percent of patients can’t tolerate CPAP, and Mr. Quintanilla was one of those people.”

“My heart used to race, and I would wake up gasping for air,” recalls Quintanilla. “Even after continuously raising the pressure on my CPAP machine, I would still wake up with headaches, and be short of breath.”

“It is so important for patients to seek alternative treatments if CPAP does not work,” adds Dr. Chia, noting that untreated sleep apnea can lead to stroke, heart arrhythmias and diabetes. “This is a great new technology to address that.”

For Quintanilla, his blood pressure has returned to normal, he has increased stamina, and he is now remembering his dreams, something he could never do prior to the new procedure.

“A lot of things have returned to normal,” he adds. “I no longer sleep in a reclining chair, and now enjoy sleeping in my bed again.”
Setting the Trend

Critical Care Medicine

At MedStar Washington Hospital Center

MedStar Washington Hospital Center is leading the way, with a trend-setting consolidation of all intensivist services into one Department of Critical Care Medicine. It is one of the first and largest academic medical centers nationwide, to bring all medical and surgical critical care under the administrative umbrella of a department.

The new organizational structure, implemented this past summer, is helping to “break down silos and facilitate a collaborative approach to care that has advantages for patients, intensivists—and referring physicians,” says Daniel Stolzfus, MD, who is leading the effort at the Hospital Center as department chair.

The departmental consolidation reflects the exploding science of critical care medicine, which increasingly calls for specialists trained in both critical care as well as a second subspecialty. “As an acute care referral center, we see the sickest of the sick—patients with a number of co-morbidities, often dependent on high-tech medical devices, and who require complex care,” Dr. Stolzfus adds. “The new structure fosters interaction and the kind of expansive thinking and interactive problem-solving, which facilitates innovative approaches to treatment and improved outcomes. It also means greater accountability across all critical care services.”

One Department, Four ICUs

The department now encompasses more than 90 ICU beds in four divisions, including the medical ICU, surgical ICU, neuroscience critical care and cardiovascular critical care. Each unit has evolved over time, as intensive medicine has become more complex and specialized. While there was some interaction between the units, they operated under different departments, with separate budgets and educational efforts, and varying care protocols and criteria for clinical privileges.

“Now we have physician leaders working with developing each division,” Dr. Stolzfus adds. “The chiefs and medical directors, chair and vice chair will meet regularly to exchange ideas, lessons learned, challenges and successes, which help to promote improved care delivery and better results.”

“Regular Friday conferences for the surgical intensivists offer a venue to discuss varying approaches to the most complex patients, and help ensure a consistent level of quality care in each ICU,” he says. “We also have resurrected the critical care committee meeting, to routinely look at broader, hospital-wide issues, and future forecasting, to include infrastructure, rapid response, technology needs and bed allocation.”

This change represents a dramatic cultural shift for the hospital, because for decades, internal medicine specialists oversaw patient care in both the surgical and medical ICUs, explains Raymond DiPhillips, MD, vice chairman. “Today, it’s harder and harder for generalists to keep pace with the needs of critically ill patients. These patients need the skills of cutting-edge subspecialists with critical care expertise, as well as additional fellowship training in heart disease or brain injury, for example—and we have them here at the Hospital Center.”

Drilling Down on Specialty Care

Christopher Barnett, MD, is one of this new breed of subspecialists who wears two hats. Fellowship trained in both cardiology and critical care, he heads up the cardiovascular ICU with co-chief Nimesh Shah, MD, a surgical critical care specialist.

“The way the service has been structured encourages professional collaboration across specialties, and a novel approach to care that benefits patients,” Dr. Barnett says. “We treat very ill patients, including those with assist devices and advanced heart failure. This newest cardiovascular state-of-the-art ICU is devoted to their complex needs, and brings together critical care and cardiovascular expertise.”

“We combine our disciplines and learn from one another,” Dr. Barnett adds.

“This approach also offers the opportunity to conduct more combined research and educational efforts that bring multiple critical care specialists together,” adds Andrew Shorr, MD, chief of the medical ICU.

“We understand that despite their primary diagnosis, patients don’t fit in a single box. They can have lots of issues, and our new structure is helping to streamline their care,” Dr. DiPhillips states.

Critical Care, a Team Sport

For Brian Lee, MD, medical director of neuroscience intensive care, the departmental level consolidation recognizes that “we have more things in common than not. We all care for critically ill patients, and are kindred spirits. This is a much more global and strategic approach, which maximizes our resources for the sickest people in the region.”

Dr. Lee was tasked several years ago with developing the Neuroscience ICU at the hospital, which has a comprehensive stroke center, and cares for a rapidly growing population of stroke patients, as well as those with critical head trauma and spinal cord injury. “We’ve always worked collaboratively—
physicians, nurses, therapists, pharmacists. Critical care is a team sport,” he says.

Nurses and Advanced Practice Clinicians are also at the core of intensive care, and the departmental consolidation opens doors to training for nurse practitioners and physician assistants who want to practice advanced critical care in trauma and surgery. “As a department with a diverse patient population, we are attractive to top-quality clinicians from across the nation,” says Kristen M. Nelson, MS, ACNP-BC, MBA, surgical critical care services. “We can recruit the best, and train the best.”

Economy of Scale
The “team sport” approach allows for economy of scale that reaps multiple benefits, says Dr. Stoltzfus. “It means we can use our financial resources more effectively, and look across multiple units to see where our money could best be spent to improve patient care. It also speeds up the process of allocating beds for incoming patients. We are talking to one another in real time, sometimes for the first time. We can now bring together all of the team we need, to ensure uninterrupted services in the event of mass casualties and epidemics,” Dr. Stoltzfus explains.

“The integrated CME and GME we can now offer fosters better understanding and educational opportunities to our trainees between specialties, and provides unique opportunities for our faculty,” he adds. “And now, we have a structure that allows physicians to move-up the professional ladder. Perhaps most important, we are employing consistent care protocols across all the ICUs, and will develop a single credentialing guideline for obtaining newer advanced privilege skill sets, such as bedside-focused ultrasonography, which can be acquired faster and more comprehensively as a team effort.”

The collaborative approach includes working closely with referring physicians, as well. “Ours are open units, to help family involvement and participation in rounds. Together, the intensivists and primary attending physicians who know the patient before a critical illness occurred can help in making the right clinical decisions. The bottom line in critical care,” Dr. Stoltzfus maintains, “is making that ‘right’ care decision, not in a vacuum, but in the context of the patient’s life story and values.”

Leadership for Critical Care Medicine includes Andrew Shorr, MD; Nimlesh Shah, MD; Christopher Barnett, MD; Susan Kennedy; Daniel Stoltzfus, MD; Matt Desmond; Kristen Nelson, ACNP-BC; Raymond DiPhillips, MD and Brian Lee, MD.

Department of Critical Care
Daniel Stolzfus, MD, Chairman
Raymond DiPhillips, MD, Vice Chairman

- Combines medical, surgical, cardiovascular and neuroscience ICUs
- More than 90 ICU beds
- Advantages:
  - Economies of scale, with administrative and budgetary consolidation
  - Collaborative team care, cross fertilization of ideas and expansive multidisciplinary approaches to complex scenarios
  - Joint GME, CME and shared teaching responsibilities
  - Accountability for consistent level of quality care and best practices
  - Opportunity for career advancement for physicians and Advanced Practice Clinicians, and increased ability to recruit the best medical and nursing teams
  - Improved preparation and response for mass casualties, epidemics
It’s not uncommon to encounter complex hospitalized medical/psychiatric patients who are also part of an aging population. The elderly can present with cognitive impairments that become a challenge to manage in a patient care unit.

In an effort to address behavioral issues that can arise in the medical setting, MedStar Washington Hospital Center developed the concept of BERT, the Behavioral Emergency Response Team.

BERT is a 24/7 program being piloted on several units at the Hospital Center. The team has one psychiatric nurse, one psychiatric social worker and one behavioral health technician. The team is available to assess patients when they begin to exhibit behavioral problems, and work with physicians, nurses and other clinicians to identify and manage possible causes of behavioral issues. Most importantly, the team members have specific training in de-escalating potentially volatile situations.

Lourdes Griffin, PhD, assistant vice president for Medicine and Psychiatry, says this team has been created specifically to “address the needs of behavioral health patients in a positive way, while making sure they get the medical care that they need.”

Multidisciplinary Team Involved
Karen Jerome, MD, vice president, Quality, Safety and Risk Management, convened a multidisciplinary team that included physicians, psychiatrists, nurses and representatives from Public Safety, Public Affairs, Quality and Risk Management, to develop an action plan to address behavioral health concerns for medical patients.

Dr. Jerome explains, “caregivers who are not mental health specialists aren’t experts on behavioral issues. Their attention is focused on the acute medical problems. Once the medical problems are corrected, behavioral health issues can emerge.”

The team studied the ways other hospitals were meeting this behavioral health challenge, with BERT as a result. Karen Johnson, MD, associate chair, Psychiatry, and director of the Psychiatric Consult Service, notes BERT is similar to other emergency response programs in the hospital. “We have Rapid Response and Code Blue teams to deal with specific medical emergencies. BERT is designed to provide clinically-driven responses to someone’s behavior, without the need for the presence of safety officers.”

Dr. Griffin states there has been a common misunderstanding, that psychiatric patients are usually only on the psych ward. But, she says, “Psych patients are everywhere. They get sick, they break their legs; they are in the main hospital.”

Dr. Johnson agrees, stating patients with medical conditions other than those with psychiatric diagnoses often present with behavior and cognitive changes associated to the underlying medical condition. She provides two examples:

- Depression in the cardiac patient
- Delirium in the patient with liver or kidney disease

Prior to the rollout of BERT, when a patient on a medical unit began displaying signs of behavioral health trouble, unit caregivers would manage such behaviors, and often consult Psychiatry to evaluate these patients. The final resort would be to call in Public Safety officers to restrain an agitated patient.

A Growing National Problem
Public Safety Director Kathleen Timmons can list reasons why the behavioral health of patients has been a growing problem in the nation’s hospitals.

“There is such a lack of behavioral health resources in the community at large. People are coming to the hospital to get...
their basic health care,” Timmons states. “The elderly population is growing every day, bringing a different set of issues related to dementia, vision and hearing.”

Timmons also points to the proliferation of illicit drugs, such as synthetic marijuana, as a cause for new levels of violence. It is a perfect storm of issues, and they all meet at our nation’s hospitals.

De-escalation Important

Alexander Ngati, MS, APRN, director of Psychiatry Inpatient and Emergency Services, points out that psychiatric workers in his division all get extensive training detecting behavioral red flags and de-escalating potentially dangerous situations. “This is what we do every day,” he explains. Ngati was tasked with developing the staffing and training for the team, and working with others on implementing and tweaking the program in its early phases.

Licensed Clinical Social Worker Erica Taylor has been on BERT since its rollout in April. She explains that team members have other responsibilities during a typical day, but “you stop what you’re doing, when a BERT is called. We touch base with the patient’s nurse, find out the issues, and then begin the process.”

In addition to early de-escalation, one of the most crucial parts of that process is to quickly inform the patient’s physician of the situation.

Arthur West, MD, president of the Medical & Dental Staff, sees potential for trouble if there is “a disconnect between the nurse and the physician in terms of patient behavior. As a member of the team that developed BERT, “We are encouraging more face-to-face communication between the nurse and the primary care provider,” he says. In addition to their checklists where a patient’s condition is reported, “nurses need to have a way to include subjective evaluations of behavior.”

Training and ongoing communication are key to BERT’s success, and the results have been extremely promising. “We are getting wonderful feedback from the pilot units,” notes Ngati.

Taylor points out that the teams continue to tweak the specifics. “It’s mostly logistics,” she notes, such as “the information provided when calls are made, and when public safety should be notified.” Administrators have continued to make necessary changes, such as where team members are stationed to increase their efficiency.

Pilot a Success

Numbers from the pilot period bear out that success. In its initial three month test, five pilot units placed 57 BERT calls. The number of calls for public safety officers to handle disruptive patients dropped dramatically. The cumulative number of public safety calls during those three months was lower than the number of calls during the month before the BERT introduction.

Dr. Jerome hopes to roll out BERT throughout the hospital this year, to complement other efforts to more effectively treat any patient with behavioral health issues. “We will have house-wide education for clinicians and nurses who are not trained in mental health.”

Dr. West foresees the time when all caregivers are trained to pick up early warning signs for behavioral issues, and communicate immediately with that patient’s primary physician, so problems can be resolved on the spot. “I want us to work together for any disruptive patient, to help that patient and the patient’s family better focus on the medical issue that brought the patient to our care. The BERT process is the right thing to do for our patients.”
When size is Everything
Adapting to the Challenges of Patient Obesity

It’s almost mind-boggling to consider just how much has changed since MedStar Washington Hospital Center was established in 1958—from the medical tools and technologies developed across a spectrum of disciplines, to the diversity and knowledge of the professionals who deliver those services.

The Hospital Center’s patients have changed over the decades as well, but not all in the healthiest of ways. According to the Centers for Disease Control and Prevention, the average adult weighs 26 pounds more today than in the 1950s.

That’s just one of the many statistics that illustrate the disturbing rise of obesity in the U.S., a pervasive increase that many say has all the attributes of an epidemic.

While the District of Columbia’s obesity rates (21.7 percent for adults, 14.5 percent for adolescents) are lower than the national average, they nevertheless portray a substantial proportion of the local population at greater risk to many preventable conditions such as heart disease, Type 2 diabetes and certain types of cancer.

And for the Hospital Center, which is committed to providing quality care for all members of the community, serving patients with a body mass index (BMI) exceeding 30—some weighing as much as 500 pounds or more—presents new opportunities and, sometimes, difficult challenges to fulfilling that mission.

Bariatric Services Enhanced
A key step has been the enhancement of the Hospital Center’s Bariatric Surgery services, offering a wider range of approaches to help high-risk obese patients, both with and without comorbidities, achieve and maintain healthier weights.

But regardless of the condition that brings them to the Hospital Center, obese patients can’t always use facilities and furnishings that most people take for granted.

“Fundamentally, obese patients are no different from anyone else we treat,” says Chief Operating Officer Robert S. Ross, FACHE. “But because of their size and weight, we do have to make accommodations so that we can effectively provide that care.”

Physical Plant Changes
Among the measures implemented in recent years are the addition of specially-designed waiting room furniture, gurneys and wheelchairs; training nurses and technicians to lift and move patients without risking their own health; and reinforcing toilet fixtures as part of renovation projects.

Where feasible, patient rooms are being reconfigured for larger beds and wheelchairs, though Ross admits that with a building constructed in 1957, “there’s only so much we can do with room size and layout, so we have to look as we renovate.”

Other adaptations to accommodate obese patients, however, are dismayingly short-lived.

Radiology Department Chair James Jelinek, MD, recalls how only two years ago, the Hospital Center had CT scanners and fluoroscopic tables capable of supporting 550-lb and 450-lb patients, respectively.

“Then, we started getting even heavier patients who couldn’t use them,” Dr. Jelinek says, noting that his department sees an average of 10 patients per week for diagnostic tests. “We now have tables that can support patients weighing up to 650 pounds, as well as upgraded ultrasounds and portable HD digital X-ray equipment.”

Surgical Considerations
Obesity adds additional considerations for surgeries.

Otolaryngology Department Chair Stan Chia, MD, says that high BMI patients are at greater risk of experiencing difficulty when securing their airway, when they undergo general anesthesia or even with sedation for surgery.

“These patients may also be more sensitive to narcotics that suppress respiratory function in the postoperative period,” Dr. Chia says. “That’s why we do a screening process, and give those patients wristbands alerting surgical teams of the potential for airway problems postoperatively.”

Obesity may well have its most significant health implications in pregnancies, where both the health of the mother and the unborn child are at stake.

“About half of the women we treat are overweight or obese,” observes Rachael Overcash, MD, MPH, an attending physician in Maternal-Fetal Medicine. “But many of them are in otherwise good health, even with a BMI above 40. And some women with a BMI above 50 can still deliver babies vaginally.”

Dr. Overcash is quick to add that because obese mothers must be carefully monitored for complications that may develop during pregnancy, the department has developed treatment guidelines for the entire pregnancy and beyond. They include frequent
assessment of fetal growth, to identify early the safest delivery option, and postpartum measures, such as blood thinners, for obese C-section patients, to reduce the risk of blood clots.

“We’re also exploring the use of special negative pressure dressings for wound therapy after C-sections, which promotes healing and reduces risk of infection,” Dr. Overcash adds.

More Physician Counseling

Another critical guideline calls for making weight counseling part of prenatal care—something she says many providers are reluctant to do, for fear of embarrassing patients.

“They’re seeing a physician on a more regular basis than normal, so we use the opportunity to discuss weight, and how to limit their calorie intake to a healthy amount,” Dr. Overcash explains.

“Mentioning it early gets patients thinking about it, which can help them keep additional weight gain during pregnancy to a minimum, and in some cases, even lose weight, with no health risks.”

Developing and maintaining healthy eating habits can be problematic for some patients who don’t have ready access to healthy food. But Dr. Overcash says the conversations are nevertheless empowering to patients. “A simple conversation and frequent interaction with a healthcare provider can drive better decision making,” she says.

A similar approach can benefit obese patients who have developed diabetes, says Meeta Sharma, MD, medical director, Diabetes team.

“Because patients have a team helping them develop a better lifestyle and eating habits, they don’t feel isolated,” Dr. Sharma explains. “Once they start losing weight, it’s amazing the sense of motivation that takes effect. That makes them more likely to follow through.”

Dr. Chia adds that losing even a relatively small amount of weight can make a dramatic improvement. He recalls a 255-pound man, whose apnea-hypopnea index (AHI) reading was 72, or very severe.

“He lost 15 pounds, and the AHI went down to 15, which is in the mild range,” he says.

Sustaining long-term lifestyle changes, however, can be the most challenging and, sometimes, frustrating part of keeping obese patients on the road to better health.

“Nothing is a gold standard, or foolproof all the time,” Dr. Sharma says. “It varies by each patient’s knowledge and awareness of what’s going on. In many ways, their own motivation is the most important.”

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**Bariatric Surgery Offers New Options, New Hope for Obese Patients**

If there’s a bright spot in the rise of obesity in the U.S., it’s that the range of surgical procedures has likewise evolved, to provide more options to more patients with severe weight issues and related conditions.

That’s why Timothy Shope, MD, director of the Hospital Center’s Bariatric Surgery section, believes in adapting the famous line from the movie, Field of Dreams: provide it, and they will come.

During the past few years, his department has experienced a 36 percent increase in patient volume, as conventional weight loss surgeries have been augmented with innovative, minimally invasive procedures, such as sleeve gastrectomy, lap-band surgery and other laparoscopic and robotic-based approaches.

In addition, the Bariatric Surgery team recently completed its move into an expanded diagnostic and treatment space, in order to support more procedures and provide patients more convenient access to pre- and post-surgery nutrition and lifestyle counseling.

Dr. Shope is particularly proud of the fact that a third of the department’s cases are revisional procedures, providing solutions for patients having long-term problems with previous surgeries completed elsewhere, or who simply haven’t been able to achieve all they had hoped to with their initial surgery at other hospitals.

“It shows we’re willing to take on patients other physicians don’t feel comfortable managing, and tackle complex cases,” he adds.

This degree of versatility likewise benefits other Hospital Center specialists who may be treating obese patients with other conditions, from diabetes and orthopaedic issues to cardiac conditions.

For example, four patients with left ventricular assist devices (LVADs) underwent gastric sleeve procedures, in order to become eligible for transplants. One patient has since received a new heart.

“They might not have had that option otherwise,” Dr. Shope says.

Like other health care professionals, Dr. Shope wishes more could be done to prevent obesity, particularly among younger people. “We’re seeing people in their 20s who already weigh 500 pounds or more,” he says.

On the other hand, they’re also seeing 60- and 70-year old patients who are still vibrant, and have decided to do something that will help them stay that way.

“In the past,” he says, “they might have just stayed home.”
Climate change and an increase in worldwide travel are subjecting humans to a dizzying array of new viruses, with a new threat erupting every year. Climate change causes virus-carrying mosquitoes to move north, and global travel spreads contagious diseases exponentially.

Zika virus was on everyone’s radar screen this summer, especially with the travel brought on by the Summer Olympics. The Zika virus has been in Africa for at least several decades, and arrived in Brazil in early 2015. It has since spread widely across Central and South America and the Caribbean. It is transmitted by mosquitoes and through sexual contact.

“Zika is unique,” says Glenn Wortmann, MD, director of Infectious Diseases and hospital epidemiologist at MedStar Washington Hospital Center. “It is relatively new; we’re still learning about it.”

What is particularly noteworthy about Zika is the risk to developing fetuses, with an apparent link to microcephaly. For non-pregnant patients, the risk of serious complications from infection appears to be low, and 80 percent of those infected with the virus show no symptoms.

How the Hospital Prepares
Lauren Wiesner, MD, Emergency Medicine, leads the department’s emergency preparedness efforts. Zika is on her radar screen, too. The first line of defense is to screen each patient who comes to the ED for travel history, to any area where physicians could find an epidemiologic link to an infectious illness. When Zika is suspected, the protocol is to relieve the patient’s symptoms, and counsel them about the risk to developing fetuses.

“There’s always a risk for a new virus,” Dr. Wiesner adds. “We can’t predict when and where one will come up.” The hospital works closely with the D.C. Department of Health and the D.C. Emergency Healthcare Coalition, to identify viruses and promote awareness.

Presently, one of her concerns is MERS, Middle East Respiratory Syndrome, and other similar illnesses. “MERS has a 30 to 40 percent death rate, and can spread easily through respiratory secretions,” she notes.

Other mosquito-borne viruses include Dengue Fever, West Nile Virus and Yellow Fever, which are now making re-appearances in certain areas around the world. Chikungunya is a newer mosquito-borne virus which arrived in the Western hemisphere in late 2013, and which can cause symptoms such as fever, joint pain, headache, muscle pain and rash. Treatment consists of managing a patient’s symptoms. Infants, the elderly and patients with compromised immune systems may occasionally develop complications.

Viruses currently on the wane include Ebola, a hemorrhagic fever, and the SARS (severe acute respiratory syndrome) virus. Both are spread through contact with an infected person. H5N1, Avian flu, also is less of a threat than once thought; it has not made the transition to human-to-human transmission.

However, some very familiar names are back in business. Measles and mumps were fading into oblivion thanks to mass vaccination, but the declining vaccination rate has allowed them to blossom once again.

Measles is a particular concern for Pam Farrare-Wilmore, B.S. MT(ASCP), CIC, a clinical microbiologist who is director of Infection Control and Prevention for the hospital. “The measles virus is so very, very contagious,” she explains. “If someone comes into the hospital with full-blown measles, it could set off an outbreak.”
Keeping Hospital Workers Safe

Standard precautions, including hand hygiene and donning appropriate personal protective equipment (PPE) when applicable should be our first line of defense to prevent disease transmission, says Farrare-Wilmore. "One of the responsibilities of an infection preventionist is to keep up-to-date on emerging communicable diseases that may impact the healthcare setting. The CDC (Centers for Disease Control) and the World Health Organization (WHO) are the go-to resources for emerging infectious diseases, including highly infectious viruses. When associates and the medical staff need to be informed, Infection Control and Prevention uses a number of different platforms to communicate."

The hospital has two teams in place to combat highly-infectious diseases. The Human Epidemic Respiratory Disease (HERD) team was established in early 2000 during the SARS scare, with members from Infectious Diseases, Emergency Medicine, Infection Control, Pharmacy, Environmental Services, Occupational Health, Public Affairs and Nursing. The BioContainment Unit (BCU) team was established last year, to prepare for a possible Ebola outbreak, and remains in place to care for patients who may require biocontainment in a future outbreak.

If an outbreak of a highly infectious agent occurred, the Emergency Department (ED) has a biocontainment unit that can be ready in less than one hour. Workers erect a wall, sealing off one-third of the ED, to house patients with specific hemorrhagic viruses, such as Ebola. The BCU has multiple rooms for specific tasks, such as donning/doffing PPE, lab functions and waste management, in addition to patient care.

But what keeps Dr. Wortmann up at night? "From an historic standpoint, the Spanish flu," he answers. "It killed 30 million people toward the end of World War I, and some victims were dead within 24 hours. The outbreak of a novel virus, to which we have no immunity, is most frightening."

As to immunity, the development of antiviral medications has been less than a total success. "It takes a long time to develop a new antiviral, five to 15 years," Dr. Wortmann notes. "We’ve not had very good success."

Two rousing successes, however, are the treatment of HIV and hepatitis C. While it took years to develop treatments for both, HIV can now be controlled, and hepatitis C can be cured in up to 95 percent of patients.

Keeping Viruses in Check

What can providers do, to keep themselves and their patients and families safe? The first order of business is vigilance, says Dr. Wortmann. He keeps tabs on CDC alerts, and passes along pertinent information to Hospital Center physicians via StarPort. He asks that physicians alert him to any suspicious patterns they find.

"Look for clusters of two or three patients with similar, unexplained symptoms. Be vigilant about asking patients with fevers if they have traveled recently. Check the CDC site for information; it has an excellent Website," Dr. Wortmann concludes.

Vaccinations, when available, also help contain the spread of viruses. For example, all hospital associates are required to have flu vaccinations to prevent the spread to patients and visitors. Another important precaution is hand hygiene, Farrare-Wilmore adds.
The hospital leader received the call that no one ever wants to get.

“I was contacted by another hospital’s infection preventionist nurse and epidemiologist, to inform us that a patient we cared for at our facility was in their ICU on a ventilator, fighting for her life, as a result of a methicillin-resistant Staphylococcus aureus (MRSA) SSI.

The patient was the fifth person to have surgery in our center. The source of MRSA was not from our center—the patient’s husband’s scrubs were the source. The patient’s husband was a respiratory therapist in a major trauma hospital, and worked in the ICU.

The patient washed her husband’s scrubs with their personal laundry, and his scrubs carried MRSA and contaminated the patient and the family’s laundry.”

This story was reported in the Association of periOperative Registered Nurses (AORN) Journal.

The AORN standards for perioperative scrubs and surgical services are accepted by the Centers for Medicare and Medicaid Services (CMS), and were one of the many policies reviewed before changes were made this past summer to the scrubs policies at MedStar Washington Hospital Center.

One of the biggest changes for those working in surgical and procedural areas all day: bouffant caps and disposable jackets stay on for the day unless soiled, and green procedural scrubs must remain at the Hospital Center for laundering.
Caren Lewis, MSHA, BSN, RN, directly proportional to OR traffic. So it is safe to extrapolate that been shown that the number of microorganisms in the OR is microorganism colonizing operating room personnel. “Also, it has For instance, he notes, one surgical site infection was traced to a their green scrubs.”

Some studies suggest home laundering does not kill bacteria, such as MRSA, and home washing machines may, in fact, become a reservoir for further transmission.

For clinicians comfortable with definitive evidence, it can be difficult to find this evolving research justifies a policy change.

“One of the biggest challenges in introducing this new scrubs policy is the lack of hard scientific data that a lot of my colleagues would like to see, to justify the changes in scrubs policy,” says Samir Gupta, MD, Anesthesiology, who worked on the scrubs policy planning committee. “Unfortunately, there is no direct evidence to show these changes reduce surgical site infections. However, there are a lot of case reports, and there is indirect evidence that supports the new changes.”

For instance, he notes, one surgical site infection was traced to a microorganism colonizing operating room personnel. “Also, it has been shown that the number of microorganisms in the OR is directly proportional to OR traffic. So it is safe to extrapolate that these organisms are shed from OR personnel.”

The evidence was enough for the CMS to adopt the new standards, says Lewis. “So now, compliance becomes an issue for the Hospital Center when we are surveyed. Hospitals across the country are getting cited, if clinicians walk out of the building in their green scrubs.”

Changes to scrubs policies are nothing new, notes Thomas J. Watson, MD, regional chief, MedStar Washington Integrated Surgery Services. “I’ve heard about scrubs policies my entire professional career,” he says. “Even the idea of not wearing scrubs home is not new.”

What has changed, he states, is that “the importance of everything related to infection control is receiving increasing scrutiny. It’s on our patients’ radar, because increased transparency has made the problem of hospital-acquired infections a news story. It’s on the radar for regulatory agencies as well. So everyone is looking very hard at any and all measures of protection.”

Dr. Watson knows of at least one hospital that where the local Department of Health threatened to suspend all surgeries at the facility, simply because their policy was not in line with the new AORN guidelines in regards to covering skull caps with bouffant covers. “Regulators have turned up the microscope,” he says. In fact, Dr. Watson suggests the scrubs policy may soon become uniform across the MedStar Health system. “We, as an organization, stand to lose a lot if we aren’t providing the optimum environment. The OR is our economic engine, and it is also a significant source of morbidity and mortality. Surgical site infections are a very important problem, especially in heart surgery and orthopaedic surgery. The ability to impact them is real, in terms of procedures and practices.”

Such standardization would be welcome, maintains Arshad A. Khan, MD, FSIR, director of Interventional Radiology, who also served on the Hospital Center scrubs policy planning committee. “We were already following a majority of the AORN guidelines,” he points out. “Our biggest concern was restricted access to corridors outside the procedural and surgical areas, and use of bunny suits for people in the hallway.” Uniform polices throughout MedStar would be helpful. “You need to be proactive, and not wait for a CMS mandate before acting.”

In fact, the scrubs policy committee is hoping to be flexible enough to respond to changes in standards going forward. Dr. Khan notes that the type of disposable jacket is already being replaced, because the first version was too warm and uncomfortable.

Dr. Watson acknowledges that changing comfortable habits like wearing scrubs from home to work and back are always difficult to change. “Whether it is clean scrubs or limiting access to sterile environments, we have to pay attention. It doesn’t take rocket science to know a beard hanging into open wound is not a good thing. But a lot of common sense is easier said than done, because it requires vigilance to make certain that hair is tucked in well.”

Dr. Gupta agrees. “Surgical site infections are devastating to the patient, obviously,” he says. “They also increase tremendously the cost of providing health care. So every effort must be made to reduce hospital-acquired infections. If there is new evidence that certain changes in scrubs policy will decrease infection, we will continue to do that.”
A Success for All Provider Participants:

MedStar Physician Leadership Development Program

MedStar Health has 25 new physician leaders set to carry the health system into the future. In June 2016, the inaugural class completed the first MedStar Physician Leadership Development Program, successfully navigating 18 months of challenges in monthly day long classes.

Participants were selected through a nomination process, after letters of recommendation and interviews by a 12-member Advisory Council headed by Stephen R. T. Evans, MD, MedStar Health executive vice president for Medical Affairs and Chief Medical Officer, who served as executive sponsor of the program.

“We recognized that we wanted world-class leadership training for our physician leaders for the future,” Dr. Evans says. “The next 10 to 20 years are going to be very different from the last 10 to 20 years.”

The overall intent of the program was to impart business and change management skills. The Wharton School of the University of Pennsylvania
was responsible for part of the program. Each participant was assigned an executive coach and a MedStar mentor, and participated in a project within MedStar. All had interactive, hands-on access to resources and access to top-level executives in MedStar. The program consisted of a mixture of didactic learning, executive coaching, mentoring and experiential learning.

All program participants interviewed agree that the program was outstanding, citing the benefit of getting to know other leaders across the system, in addition to the program’s content. Further, they all were impressed by the dedication of the MedStar leadership to invest in their physician leaders.

Tamika Auguste, MD, is an obstetrician/gynecologist and associate medical director of SiTEL. By participating in the program, she hoped to develop leadership skills and a better understanding of MedStar as a system.

“I learned a lot more about myself—what drives me, what inhibits me and the type of leader I want to grow into. The other participants really gave me great examples to role model. We have so many great people here at MedStar doing such great things. I feel as though I took a little bit from everyone, things that I will always remember and use,” she says. As a result, she now takes safety issues to her department leaders, with clear solutions in mind and an offer to lead the path to resolution.

Jennifer Ayscue, MD, is director of Colorectal Surgery at MedStar Washington Hospital Center. She hoped to gain leadership tools and acquire knowledge about the business and economics of medicine, as well as get to know other physicians and executives throughout MedStar.

“We learned about emotional intelligence and team building to institute change and optimize the work environment, and principles of the financial/economic side of medicine. This has helped me to interact better with my colleagues and staff, and to look for innovative opportunities for improvement and institute change in those areas,” she says. As a result, she was able to utilize the support of a colleague in the program, to better manage a project for the hospital’s Foundation, plus work toward improving colorectal screening for all patients.

Jonathan Davis, MD, is an Emergency Medicine physician who is program director for the MedStar Georgetown University Hospital/MedStar Washington Hospital Center Emergency Medicine residency program. He hoped to develop leadership skills and network with other rising leaders.

“It was an absolutely amazing program, a career-altering experience. It was an amazing cohort of colleagues, but the greatest part was the participation of so many MedStar leaders. It gave me a much deeper understanding of MedStar as an organization, and everything that we do to back the core mission. They hit a home run,” he says. As a result, his team looks at every aspect of what they are doing, to make sure it adheres to the system’s mission and vision.

Rollin “Terry” Fairbanks, MD, MS, is an attending physician in Emergency Medicine, and also is associate director of the MedStar Institute for Innovation, where he is responsible for innovation in safety (Human Factors Center) and innovation in learning through MedStar SiTEL.

“This program helped broaden my understanding of the business of healthcare, which makes me a better leader in my environment today, but also prepares me for future roles. For example, I now understand things such as what impacts MedStar Health’s bond ratings and why this is important, knowledge that impacts my perspective but that I never would have picked up in my daily role. The curriculum was extensive, and included several diverse areas that impact leadership, and the teaching was some of the best I have experienced in my academic career.

They went all out on this. The exceptional didactic curriculum was paired with exercises relevant to MedStar Health, and MedStar leaders shared their experiences. We also had individual leadership coaching, and pairing with a senior leadership mentor. One of the best parts of this was getting to know the others in the program, all of whom are high caliber successful leaders in their own domains, but also wonderful people.”

Amie Hsia, MD, is a vascular neurologist and medical director of the Hospital Center’s Comprehensive Stroke Center. When she began the leadership program, she was also beginning to work with others in the MedStar Washington region to develop a regional stroke program, so she hoped to develop collaborative relationships and learn how to leverage strengths across the system.

“I learned more about how to be an effective communicator through active listening, and what makes an effective leader. There was a mixture of ways to learn, lectures interspersed with role-playing, assigned readings and lots of interaction with my peers. The Wharton portion of the program was healthcare-specific, so it was very relevant,” she says. As a result, she has been able to move the regional stroke program significantly forward.

Eric Skolnick, MD, is director of Thoracic Anesthesia and director of equipment and new technology at the Hospital Center. He hoped to gain a greater understanding of the business of medicine, specifically within MedStar.

“The program far exceeded what I expected. It was a crash course, not just in the economics of health care; it applied specifically to MedStar, giving me a better understanding of how even small savings impact the profit margin. It included a team activity, in which we had to defend MedStar’s bond rating. We even spent a day on Capitol Hill learning about legislative issues,” he says. As a result, he was able to work with a vendor to resolve a software glitch in a new anesthesia machine, ending in a win-win solution for both sides.

John Steinberg, MD, is director of Podiatric Surgery at both the Hospital Center and MedStar Georgetown University Hospital, and also serves as program director for the Podiatric Surgery residency program at the Hospital Center. He was hoping to gain insight and exposure to what MedStar is all about, and what his future role might be in the organization.

“The personal contact, intimacy and time with executive leadership were all outstanding. I learned that they don’t have a plan for us; they wanted us to be part of making a plan. They gave us the language, skill set, exposure and inner working of the factory. At the end, we felt like a team, and are excited about the direction we could go in MedStar. We ended up with a room full of cheerleaders,” he says. As a result, he has improved his person-to-person communication skills, with more in-person and less electronic contact.

For his part, Dr. Evans is very pleased with the outcome. “On all fronts, the program exceeded our expectations,” he says. “The success of this organization is based on people, first and foremost.” Plans are underway for the next cohort to begin in January 2017.
Upcoming CME Conferences

MedStar Conference Highlight
10th International Congress on Peritoneal Surface Malignancies
November 17-19 | Omni Shoreham Hotel | Washington, D.C.
Course Director – Paul H. Sugarbaker, MD
The 10th International Congress on Peritoneal Surface Malignancies (PSOGI 2016) is a 2 and a half day conference that will provide clinical and scientific information on peritoneal surface malignancies and to create awareness regarding innovative treatments that will improve the quality of life for patients. It will feature keynote lectures, didactic sessions, debates, meet the professor breakfast sessions, exhibits and poster presentations.

For more information and to register, please visit psogi2016.com

SAVE THE DATE FOR THESE ADDITIONAL FALL CME EVENTS:
Management of ENT Conditions in Primary Care
October 21 | Washington Hilton | Washington, DC
Course Director – Stanley H. Chia, MD
MedStar Associate discount available, contact 202-780-1655 for discount

Evaluation and Management of Common Anorectal Problems
October 28 | Bethesda North Marriott | Bethesda, MD
Course Director – James F. FitzGerald, MD
MedStar Associate discount available, contact 202-780-1655 for discount

Melanoma Biology & Patient Management
October 29 | Georgetown University Hotel and Conference Center | Washington, DC
Course Directors – Michael B. Atkins, MD; Waddah B. Al-Refaie, MD; Geoff T. Gibney, MD
MedStar Associate discount available, contact 202-780-1655 for discount

HIV/AIDS Continuing Education for Healthcare Professionals
November 4 | True Auditorium, MWHC | Washington, DC
Course Director – Glenn W. Wortmann, MD
MedStar Associates Registration is only $25

Sports Medicine 2016: Beyond ACLs and Ankle Tape
November 5 | MedStar Health at Lafayette Centre | Washington, DC
Course Directors – Wiemi A/ Douoguih, MD; Christopher Arrigo, PT
MedStar Associate discount available, contact 202-780-1655 for discount

Lung Cancer 2016: Progress and Future Directions
November 12 | Capital Hilton | Washington, DC
Course Directors – Giuseppe Giaccone, MD, PhD; Deepa S. Subramaniam, MD, MSc
MedStar Associate discount available, contact 202-780-1655 for discount

Thyroid Update 2016
December 2 | Kellogg Hotel and Conference Center | Washington, DC
Course Directors – Kenneth Burman, MD; Jason Wexler, MD

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

CME Transcripts are Available Online
You can download, print or e-mail your CME transcript. Visit cme.medstarhealth.org and click on "View Your CME Transcript" for complete instructions.
Wendy Penny, RN, BSN, MBA, New Vice President
MedStar Heart & Vascular Institute

Wendy Penny, RN, BSN, MBA, is now responsible for daily operations and oversight of MedStar Heart & Vascular Institute.

Penny started her career at AtlantiCare Regional Medical Center in Atlantic City, NJ, where as a registered nurse, she became manager of two pediatric units and a pediatric special care unit. Penny then became the director of telemetry, medical surgical units, pediatrics and oncology. In 2005, she was named assistant administrator for the 350-bed mainland campus, responsible for the Emergency Department, Critical Care Units, telemetry, medical-surgical units, pediatrics, food services, environmental services, facilities and customer experience. In 2009, Penny became assistant vice president of cardiovascular services, responsible for all cardiovascular services across the hospital system. She then joined the HCA/Osceola Regional Medical Center in Orlando, as vice president of Central Florida’s Heart and Vascular Institute.

Penny is a member of the American Academy of Medical Administrators, American College of Cardiovascular Administrators and holds a certification as nurse executive in administration. She holds a Bachelor of Science degree in Nursing from Richard Stockton College of New Jersey, and a Master of Business administration from St. Joseph’s University Haub School of Business in Philadelphia, Pa.

Welcome to New Members of the Medical & Dental Staff

Alexa Aramini, AA
Anesthesiology
Jeremy Gold, MD
Anesthesiology
Jorjetta Illieva, AA
Anesthesiology
Kanchanish Kaur, AA
Anesthesiology
Randi Neubeck, AA
Anesthesiology
Priscilla Patel, AA
Anesthesiology
Jane Allen, CRNP
Critical Care Medicine
Martha Beene, CRNP
Critical Care Medicine
Bryan Hendren, MD
Critical Care Medicine
Laura Cowen, MD
Endocrinology
Daniel Baker, CRNP
Hospitalist Service
Alexander Cho, MD
Hospitalist Service
Manie Juneja, MD
Hospitalist Service
Michelle Krieger, MD
Neonatology/Pediatrics
Seiji Ito, MD
Neonatology/Pediatrics
Laura Rusch, MD
Neonatology/Pediatrics
Ikenna Ezumba, MD
Nephrology
Joshua Levinson, MD
Ophthalmology
Scott Rothenberg, DDS
Oral & Maxillofacial Surgery
Selena Heman-Ackah, MD
Otolaryngology
Norman Lester, MD
Otolaryngology
Luis Guerrero, MD
Physical & Rehab Medicine
Richard Zorzowitz, MD
Physical & Rehab Medicine
Laure Ndetchoua, CRNP
Psychiatry
Sandra Joo, MD
Radiology
Arvind Sivakumaran, MD
Radiology
Leticia Kusi, CRNP
Surgery
Elizabeth Warner, MD
Surgery

The Brothers Flanagan gave their annual rendition of The Star Spangled Banner at the September 10 Washington Nationals game. Pictured left to right are Doug Smith; Robert Bunning, MD, FACP, FACR, Rheumatology and director, Orthopaedic and Musculoskeletal Rehabilitation Programs at MedStar NRH; Nationals mascot Screech; Joel Schubbe and Bernie Kellett.
When Taryn Travis, MD, was nine years old, her father nearly died in a car accident. He spent three months hospitalized, with more than 60 percent of his body covered in burns. In the 1990s, surviving that level of burns meant beating the odds.

Shortly after his release from the hospital, Dr. Travis remembers finding her father in the family’s garage. This man, whom she idolized and who still had so much of his life ahead of him, stood before her with a fused ankle, one leg that was now shorter than the other, and much of his body still wrapped up like a mummy. Yet, Dr. Travis found her father working to fashion a lift for one of his water skis—a favorite family pastime.

“I knew he was never going to be the same,” Dr. Travis recalls, “but I also knew he was going to find some way of going back to the life he had lived, to get us back to our life as a family.”

For Dr. Travis, now chief administrative resident in general surgery at MedStar Washington Hospital Center, her drive to become a doctor and, ultimately, a burn surgeon, was forged during that moment in the family’s garage.

“I saw my parents as people who were tough as nails, who were the definition of determination, and who wanted this life to be as full as it could possibly be,” she says. “I wanted to be the kind of doctor who could get patients through similar injuries, and the kind of daughter who could take care of my family, once they could no longer take care of themselves.”

Dr. Travis grew up in Los Angeles, and attended the University of Southern California for medical school. She elected to complete one of her medical school rotations at the very burn center where, more than a decade before, her father had started his long road to recovery. For her parents, Dr. Travis says, that milestone was incredibly powerful.

When Dr. Travis arrived at the Hospital Center for her residency, it was her first time on the East Coast. After two years in the general surgery residency, Dr. Travis stepped out of the clinical residency, and into a research role under the tutelage of Jeffrey Shupp, MD, director of Burn Research and The Burn Center at the Hospital Center. During that time in burn research, Dr. Travis focused on different aspects of scars and wounds, and how pressure therapy affects scars. Originally a one year project, she expanded her research for an additional year, and solidified the decision that this was the specialty for her.

Now, seven years after entering the residency program at the Hospital Center, Dr. Travis feels incredibly blessed to know exactly what she’s doing after her residency, and to be fulfilling, what, for her, has long been a dream: She will stay on at the Hospital Center, to join The Burn Center as an attending physician.

“I am nothing less than honored,” says Dr. Travis. “Dr. Jeffrey Shupp and Dr. Laura Johnson are brilliant and energetic, and the team here at The Burn Center is fantastic.”

In her final year of residency, Dr. Travis sees her role as chief as an opportunity to develop her leadership skills, as well as the discipline and sense of personal responsibility of her surgical residents.

“I want the group that I represent to be confident clinicians who are dependable and skilled,” she says. “And that comes with holding all of us to a high standard.”

The only downside of her decision to remain at the Hospital Center? Breaking the news to her parents that she will not be returning to the West Coast any time soon. Luckily for the Hospital Center, they gave her the unequivocal thumbs up.

“They’ve met Dr. Shupp and Dr. Johnson, and they love them,” she says, “so they said, ‘Go for it.’”
Growing up in Vienna, Virginia, Hyun Bang, MD, knew there were three very specific career paths he could follow. He could be a surgeon, an investment banker on Wall Street or the quarterback for the San Francisco 49ers.

He quickly ruled out following in his idol Joe Montana’s footsteps, so as an undergraduate at the University of Virginia, he started on a path toward medical school. But when a fraternity brother recommended a financial firm in New York, Dr. Bang engaged in an informational interview, returned to school and changed his major to economics.

He graduated in 2001, and moved to New York to fulfill that childhood dream of being a Wall Street investment banker for J.P. Morgan. But after September 11, Dr. Bang started asking successful colleagues a simple question: What did they want to do with their lives—really do with their lives—outside of banking?

The answer surprised him: “They said they could never leave Wall Street, because their families were used to this lifestyle.”

For Dr. Bang, the response proved a cautionary tale, and made him re-evaluate his priorities, bringing him back to that third career dream: to become a doctor.

This past spring, Dr. Bang, an interventional oncologist, vascular and interventional radiologist and diagnostic radiologist, joined MedStar Washington Hospital Center. Working with his fellow Interventional Radiology colleagues, medical oncologists and surgical oncologists, Dr. Bang helps to control and treat many tumors locally with ablation, by burning or freezing them as well as catheter-directed therapy, by infusing radiation and chemotherapy directly into the tumor via their vascular supply.

Dr. Bang provides treatment for patients when traditional surgery is not an option, and describes his work as a surgical hybrid. “Every time someone has a CT or MRI scan, I use that to do, in essence, a minimally invasive surgery. I love having access to cutting-edge technology,” he says.

“Historically, people use to think of us last,” Dr. Bang says of interventional oncology. But as he shares a story about putting in an airway stent for a lung cancer patient, who had his entire right mainstem airway obstructed with lung cancer. Dr. Pamela Randolph-Jackson, chairwoman, Radiation Oncology, recommended that Dr. Bang evaluate the patient. After the evaluation, Dr. Bang worked closely with Dr. Jessica Wang Memoli, director, Bronchoscopy and Interventional Pulmonology, to recreate the patient’s right airway. The patient went from gasping for air in the ICU, to having no oxygen needs and being transferred out of the ICU.

“They had called us and said, ‘Is there anything you can do?’” Dr. Bang states. “It’s nice that people are starting to think about our team. That multi-disciplinary approach is what I love most about MedStar. We can offer additional treatments through this team approach, which results in more options for care for patients.”

While completing his residency in diagnostic radiology at Wayne State University/Detroit Medical Center, Dr. Bang met his mentor, Peter J. Littrup, MD. He spent four years as Dr. Littrup’s research associate, running a lab and investigating the role of cryoablation in the management of multiple types of metastatic diseases, as an option for palliative care.

He completed a fellowship in vascular and interventional radiology at Miami Cardiac & Vascular Institute, where he specialized in endovascular therapies for both arterial and venous diseases, and joined a private practice in Florida before moving back to the D.C. area.

Dr. Bang wasted no time rolling up his sleeves and getting to work. He’s helped strengthen the existing interventional oncology service line, to include a robust catheter-directed liver therapy program. The existing ablation program now includes cryoablation, microwave and radiofrequency ablation for renal, liver, lung and bone disease for local regional therapy.
Physician's Perspective

From the Desk of…

George Obeid, DDS
Chair, Oral and Maxillofacial Surgery

With two full-time, one-half-time and 12 residents, the Department of Oral and Maxillofacial Surgery offers patients comprehensive care for oral and facial problems. We also have 20 active private practitioners, to further enhance resident teaching. The department has been at the hospital since it opened in 1958, and has become one of the premiere maxillofacial surgery centers in the mid-Atlantic region.

Our services include dental extractions, dental implants and bone grafting, but it’s the more complex surgeries that set us apart. We are one of the leading centers in the region for corrective jaw surgery, facial trauma, tumors of the oral cavity/jaws, osteonecrosis of the jaws, sleep apnea surgery and temporomandibular joint surgery.

As part of the MedStar system, we have access to top otolaryngologists, plastic surgeons and other specialists. With this expert team, our department has become noted for providing comprehensive care for complex mouth and jaw tumors. Our team also works with Children’s National Health System, to provide maxillofacial surgery to pediatric cleft and craniofacial patients.

Each year, we see some 8,000 outpatients, and perform 500 to 600 inpatient surgeries. Our broad scope and talented team have been paramount in creating a top destination for patient care and resident teaching.

Technology has evolved dramatically in the last 10 years, with 3D planning playing a huge part in improving outcomes. We have an in-office CT scanner, allowing us to perform virtual surgery, to enhance outcomes for corrective jaw surgeries. In addition to the standard methods of bone reconstruction, we also utilize growth factors to enhance bone augmentation, negating the use of secondary surgical sites.

Our research interests include utilization of 3D technology for pre-operative planning, and a study of outcomes for both corrective jaw surgery and facial trauma. One of our surgeons works with the National Institutes of Health, on a clinical trial for removal of third molars.

Finally, our residency program is outstanding. We accept three new residents into our program each year. We are fortunate that many of our graduates practice in the region, keeping close ties to the hospital. For any questions or to contact us to refer patients, please call 202-877-7332.