



THE JOHNS HOPKINS

# CuttingEdge



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## From Poor Odds to the Best Outcome

Everything seemed normal for J. Frederic Redslob, with the exception of a handful of symptoms he never imagined to be major—diarrhea, itchiness across his body and, eventually, what seemed to be a mild case of jaundice. So when he heard the word cancer, his world turned upside down.

“You have visions of chemo and losing your hair and weakness, and it just preys on your head,” says Redslob, a self-employed, 66-year-old Kiwanis volunteer from Dillsburg, Pa.

A CAT scan revealed he had a malignant mass on the bile ducts of his liver. The prog-

“People who see me now have difficulty believing I underwent the surgery I did. Except for my scar—which no one sees—you’d never know I’d gone through this ordeal.”

nosis, he remembers, looked dim. He and his wife Linda began getting his affairs in order. They met with their lawyer and their accountant to discuss preparations should he not make it. He considered selling his business and downsizing their home.

Meanwhile, believing no hospital or physician nearby was equipped to handle the large operation necessary to remove the tumor, Redslob’s

physician referred him to The Johns Hopkins Hospital, where he met hepatobiliary surgeon Timothy Pawlik.

While Redslob tried to come to terms with the cancer diagnosis, his children were researching Hopkins and Pawlik in search of any information that might indicate what he was facing and what his chances were. And, what they read was reassuring. What they learned about the cancer was not. “This was serious stuff,” Redslob says.

It was so serious, he says, that at first even Pawlik seemed concerned about whether Redslob’s tumor was operable. In order to proceed, the surgeon needed to know he could preserve at least 20 percent to 30 percent of his patient’s liver—the minimum amount that a person needs to survive. But, Pawlik says, a series of tests—including an MRI scan to measure the volume of Redslob’s liver—showed the odds looked better than anyone expected. And so, Pawlik agreed to do the surgery.

The operation took 8 hours and left behind 30 percent of Redslob’s liver. “It’s a complicated surgery,” Pawlik says,



J. Frederic Redslob bounced back quickly from the complicated surgery that removed a dangerous cancer from his liver in November 2008.

“because the tumor was encasing an important vein, the portal vein, which controls blood flow to the liver. We had to take out all of his right liver, part of the left and then a portion of his left portal vein.”

Because few other hospitals would tackle such an operation, Pawlik says, it’s not uncommon for patients in similar circumstances to be told their tumors are inoperable. “But the bottom line is we got all the

cancer out,” he says. Best of all, Redslob was able to avoid the chemotherapy and radiation that he had so dreaded. Today, he’s back at work, living his life and feeling great.

“I’ve been able to bounce back so quickly,” he says. “People who see me now have difficulty believing I underwent the surgery I did. Except for my scar—which no one sees—you’d never known I’d gone through this ordeal.” ■

### The Surgeon Speaks

#### “A huge undertaking”

There are few other places that would have taken a chance on Fred Redslob. With a tumor involving both bile ducts to the right and left side of his liver and his right portal vein, this man’s cancer would have been considered inoperable almost anywhere else.

Fortunately, at Hopkins we have access to resources that other hospitals don’t.

First and foremost, we have more experience with surgeries of this type and magnitude than any other institution. But we also have access to something that for Mr. Redslob proved equally valuable: a form of medical testing called volumetrics.

Before proceeding, we needed to know we could preserve between 20 and 30 percent of the liver. And, while other practitioners might have to guess, we use an MRI scan to measure the volume of a patient’s liver, to predict what we can salvage.

Even with the volumetrics testing, the surgery was a huge undertaking. At Hopkins, we do about 30 of these procedures each year. Most other hospitals never do this at all. Aside from taking out 70 percent of his liver, we also had to remove a large portion of his portal vein, which is responsible for draining blood from the gastrointestinal tract into the liver, and reconstruct it. Then we rerouted his intestinal tract and reconnected his bile duct using a piece of his intestines.

In the end, this patient went from having what most would have considered an incurable disease to having a better chance of success than anyone could have dreamed. All tests have shown him to be cancer-free, and today, by all indications, the outlook for his life is good. ■

—Timothy Pawlik





From Julie Freischlag  
Director of Surgery

## Succeeding Through Struggle

With the economy foundering, it's natural to worry about the state of healthcare and how to succeed in a financial climate that is predisposed to hardship. Now, more than ever, we must apply the values that I call "the Ps of success in academic surgery." These are traits that, while crucial to any physician, aren't learned in medical school. They're innate within us.

The effects of a recession on the medical world often go unnoticed by those outside the field, who often think that because financial struggles do not stop people from getting sick, physicians and other providers are unlikely to feel the consequences of an economic downturn. Unfortunately, however, that is not the case. The failings of our nation's financial system are, in fact, having a profound effect on our day-to-day jobs. There are grants we can no longer count on, donors who can no longer give, jobs we can't fill, and patients who've lost their jobs and can no longer afford insurance.

No, like investment firms and automobile manufacturers, the field of medicine is indeed vulnerable to the staggering economy, and we are slowly but surely beginning to feel the pinch. Even so, it's at times like these that we must always remind ourselves why we are here. And here is where the Ps of success become important.

We're here because we love **practicing** medicine. We're here because we want to make a difference in the lives of the **patients** who trust us. To succeed, we must have **patience** and **perseverance**. We must **prioritize** and approach our work with **purpose** and **pride**. And, most of all, we must have **passion**.

It's during difficult times like these when I realize that the depth and strength of our spirit is not measured by how we perform when circumstances are optimal. Instead, our character is best judged by how we respond during times like these, when money is tight, resources are strapped and the future is uncertain. And, after months of watching our faculty and staff adjust to the difficulties we're facing daily, I'm proud to say that strength of character is something our department possesses in abundance. ■

# Making Care Patient-Centered

With so many patients and clinical responsibilities, physicians and surgeons may be tempted to restrict their clinical worlds to the operations they perform and the medications they prescribe. But providing the best patient care and ensuring the best possible outcomes require something more.

Too often, says surgery resident Hari Nathan, there's a disconnect between patients and the physicians, nurses, social workers and other providers who care for them. Patients have families and jobs and lives that must be taken into consideration when developing a plan for medical care. Communication plays a critical role in ensuring that all aspects of their lives—not just their physical condition, but also their day-to-day existence—provide the best conditions for recovery. Not allowing for these factors, says Nathan, may result in longer patient stays and poor patient outcomes.

Now, however, a group of physicians, including Nathan, along with nurses and other staff have joined forces to improve how providers work with patients and their families and to ensure that the surgery department consistently offers patient-centered care.

When considering patient outcomes, seemingly minor issues like transportation home from the hospital and planning work schedules can become paramount, both before and after discharge. "Clinical issues occur when care isn't coordinated," explains Amy Deutschendorf, senior director of utilization and resource management for The Johns Hopkins Hospital and a member of the surgery department's patient-centered care team. For instance, she says, poor communication between patients and providers can result in lengthened hospital stays for patients who, without a discharge date, might be unable to plan for a ride or a flight home or to arrange nursing care or family assistance. Conversely, she says, when the entire care team works with the patient, a treatment and discharge plan can be developed and followed, allowing for more efficient, comprehensive care and shorter stays.

Every hospital bed that remains occupied longer than necessary equals one patient who might be better off at home and another patient still waiting to be



Hari Nathan, Amy Deutschendorf and Deborah Baker are among several members of the surgery department's patient-centered care team.

admitted and receive care. As a result, clinical and financial outcomes suffer, Deutschendorf says. But when everyone works with a common plan, it ensures that patients receive coordinated, efficient and quality care that keeps their needs in mind. "In an environment where care is not patient-centered, the plan of care is a secret and the discharge order is a surprise," she says. "Our goal is that everyone, from the patient to the provider, is involved and knows what to expect from admission until discharge."

Of course, Nathan says, busy schedules

and large clinical volumes make achieving that kind of communication a difficult goal. "A lot of times we're very successful at doing these things and it works great," he says. "But you want it built into the system so that everyone is involved and there are checks and balances making sure that everything falls into place."

So far, the patient-centered care team has concentrated their efforts on the Weinberg 4 and Nelson 6 surgical floors. Among the options the team is examining, Deutschendorf says, is daily

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## Let's Meet: The 2009 Class of Surgery Residents

The Department of Surgery wishes to congratulate its graduating class of residents. Whether remaining with us at The Johns Hopkins Hospital or moving on, all are headed for great things.

**Eric Hanly**, also a Johns Hopkins medical school graduate, will continue his training with a minimally invasive surgery fellowship at Duke University.

**Jason Williams** attended Harvard Medical School and will go to Duke University for a cardiothoracic surgery fellowship.

**Jordan Winter**, who attended Cornell University Medical College, has accepted a fellowship in surgical oncology at Memorial Sloan-Kettering Cancer Center.



Photo by zuhair kareem

**Ying Wei Lum**, who attended Jefferson Medical College, is continuing at Hopkins with a fellowship in vascular surgery.

**Meghan Arnold**, who attended the Johns Hopkins School of Medicine, has accepted a pediatric surgery fellowship at the University of Michigan.

**Prashanth Vallabhajosyula**, who attended the Yale School of Medicine, will go on to a cardiothoracic surgery fellowship at the University of Pennsylvania.

**Christopher Simpkins**, of the Johns Hopkins School of Medicine, has accepted a transplant surgery fellowship at Hopkins.

## Transplanting Hesitation With Reassurance

**F**or any patient, choosing to undergo a kidney transplant can be a difficult and life-altering decision. But for one group of patients—those 65 and older—the decision is often made with unfortunate speed and little hesitation: They opt not to have the surgery at all.

Perhaps, says transplant surgeon Dorry Segev, those patients shy away from fear of immunosuppressant drugs or because of a lack of family support. Others, along with their physicians, worry about the dangers associated with having a major operation. Some simply believe they are too old. But, Segev says, for many of those patients, such worries are as unwarranted as they are common. Worse still, these concerns are preventing countless patients from receiving life-saving kidney transplants every year.

Segev believes that, given the proper information and data, many of these older patients—and the physicians who may discourage them from surgery—would embrace

the possibility of a kidney transplant and the better quality of life the operation could offer. After all, he explains, for a patient who spends multiple days every week receiving and recovering from dialysis treatments and managing multiple medications, a new kidney could mean twice the life expectancy and a chance at a fuller, more active existence.

And, with multiple studies in the works examining how older kidney failure patients make treatment decisions and what

kind of tools and education materials might assuage their worries, Segev believes he can demonstrate that transplants are the best viable option for many—though perhaps not all—patients, regardless of age.

“The less they know, the less likely they are to pursue a transplant,” Segev says. “We believe that a lack of understanding limits older patients’ access to kidney transplants. But if we can gain a better understanding of the barriers to transplantation, we can develop better educational materials that might lead to a better decision-making process.”

“The less they know, the less likely they are to pursue a transplant.”



Dorry Segev believes more older patients would receive life-saving transplants if they had better information.

He hopes his research, which includes focus groups and examining national patient data, will yield ideas. In the end, Segev hopes to provide physicians and patients with decision tools and educational materials more tailored to their circumstances and needs, and to prove to the health care world that age does not have to be an obstacle to surgery.

It’s an ambitious goal and the statistics are daunting, especially with one of the greatest barriers standing between older patients and kidney transplants being the physicians they most trust. Across the nation, people

older than 65 account for 50 percent of end-stage renal disease patients, but they make up only 11 percent of kidney transplant recipients each year. “The referral rate is only one-seventh that of their younger counterparts,” Segev says. “Not knowing with absolute certainty whether an older adult is going to be a good candidate for surgery makes those patients and their physicians more reluctant to pursue it. The providers don’t want to refer a patient to a procedure they think is too risky.”

And yet, Segev says, the decision not to have surgery is equally—if not more—risky. The older a patient grows, the

higher their chances of dying while on dialysis become. But for eligible patients, the risk of death associated with a kidney transplant can be much lower, and the chances of a longer, more comfortable life increase. “The numbers can be very depressing, because if you’re over the age of 65, the risk of death on dialysis is 20 percent per year. That’s a very high number,” Segev says. “But with a kidney transplant, you have a 90 percent chance of surviving every passing year. It’s a much improved life expectancy and quality of life. We just need to find a way to show these numbers to the people who need them: the patients.” ■

### On the Job

#### Catherine Casey, Clinical Operations Manager

For **Catherine Casey**, medical administrative work is second nature. Long before joining Hopkins’ Department of Surgery four years ago, she grew up helping with her father’s internal medicine practice. Later on, she worked for UCLA as a medical office manager for internal medicine and surgical coordinator of the breast cancer program.

As the surgery department’s clinical operations manager, Casey analyzes how day-to-day duties are performed and how they could be improved. Most recently, for example, she helped roll out a computerized system for surgeons to input procedure and diagnosis codes directly to a patient’s electronic medical record.



#### What do you like most about your job?

I love the process improvement aspect of what I do. For example, we recently set up a new patient referral office, so if your doctor refers you to Johns Hopkins because you have a hernia, you no longer have to call a whole list of doctors to find one available. By calling one number, you get one of our operators, who will gather your documents and set up a surgery consultation.

#### How is that going so far?

We’re getting roughly 100 calls a day and have processed 2,000 patients since last July. People might see that the Department of Surgery has a new referral office and call for any surgical issue,

but we don’t handle problems like broken legs. We don’t just say, “We don’t do that” and hang up. We say, “You need an orthopedic surgeon, and here’s the phone number” and transfer them. Our customer service representatives take pride in that.

#### What challenges you most in your work?

Teaching new technologies. Learning new systems can be difficult for people, especially when they’re used to doing things a certain way. When we’re introducing new ideas and procedures, I try to put myself in every person’s shoes. I go to those eager to learn first, and work out all the kinks, so everything is ironed out by the time we need to get everyone involved. ■

## A Family Affair

For Mickey Miller Jr. and his wife Susan, supporting the Johns Hopkins Department of Surgery is more than a show of gratitude—it's a family legacy.

Miller's father, Mickey Miller Sr., is also a long-time supporter of the institution and a trustee emeritus of The Johns Hopkins University. Mickey Sr. is also a patient of Department



Mickey Miller Jr., his mother Susan Miller, his wife, also named Susan Miller and his father Mickey Miller Sr. have made supporting Hopkins a family tradition.

"The more exposure Susan and I have had to the talent and dedication of the people who work there, the more we've become bound to the institution and its success," Miller says. "We feel like we need to do whatever we can to support and be a part of it."

of Surgery Director Julie Freischlag, who considers the family to be close friends. With so many connections to the university and hospital, it's no surprise that the Miller family has supported Hopkins in myriad ways. But over the past few years, the family's loyalty has become even deeper as his father has found himself in Hopkins' care on multiple occasions, needing everything from vascular to

cardiac surgery. Meanwhile, the family—Miller and his wife, as well as his parents—have shown their gratitude the best way they know how: by giving back to the department.

In 2007, Miller's parents funded the renovation of the surgery department's library. This year, Miller and his wife agreed to support a lecture

series, featuring young faculty members speaking about cutting-edge interventions and treatments. Dubbed the Miller Family Lectureship in Vascular and Cardiac Disease, the annual series will debut next May with a presentation by cardiothoracic surgeon David Yuh.

"The Millers have been friends of Hopkins for years," says Freischlag. "They're like family. So it's fitting that their gifts are helping our family in the surgery department."

As for Miller, he credits Freischlag—along with several other surgeons—with saving his father's life. Hopkins, he says, has played an integral role in his family's lives, and he's never been disappointed with the care his father has received. To be able to support a

team of people who've done so much for his family, the community and the world, he says, is an honor.

"The more exposure Susan and I have had to the talent and dedication of the people who work there, the more we've become bound to the institution and its success," Miller says. "We feel like we need to do whatever we can to support and be a part of it." ■

*To make a gift to the Department of Surgery, contact Kathleen Hertkorn at 410-516-0296 or [kprice8@jhmi.edu](mailto:kprice8@jhmi.edu). To no longer receive information about supporting the department, contact her using the information above.*

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multidisciplinary rounds when all providers come together to discuss the needs and discharge plans for every patient. "We think this is one way that we can achieve truly patient-centered care," she says. "It's a process that can be employed on every unit, every day, so that all providers are in the same room and can talk in real time about information relevant to the patients and leave knowing what is expected."

On Weinberg 4, they've also instituted a type of mini-rounds, called huddles, during which the charge nurse meets with physicians while they're rounding so that there is communication between the nursing staff and the physicians. Among the benefits, Deutschendorf says, has been "a great improvement in the communication between the physician team and the nursing team." Additionally, she says, care teams are finding it easier to project discharge dates and coordinate post-discharge care because everyone knows there's a plan and what needs to be done to meet it.

"Patients are more prepared to return home because they've gotten the education, referrals and preparations they need to decrease discharge delays," says Deutschendorf. "Ultimately it improves patient satisfaction because they feel like they've been a part of the decision-making process." ■

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