2019 Gold Headed Cane Award:

Congratulations to
Arthur West, MD and
Carmella Cole, MD
You’ve seen your patient, who now has the correct diagnosis and treatment plan. But it’s also important to make sure you and your team meet the patient’s expectations for a good experience at the Hospital Center.

Every day, we work together to provide the highest quality, safest care to everyone who comes to us for their healthcare needs. But for our care to be effective, think of the three wheels of a tricycle. Quality is one wheel, safety is another, and the patient experience is the third. The tricycle can’t move forward without all three of the wheels in motion at the same time. The same is true for the care we provide.

Our patients need to understand that their care is second to none. It’s their experience while at the hospital that colors their perception on what kind of care they received. We all know that perception is reality for most people, and that’s true for our patients. If we take a step back and look with fresh eyes at how we treat our patients, we should see how we can positively affect the patient experience.

First, let’s look at the ambulatory setting:

• Was your patient pleasantly greeted, and verification about insurance and other personal details quietly discussed?
• How long was your patient sitting in the waiting area?
• If your patient waited past the appointment time, did you apologize for the delay?

If you think about these points, you may find small changes for your team that could help improve the patient path through care.

For a proceduralist, as the team leader for the patient’s care, please introduce the other members who will be involved in the procedure. It’s important for the patient to talk with you before anesthesia, as well as after the procedure is completed. These may seem like basic steps, but we know from patient reporting that our process isn’t hardwired into every department.

If your patient is going to a care unit after the procedure, it’s important to follow the IMOC model. Patients don’t always remember a PACU visit, and five minutes at the bedside will help your patient feel that you’ve paid attention to him or her.

If you must get to your next patient, try to have the other care team members with you. You can introduce them, explain that you’re always involved with care when your patient has questions, even if you’re not on the unit, and those questions can be directed to the nurse, or your fellow or resident. It’s also important to stop by every day, or if not every day, at least before you discharge your patient. Again, simple ideas, but they help make the patient feel listened to and cared for, and they produce great responses when patients are asked about their time with us.

We should always keep in mind the HCAHPS questions that patients answer, particularly the questions that focus on physicians:

• How often did your doctors treat you with courtesy and respect?
• How often did your doctors listen carefully to you?
• How often did doctors explain things to you in a way you could understand?

You might be surprised to learn that eight of the 27 HCAHPS questions focus on the patient’s experience in the hospital. Two focus on the hospital environment, and two ask patients to rate the hospital, based on their time with us. We provide excellent clinical care that should be rated a 9 or 10 on the HCAHPS 10-point scale, but if the experience the patient has with us is less than stellar, the patient’s reality is that care was sub-par.

By the time you read this column, you should have taken or will soon take the SiTEL training module that lets you walk the path our patients take. It’s part of our ONE TEAM Training, as we move forward to Five Stars from the Centers for Medicare and Medicaid Services (CMS).

Thank you for the care you provide every day, and for being part of the team at the Hospital Center.

Jeffrey S. Dubin, MD, MBA, is sr. vice president, Medical Affairs & Chief Medical Officer at MedStar Washington Hospital Center. Contact him at jeffrey.s.dubin@medstar.net.
Like many people, Patty Casey avoided getting a colonoscopy. So much so that the Creative Services Manager in the Communications & Public Affairs Department at MedStar Washington Hospital Center put it off until age 65, two decades beyond the recommendation for initial screening, according to American Cancer Society guidelines.

“I never had any gastrointestinal issues whatsoever, and there is no family history of colon cancer,” Casey says. “Aside from some mildly elevated blood pressure, I’ve been perfectly healthy all my life.”

But after delivering new colonoscopy brochures to Gastroenterology, administrator Cherrell Freeman-Davis asked Casey if she had ever had one. She said no.

Freeman-Davis then informed her about a screening colonoscopy event on an upcoming Saturday in March. She jokingly told Patty that she couldn’t leave until she signed up. With a little more arm twisting, Casey registered for the event, a decision that may have saved her life.

Casey was the first appointment of that Saturday event for Z. Jennifer Lee, MD, a gastroenterologist at the Hospital Center, who performed Casey’s colonoscopy. She found 19 polyps, including one so large that it had to be removed in portions. In addition, Dr. Lee also discovered a large growth in Casey’s terminal ileum.

“She told me right then and there that I would need to get that growth removed,” recalls Casey. “And I also knew that double digits, in regard to the number of polyps, were not good.”

Dr. Lee confirmed that 19 polyps was a very high amount. “I removed all the polyps, and while I couldn’t remove the entire growth, I was able to biopsy it,” she says. “The pathology report showed it was a neuroendocrine tumor, so for two separate reasons, it was a good thing that Patty had the colonoscopy.”

Neuroendocrine tumors are a rare and slow-growing tumor that arise from neuroendocrine cells and can develop anywhere in the body, explains Brian Bello, MD, a colorectal surgeon who would soon operate on Casey. Most develop in the digestive tract, lungs, pancreas, appendix, and rectum.

After meeting with Dr. Bello, Casey underwent laparoscopic surgery on April 29. Dr. Bello removed the tumor, as well as several lymph nodes. He also resected 15 centimeters of Casey’s small intestine and colon. After spending two nights in the hospital, Casey returned home.

Casey was then referred to Oncologist David Perry, MD. After reviewing her records, he recommended surveillance. “A neuroendocrine tumor is a cancer,” Perry says, “but it is slow growing, and currently, there is no chemotherapy to prevent it from coming back. So follow up on a regular basis is key.”

For Casey, a PET scan prior to surgery showed no other occurrence of disease. Going forward, she will need yearly scans, as well as more frequent colonoscopies.

“Patty is fortunate that she got her colonoscopy when she did,” says Dr. Bello. “Thankfully, this type of tumor doesn’t need any other therapy besides surveillance. We all know that colonoscopies are used to prevent colon cancer, but sometimes other things can be found. The bottom line is, people need to get their colonoscopies done.”

For Casey, no more convincing is needed. “Tell me where and when, and I will be there,” she says, in regard to follow up exams or future colonoscopies.

Casey offers this advice for those who may still be reluctant to schedule a colonoscopy: “Just pick up the phone and make the appointment. It is not that bad, and the procedure is not painful at all. And, it just may save your life.”

Providers who would like to consult with a Gastroenterology physician or Advanced Practice Provider should call 202-877-6280.
Two long-tenured physicians were honored as this year’s Gold-Headed Cane Award winners. The distinctive award was presented to Carmella Cole, MD, interim chair, Internal Medicine, and Arthur West, MD, Gastroenterology and former President, Medical & Dental Staff.

Both Dr. Cole and Dr. West were surprised to get the notification phone call from Gold-Headed Cane Committee Chair James Jelinek, MD.

“It’s quite a compliment; I would never have expected this honor,” says Dr. Cole. Dr. West agrees, stating, “I was shocked. I know I didn’t do anything special to deserve it. What I do here is not a job, it’s what I was born to do. I’m not looking for kudos. My reward is when I help make people better.”

The Gold-Headed Cane winners every year are selected by past winners, which was noted by Dr. Cole. “It’s nice that your colleagues believe that you’re worthy of the distinction.” Dr. West adds, “When I look at the past Gold-Headed Cane winners, these are my mentors. They’re the people who gave me the skills I use every day.”

The tradition of the Gold-Headed Cane Award began in 1689 in England, with the passing down of the same cane to five physicians during a 150-year period. John Radcliffe, personal physician to King William III, distinguished himself as THE royal physician, by carrying not just an ordinary gentleman’s cane of the day, but one that had a gold head, adorned by a cross bar on top, instead of the traditional knob. The Gold-Headed Cane has been a tradition at MedStar Washington Hospital Center since 1951, originating in one of the three hospitals that merged to become the Hospital Center in 1958.
Above: Past awardees of the Gold-Headed Cane came to celebrate with this year’s winners. Front row, left to right, are George Obeid, DDS, 2016; Robert Laureno, MD, 2001; Dr. West; Dr. Cole; Kenneth Burman, MD, 2014; Steven Goldstein, MD, 2009; Jayashree Krishnan, MD, 2018. Row 2, Paul Sugarbaker, MD, 2016; Max Heffgott, MD, 2004; Michael Gold, MD, 2003; Stephen Peterson, MD, 2015; Mohan Verghese, MD, 2014. Top row, Dennis Priebat, MD, 2015; David Buck, MD, 2004; James Jelinek, MD, 2013; Stephen Gunther, MD, 2006; and David Johnson, MD, representative from the Medical Board.

Below: David Moore, MD, new president of the Medical & Dental Staff, welcomed everyone to the event. Below: Robert Bunning, MD, at the piano, and Marc Schlosberg, MD, on saxophone, were half of the quartet that provided entertainment for the evening.
A recent article in The New York Times presented the risk of spreading germs through a doctor’s traditional white coat. The article stated that a majority of physicians go more than one week without having their white coat washed, and 17 percent go more than one month without washing a white coat. When assessments were performed, as many as 16 percent of white coats tested positive for MRSA, and up to 42 percent for the bacterial class gram-negative rods. We asked two Infectious Diseases physicians for their opinions on the article.

We have to be careful what we do in patients’ rooms. There’s a balance between looking professional, while still guarding against bacterial contamination. In clinic, I don’t always wear a white coat, but when I see inpatients, I do wear a coat. It’s a convenient way to carry a patient list, dosing guidelines, stethoscope, and flashlight.

Sometimes what is lost in this debate about white coats is what should be our number one priority: hand hygiene. We’ve known for years that many clinicians don’t wash their hands before and after each patient visit. Even if we do everything else: wash our white coats, wear sleeves that don’t extend beyond the elbow, tuck in ties and badges – without proper hand hygiene, we are doing a disservice to our patients.

We need to always observe proper hand hygiene techniques. An alcohol-based hand sanitizer is usually sufficient, but if hands are visibly soiled or there is concern for a spore-forming organism, such as Clostridium difficile, then handwashing with soap and water is the way to go. A common misconception is that hand hygiene is optional when wearing gloves. It is critical to observe proper hand hygiene even when we wear gloves. When we put on and remove gloves, there still is the opportunity for contamination.

There have been a lot of studies of creative ways to get people to wash their hands. They all work for a while, then people revert back to their original behaviors. An effective means of changing behaviors is role models setting an example. Research shows that if a team leader performs appropriate

Saumil Doshi, MD

The article’s findings are no surprise. Bacteria are everywhere, not just on white coats. Ties and ID badges have also been a concern, because they can dangle and offer bacteria free rides from one patient to another. Furthermore, ties are almost never washed or dry-cleaned.
hand hygiene, the entire team is likely to follow suit. This jives with my personal experience; if an attending physician washes her hands, then the rest of the team - from the chief resident to the medical student - are much more likely to wash their hands. I have a ‘two strike’ policy with trainees. I have a conversation with them the first time I notice they haven’t performed appropriate hand hygiene. If an omission happens more than once, they don’t get credit for the rotation. Fortunately, it has never come to the second strike!

Sheena Ramdeen, MD, MPH

The study discussed in the article is not at all a surprise, and supports prior literature on the topic of white coats and infection risk. While some may say it is an outdated symbol, I personally like wearing the white coat for patient interactions. I think it adds a layer of professionalism that patients appreciate. Frankly, I believe it also helps identify me as a physician, since even in 2019, I run into patients who have a hard time realizing they have a woman as their doctor.

It is also a practical way to carry the things I need for my inpatient work on the consult service, which would otherwise be a challenge, with the lack of pockets in women’s clothing.

Another consideration in the infection risk we pose to our patients is the stethoscope, which is rarely cleaned at all, yet alone between patients. There is evidence to suggest that stethoscopes do harbor bacteria, but the jury is still out on whether or not this results in higher rates of nosocomial infection. Still, it couldn’t hurt to try to remember to clean our stethoscopes with an alcohol prep between patients.

The concept of “bare below the elbows” is an interesting one, but I wonder how effective it really is in reducing infection risk, when there are bacteria everywhere, and so many other ways patients can be exposed to pathogens in the hospital setting. I typically change my white coat once a week, or sooner, if it gets visibly dirty.

I think the best opportunity we have to protect our patients from infection is simple hand hygiene, something we learn in childhood, and really should have no trouble practicing with each patient encounter.

Emergency Medicine: More Often, Scrubs and Polo Shirts

For the past 10 years, physicians and Advanced Practice Providers on shift in the Emergency Department have been wearing dark blue scrubs, or dark blue polo shirts with “MedStar Emergency Physicians” embroidered on them.

“We’re happy to have more versatile options,” says Emergency Medicine Assistant Chair Lauren Wiesner, MD, who also focuses on infection control and prevention for the department. “We have multiple patient encounters during our shifts, and a clinician may see 16 to 18 patients. Many of us find that it’s more practical not to wear a white coat, but we leave wearing a white coat to personal preference.”

Anecdotally, Dr. Wiesner notes, it’s not easy to keep a clean coat in real time. “Of course, we offer cleaning services for the white coats worn by our staff, as well.”

Emergency Medicine physicians and APPs are on their feet for most of a shift, and even if they don’t normally wear a white coat, they do find they put them on in some instances. “The white coat is a powerful symbol of the honor of the profession of the physician and our practice, so many of us do wear white coats when we have to give difficult news to family members,” she says. “We also tend to wear them when we are at hospital meetings, so we can be identified as members of the Medical & Dental Staff.”

Dr. Wiesner adds that the ED physicians are well-aware of the data of infection control, and that knowledge may have been one of the original decisions for many, to practice “bare below the elbows.” “We’ve also considered other potential fomites, such as ID badges and ties, and anything else that might spread infection. We try to reduce the risk of these as much as we can.”
Where Are They Now?
Former Residents Pursue Exciting Careers

Each year, some 200 residents complete their training at MedStar Washington Hospital Center, and then head out into the world to new practices. Here is an update on what four former residents are doing since they left training.

**Virit Butani, DPM**
*Year graduated: 2015*
*Program: Podiatric Surgery*
*Current practice:* California

I’m originally from Los Angeles, and I wanted to come back here after residency. I’m currently in a private practice affiliated with UCLA Health.

I practice all aspects of podiatric medicine and surgery. I am able to do everything we were trained for in residency. At MedStar Washington Hospital Center and MedStar Georgetown University Hospital, we had a lot of patient encounters and interactions with other specialties. This helps me in my practice, because I can better communicate and coordinate; I understand the verbiage, I know what other specialists do.

There are many podiatric residences that provide great training and an overall experience, but MedStar takes it to another level. Residency was high stress and high patient load. It taught me to maintain my composure and manage my time effectively.

I continued to grow every year in residency, getting more comfortable by the day. It prepared me very well in all aspects of podiatric medicine and surgery.

**D. Winslow Blankenship, MD**
*Year graduated: 2017*
*Program: Dermatology*
*Current practice:* Colorado

After my residency, I moved to Vail, Colorado, to join a busy dermatology practice. Colorado has a healthy and active population that spends a lot of time outdoors. Because of the elevation, sun exposure is very intense, and the skin cancer, particularly melanoma, incidence is much higher than other areas of the United States.

I have an integrated practice that includes medical, cosmetic, and surgical dermatology. The residency program at the Hospital Center could not have prepared me better for my current practice, especially for the complex medical dermatologic cases. No patient has walked into my clinic with a condition that I have not seen before and cannot comfortably manage. The faculty was great; I’ve emailed attendings at the hospital multiple times, to tell them how grateful I am for the training I received. I’m confident and prepared for anything.

I had been skiing in the Vail Valley with my family since childhood, and my mother moved to the mountains 20 years ago. We have adjusted well to mountain life. Our daughters are fourth generation Vail skiers, and my husband, Ross, and I are expecting a baby boy in December.
Matt Snow, DPM  
**Year graduated:** 2017  
**Program:** Podiatric Surgery  
**Current practice:** California

Being a California native, my professional and residency affiliations allowed me the opportunity to return home and practice. I joined a private practice affiliated with UCLA Health that allows me to work extensively in both the inpatient and outpatient settings.

My residency experience at MedStar Washington Hospital Center provided a great foundation for my practice today. It was multidisciplinary, and required close interaction with other specialties during my training. This close relationship provided me with a certain comfort level that allowed me to incorporate a host of other specialties in the care of my patients, and particularly, complex patients suffering from diabetes.

At the Hospital Center, we treated a very high volume of patients, which added a great deal of variety and complexity to my training. This exposure enabled me to be comfortable with many procedures and pathologies. In particular, we were exposed to a wide variety of trauma which has become useful, as my current employment provides services to a Level 1 trauma center.

Ravi Agarwal, DMD  
**Year graduated:** 2012  
**Program:** Oral and Maxillofacial Surgery  
**Current practice:** Washington, D.C.

During my training, I formed close relationships with the faculty, especially George Obeid. I also fell in love with the hospital setting and the atmosphere here at the Hospital Center. That’s why I decided to stay here, after finishing my residency. In 2014, I became the program director for the Oral Surgery residency program.

Here I find a balance of elective procedures, acute care and trauma. It’s very interesting and entertaining. I work with smart, motivated individuals, and it makes me stay on my toes. My leadership position has presented a challenge: you learn a lot about yourself and about leadership. It has helped me grow. Because I trained here, I can relate better to residents’ issues, different personalities. I can improve aspects of the training to energize the program further.
A multidisciplinary treatment approach made a huge difference for Kevin Grant.

Diagnosed at another hospital with a severe infection in his left foot, the 58-year old owner of a D.C.-area adult daycare business underwent a partial amputation of his foot. The hospital’s surgeons advised Grant that he’d likely lose his leg below the knee as well. Grant sought a second opinion from another hospital, only to come up with the same conclusion: major amputation.

“Losing part of my foot, I could understand,” Grant recalls. “But the fact that neither hospital provided much information or offered another option made me very uncomfortable with that approach.”

The experience took a toll on Grant’s overall health. Already dealing with weight and diabetes issues, he was diagnosed with congestive heart failure, the possible result of a staph infection from his many hospital visits.

While the recommendation for below-the-knee amputation was not out of the question, the recommendation from the other hospitals seemed premature to Grant. Still, he faced an uphill battle. Along with osteomyelitis in the remaining foot bones and above normal blood glucose levels, his underlying congestive heart failure made him a high risk for surgery.

Convinced that there had to be another way, Grant sought out care from wound healing and limb salvage specialists at MedStar Washington Hospital Center, where he was evaluated by Podiatric Surgeons John Steinberg, DPM, FACFAS, and Tammer Elmarsafi, DPM.

“Our team at the Hospital Center is well-equipped with resources for these type of referrals, and we are often called upon to be the safety net for just this type of patient,” says Dr. Steinberg. “A key factor that makes us unique is the immediate access to all specialists involved, and the inherent close communication to tie it all together. When a patient with diabetes has a threatened limb, everything has to happen rapidly and simultaneously, in order to maximize the chances for a good outcome. This
is a big part of what we do every day, and our team is built to handle these complex patients."

“No part of his admission was straightforward,“ adds Dr. Elmarsafi. But Grant sensed that this approach to his foot would be different. “Because the Hospital Center saw amputation as a last resort, they brought in a whole team of people to look at all the issues,” he says. “They kept me involved and informed throughout the process.”

A Vascular Surgery consultation confirmed that Grant was strong enough to undergo surgery, so Caitlin Zarick, DPM, and Dr. Elmarsafi performed separate procedures for him.

“Mr. Grant had multiple, staged surgical procedures to remove all infected and necrotic tissue,” says Dr. Zarick. “We had initially been concerned about continued bone infection, and I performed bone biopsies of multiple bones in his foot. The goal of the initial surgery was to remove bacteria, and to prepare his wound for possible closure, grafting, or possible amputation.”

The surgeries ultimately led to a completely closed Chopart amputation—leaving Grant a shorter, yet still functional foot. Infectious Diseases Physician Saumil Doshi, MD, and Vascular Surgery Chair Edward Woo, MD, were also brought in to consult on Grant’s case, to ensure success as rehabilitation was scheduled.

As Grant began his rehabilitation regimen, he encountered a few bumps. A small area of flap necrosis required a referral to MedStar Georgetown University Hospital’s Center for Wound Healing for hyperbaric oxygen therapy, supervised by Kelly Johnson-Arbor, MD.

“Because he had a history of congestive heart failure,” explains Dr. Johnson-Arbor, “I referred him back to his cardiologist for repeat evaluation, and he underwent echocardiography which showed his heart function was still very compromised. I deferred hyperbaric oxygen therapy for him because of this. Patients with severe congestive heart failure can have worsening of their condition when treated under hyperbaric conditions. As hyperbaric oxygen therapy was too risky of a treatment for this particular patient, I referred him back to Dr. Elmarsafi for additional podiatric surgical care.”

Grant was cleared to begin rehabilitation with MedStar National Rehabilitation Network, where his care was supervised by Howard Gilmer, DO. Grant was fitted with a customized brace to maximize his walking ability. He was ready to resume his life, and Grant didn’t waste any time. He began a supervised exercise and dietary regimen that brought his weight down to a healthier level, and eliminated the need for diabetes medication.

Regaining strength in his left leg further reinforced his commitment to healthier living, to the point where he asked Dr. Elmarsafi about running a 5K race.

“I had to talk Kevin out of that, as he remains at high risk of amputation,” Dr. Elmarsafi says. “He needed to focus on his current recovery process, and avoid any possibility of reopening his wound.”

Dr. Elmarsafi recommended swimming and using elliptical-focused training at the gym. Grant now swims several laps every other day to stay fit, and goes to the gym on a regular basis.

Though he’s not abandoning his racing ambitions, Grant is content to take a more measured approach to his recovery, noting that his only regret is not having sought help sooner from the Hospital Center.

“All the doctors were caring, ethical, and fully invested in supporting me and my family,” he says. “When you have an entire team looking at a challenge, you will likely have better outcomes.”

With that kind of attitude, Dr. Elmarsafi says, anything is possible. “Kevin continues to amaze me,” he says. “I’m very proud of him.”

“When caring for patients with complex limb threatening problems, it is imperative to ensure a comprehensive team of dedicated specialists be integrated into the patient’s plan of care,” Dr. Elmarsafi adds. “At the Hospital Center, and in collaboration with teams at MedStar Georgetown University Hospital, and MedStar National Rehabilitation Hospital, Kevin was afforded something much greater than just prevention of a major amputation, but rather has been given a wonderful and exciting prospect of living a wound-free, active, and healthy lifestyle.”
The passport belonging to Amanda Beirne, CRNP, is only about four years old, but its pages are already filled with visa stamps from overseas travels, an expression of pent-up wanderlust she could finally indulge after finishing years of professional education.

Beirne is Medstar Heart and Vascular Institute’s director of Advanced Practice. She says her husband Lucas, an attorney with the Federal Reserve System, has a knack for tracking down low-cost travel deals to destinations across Europe and Latin America. With some careful flight planning, the couple frequently doubled their pleasure trips with some quick layover sight-seeing, such as visiting the famed Panama Canal en route home from Chile.

By now, one would expect trip packing and preparation to be second-nature. But as a scheduled two-week adventure in January that included eight days touring Morocco drew near, a new consideration arose—Beirne was five months pregnant with the couple’s first child.

Unsure whether she’d feel up to any kind of travel by that stage in her pregnancy, let alone journeying through the north African outback, Beirne consulted both her Ob/Gyn and Maternal Fetal Medicine physicians.

“Both cleared me to go, as long as I stayed hydrated and didn’t do anything extreme,” Beirne says. As for a planned camel ride as part of the itinerary, their advice was simple: “Don’t fall off.”

Working with a travel organizer, the couple cut the more strenuous mountain cycling and hiking activities from their original tour package, in favor of simpler yet still interesting ways to experience the country. Travel insurance with evacuation coverage provided additional peace of mind, as did the fact that even in what seemed the middle of nowhere, tour guides would always have reliable cell phone service.

An “easier” itinerary didn’t keep Beirne from getting a workout, however. After arriving in Marrakesh, it was off to the Atlas Mountains for “village trekking”—two days of 10-mile hikes that took the couple through scenic, though rather hilly terrain.

Though pleased with how she was handling the challenge, Beirne asked their guide if he’d escorted other pregnant hikers before. After hearing about a German mother-to-be who’d spent several days on
the trails, Beirne admits to feeling somewhat slouch-ish—at least until the guide lamented the other woman’s propensity for being slow and frequent stops.

“He complimented me on keeping up so well, which gave me an extra boost up the next mountain,” Beirne adds.

The couple’s next stop was a “luxury” desert camp in the Sahara—tents with a bed, a heater for chilly nights and a porta-potty that passed for a bathroom. There, they savored spectacular sunsets, and went on four-wheeling romps across the sand dunes that her husband loved, but left Beirne somewhat less impressed.

“The guide yelled, ‘How’s baby?’,” she recalls. “I replied that baby’s fine, but I might throw up.”

More surprises were in store when camel ride day arrived. Astride a wooden saddle held in place only with twine, Beirne held on tight as her “ship of the desert” gradually rose from its belly to full hump-top height of just under seven feet. Heeding her physicians’ advice, she managed to stay aboard for the entire ride.

“Then I get back and hear ‘horror stories’ about how that twine often breaks, causing people to fall and break bones,” Beirne adds.

One thing the couple—and their baby—didn’t have to worry about was eating well, whether on the trail, in the villages or back in the capital of Marrakesh. Spicy meat dishes slow-cooked in a special pot, called a tagine, became a tasty staple of their diet. Their last day before spending a few days in Europe included a cooking class.

“Of course, it was how to make tagine,” Beirne says.

These days, Beirne and her husband are fully focused on their daughter, Ella Paige, who arrived in late April. But don’t expect the family to be homebodies for long. Beirne says the search is on for the next trip destination.

“I guess that means I’ll have to learn about traveling with an infant,” Beirne says. She notes that Ella Paige already has a good head start on being a world traveler, having “toured” Europe and north Africa, and bounced along atop a camel.

“But as is typical with kids,” Beirne says with a laugh, “she won’t remember any of it.”
Patrick Finan, MD
Emergency Medicine

As Patrick Finan, MD, leans into his role as Chief Resident for Emergency Medicine, he anticipates things might get a little bit dramatic—but in the best way possible.

“I think the best way adult minds learn is experientially,” Dr. Finan says. He hopes to bring his theater background to the foreground this year, and capitalize on the department’s orientation toward simulation learning.

“In simulation, you have this safe environment to make mistakes, and bounce ideas off of each other, and see how others practice. It offers a no-risk zone to work on difficult conversations.”

Dr. Finan believes this type of practice is especially vital in Emergency Medicine, where care providers often have only a few minutes to establish relationships with patients, many of whom may be entering with misconceptions about the medical establishment. “It’s tricky,” Dr. Finan says, “but through simulation, we can make ourselves into the best possible caregivers.”

The former theater enthusiast notes that he’s lucky to work in a department that already has a robust simulation program, where residents are encouraged to find new areas for learning and create opportunities to build upon that learning.

That opportunity to help shape curriculum is particularly exciting for Dr. Finan, who hopes to develop training around the LGBTQIA+ community and possible barriers to care, including discrimination.

“I’m excited to focus on providing culturally compassionate care training, including simulations where we really delve into how to have difficult conversations with an underserved patient population.”

For Dr. Finan, such learning is the perfect intersection between personal passions and past experiences. While an undergraduate at Emory University in Atlanta, Dr. Finan ran a theater camp, as well as a math and literacy program, in Atlanta schools for at-risk students.

“The potential of education in Emergency Medicine really drew me in,” says Dr. Finan, who sees opportunity not just in bedside teaching for patients around risk factors, but also in working with colleagues, and the learning that happens in both directions. “Every shift, I learn things from the nurses, physician assistants, and technicians. There’s a wide breadth of knowledge required to work in Emergency Medicine, so I’m getting a front row seat in teaching.”

Dr. Finan sees his theater background as critical in another way, building empathy. “In theater, you get to know people’s motivations—what makes a person a person. It gives you insight into why people do the things they do.”

Even with all he hopes to take on in his chief year, Dr. Finan’s philosophy on life outside of residency is all about balance.

“Volume takes the shape of its container,” he says, a reminder of his belief that keeping passions and relationships alive and strong outside of residency will ultimately make him a better doctor. “It gives me energy to go back into work. I come back in with a full tank, so that I can give a full tank.”
Min Deng, MD
Dermatology

If you haven't heard of Mohs surgery, Min Deng, MD is hoping that's about to change. As the Director of Mohs Micrographic Surgery, a new service at MedStar Washington Hospital Center and MedStar Georgetown University Hospital, Dr. Deng will now bring that advanced procedure to skin cancer patients within the larger MedStar network.

Named after Dr. Frederic Mohs, the surgery involves a precise, microscopically-guided surgical technique, in which thin layers of skin are removed and examined in real time, until only cancer-free tissue remains.

“We’re trained not only to remove skin cancers, but to interpret the pathologies in the lab right then and there, so there’s that immediacy,” Dr. Deng says, noting the surgery offers patients the highest cure rate, up to 99 percent, and the smallest scar possible.

In a typical skin cancer removal, Dr. Deng explains, there is some guesswork on the part of the surgeon as to how wide or how deep to go. Typically, the surgeon removes more than is needed, often leaving a larger scar but also the possibility that, in the case of more aggressive tumors, not enough tissue was removed.

But, says Dr. Deng, because Mohs is microscopically-guided, a surgeon can obtain a complete surgical margin evaluation, and let the tumor dictate the size and depth of removal. She notes that this type of surgery is typically reserved for tumors in areas that are cosmetically and functionally important, such as the head and neck, genitalia, hands and feet, as well as areas with limited skin, such as the shin, and with more aggressive tumors.

Dr. Deng describes her pathway to Dermatology as a gradual discovery. “Dermatology touches upon so many facets of medicine: skin cancer, infectious diseases, connective tissue diseases. It’s a wonderful field, with so many possibilities for you, as a specialist, to understand one organ in its entirety.”

Dr. Deng attended Case Western Reserve University School of Medicine. She completed her dermatology residency at the University of Chicago, where she also served as Chief Resident. She then completed a subspecialty fellowship in micrographic surgery and dermatologic oncology at Cooper University Hospital in Camden, New Jersey. In addition to performing Mohs surgery, Dr. Deng also has expertise in the diagnosis and management of the most prevalent skin cancers.

“T​he benefits of this service can be illustrated in a patient who neglected treatment of a basal cell cancer on her lower eyelid for 20 years, in part because of a fear she’d lose her entire eyelid in surgery. “It was so gratifying to be able to offer Mohs surgery instead of removing her eyelid,” Dr. Deng recalls. “Today, if you saw that patient, you wouldn’t even know she had undergone surgery.”
The Burn Center at MedStar Washington Hospital Center serves as the regional center for adult burn patients. Our Center is verified by the American Burn Association and the American College of Surgeons Committee on Trauma, and is nationally recognized as a leader in innovative burn care and research. Our dedicated team of specialists treats patients at every stage, from treatment for acute burns, to long-term recovery, including scar management and rehabilitation. Many are active in national and international efforts to improve the lives of those injured by burns.

Each year, we admit some 800 patients with acute burns, and treat another 500 outpatients. We have a 10-bed ICU with an operating room, and a 24-bed step-down unit for less critically-ill patients.

At our burn center a dedicated team is in place and poised to provide multidisciplinary care from the time of injury through to recovery. The staff include surgeons, Advanced Practice Providers, rehabilitation therapists, a psychologist, a pharmacist, a nutritionist, dedicated nursing staff as well as many other allied health providers.

Burn treatments are evolving rapidly, and we continue to play an active role in their development through research and innovation. One example of this is the ReCell® System. This system allows for a surgeon to literally spray a patient's own skin cells onto injured areas. This technology can take a 2cm x 2cm piece of skin and expand it to a solution large enough to cover an 80cm x 80cm wound bed. This allows for larger burn areas to be grafted with less donor site and fewer operations.

We work with technologies like cultured epidermal autografts (lab-grown skin). A small biopsy is harvested and sent to the lab where the cells are isolated. The cells are then stimulated to grow into sheets of skin in lab and then brought back to the operating room to be grafted on the patient. We also use bio-engineered substitutes and donor skin for grafting.

Scar management has recently improved through innovations in burn care. We have a dedicated LASER program for treating hard, raised and debilitating burn-related scar. We have technology that can not only change the “feel” of scar but also change the appearance. This coupled with aggressive physical and occupational therapy are accelerating recovery and a return to pre-injury function and activities.

Most patients admitted to our center are offered participation in clinical trials. The Burn Center usually has greater than 10 active clinical trials at any one time. In addition to enrolling patients in clinical trials our center is performing basic and translational research that is focused at advancing health and finding novel and innovative solutions to improve burn care.

Burn care is moving along at a rapid pace. If you have any questions about what we do, please contact me, at 202-877-7347.