

Physician

A comprehensive information for and about the local medical community

Lisa Barr, MD



Achievements in:

Orthopaedics and Pain Management

Mark McFarland, DO



Kevin Bonner, MD



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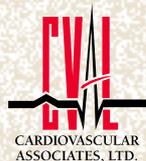
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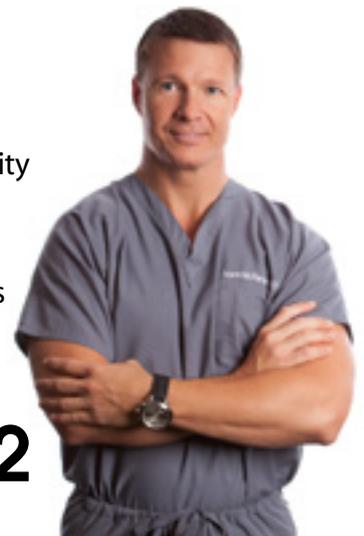


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Vol I, Issue III, Summer 2013

Recognizing the achievements of the local medical community

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Welcome to the Summer issue of *Hampton Roads Physician*

We've been particularly gratified by the medical community's response to this magazine, and especially to this issue's topic: orthopaedics and pain management. The sheer volume of nominations we received in each category assured us that innovative, ground-breaking care for patients with musculoskeletal illness and injury is readily available in Hampton Roads, from the finest practitioners in every aspect of both fields.



Holly Barlow
Publisher

Our Physician Advisory Board (pictured on page 6) worked overtime sorting through the nominations to finally settle on the three physicians pictured on the cover. But as evidenced by the items in our "In the News" column, these three are not alone in offering cutting-edge treatment to patients in Hampton Roads.

While we offer our heartiest thanks to the members of our Physician Advisory Board for their efforts, we are excited to offer them their next task: to choose among the physicians in Hampton Roads who will be nominated for their work in treating patients with diabetes, and those who are struggling with obesity. According to the World Health Organization, obesity has reached epidemic proportions globally, with at least 2.8 million people dying each year as a result of being overweight or obese. And the link between obesity and diabetes is well-documented: physicians and researchers alike have found that obesity and diabetes are connected. Persons who are obese are at high risk for developing Type 2 diabetes (also known as "insulin-resistant" or "adult-onset" diabetes), particularly if a close family member is affected with diabetes.

It's a vitally important topic, and we invite you to go to our website – hrphysician.com – and **nominate local physicians who are working to help their patients beat the odds on these devastating diseases.**

The deadline for submissions is September 3.

It is your input that brings the excellence of medical care in Hampton Roads to light. You can reach us at Hampton Roads Physician any time at 757.237.1106 or 757.773.7550. We want to hear from you, to share your stories and your accomplishments.

We're here – for you. ■

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Dr. Bonner - Joseph Lust Designs LLC
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Bobbie Fisher
Editor



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Meet the Physician Advisory Board

Hampton Roads, Virginia is the home of world-class physicians who provide medical care of the highest quality to the 1.7 million citizens of the region, as well as to the many others who travel here for care and treatment.

Hampton Roads Physician is pleased to introduce our inaugural Physician Advisory Board



JOSEPH A. ALOI, MD, FACP, FACE
Endocrinology, Diabetes, and Metabolism

Dr. Aloï is an Associate Professor of Medicine at Eastern Virginia Medical School, and Clinical Director of the Strelitz Diabetes Center for Endocrine and Metabolic Disorders. He is Board certified in Diabetes, Metabolism & Endocrinology, and in Internal Medicine.



DAVID R. MAIZEL, MD
Family Medicine

Dr. Maizel serves as Senior Physician Executive responsible for the overall operations/operational performance of the Sentara Medical Group. He is Board certified in Family Medicine.

JEFFREY R. CARLSON, MD
Orthopaedics

Dr. Carlson joined Orthopaedic and Spine Center in 1999. He is Board certified in Orthopaedics, and is currently Chief of Surgery at Mary Immaculate Hospital.



JOHN M. SHUTACK, MD, FAANS
Neurosurgery

Dr. Shutack specializes in general surgery with an emphasis in Spine Surgery. He practices with Atlantic Neurosurgical Services, which is affiliated with the Chesapeake Regional Medical Center. He is Board certified in Neurosurgery.



ERIC C. DARBY, MD, FACS
Urology

Dr. Darby practices with Tidewater Physicians Multispecialty Group in Newport News. He is Board certified in Urology and is currently Chief of Staff at Mary Immaculate Hospital.



I. PHILLIP SNIDER, RD, DO
Family Medicine

Dr. Snider practices with Amelia Family Associates, and is Regional Medical Director of Bon Secours Medical Group at DePaul Hospital. He is Board certified in both Family Medicine and Bariatric Medicine.



KEVAGHN P. FAIR, DO
Pathology

Dr. Fair is a founding partner of Dominion Pathology Laboratories, an independent diagnostic and consultative practice serving all of Hampton Roads. He is Board certified in Anatomic, Clinical and Dermatopathology.



LAMBROS K. VIENNAS, MD, FACS
Plastic Surgery

Dr. Viennas is Chief of the Division of Plastic Surgery and Assistant Professor of Plastic Surgery at Eastern Virginia Medical School. He is Board certified in Plastic and Reconstructive Surgery.



JANICE M. NEWSOME, MD
Interventional Radiology

Dr. Newsome joined Peninsula Radiology Associates in 2005. She is Board certified by the American Board of Radiology and also holds a Certificate of Advanced Qualification in Interventional Radiology.



CHRISTOPHER J. WALSH, MD, FACOG, FACS
Urogynecology

Dr. Walsh practices with Atlantic Urogynecology in Suffolk. He is Board certified by the American Board of Obstetrics and Gynecology, and a member of the American Urogynecologic Society.



The Ever Evolving World of Orthopaedics and Pain Management

By Bobbie Fisher

Twenty-first century scholars can only guess the real identity of the first physician, although ancient scrolls suggest that Imhotep, an Egyptian who lived around 2650 BCE, was the first medical doctor known by name. Among Imhotep's contributions to medicine was a textbook on the treatment of wounds, tumors and broken bones – suggesting he might qualify as the first orthopaedist as well. Certainly we know that Egyptian practitioners dealt with orthopaedic cases: Egyptologists have found mummies with splints made of bamboo, reeds, wood or bark, padded with linen.

Hippocrates, who was born in 460 BCE, wrote detailed instructions for the treatment of dislocations of the shoulders, knees, and hips, as well as treatments for infections resulting from compound fractures. He is noted for saying that war is the only proper school for surgeons, and indeed, it is well established that much of what has been learned about musculoskeletal care was the result of caring for soldiers on the battlefield.

Galen himself, who practiced during the rise of Rome despite his Greek heritage, was a gladiatorial surgeon. He studied the skeleton extensively, as well as its surrounding muscles, and there are accounts from his era of wooden legs, iron hands and artificial feet.

On the battlefields of the Middle Ages, the injured were treated with bandages soaked in horses' blood, which dried to form a stiff splint. The years – and the wars in between – produced remarkable innovations: the American Civil War introduced a host of orthopaedic and surgical advances. Even though the dire consequences of bacteria and infection were not realized until after the war's end, many modern medical practices originated on the battlefields and in the hospitals, including the use of pulleys and weights to realign lower extremity fractures. Traction and splinting were developed during World War I. Since WWII, treatments have evolved to include joint replacements, arthroscopy, and a whole host of technologies. It remains to be revealed the myriad of developments that will come from the efforts of orthopaedists and pain specialists treating the soldiers fighting the wars in Iraq and Afghanistan.

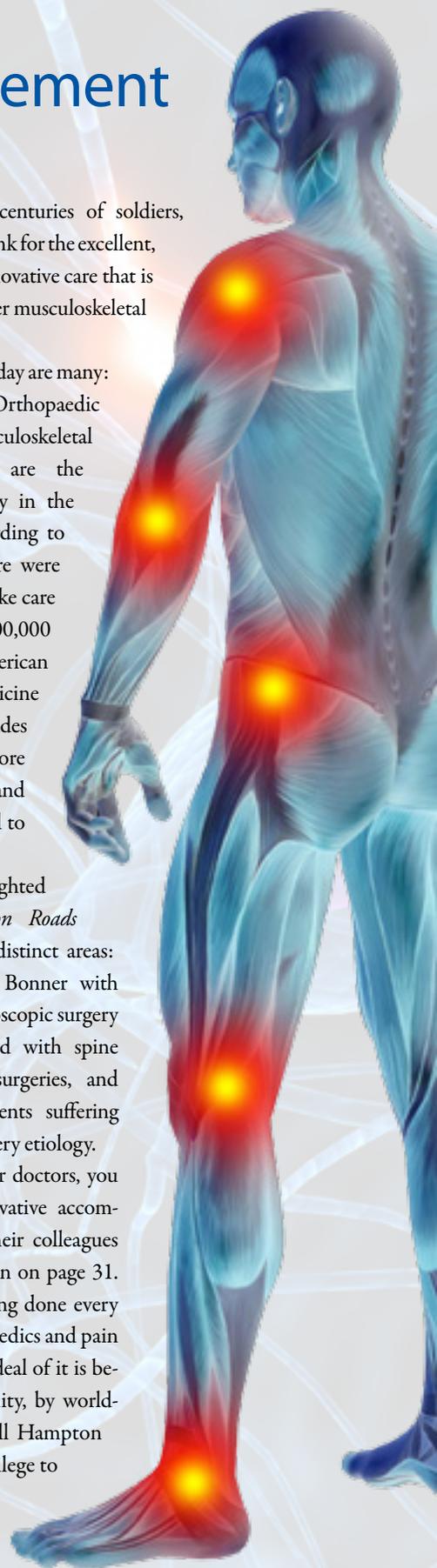
Throughout this history, physicians and healers have employed a multitude of remedies to relieve the pain associated with musculoskeletal injury and disease. Early theories of pain included the presence of evil spirits, an imbalance of bodily fluids, or simply punishment by whichever gods had been angered. Archeologists have discovered evidence of opium use to relieve pain as early as 5,000 BCE. Later, everything from herbal remedies, placing electric eels on a wound, or even sacrifices of goats and other livestock was used to manage pain.

Today's patients have centuries of soldiers, surgeons and healers to thank for the excellent, minimally invasive and innovative care that is available to those who suffer musculoskeletal injury and pain.

And those who suffer today are many: the American Academy of Orthopaedic Surgeons notes that musculoskeletal disorders and diseases are the leading cause of disability in the United States. Also according to the AAOS, in 2012, there were 27,773 orthopaedists to take care of them, or 8.72 per 100,000 patients – while the American Academy of Physical Medicine and Rehabilitation includes in its membership more than 8,000 physicians and physiatrists Board-certified to treat musculoskeletal pain.

The physicians spotlighted in this issue of *Hampton Roads Physician* focus on three distinct areas: orthopaedists Dr. Kevin Bonner with sports medicine and arthroscopic surgery and Dr. Mark McFarland with spine and joint replacement surgeries, and Dr. Lisa Barr with patients suffering musculoskeletal pain of every etiology.

In addition to our cover doctors, you can read about the innovative accomplishments of many of their colleagues in our In the News column on page 31. Extraordinary work is being done every day in the fields of orthopaedics and pain management, and a great deal of it is being done in this community, by world-class practitioners who call Hampton Roads home. It is our privilege to showcase these dedicated physicians. ■



Lisa B. Barr, MD



Lisa Barr has been treating patients with pain issues for nearly 30 years, but she doesn't call herself a pain management physician. "The phrase pain management implies that you can't treat the problem, so you have to manage it," she says. "Einstein says you can't solve problems with the same thinking that created them. I strive to evolve the way I look at these problems."

A native of Hampton Roads, Dr. Barr graduated from Eastern Virginia Medical School, where she was Chief Resident in Physical Medicine and Rehabilitation. She founded APM Spine and Sports Physicians in 1990, where she and her partners focus on treating, not managing, chronic and acute pain problems. "By constantly refining our procedural skills, leveraging technology and looking for unique, innovative ways to treat the cause," she explains, "we're able to expand and integrate our skills into effective healing strategies."

Her passionate belief in the body's innate ability to heal itself is at the heart of her approach to treating patients. "I started out with a keen interest in the mind-body connection," she says, "I believe real healing that addresses the whole person is the future of medicine."

"Listening to each patient's unique story and looking with a keen eye at the mechanism of injury and extrapolating their compensatory strategies is part of the fun and part of the challenge," Dr. Barr says. "Every patient with a lower extremity issue has to walk and run, if possible, in the hall. I want to see how their bodies move and adapt. This exercise, as well as a very hands-on assessment of their joint mechanics, soft tissue reactions and neural processing, often reveals the core issue that cannot be revealed by static x-rays or MRI scans."

Dr. Barr likens the body to "a flesh-covered computer with potential hardware and software issues. Being humans, we also have the overlay of feelings and emotions which must be taken into account in any effective therapeutic doctor-patient relationship," she emphasizes. "Intervening early is the key to a successful outcome as we minimize dysfunctional behavioral patterns and abnormal kinetic forces that can eventually lead to irreparable changes."

From traditional spinal interventions like epidural steroid injections and facet therapies to the newer biologic therapies such as PRP and prolotherapy, Dr. Barr focuses on optimizing how the body functions and moves. "Treating pain is very rewarding when you can focus on the source and return people to productive lifestyles without dependence on medication," she says.

What used to be considered alternative treatment is now considered biologic. In 1992, Dr. Barr became the first physician in Virginia to offer prolotherapy to patients with sports injuries, arthritis and other injuries. "We inject a solution of sugar water with Xylocaine and fish oil into the ligament or tendon where it attaches

to the bone," she explains. "The sugar water acts as an osmotic pressure gradient, while the Xylocaine blocks pain receptors. The fish oil acts as a chemotactic agent. The injection causes localized inflammation, which increases blood supply and the flow of nutrients into the affected area and removes debris." In other words, "the injection stimulates the body to heal itself."

In an era of biologic treatment, Dr. Barr says, patients are now using their own cells to help repair injured tissue, rather than relying on an artificial substance. About 10 years ago, she introduced the newer PRP injection therapy to Hampton Roads. PRP is produced using the patient's own blood, by concentrating healing growth factors, normal proteins found in blood. After concentrating the blood in a special centrifuge, Dr. Barr extracts the Platelet Rich Plasma and injects it under x-ray or ultrasound guidance. She is supported by no less than New York's prestigious Hospital for Special Surgery: in a study reported in the February 2013 *Clinical Journal of Sports Medicine*, researchers found that PRP treatment improved pain and function, and in 73 percent of patients, appeared to delay the progression of osteoarthritis of the knee, compared with hyaluronic acid, a common injection treatment. PRP was found to be superior to HA at each time point, with sustained improvement at the final six-month follow-up.

For Dr. Barr, leveraging the technology means merging the science and the art in an individualized approach for each patient. She knows her approach has been called unorthodox, but "I do what works for my patients," she says. "If an appropriate tool is available, we're going to offer it to our patients" – whether a standard treatment or innovative procedures like prolotherapy, PRP or any of the many healing modalities she studies. She's experienced in interventional pain, skilled in osteopathic manipulation, a licensed acupuncturist, a yogi and a Reiki master.

She insists that her patients understand their diagnoses, how she intends to treat them and importantly, what's required of them. "While I recognize not everyone I treat is a pro athlete, I enjoy working with motivated patients who don't want to give their power away to pills, machines or doctors," she states plainly, "patients who want to engage in a process of change and transformation in their body."

In addition to her practice, she's a consultant for ProGolf Health, a group of clinicians who provide holistic health care for professional golfers worldwide, and she'd like to start a golf medicine clinic here in Hampton Roads. She's also working on a screenplay, and a book about holistic healing and the mind-body connection. ■

Kevin F. Bonner, MD



Growing up in a small farming community, Kevin Bonner developed a strong work ethic, as well as an early interest in both sports and the sciences. “To be honest, at the time, it was not much fun getting up quite early to take care of cows and chickens before walking to the bus stop,” he says, “but I think it does instill drive and character, which helps you for the rest of your life.”

Kevin Bonner was a three-sport athlete in high school, but he eventually concentrated on baseball, earning him an athletic scholarship to Georgetown University. He played well; however, like many pitchers probably threw too often, ultimately sustaining an injury to his elbow. The silver lining was that his injury spurred his interest in orthopaedics and sports medicine.

After completing his undergraduate degree, Dr. Bonner attended Georgetown University School of Medicine on a scholarship from the United States Navy. He continued his training in orthopaedic surgery at the Hospital for Special Surgery/Cornell University Medical Center, where he had the opportunity to work with many of the pioneers in the field. The Navy subsequently brought him to Hampton Roads to start his career at Portsmouth Naval Medical Center. By the time he left, he was Chief of Sports Medicine. “Coming from New York, we didn’t know anything about this area,” Dr. Bonner says. “We didn’t expect to stay here, but my family and I really ended up loving the area.” He joined the Jordan-Young Institute, where he enjoys “practicing with great partners who share the same philosophy of delivering a level of care equivalent to leading academic medical centers.”

Today he focuses mainly on sports medicine and arthroscopic surgery, treating athletes from high school students to professional athletes to the weekend warrior. “Middle-aged athletes are getting older and older, which is great since I’m now in that category,” Dr. Bonner says, “and the type of injury is often dependent on the age of the athletes and their sport of choice.” It is the 60-year olds who tear their rotator cuff, but frequently the 16 year olds who tear their ACL. He sees what he calls a “nice spectrum” of patients with primarily knee and shoulder problems.

“There’s been a tremendous innovation and advances in arthroscopic surgery and sports medicine over the past 10-15 years as a result of the contribution from a worldwide orthopaedic community, particularly in shoulder cases,” he says. “Other than replacements, we’re able to do most shoulder cases arthroscopically – rotator cuff repairs and labral repairs are today truly minimally invasive, which generally translates into less perioperative pain. We can actually do more difficult cases through scope easier than an

open approach due to advancements in arthroscopic techniques. I often stay up late into the morning just trying to think of what can we do next?”

In addition to his busy caseload, Dr. Bonner serves on the clinical faculty at EVMS, which gives him the opportunity to work with medical students, particularly those who are interested in orthopaedic surgery and associated research. “It is really a pleasure teaching and mentoring our EVMS students and hopefully helping them fulfill their career goals, just as others helped me. I consider myself so lucky to do something everyday that I love and hopefully, that’s evident to the students, and most importantly to my patients.” he says.

That workload alone could fill the busiest surgeon’s hours, but Dr. Bonner doesn’t stop there. He also does research, serves as faculty for many Orthopaedic conferences and writes: he’s currently working on his ninth textbook contribution. And he frequently works with physicians both nationally and internationally to develop and evaluate new techniques.

Growing out of a particular interest in cartilage surgery, he was a member of the team of physicians and scientists that developed the DeNovo NT Natural Tissue Graft, a juvenile cartilage allograft tissue that provides surgeons with an early-intervention option for the repair of focal articular cartilage defects. “These things take a lot of time. Typically years of development before release,” he says. Dr. Bonner did the first case in the world at Sentara Leigh in 2007; and now, more than five thousand of these have been done across the country.

As for evaluating new modalities, he approaches the task with trepidation: “We’re always looking for new developments and improvements for everything we do,” he notes, “but our enthusiasm to explore novel ideas to improve on current outcomes must also be tempered with appreciation of our past failures. Everyone’s looking for the ‘holy grail,’ but as we evaluate the latest technologies, we try to be both scientific and realistic.”

But he won’t stop trying. “Inherent to the privilege of practicing medicine is the incessant challenge to acquire and synthesize ever-expanding information and evidence. Medicine is always changing, always evolving, and that’s why treating patients is such a dynamic process,” he says. “People kid me about reading so much, but I believe the day we are satisfied with our knowledge and performance is the day we need to pass the torch.”

Happily, for Dr. Bonner, that day is far off in the future. ■

Mark W. McFarland, DO



Mark McFarland grew up listening to stories about his great-grandfather, Dr. Bruce Inman, a well-respected surgeon who traveled around rural Oklahoma in the 1920s and 30s, doing basic surgery and taking care of patients who paid him with whatever they had on hand. Dr. McFarland's grandmother, a nurse, became another factor in his decision to pursue medicine as a career. He knew early on that he wanted to follow in their footsteps. His parents, both educators, supported his decision enthusiastically.

He received his undergraduate degree in physiology from Oklahoma State University in Stillwater and, initially opting for a career as a Physician's Assistant, enrolled in the PA school at the University of Oklahoma-College of Medicine in Oklahoma City. He took a position with an orthopaedic surgeon at the same time. He'd been an athlete in school (basketball, baseball and football) and had developed an interest in orthopaedics when he met the surgeons who cared for him and his teammates on the field. And, he remembers, "During my PA training, I found that I really enjoyed orthopaedics. I really liked sports and sports medicine."

He worked as a PA for the orthopaedist for a while, he says, "when something clicked, and I knew I wanted to be doing the surgeries, not assisting with them." He was just 22 when he applied to and was accepted at the University of Oklahoma-College of Medicine in Tulsa. He received his Doctor of Osteopathy degree in May of 1999.

"I knew I wanted to do surgery," Dr. McFarland remembers. He completed a traditional internship in orthopaedics and a residency in orthopaedic surgery at Ohio University Doctors Hospital in Massillon, Ohio. He enjoyed, and still enjoys, everything about surgery. "I enjoy treating conservatively to see how much we can accomplish that way. It also gives me great satisfaction to go into the OR and make a difference right then and there in the lives of my patients," he says. He wanted to be able to perform joint replacements and arthroscopic procedures when his patients needed them.

During his residency at Doctors Hospital, he met Dr. Jeff Cochran, who he calls "an amazing surgeon." He says he was lucky because there were so many talented surgeons at Doctors – and luckier still because many of his fellow residents weren't interested in spine surgery. "I was able to take extra rotations with Dr. Cochran," Dr. McFarland says, "and after I worked with him just a few months, I had made up my mind."

He did a fellowship in spine surgery at the Florida Spine Institute in Tampa/Clearwater, and found that he really liked doing the complex, protracted spine procedures that many

surgeons avoid. He admits it's not the easiest path: "Spine surgery is one of the toughest procedures we do as orthopaedic surgeons, with the most riding on the outcome for the patient."

Today, as a member of Orthopaedic & Spine Center, Dr. McFarland's practice consists of 75 percent spine patients, and the rest joint replacements and sports medicine procedures.

And yet, this surgeon says that surgery is always his last thought. "I'm very conservative," he explains. "I don't take patients to surgery unless I'm sure they can have a good outcome."

"It's true," he continues. "If we don't have to be invasive to treat a patient, we won't. I know that patients only see a doctor because they have some ailment, or because they're in pain. No one comes to see me because they want to have surgery – they just want to get better."

But he also knows that problems arise when people wait too long to see an orthopaedist. "We understand their fear of surgery," Dr. McFarland says; "but unfortunately, too often patients who put off making an appointment to avoid surgery can develop other problems in the meantime, and deprive themselves of the conservative modalities that we can offer – and they wind up needing more complicated surgery. There are so many things we can do for patients today, so many ways to make people better without taking them to the operating room." So many, in fact, that fully 95 percent of his patients are never scheduled for surgery.

As more and more non-surgical techniques and other modalities become available, that figure may go up. "Every day, we're coming up with innovative new ways to treat people that don't involve surgery," he says. "There's exciting new stem cell research that will help people with arthritic knees, arthritic hips, and even degenerative discs in their spines."

He explains: "It's a degenerative cascade when these discs start to wear out. Right now, we really don't have a treatment other than managing them with therapeutic medicines, injections, and ultimately surgery. But in the future, we'll be able to put medicine, or stem cells, directly into those discs and get them to regenerate. There are many researchers working on this now. It's been done with animal models that show its effectiveness."

In addition, joint replacements are becoming even more minimally invasive with computer-assisted surgeries. "The placement in the body is just about perfect," he says, "and gives the patient excellent range of motion with an implant that won't wear out as quickly."

Spine surgery and joint replacements are "a bit of a different mix for an orthopaedist," Dr. McFarland concedes, "but that's how my practice has developed, and I absolutely love it." ■

Tidewater Physical Therapy Now Offers Aquatic Therapy in Virginia Beach

Ask Paul Reed, PT, DPT about a patient he's never been able to forget and you'll hear a story about a young man living with cerebral palsy.

For weeks, Reed worked with the patient in a physical therapy clinic, attempting to help him move more effectively through life, completing basic everyday tasks.

"But his body was so taken over with tone that we really struggled with ways to get him stronger, to stretch him," Reed said. "As he moved his joints, his muscles flexed, preventing him from moving the joint at all. As a result, joint deformities occurred."

The patient moved on from the clinic, but Reed still wonders what could have happened if he could have gotten that patient into an aquatic therapy program. He was the perfect candidate, Reed said, and the combination of water, temperature and pressure of a therapeutic pool and exercise program could have helped inhibit the neurological effects of the cerebral palsy.

Tidewater Physical Therapy will open its newest clinic location off of First Colonial Road in Virginia Beach – at 1745 Camelot Drive, Suite 100, in September 2013. The clinic will serve outpatient physical therapy patients of a variety of diagnoses and include a state of the art therapy pool.

Reed will serve as First Colonial's first Clinical Director, alongside Brian Beaulieu, PT, MPT, Tidewater Physical Therapy's Regional Director of the South Hampton Roads operations.



"We continue to look for ways to increase ease of access to services for patients throughout the region," Beaulieu said.

Partially, that's done, Beaulieu said, by offering services "where patients live, work and consume medical services."

Tidewater Physical Therapy remains a physical therapist-owned, independent, outpatient physical therapy practice, with, following the opening of the First Colonial clinic, 33 locations across Southeast and Central Virginia.

In Beaulieu's South Hampton Roads region alone, Tidewater Physical Therapy operates nine clinics, including locations in Virginia Beach's Red Mill and First Colonial areas; Kempsville in Norfolk; Great Bridge, Battlefield, and Western Branch in Chesapeake; Smithfield; Windsor and Franklin.

In addition to the aquatic therapy, the Tidewater Physical Therapy's South Hampton Roads clinics feature arthritis management, functional capacity evaluations, impairment rating work ups, lymphedema therapy, manual therapy, neurological rehabilitation, pediatric orthopedic rehabilitation, sports injury and performance programs, TMJ disorder therapy, vestibular and fall prevention programs, women's health (including pelvic floor pain), work injury rehabilitation, and work conditioning and hardening.

Reed joined Tidewater Physical Therapy in May of 2013, impressed by the range of services they offered patients, and the culture of making access easy. Reed came to Virginia Beach from Phoenix, Az.

Tidewater Physical Therapy operates 33 clinics throughout Southeast and Central Virginia, including nine in South Hampton Roads.

- Virginia Beach: First Colonial
- Virginia Beach: Red Mill
- Norfolk: Kempsville
- Chesapeake: Battlefield
- Chesapeake: Great Bridge
- Chesapeake: Western Branch
- Smithfield
- Windsor
- Franklin



after enlisting in the U.S. Navy in 1994. He earned his Doctor of Physical Therapy from Old Dominion University.

“We pride ourselves on bringing together the highest caliber clinicians, our dedication to manual therapy and hands on care, as well as access to the best possible programs,” Beaulieu said.

“The opening on First Colonial, in an area where people are going to see their physician and other medical professionals will help us be of service to more people. Being the only clinic along the First Colonial medical corridor to offer a therapeutic pool to perform aquatic therapy helps us improve our ability to help people return to their active lives.”

Aquatic Therapy.

The therapeutic pool at Tidewater Physical Therapy’s First Colonial clinic will feature resistance jets and a submerged treadmill, as well as private dressing rooms close by.

It’s large enough to work with multiple patients at a time, Reed said, yet small enough to control the temperature, which is set several degrees higher than most swimming pools, but cooler than a hot tub.

That’s the benefit of a therapeutic pool, he said.

“The size does matter,” Reed said. “We don’t want the pool to be so vast that we can’t get a handle on the temperature and keep it at optimal therapeutic temps.”

It’s because of the temperature, pressure and buoyancy of the water that “with aquatic therapy comes the opportunity and availability for us to treat several new diagnoses, from athletes recovering from an injury to patients who need to manage chronic pain, such as fibromyalgia, and people who have undergone joint replacements and lumbar surgeries.”

Aquatic therapy can impact the total health and wellness of patients. A patient with chronic pain, for example, is likely not exercising, sleeping well or eating well.

Without a therapy pool, “physical therapists do a lot of soft tissue work – hands on manual therapy – with individuals to get them ready for land based exercises. With aquatic therapy, we still do that hands on therapy, but we are able to get the patient exercising in the pool sooner, building up those muscles, burning calories.”

And when you burn calories, you use energy, start eating, and improving sleep cycles.

“Because I’ve been in practice for almost 40 years, I have a large geriatric patient population,” said Dr. Michael Moro of Independence Family Medicine. “Aquatic therapy for them can be a godsend.”

Especially, Dr. Moro added, for patients with diagnoses like arthritis.

“With aquatic therapy, they can increase their muscle strength without trauma on the joints.”

Someone with increased levels of arthritis in their legs or back benefits from aquatic therapy in several ways. The warm water and buoyancy helps soothe patients, which makes them more likely to move through larger ranges of motion than they normally would on land. Over time, the movement in the water helps improve the lubrication of their affected joints, slowing the progression of arthritis and allowing the patient to improve how they can move with less pain.

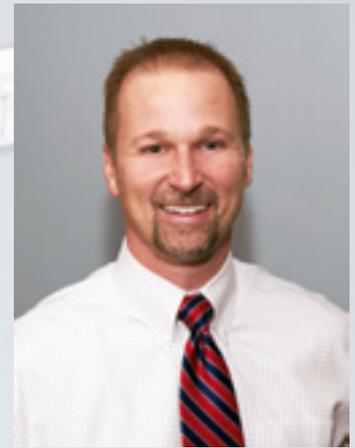
Returning to an Active Life.

Reed speaks just as passionately about treatment philosophies as he does about the uniqueness of offering aquatic therapy.

It’s not just about the pool or the manual therapy or the prescribed exercises on land or in water, Reed said. It’s about taking those therapies and applying them to a real life goal.



Paul Reed
First Colonial Clinical Director



Brian Beaulieu
Southside Regional Director

Every patient, Reed said, receives a one-hour evaluation as soon as they arrive at the clinic to set goals and develop treatment plans.

“When a patient is referred to us, we value the importance of status reports and not only helping patients, but also helping their physician see the objective results of their prescribed therapy,” Reed said.

That starts with a thorough evaluation and setting real life, functional goals.

“I have the greatest confidence in (Tidewater) and the way they treat people,” Dr. Moro said. “When you go to your doctor’s office you want to feel like you’re the only person in that room. (Tidewater) treat(s) patients as individuals.”

It’s not just about getting you to be able to lift a 10-pound weight or walk 20 minutes on a treadmill submerged in water. It’s about helping a patient be able to take a gallon of milk out of the refrigerator, or turn to check a blind spot when driving.

“It’s about making real, meaningful progress,” Reed said, “that’s measurable in someone’s life.” ■

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Promotional Feature

Stroke Care Update

By Bobbie Fisher

It's well-recognized that stroke kills almost 130,000 Americans each year – that's one in every 19 deaths, or one every death four minutes. It's also well-recognized that annually, approximately 795,000 people in the United States suffer a stroke, and about 610,000 of those are first (or new) strokes. Eight in ten are ischemic.

Far less understood are today's options for treating ischemic stroke patients. For some time, says Dr. Karah Lanier, an interventional neuroradiologist with Medical Center Radiologists, "IV tPA was all we had to treat stroke patients." IV tPA, a thrombolytic agent, was approved by the FDA in 1996 to treat ischemic strokes within the first three hours, given to help dissolve the clot quickly, and restore the blood flow to the brain. "We've gotten better at using IV tPA, and patients are getting to the hospital faster," Dr. Lanier says.

But tPA isn't appropriate for every stroke patient. Those who cannot be treated within three hours of their first symptom, patients with certain medical conditions, and patients with certain types of strokes will not qualify for this treatment – although recent results of the European Cooperative Acute Stroke Study show evidence of an expanded time-window between three and four-and-a-half hours for patients with acute ischemic stroke symptoms.

And the risks associated with tPA include hemorrhage in the brain or in other parts of the body. In six of 100 patients, bleeding can occur into the brain, causing further injury. And for one of those six, it can mean death or long-term serious disability.



Catheter Intervention is Changing the Landscape of Stroke Care

Today, there's another level of stroke care when tPA isn't appropriate, doesn't work or isn't sufficient because the clot is too big, Dr. Lanier explains. A number of FDA-approved devices have become available within the last 18 months that have significantly improved physicians' ability to rapidly restore blood flow to the brain. Interventional



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neuroradiologist Dr. John Agola of Medical Center Radiologists cites two prototypes:

- In March 2012, the FDA approved a new clot retrieval system, the Covidien Solitaire Flow Restoration Device, a mechanical thrombectomy device combining the ability to quickly restore blood flow, administer medical therapy, and retrieve clot in patients experiencing acute ischemic stroke. Solitaire utilizes a self-expanding, stent like design, and once inserted into a blocked artery using a thin catheter tube, compresses and traps the clot. The clot is then removed by withdrawing the device, which operates on the same principle as a Chinese finger trap, reopening the blocked blood vessel.
- In November of 2012, Stryker launched the Trevo ProVue Retriever, the first clot removal device that is fully visible during the procedure for precise positioning within the clot and optimized clot retrieval in patients in acute ischemic stroke.

“These have been well validated in the European and American markets, and now in our own hands,” Dr. Agola says.

With these remarkable new tools at their disposal, a unique aspect of these two physicians’ stroke practice is their insistence on being on the front line of triage of these patients. “A lot of systems put interventionalists at the back of the triage system,” Dr. Agola notes, “but that wastes precious time.” This participation has been part of a system protocol that has been acknowledged and blue printed for best practice by the American Hospital Association. Both Dr. Lanier and Dr. Agola carry stroke pagers, and respond to calls on a 24/7 basis, 365 days a year – 600 in 2012 alone. And it’s a regional effort: they know the services are difficult to reproduce because of the high level of training, equipment and support staff required to effectively treat stroke patients using the newer modalities, so they screen patients for hospitals and physicians all across Hampton Roads.

“To further expedite timely treatment, we will frequently meet patients in the ER and take them immediately to the cath lab for intervention,” Dr. Agola says, because “with stroke, timing is absolutely critical.” To these interventional neuroradiologists, the key to treating stroke patients today is educating everyone, at every level, who has contact with them. So they strive to make sure that everyone who has any contact with a stroke patient understands the urgency of maximizing each second. They have developed a unique visual educational tool that explains each case – presentation, the diagnosis and treatment. These are laminated and presented to the EMS who

transports the patient, to ER and ICU nurses, even to the patients themselves. “We show exactly what those seconds mean with these images,” Dr. Lanier says. “They’re very motivating.”

As opposed to the standard IV tPA treatment, “there are very few contraindications to what we do,” Dr. Lanier says. “It doesn’t matter if they’re on Coumadin or if they’ve had a massive GI bleed or had recent surgery – none of that matters. We’ve treated people with machines that pump their heart; there’s usually little you can do for them, but we can still put a catheter in their blood vessel and take the clot out and restore blood flow to their brain.”

It may be a tired analogy, they say, but stroke really is “a heart attack of the brain.” The urgency of heart attack care is now rote. They’d like to see that urgency become rote in stroke care as well. ■

R. Michael Graham, MD

The Orthopaedic Center for Foot and Ankle Reconstruction (OCFAR)

After completing his extensive training, Dr. Graham arrived in Hampton Roads in 1989 to begin his practice. After serving as the head of the Foot and Ankle Division for Atlantic Orthopaedic Specialists, he opened his own practice, The Orthopaedic Center for Foot and Ankle Reconstruction at Bon Secours DePaul Medical Center in 2005. Recognizing a medical need on the Peninsula, he opened a second Foot and Ankle Center at Bon Secours Mary Immaculate Hospital in March of 2008. Dr. Graham and his practice offer the most advanced state of the art treatment for all problems of the foot:



Dr. Graham has numerous success stories to share. He is dedicated to meeting the needs of his patients and working hard to provide great service and the best possible outcome.

- Dr. Graham has developed the only free-standing orthopaedic foot and ankle center in Hampton Roads. He has offices on the Southside and on the Peninsula to service the entire region.
- Dr. Graham offers the management of arthritic conditions of the foot and ankle, focusing on pain relief and maintaining function. He is the recognized leader in Hampton Roads for the treatment of all stages of foot and ankle arthritis. Much of the treatment is nonsurgical. When surgery is needed, Dr. Graham and the center offer the most sophisticated techniques available anywhere in the country.
- Dr. Graham has pioneered total ankle replacements in our region, performing three different types of ankle replacement surgery each designed for a different circumstance or diagnosis.
- Dr. Graham has extensive experience in the surgical reconstruction of neurological injuries to the lower extremities associated with stroke or spinal trauma. In many cases, this reconstruction can restore a patient’s ability to walk.



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Recognizing Outstanding Nurse Practitioners and Physician Assistants in Hampton Roads

EMILY L. FORBES, RN, MSN-HCA, FNP-C Nurse Practitioner

Emily Forbes always knew she wanted a career in medicine. When she was little, she told her family she was going to become a doctor. “But at five,” she says, “you don’t really understand what it’s like to be a doctor.” As she matured, she found that the role of Nurse Practitioner was the right path for her. It’s a role she has embraced and even expanded, to serve the patients she cares for as part of the cardiology team at Bon Secours DePaul Medical Center.

Forbes received her Bachelor of Science in Nursing from Winona State University in Minnesota. She enrolled in the Nursing and Healthcare Administration program at the University of Minnesota, and earned her Master of Science as a Women’s Health Nurse Practitioner, concurrently with a Master’s in Nursing and Healthcare Administration. She went on to complete a post-Master’s degree as a Family Nurse Practitioner from Hawaii Pacific University.

Forbes served on the nursing faculty at the University of Hawaii-Manoa and Hawaii Pacific University. She’s Board-certified as a Family Nurse Practitioner from the Academy of Nurse Practitioners, a member of the American Association of Heart Failure Nurses, and a Board member of the Tidewater Nurse Practitioner Council.

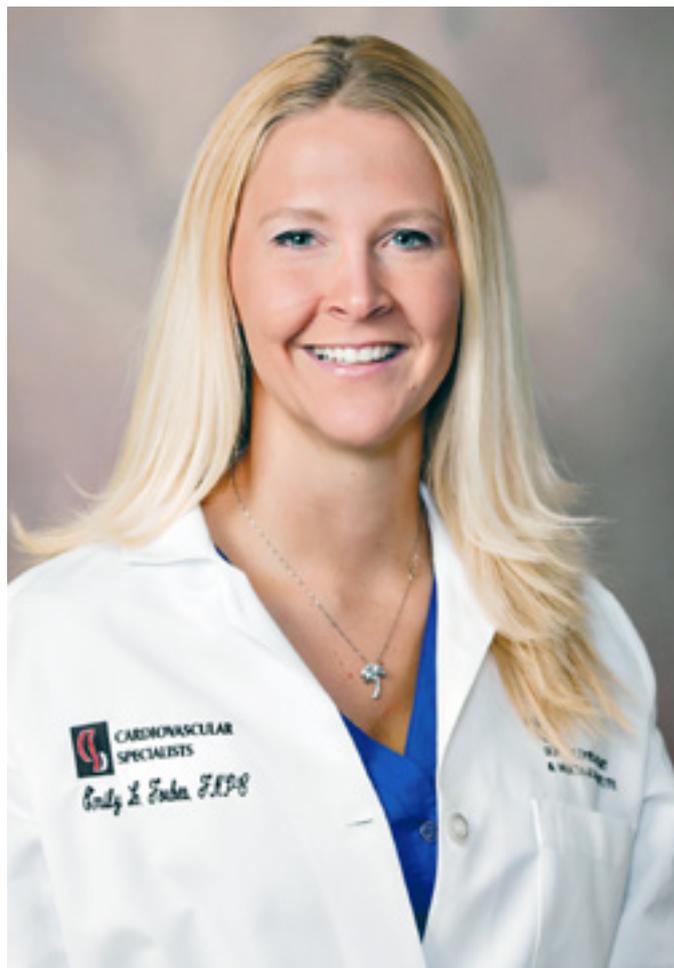
She came to Hampton Roads with her military husband, and secured a position with Bon Secours Cardiology Specialists at Maryview Hospital. “I can’t say enough about the team I’ve worked with,” Forbes says, especially Amy Barco, a PA who, she says, “took me under her wing when I first came on. She was a mentor.” Nine months later, Forbes was transferred to the fledgling cardiology practice at DePaul.

“The practice was in early growth, so patient load was not at full capacity at DePaul yet,” she recalls, “so I started going to meetings to learn more about how things were done.” Because of her background in administration and her previous work at a magnet status hospital in Hawaii, she was often asked to share her perspective.

As DePaul’s cardiology practice grew, Forbes observed that patients were often readmitted, especially with congestive heart failure. “The light bulb came on when I had a patient come back to the hospital with heart failure three times within 30 days,” she says. “I knew we had to do something about it.”

And she did. “I asked the physicians if I could have a couple of clinic days to see patients in the out-patient setting,” she says. In September of 2011, she started the heart failure clinic at DePaul. She calls it an education issue: “Patients don’t always completely understand their diagnosis, and what they’re supposed to do when diagnosed with heart failure. Nurse Practitioners are best known for their patient education.”

She started with just a few patients. She’d have them come to the clinic a week after discharge, and again after two weeks, so she could assess them, talk with them and reinforce their education. In the



nearly two years since she opened the clinic, DePaul’s readmission rate for heart failure patients has significantly improved.

Forbes created a 16-hour curriculum for nurses, utilizing the American Academy of Heart Failure criteria, and developed a telemetry class to improve cardiac monitoring, education and knowledge of DePaul’s nursing staff. She recently added the role of interim educator for the Intensive Care Unit, and sits on several committees at DePaul Medical Center.

All of which she juggles with her latest role: new mother. She and her husband welcomed their first child earlier this Spring.

She was also recently selected by her peers to receive the 2013 Daisy award for stewardship during Nurses Week. ■

If you work with or know a physician’s assistant or nurse practitioner you’d like to nominate for a profile in Hampton Roads Physician, please visit our website or call our editor, Bobbie Fisher, at 757-773-7550.

The Faces of Pain

By Bonnie Nock DO, APM Spine & Sports Physicians

"Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage," per the definition used by the International Association for the Study of Pain. Pain is a major symptom in many medical conditions and can interfere with a person's quality of life and general functioning. However, the pain mechanism is also an important component of our body's defense system and allows us to remove ourselves from dangerous situations.

When patients visit a doctor about pain, unless the source is obvious, the physician will determine if the pain is acute versus chronic, and then try to determine the source. Acute pain is part of a rapid warning system of the central nervous system to detect and minimize physical harm and is generally transitory, lasting only until the stimulus or underlying damage has healed. Chronic pain, with symptoms lasting greater than six months, generally serves no biologic function and is not a symptom of a disease, but generally felt to be a disease itself.

Pain is broken down into two distinct categories—nociceptive and non-nociceptive. In nociceptive pain, specific receptors are activated that signal tissue irritation, impending injury or actual injury to the brain. The pain is typically well localized, constant and described as throbbing, aching or sharp. Examples include sprains, bone fractures, burns, bruises, inflammation, obstructions and myofascial pain. Arthritis is an exception to the general rule in that it is recurrent and not time limited. Nociceptive pain tends to be responsive to a wide variety of medications, including anti-inflammatories, narcotics, anti-seizure and antidepressants.

Non-nociceptive pain is not related to any specific receptor and occurs within the nervous system. It is the result of an injury or malfunction in the peripheral or central nervous system. The damage or malfunction causes a nerve to send abnormal signals to the brain, which the brain interprets as pain. Pain may persist for months or years beyond the apparent healing of any damaged tissues. Patients generally complain of numbness, tingling, burning, pins and needles, electric shocks and sensitivity to temperatures and touch. Examples include post herpetic neuralgia (shingles), peripheral neuropathy, phantom limb pain (amputation of limb), fibromyalgia and nerve entrapments such as carpal tunnel syndrome. Non-nociceptive pain is frequently chronic and tends to respond well to anti-seizure and antidepressant type medications, but is less responsive to narcotic type medications.

In some conditions the pain appears to be caused by a mixture of nociceptive and non-nociceptive factors. A classic example of a mixed condition is chronic myofascial pain syndrome. It is felt that myofascial pain syndrome is initially caused by a muscle injury that then causes a malfunction of the nervous system, with development of continued abnormal muscle sensations and pain long after the muscle itself has healed. The treatments for mixed-type pain patterns are similar to those of the non-nociceptive group in that they respond to anti-seizure and antidepressant type medications and respond poorly to narcotics. ■



Dr. Bonnie Nock earned her Doctorate of Medicine from Health Science Center of North Texas, has a degree in Physical Therapy and a Masters degree in Physicology, and is Board Certified in Physical Medicine and Rehabilitation. She joined APM Spine and Sports Physicians in 1995 after serving as medical director for DePaul Medical Centers Rehabilitation Unit for nine years.

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Taking on Practice Debt

By Newkirk Products, Inc. and submitted by McPhillips, Roberts & Deans, PLC



A short-term loan or line of credit is often the solution to a medical practice's temporary cash flow problems. For an investment in equipment or office space, longer term financing may be appropriate. Before you borrow, you'll want to carefully evaluate your practice's needs and gather the financial information lenders will require when they are reviewing your request for credit.

What's Required?

It makes sense that prospective lenders will want to assess your practice's ability to repay the amount it borrows. Along with tax returns, prospective lenders may ask your practice to provide formal financial statements. In some cases, lenders may require financial forecasts in addition to recent financial statements.

Collateral and Guarantees

Lenders typically insist on collateral as security for any loans they make. In the case of a medical practice, acceptable collateral may

include practice equipment and accounts receivable. With respect to accounts receivable, prospective lenders will be interested in knowing not just the amounts recorded on your books, but also the percentage of your receivables you expect to collect. Be prepared to substantiate your average collection rate with historical data.

Don't be surprised if lenders require you and your partners to personally guarantee the practice's debt. You may even be asked to provide personal collateral as security for a loan.

Look at Multiple Financing Sources

It's a given that rates and terms on most types of loans vary from one lender to another. At a minimum, you'll probably want to contact three lenders. Review their proposals and compare fees, interest rates, and other terms. Some lenders whose terms may not seem initially attractive may make a counteroffer if they learn you are in discussions with other lenders.

Pay careful attention to any proposed loan covenants that will require your practice to meet certain requirements while the loan is outstanding. For example, an agreement might require your practice to submit periodic financial statements to the lender and maintain specified levels of working capital and net worth. The lender will have the right to take certain steps — such as modify the loan's terms or even call the loan — if your practice fails to meet the covenants.

As an alternative to seeking outside financing that demands collateral, some physicians opt to lend money to their practices, backing their actions with a formal loan agreement that specifies an interest rate, repayment terms, and other particulars about the loan.

We can work with you to determine your practice's ability to carry the debt you are considering, ensure you have the necessary financial information to give prospective lenders, and evaluate the loan proposals you receive.

Look at Taxes

The cost of acquiring new equipment for your practice can be mitigated somewhat by taking advantage of certain tax law provisions. For example, you can elect Section 179 expensing for up to \$500,000 of qualified assets acquired in 2013, with a \$2 million threshold over which the maximum deduction begins to phase out. After 2013, these numbers are scheduled to be reduced to \$25,000 and \$200,000, respectively. Also, as part of its attempts to stimulate the economy, Congress has extended a provision allowing business taxpayers to claim 50 percent "bonus" first-year depreciation for certain asset purchases placed in service through 2013. ■

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Disability Facts that Might Surprise You

Provided by Danijel Velicki, Founder/Senior Partner with The Opus Group of Virginia, who represents MassMutual and other companies; courtesy of Massachusetts Mutual Life Insurance Company (MassMutual)

In times like these, good decisions matter. And when it comes to protecting a portion of your income from disability risks, it's important to base your decision on the facts. In the case of disability, some of those facts might surprise you.

For example, more than one-quarter of today's 20 year-olds will become disabled before they retire.¹ And if you are covered by a group disability income policy through your employer, you might not know about the likely gap between your policy's benefits and your family's actual needs.

To start with, the typical group plan only covers 50-70% of income. And benefits are often taxable, have maximum limits, and don't cover bonuses, commissions or 401(k) contributions. In some cases, worker's compensation helps bridge the gap, but less than 5% of disabling accidents and illnesses are work related.²

If you run a business, your insurance protection should help cover its operating costs, possibly provide the funds for a partnership buyout, and protect a portion of lost earnings – either yours or your employees'.

The most common way to close the gap between existing coverage and actual needs is to obtain a supplemental individual disability income insurance policy. Because you own it, you can take it with you throughout your career.

And the best way to make a good decision about that policy is to work with a trusted, trained financial professional. No surprise there.

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¹ Social Security Administration, Fact Sheet March 18, 2011

² Council for Disability Awareness, Long-Term Disability Claims Review, 2011 http://www.disabilitycanhappen.org/research/CDA_LTD_Claims_Survey_2011.asp

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Motivational Interviewing

By Dr. Margaret Gaglione FACP

“Change is inevitable, growth is intentional” — Helen Keller

Moving someone from inaction to action is a challenging task. We can all list the stages of contemplation to describe where a patient is, but motivating a patient from passivity to activity takes skill and time.

Many of us are frequently frustrated by the passivity we see in our patients and their lack of ownership of their own health and nutrition. We may become overwhelmed by the sheer number of drugs we are using to keep their glucose near normal, blood pressure and lipids down, as they continue to get worse despite our best efforts.

We have all been asked: “Can’t you give me a pill or do a surgery that will make this better?”

To become better motivators, we each need to assess our own biases. Do we honestly think change is possible? Do we honestly think growth is possible?

Growth only happens when individuals make conscious, deliberate decisions. Growth only happens when individuals make their goal a priority and let go of their other desires. To succeed in any task, priorities need to be set, many temptations need to be avoided, and repetitive conditioning needs to occur. To become a master, one needs to grow through the stages of novice, proficiency, and ex-

pert. Such growth takes time, effort, determination, practice, practice, and more practice.

Growth is not mindless. Individual growth is not done by someone else, nor is it done by a magic pill.

Do your patients see themselves as a prized possession? Do they see themselves as the most important gift that they have? Do they take better care of their cars, their homes, their pets, than themselves? One cannot expect to get 150,000 miles on a car, barring a major accident, without regular maintenance and good daily care. How would they grade *their* care of themselves? Do they see the care of themselves as *their* job? Do they take ownership for *their* own health? Asking a patient, “who is responsible for your health?”, is a good place to start to assess a patient’s level of insight to self-responsibility and motivation.

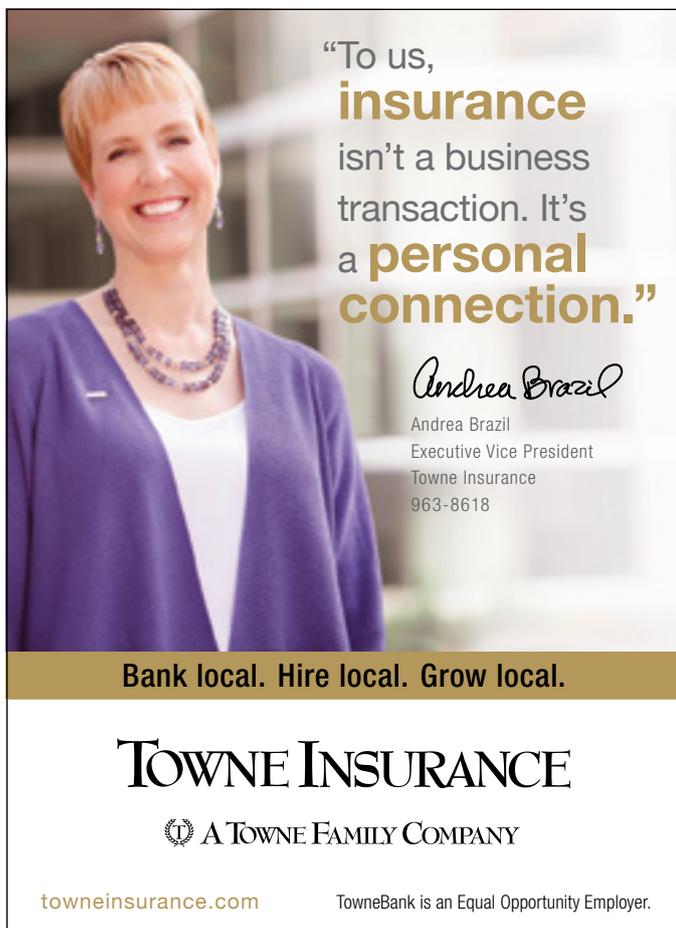
Obesity is a behavioral and physiological disease. It occurs because of an excess intake of calories. To be successful in weight loss takes intense intervention and continued practice; the same variables that are needed for success in any endeavor. For an individual to succeed they must:

1. Commit to the goal
2. Commit to learning new behaviors and daily practice of those behaviors regardless of mood, time, weather etc.
3. Commit to the goal no matter what the circumstance
4. Work hard and sacrifice

Writers, sportsmen, musicians, physicians, good parents, good spouses, even good drivers don’t just magically happen. They happen because of intense education and practicing the positive behaviors that fostered the successful development.

Successful weight loss is possible. Change is possible but it does not happen without an intense aggressive program and a dedicated patient committed to being healthy and not waiting for it to magically happen.

If you have a patient who is ready to commit to his or her own health Tidewater Bariatrics will provide the instruction and the mentorship for their success. We promise you that we will deliver an intense challenging curriculum with medical supervision that will guarantee success for patients who have made the commitment to themselves. ■



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Dr. Margaret Gaglione FACP is a Board-certified Bariatrician and Internal Medicine physician at Tidewater Bariatrics. She and her staff are committed to helping your patients achieve their weight loss goals.

Honoring the Volunteer Service of **Michael M. Romash, MD**

Like many orthopaedists, Dr. Michael Romash developed an interest in his specialty on the playing field. A high school football player, he originally studied engineering at West Point, but remained fascinated by the mechanics of the human body. After graduating in 1968, he served as a Field Artillery Officer in Germany, and when the Army offered to train regular Army officers to become physicians, he returned to the States to enroll in Temple University of Medicine. He completed his residency in orthopaedic surgery at Tripler Medical Center in Hawaii, where he later became Chief of Joint Replacement and Foot and Ankle Services. He did his fellowship in Adult Reconstructive Surgery, Sports Medicine at Duke University Medical Center. Dr. Romash served as physician for the 82nd Airborne Division for three years.

He joined Sports Medicine and Orthopaedic Center in Chesapeake in 1988, recently celebrating his 25th year in practice.

For nearly every one of those years, Dr. Romash has volunteered his time and talent on behalf of local athletes, particularly those on the soccer field. He has coached the Chesapeake United Soccer Club for 20 years. He coached the Great Bridge girls' Junior Varsity soccer team for 14 years, and served as assistant coach to the Varsity girls. He's a former Interim Director of Coaches for the Chesapeake United Soccer Club, and served on its Board of Directors. He served as the Southeast Region Olympic Development Coach, and is on the Virginia Youth Soccer Association Combined Coaching Faculty, where he presents coaching education courses to other coaches. He holds a National A license with the United States Soccer Foundation.

Since Hickory High School opened in 1996, Dr. Romash has proudly been "the doc on the field." For him, it's just a question of paying it forward. "When I was in high school playing football, there was always a physician on the field for us," he remembers. "And when I was in med school, there were professors who took me under their wing. They didn't have to, but they did."

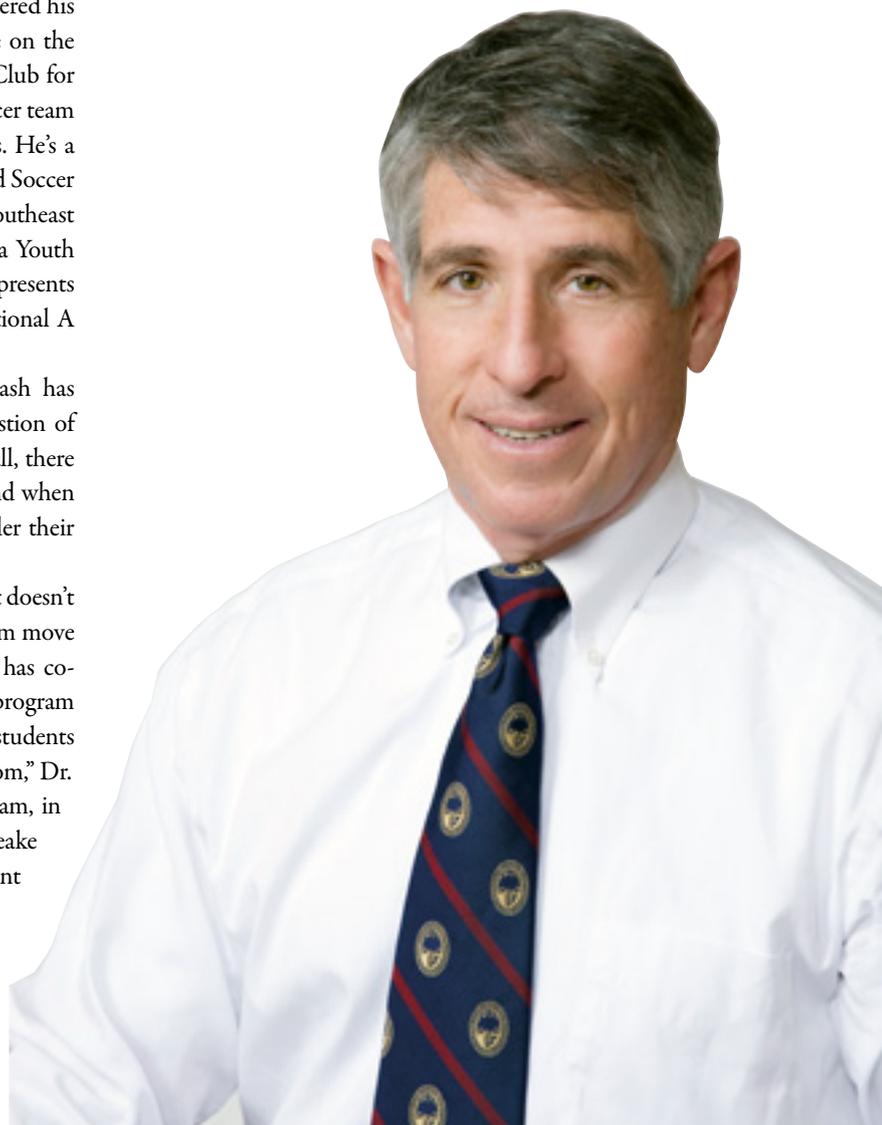
It's the idea of helping young people that inspires him. And it doesn't stop on the playing field: he's equally interested in helping them move forward in their lives and careers. For the past 15 years, he has co-sponsored the High School Sports Medicine and Anatomy program at Great Bridge High School with Sharon Ivey. "We have students come to the office, and even accompany us to the operating room," Dr. Romash says, proudly adding, "It's been a very fruitful program, in that a couple of the surgical assistants now working at Chesapeake Regional Medical Center were high school students who went through the program."

In addition, each year, Dr. Romash works with Mrs. Ivey to identify two students who excel in the program. They are presented with a medical text book, and he's quick to boast that one of the past recipients, Lena Sifen, now works with him as his Physician's Assistant. Others have gone on to pursue physical therapy, nursing and medicine.

One of his proudest accomplishments was working with Mr. Bullock, whose son died tragically while on the basketball court. "I was proud to be a member of the board of the Bullock Foundation which was established in his son's name," Dr. Romash explains. "We raised awareness, and we raised money, and we were able to get defibrillators placed in all the local schools. Of course, now they're readily available, but back then, it was quite a coup."

As he embarks on his second 25 years, he's starting to attack his bucket list: this summer's trip to Alaska will include a ride on a zip line. ■

If you know physicians who are performing good deeds – great or small – who you would like to see highlighted in this publication, please submit information on our website – www.hrphysician.com — or call our editor, Bobbie Fisher, at 757-773-7550.



"I Feel Your Pain"

Prescribing Under the Scrutiny of the Board of Medicine

By Michael Goodman

In recent years, physicians who prescribe opioids and other controlled substances for the treatment of chronic pain increasingly have found themselves before the Virginia Board of Medicine ("Board") to defend their prescribing practices. Clearly, the Board's role is not to dictate any particular provider's medical decisions, nor will the Board discipline a provider solely for prescribing opioids for legitimate medical purposes. However, in light of the growing epidemic of prescription drug abuse in Virginia and nationwide, the increase in patient complaints to the Board, and the relative ease by which the Board can use a practitioner's Prescription Monitoring Prolife (PMP) to analyze his/her prescribing practices, this trend of heightened scrutiny and regulation by the Board will no doubt continue.

Three words to the wise doctor who treats chronic pain: 1) Don't "dabble", and 2) Document.

1. Don't Dabble in Pain Management. Often, primary care providers treat some of their patients for chronic pain. These PCPs see themselves as attempting, in good faith, to treat a largely underserved population with "no place else to go". However, the documentation requirements and complicated care involved when treating for chronic pain demands a significant level of focus and effort by the prescribing physician. Bottom line, lack of knowledge regarding the standard of care for pain management or the Board's policies on pain management

and/or a path of good intentions will not serve as an excuse or a mitigating factor before the Board.

2. Document, Document, and Then Document Some More. The medical records should clearly reflect that the physician has prescribed opioids based on sound clinical judgment and clear documentation of unrelieved pain, including but not limited to, the following:

- A complete history and physical;
- Appropriate diagnosis for etiology of pain (and associated labs/diagnostic tests);
- Review of prior medical records;
- Regular follow-ups and evaluations;
- Written treatment plan and goals;
- Monitoring of progress with measurable objectives (i.e., pain rating scales, physical and social functioning);
- An informed consent and written agreement for opioid treatment ("pain contract");
- Periodic review of the course of pain treatment;
- Monitoring of patient compliance (i.e., random urine drug screens, pill counts, early refill requests, drug seeking behavior, aberrant behavior);
- List of medication(s) prescribed (dose and quantity) and the reasons for the selection;
- Consultations and referrals to specialists as needed, especially with high risk patients;
- PMP checks at each visit;
- Referrals and dismissal from practice when pain contract violated.

Being knowledgeable and taking all steps to stay compliant with the laws and policies regarding chronic pain management will serve physicians well should they ever have to defend their practices before the Board. For further information I commend to your reading the "Model Policy for the Use of Controlled Substances for the Treatment of Pain" (VA Guidance Document 85-24), and the book, "Responsible Opioid Prescribing" (for sale on Federation of State Medical Board's website, www.fsmb.org). Both the guidance document and book provide valuable insight into how the Virginia Board of Medicine understands and oversees matters of prescribing and pain management. It shouldn't be a bitter pill to swallow. ■



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Michael Goodman is an attorney with the law firm of Goodman, Allen & Filetti. His practice is focused on health care, and the representation of health care providers in credentialing matters and regulatory issues before the Board of Health Professions.

What Can Interventional Pain Management Do For Your Patients Who Suffer With Chronic Pain?

By Raj N. Sureja, MD

Physiatrists are fellowship-trained Physical Medicine & Rehabilitation Physicians who practice Interventional Medicine. We look for the root cause of pain and attempt to treat the cause, not just the symptoms.

Typically, patients who are referred to physiatrists have neuropathic pain, and have seen many other physicians, seeking relief. Some have undergone surgeries to relieve their symptoms, and some have chosen non-surgical remedies. Some may be addicted to narcotic pain medications, while some use such medications appropriately.

The procedures physiatrists perform are office-based, which represents a significant cost advantage over performing them in a hospital setting. It also greatly reduces the time it takes to perform the procedure.

Some of the procedures physiatrists perform are:

- Kyphoplasty** – used to treat compression fractures of the spine
- Vertebroplasty** – used to treat compression fractures of the spine
- SCS** – Spinal Cord Stimulator – Trial implantation
- Spinal Epidurals** – for nerve pain caused by disc herniations, stenosis, etc.
- Facet Joint Injections** – for arthritic facet joints
- SI Joint injections** – for arthritic SI Joints
- Radio Frequency Ablation** – nerve destruction for pain relief
- EMG** – To determine extent of nerve function and/or damage

In managing medications, the goal is to relieve the patient's pain as much as possible with the minimum amount of narcotics possible. It's important to do a comprehensive review of the medications a patient is taking to determine how well they are working. Physiatrists have many effective ways to deal with pain, and I have often found that patients can obtain more pain relief with drugs that work on reducing nerve pain or treating depression than with a full-load of narcotics.

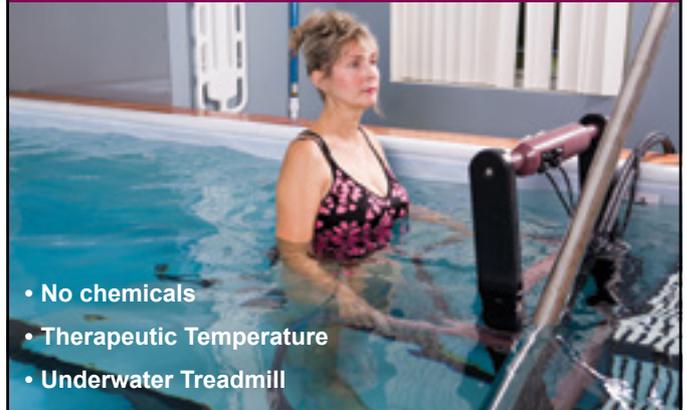
While narcotic drugs can be a necessary component of a multi-modal treatment plan, careful physiatrists try to minimize their use with patients. In my practice, every patient signs a Medication Contract, agreeing to abide by my prescribing rules. They understand they will be monitored and tested randomly so I can ensure they are taking the prescribed amount of the drug. I also test for drugs that are illegal and for those I do not prescribe. For the patient's safety, continued non-compliance with the prescription program will result in dismissal from my practice.

Patients who are in pain can become frustrated when they aren't immediately given prescriptions, when their pain isn't immediately alleviated or if they feel the treatment plan is not going their way. Sometimes, they take that frustration out on the referring physician. It is important for all parties to communicate about the treatment plan and everyone's role in making the plan work effectively. ■



Raj N. Sureja, MD is a Fellowship-trained, Board-certified, Interventional Pain Management Specialist who practices at Orthopaedic and Spine Center in Newport News. Dr. Sureja has been named a "Top Doc" in a physician survey sponsored by Hampton Roads Magazine for 2012 and 2013. For more information on OSC or Dr. Sureja, please go to www.osc-ortho.com

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ICD-10 is Coming to Town. Start Getting Ready Now.

By Bassam A. Kawwass, FACHE



“We agree with your recommendation to continue progress towards ICD-10 implementation and maintain our commitment to the October 1, 2014 compliance date. Based on your feedback and other stakeholder input, the Centers for Medicare & Medicaid Services (CMS) believes that the one-year extension offers physicians adequate time to train their coders, complete system changeovers,

and conduct testing. Furthermore, we have found that many private and public sector health plans, hospitals and hospital systems, and large physician practices are far along in ICD-10 implementation. CMS has taken action to reinforce this message to the industry and have responded to the American Medical Association.

Likewise, we believe that ICD-10 is foundational for healthcare reform and a cornerstone of several integrated programs that build toward a modernized health care system and work in concert to achieve better care, better health, and lower costs. Integrated programs such as Version 5010, the ICD-10 code itself, the Medicare & Medicaid Electronic Health Record Incentive Programs, and the physician quality reporting system are all aimed at accomplishing these outcomes. Together, they move America’s healthcare system towards better coordinated care through greater interoperability and ease of transmitting electronic data; better quality measurement and reporting of clinical outcomes data; and lower costs achieved through operational efficiencies.”

CMS Office of E-Health Standards and Services, February 13, 2013

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It certainly is an exciting time of healthcare reform for the United States. Some of that excitement (or anxiety) revolves around the transition from ICD-9 to ICD-10, which is the classification system currently being used by the majority of the world. The US is the only industrialized nation not using an ICD-10-based classification system.

ICD-10-CM is a clinical modification of the World Health Organization's ICD-10, which consist of a diagnostics classification system. With 68,000 diagnoses codes, ICD-10-CM includes the level of detail needed for morbidity classification and diagnostics specificity in the United States. It also provides code titles and language that complement accepted clinical practice in the US. ICD-10-PCS (87,000 procedure codes) was developed to capture procedure codes. This procedure coding system is much more detailed and specific than the short volume of procedure code included in ICD-9-CM.

Two main reasons have been stated for the necessity of the transition to ICD-10-CM/PCS:

1. Payors cannot pay claims fairly using ICD-9-CM since the classification system does not accurately reflect current technology and medical treatment. Significantly different procedures are assigned to a single ICD-9-CM procedure code. Limitations in the coding system translate directly into limitations in the diagnosis-related groups (DRG).

2. The healthcare industry cannot accurately measure quality of care using ICD-9-CM. It is difficult to evaluate the outcome of new procedures and emerging health care conditions when there are not precise codes. Most importantly, we have a mission to improve our ability to measure health care services provided to our patients, enhance clinical decision-making, track public health issues, conduct medical research, identify fraud and abuse and design our payment systems to ensure services are appropriately paid.

A lot of education and preparation on the structure, benefits and changes will be required if we want to achieve a smooth transition by October 2014. ■



Bassam A. Kawwass, FACHE is the administrator for Cardiovascular Associates, Ltd. (www.cval.org), the premier largest independent, full-service cardiology practice E-mail: bkawwass@cval.org. Mr. Kawwass served as past Regent at Large for the American College of Healthcare Executives. He earned a Master's in Health and Hospital Administration from Virginia Commonwealth University, a Medical Records Administration degree from St. Louis University, and a Bachelor's in Business Administration from the American University of Beirut, Lebanon.

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Acknowledging and introducing medical professionals who have recently joined the community of Hampton Roads



Philip D. Kondylis, MD, FACS, FASCRS, has joined the Colon and Rectal Surgery Division of Tidewater Surgical Specialists, a Bon Secours Virginia Medical Group specialty practice. He is Board-certified in general surgery and fellowship trained in colorectal surgery. Dr. Kondylis earned his medical degree from the University of Massachusetts Medical School in Worcester,

MA., where he also completed a National Heart, Lung, and Blood Institute student research fellowship. He completed a general surgery residency at the Yale University-affiliated Hospital of Saint Raphael in New Haven, CN. He completed a colorectal surgery fellowship at Saint Vincent Health Center in Erie, PA.

David Castaldo, MD, is now associated with Amelia Medical Associates, a Bon Secours Medical Group practice. Dr. Castaldo completed his bachelor of science at the University of Illinois and received his medical degree from Loyola University Chicago



Stritch School of Medicine in Maywood, IL. He went on to perform an internship, followed by an internal medicine residency at Eastern Virginia Medical School in Norfolk. Dr. Castaldo's professional career includes an academic medicine background, as well as 15 years of experience seeing patients. He provides a full spectrum of general medicine care for adults with emphases on men's health, hypertension, elevated cholesterol, diabetes and overall health maintenance. He has received numerous awards for excellence in teaching and patient care.

Dr. Stephen H. Lin, a general surgeon who specializes in minimally invasive and robotic surgical techniques, has joined Chesapeake Regional Medical Group. He practices with Chesapeake Surgical Specialists. A Board-certified surgeon, Dr. Lin earned his medical degree at the University of North Carolina School of Medicine in Chapel Hill, NC. He completed a residency in general surgery at Rush University Medical Center in Chicago. Lin specializes in minimally invasive robotic and laparoscopic surgery and is a fellow of the American College of Surgeons.



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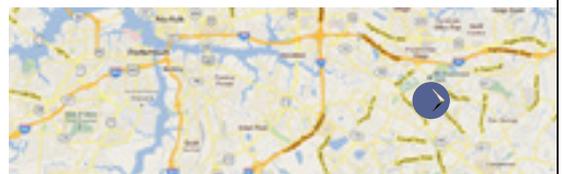
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David Horwitz
dhorwitz@hcreit.com | 800.793.9289
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Dr. J.D. Burrow has joined Orthopaedic & Spine Center's team, fellowship-trained orthopaedic surgeons. Dr. Burrow, a western Tennessee native, is moving to Hampton Roads with his wife, who is a primary-care physician. Dr. Burrow has trained in the most advanced surgical techniques for joint replacement and will bring that expertise to the Hampton Roads Community.

Kapil G. Kapoor, MD a Board-certified ophthalmologist specializing in vitreoretinal surgery, has joined the clinical team of Wagner Macula & Retina Center. Dr. Kapoor received his undergraduate degree Magna Cum Laude from Ohio State University. He obtained a medical degree from University of Texas Medical Branch – Galveston and completed his fellowship in vitreoretinal surgery at The Mayo Clinic. Dr. Kapoor will begin seeing patients in August 2013.

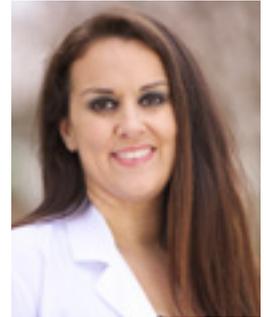


Dr. Paul Maloof will be joining Tidewater Orthopaedic Associates in September 2013, seeing patients in both their Hampton and Williamsburg offices. Dr. Maloof is fully trained as an Orthopaedic surgeon, and fellowship

trained at Duke University in Foot and Ankle surgery. Duke is known as a pioneer in ankle replacement surgery and Dr. Maloof will be bringing his advanced training in this area of Orthopaedics to the Hampton Roads area. Dr. Maloof trained in Rutgers Medical School one of the busiest Level 1 Trauma Centers on the East Coast where he served as Administrative Chief Resident

WELCOME TO THE COMMUNITY – PAs and NPs

Jennifer Brooke Fortune, a certified physician assistant, has joined Bon Secours Patient Choice – Oceana in Virginia Beach. Ms. Fortune received her undergraduate degree from Old Dominion University in Norfolk, Va., and earned her master of physician assistant degree from Eastern Virginia Medical School, also in Norfolk. Her professional experience includes working with a plastic surgery practice as well as with an urgent care practice where she treated patients and prescribed medications for minor emergency issues.



We want to extend a welcome to all of the physicians and medical professionals who join the Hampton Roads community. Please send announcements (with photos) to our editor at bobbie@hrphysician.com - or call 757.773.7550.



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Spotlighting what's happening in the medical community, and who's making news



Dr. Timothy O'Connell and Dr. Richard Campana announce the opening of the American Treatment Center. The focus of the practice is to treat patients with addiction to opioids that includes a variety of pain medicine as well as heroin. 12695 McManus Blvd., Building 2 in Newport News. 757-234-4139

Dr. J. Abbott Byrd III, Orthopaedic Spine Surgeon with Atlantic Orthopaedic Specialists, has been named member of the Practice Management Instructional Course Committee (ICC) of the American Academy of Orthopaedic Surgeons (AAOS). The key mission of the ICC is the planning, implementation and evaluation of instructional course lectures at the AAOS's annual meeting. It also ensures that curricula provided meets the current needs of Academy fellows and is in accordance with all essential standards of the Accreditation Council for Continuing Medical Education (ACCME).



Dr. Wilford K. Gibson, Orthopaedic Surgeon with Atlantic Orthopaedic Specialists, was recently appointed Chair of the American Academy of Orthopaedic Surgeons (AAOS) Board of Councilors at the AAOS Annual Meeting in Chicago. He is a past President of the Virginia Orthopaedic Society, the Norfolk Academy of Medicine and the Seaboard Medical Association. Dr. Gibson also serves as the Medical Director of Bon Secours DePaul Orthopaedic Institute.

Bon Secours DePaul Orthopaedic Institute.

Jeremy J. Hoff, DO, of Bon Secours-affiliated Hampton Roads Sports & Orthopaedic Medicine and Jonathan Bernardini, MD, of the Bon Secours Neuroscience Center for Pain Management, have qualified to perform the FDA approved mild® procedure, the only two physicians in the Hampton Roads region to be qualified to date. Developed by Vertos Medical Inc., the FDA approved mild® procedure includes X-ray-guided, fluoroscopic technology to treat patients suffering from lumbar spinal stenosis (LSS), a narrowing of the lower spinal canal that leads to lower back pain and reduced mobility, most often occurring in adults over age 50.



On June 17th, cardiologists Dr. Ryan Seutter and Dr. Jun Chung performed the region's first LARIAT® Suture Delivery Device, a new nonsurgical therapy, at Bon Secours Maryview Medical Center. The patient was a 71-year old female with a long history of atrial fibrillation, who could not tolerate blood-thinning medications. The FDA-approved LARIAT® Suture Delivery Device consists of a wire system and a pre-formed suture loop, similar to a lasso, used to tie off the left atrial appendage (LAA). Once in place, the LARIAT places and tightens a loop stitch around the base of the LAA, permanently sealing it off from the rest of the heart and blocking stroke-causing blood clots from traveling to the brain.

Bon Secours Health System and Aetna have announced a new accountable care agreement that will support 57,000 fee-for-service Medicare beneficiaries in Kentucky, New York, South Carolina and Virginia. Bon Secours will use technology and care coordination services from Aetna subsidiary Healthagen to help coordinate health care for Medicare beneficiaries whose primary physician participates in the Good Help ACO. The agreement is designed to improve the quality of care for Medicare beneficiaries under the Medicare Shared Savings Program while lowering overall health care costs. Aetna will begin administering Bon Secours' employee medical benefits plan beginning September 1, 2013.

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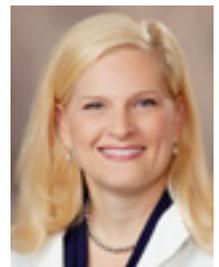
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Bon Secours Mary Immaculate Hospital has installed a new catheterization lab, equipped with a General Electric Innova interventional cardiology system. Dr. Leslie



Webb, interventional cardiologist with Cardiovascular Specialists in Newport News, recently performed the first diagnostic catheterization in the new cath lab. The new system features a flat plate imager, an intravascular ultrasound and a fractional flow reserve. The intravascular ultrasound and a fractional flow reserve are mounted directly on the table, conveniently allowing the physician to make adjustments.

Bon Secours DePaul Medical Center has been designated as a Nurses Improving Care for Healthsystem Elders (NICHE) hospital for its dedication to improving the quality of care provided to older adult patients. The NICHE designation was bestowed by the Hartford Institute for Geriatric Nursing – New York University College of Nursing. As a NICHE hospital, Bon Secours DePaul is now part of a distinguished network of nearly 450 healthcare facilities throughout North America that are committed to improving care of all patients 65 and over.



Chesapeake Regional Medical Center has named former President and CEO Donald S. Buckley, PhD., its president emeritus. Buckley received the title as a sign of appreciation for his vision and significant contributions to the growth and success of Chesapeake

General Hospital, Chesapeake Health and Chesapeake Buckley served as the founding administrator of Chesapeake General Hospital from 1971 to 2005. As president and CEO of Chesapeake General Hospital and Chesapeake Health, Buckley guided the construction and creation of Chesapeake General Hospital as Virginia's first private-room hospital. During his tenure, Buckley ushered the expansion of the hospital's equipment, expertise and medical capabilities while expanding Chesapeake General Hospital from 171 beds to 310 beds.

Stephen H. Lin, MD performed Chesapeake Regional Medical Center's first robotic belly button surgery on Friday, June 14. Belly button, or Single-Site™ surgery, requires only a 2-centimeter incision in the navel.

After surgery, the scar is almost impossible to see. Lin, who practices with Chesapeake Surgical Specialists, is one of only two surgeons in the region using the da Vinci® surgical system to perform this type of procedure. He is able to use minimally invasive, Single-Site surgery for many outpatient procedures, including gall bladder, hernia and appendix removal, and small bowel.



Chesapeake Regional Medical Center physicians enrolled their first patient in the ROADSTER study, a global, multicenter clinical trial evaluating the safety and efficacy of the Silk Road™ System for the treatment of carotid artery disease in high surgical risk patients. The ROADSTER trial is investigating a new system designed to combine the advantages of both carotid endarterectomy (CEA) and carotid artery stenting (CAS) in a procedure called Transcarotid Stenting with Dynamic Flow Reversal, also known as the Silk Road procedure. CRMC was selected as one of 25 centers around the world participating in the trial, which is expected to enroll 140 patients. The trial is intended to support FDA clearance of the Silk Road system in the United States.

Chesapeake Regional ComfortCare Home Health and Hospice has achieved Level

Three Partner status with We Honor Veterans, a program of the National Hospice and Palliative Care Organization and the U.S. Department of Veterans Affairs. ComfortCare provides hospice services for area residents and their families who are facing end-of-life issues. Many of its patients are veterans. The organization partnered with We Honor Veterans in 2011 to address the special needs facing veterans.



Elza Mylona, PhD, an expert in faculty development, has joined Eastern Virginia Medical School as Associate Dean for Faculty Affairs and Professional Development, following a national search.

Dr. Mylona came to EVMS from the State University of New York (SUNY), Stony Brook School of Medicine where she was Associate Dean for Faculty Development. She holds a doctorate in instructional technology from the University of Southern California, Los Angeles, (USC) with an emphasis on adult distance education.

Michael Stutts, PhD, Professor of Clinical Psychiatry and Behavioral Sciences at EVMS, received the 2013 award from the Virginia Academy of Clinical Psychologists for Distinguished Contributions to the Practice of Clinical Psychology.

Stephanie Troy, MD, Assistant Professor of Internal Medicine at EVMS, has been named an associate editor of the Journal of Tropical Pediatrics.

Craig Derkay, MD, Professor of Otolaryngology-Head and Neck Surgery at EVMS, has been elected to the position of Senior Examiner for the American Board of Otolaryngology.



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The Virginia Center for Innovative Technology (CIT) recently announced awards for this year's Commonwealth Research Commercialization Fund. EVMS was given two awards totaling \$100,000 each. The first, for pre-clinical development of new characterized compounds that preserve functional beta cell mass in diabetes, was awarded under the life sciences category. David Taylor-Fishwick, PhD, Associate Professor of Internal Medicine, is the principal investigator. The second, for proton therapy simulation and treatment planning algorithm development, was awarded in the modeling & simulation category to principal investigator Cynthia Keppel, PhD, Adjunct Professor of Radiation Oncology and Biophysics.



Orthopaedic surgeon John Aldridge, MD, of Hampton Roads Orthopaedic & Sports Medicine, was the first in the world to perform total hip arthroplasty using the Exactech LPI Prime hip system. The Exactech LPI Prime hip system is a more conservative treatment option, designed for maintaining the maximum amount of proximal femoral bone while providing excellent initial stability, enabling biological fixation. Dr. Aldridge, an Exactech consultant, serves on the design team for the LPI Prime system. He specializes in minimally invasive muscle sparing spinal surgery and total joint replacement surgery in the Hampton Roads area since 2002.

Orthopaedic surgeon Anthony T. Carter, MD, of Hampton Roads Orthopaedic & Sport Medicine,



was featured in the May Issue of Orthopedics Today as one of six participants in a national panel of surgeons discussing advantages and downsides of direct anterior total hip arthroplasty. Dr. Carter has performed more than 3,000 direct anterior total hip arthroplasties to date.

Dr. Jeffrey R. Carlson, an orthopaedic surgeon with Orthopaedic & Spine Center,



performed Virginia's first outpatient posterior lumbar disc fusion surgery on June 4, 2013. Dr. Carlson performed the procedure at Bon Secours Mary Immaculate Hospital in Newport News, using instrumentation and hardware from Spine Frontier. The 58-year old patient spent 45 minutes in surgery and less than 4 hours in the hospital. She was released to return to work at her 10 day follow-up appointment.

J. Frank Gallagher, III, a 26-year veteran of inpatient psychiatric services, is the newly-appointed vice president of behavioral health services for Norfolk, Virginia-based Sentara Healthcare.



Gallagher joins Sentara after five years as CEO of Virginia Beach Psychiatric Center, a 100-bed acute care psychiatric hospital. He was previously CEO of The Pines Residential Treatment Center campuses in Norfolk and

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Portsmouth, Virginia and Poplar Springs Hospital, a 168-bed facility in Petersburg, Virginia. With Sentara, Gallagher will work closely with the system's Behavioral Health Task Force, which includes representatives from Sentara hospitals, Optima Health, Sentara Medical Group, community services boards and advocacy groups.

Sentara Cardiovascular Research Institute is enrolling heart patients in a randomized multi-center clinical research trial to study an investigational "dissolving" device to treat blockages in the vessels serving the heart. The study device, Absorb™ is made by Abbott and is designed to open blocked heart vessels and restore blood flow to the heart. Cardiologists practicing at Sentara Heart Hospital have opened the ABSORB III study to patients to test the safety and effectiveness of this new device compared with current standard treatment of medicated metallic heart stents called drug eluting stents. Sentara will enroll up to 200 patients in the study with coronary artery disease, randomized to either receive the study device or have the standard drug eluting stent.

Sports Medicine and Orthopaedic Center (SMOC) announced today that Dr. Edward D. Habeeb has entered into a strategic partnership with SMOC and will be relocating his practice to SMOC facilities.

Dr. Habeeb has been a general orthopaedic surgeon for more than 30 years and is known for his "mom and pop" style of care. He will see patients at the SMOC facilities in Chesapeake.

Dr. Habeeb has practiced in South Hampton Roads since 1979 and is



a respected authority in orthopaedics, specializing in joint replacement. He obtained his medical degree and completed his residency at SUNY Upstate Medical Center in Syracuse, NY.



Alan L. Wagner, MD, FACS of Wagner Macula & Retina Center is pleased to announce the opening of his newest office, at 1800 Republic Road, Suite 102, in Virginia Beach, Virginia. Opening in August 2013, the office's unique Bauhaus design supports the team's Lean Six Sigma approach to patient-centered care. Dedicated to saving sight and enhancing lives, Wagner Macula & Retina Center offers patients eight convenient locations, reduced wait times, and the comfort of the highest level of personal care and expertise.

Hampton Roads Physician is pleased to provide this bulletin board for and about the good work physicians and health care providers are doing throughout our community and elsewhere. If you'd like to share what's happening in your hospital, clinic or practice – or some exciting research or event – please email notices to our editor at bobbie@hrphysician.com.

Deadline for announcements submission for the Fall issue is October 8.

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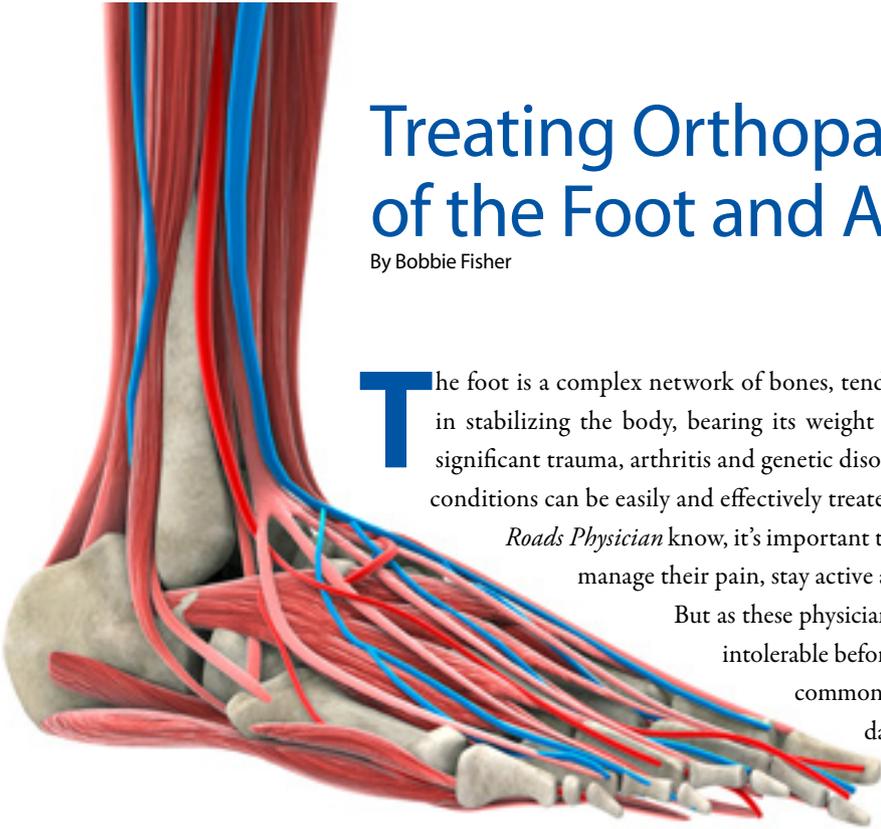
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Treating Orthopaedic Problems of the Foot and Ankle

By Bobbie Fisher

The foot is a complex network of bones, tendons, ligaments and muscles. Because of its function in stabilizing the body, bearing its weight and enabling its movement, the foot is subject to significant trauma, arthritis and genetic disorders that can cause tremendous pain. Many of these conditions can be easily and effectively treated; but as the orthopaedists in this issue of *Hampton Roads Physician* know, it's important to intervene early. With proper treatment, people can manage their pain, stay active and live fulfilling lives, often without surgery.

But as these physicians also know, people too often wait until their pain is intolerable before seeing an orthopaedist. This article will address two common conditions that, left untreated, can result in significant damage, requiring expert and innovative care.

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Ankle arthritis can be a significant source of pain and disability. The most common causes are prior ankle fracture, ankle instability as a result of prior ankle sprains, or inflammatory arthritis.

Total Ankle Replacement – the Gold Standard for Ankle Arthritis Treatment?

Ankle arthritis can be a significant source of pain and disability. The most common causes are prior ankle fracture, ankle instability as a result of prior ankle sprains, or inflammatory arthritis.

“Ankle fusion has long been considered the gold standard treatment for ankle arthritis,” says Dr. Paul Maloof, an orthopaedic surgeon with Tidewater Orthopaedic Associates. “Early attempts at total ankle replacement in the 1970s were fraught with high rates of complications, which played a large role in the abandonment of ankle replacement in favor of ankle fusion for the treatment of end-stage ankle arthritis.”

Successful ankle fusion will provide relief of pain and return to activities of daily living, Dr. Maloof notes, but can also result in loss of ankle motion, requiring compensatory motion in the adjacent joints during gait. “Long-term studies have demonstrated that joints of the hindfoot adjacent to the ankle will degenerate and develop arthritis following ankle fusion,” he adds, noting that recent advancements in prosthetic design, combined with a better understanding of surgical techniques, have renewed interest in total ankle replacement as an alternative to ankle fusion. With modern prostheses, total ankle arthroplasty has shown equivalent pain relief and improved function when compared to ankle fusion. In addition, early evidence suggests that adjacent joint degeneration is mitigated by ankle arthroplasty when compared to ankle fusion.

Current generation implants can be divided between fixed bearing and mobile bearing designs. In fixed bearing prostheses, the polyethylene component is fixed to the metallic tibial component, whereas in a mobile bearing prosthesis the polyethylene component is positioned between the metallic components of the tibia and talus, creating two articulating surfaces.

“Total ankle arthroplasty is indicated in patients with end stage ankle arthritis who have sufficient bone stock available in the tibia and talus to support a prosthesis,” Dr. Maloof says. “Patients with associated arthritic changes in adjacent joints of the hindfoot and midfoot are ideal candidates.” Contraindications include active infection in the ankle, arthritis due to neuropathy, and collapse of the ankle joint secondary to poor blood flow to the bone. Relative contraindications include poorly controlled diabetes, peripheral vascular disease, peripheral neuropathy, poor

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Posterior tibial tendon dysfunction is one of the most common problems of the foot and ankle, according to the AAOS. It occurs when the posterior tibial tendon becomes inflamed or torn, and unable to provide stability and support for the arch of the foot – resulting in flatfoot.

soft tissue envelope, and a history of tobacco use. Patients should have failed appropriate non-operative management, which may include activity modification, non-steroidal anti-inflammatory medications, intra-articular corticosteroid injections, bracing, and physical therapy.

Successful total ankle replacement surgery can provide significant pain relief and will allow patients to return to some of their favorite activities again. Dr. Maloof summarizes: “It’s often said that this procedure may not add years to your life, but it certainly can add life to your years!”

Triple Arthrodesis – Curing Significant Deformity While Relieving Pain.

Posterior tibial tendon dysfunction is one of the most common problems of the foot and ankle, according to the AAOS. It occurs when the posterior tibial tendon becomes inflamed or torn, and unable to provide stability and support for the arch of the foot – resulting in flatfoot. Flatfoot is very common in children, and well tolerated by them, because they are so elastic. Their tissue is new, and much more readily able to withstand stress.

But as we age, the blood supply to the tissue decreases and the chemistry of the tissue changes, making it more vulnerable to injury. The tendency to gain weight over the years exacerbates the condition. “Weight, and especially obesity, has a tremendous impact on lower extremity joints, particularly the foot,” says Dr. R. Michael Graham, of the Orthopaedic Center for Foot and Ankle Reconstruction, “because of the high impact forces generated by normal walking. With increasing weight and age, these structures are more likely to overload and break down. So an activity that once was easily tolerated now becomes intolerable.

In severe cases of prolonged flatfoot, a complex and technically demanding procedure known as triple arthrodesis is indicated. Dr. Graham describes a

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from flat feet his entire life. “On one foot, he had ruptured his post tibial tendon a few years ago, causing his foot to deform enormously,” he explains. “He was walking almost on the inside of his foot, and the heel had shifted so far out it was almost parallel to the floor. He’d been told to have it amputated.”

The surgery took three-and-a-half hours, Dr. Graham says. “We did a selective fusion of some joints in his hindfoot, but preserving the ankle joint. We were able to completely bring the patient’s foot all the way around and line it up perfectly.” It will take three months for the patient to heal, and when it does, he’ll be able to walk normally – something he has been unable to do for many years.

The patient will experience some loss of function, Dr. Graham explains, “because this is a massive reconstruction of the foot, and in order to preserve the ankle joint, we have to give up some other joints in the hindfoot.” As a result, the hindfoot doesn’t move in and out; it only goes up and down. But, as Dr. Graham notes, luckily, the world we live in today is relatively flat.

And, he adds, painful motion is useless motion. This 65-year old patient, in addition to being able to walk normally, will have a pain free foot for the first time in years.

Driven by Technology.

As should be evident from this article and this issue of *Hampton Roads Physician*, technology is driving the tremendous advances in orthopaedic care that are being introduced practically every month. It takes the practiced hand

recent case: a 65-year old who had suffered

of exceptional specialists to know when these new modalities are appropriate to be brought to bear for each individual patient. No matter how difficult the condition or complex the solution, Hampton Roads is the home of exceptional orthopaedists who can care for every part of the human body. ■

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The Global Tobacco Epidemic

Strategies for Intervention

By Madhukar Kaloji, MD, FCCP

Tobacco smoking remains the single most preventable cause of morbidity and mortality across the world. About six million people die each year from tobacco-related illness worldwide. Tobacco is a well-known cause of up to 90 percent of all lung cancers, but is also a major risk factor for coronary artery disease, peripheral vascular disease, COPD and fetal developmental abnormalities. More than 30 percent of all cancer-related deaths annually are due to tobacco dependence. Tobacco dependence is a chronic illness and needs to be as aggressively treated as any other chronic illness, such as diabetes, systemic hypertension, hyperlipidemia, etc.; but more often than not, it ends up as a recommendation for change in lifestyle at the conclusion of a doctor's office visit.

Research has shown that the cost-per-life-year saved by smoking cessation interventions makes it the most cost-effective strategy in preventative healthcare. Prevention, especially among youth, and cessation remain the two most important priorities in combating this epidemic. The magnitude of the problem can be best understood in terms of direct medical costs, which add up to as much as \$85 billion

dollars in lost productivity. About 60 to 70 percent of smokers say they want to quit, but the success rate is less than five percent per year.

The need for effective and lasting intervention strategies cannot be overemphasized, and needs to be part of every patient interaction in the course of a typical physician's practice, regardless of the reason for the visit, if we hope to make even a slight difference overall. A mass media education campaign to encourage tobacco users to quit is only effective when combined with individual intervention and should include pharmacological and non-pharmacological strategies. Interventions targeted to the community as a whole include media campaigns, access to cessation services, smoke-free environments and increases in tobacco pricing and taxation. Delivering smoking cessation services also needs to occur in non-clinical settings such as stores, restaurants, religious organizations and places of employment. Nicotine replacement products are aimed at controlling the cravings by replacing nicotine through various delivery systems. Nicotine transdermal patches are available in varying doses and deliver nicotine slowly over a 12 to 24 hour period. Nicotine patches were found to be effective up to 70 percent in some studies in achieving smoking cessation. Nicotine lozenges and gum are other alternatives.

Pharmacologic therapy includes medications such as Varenicline tartrate, Bupropion hydrochloride and some nicotine receptor antagonists that are not yet commercially available in the United States.

A comprehensive strategy to combat tobacco dependence is urgently needed and should include a strong commitment by the healthcare providers as well as policy makers and the community as a whole to motivate individuals to quit the use of tobacco products in order to achieve better healthcare outcomes. ■

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We're proud to welcome Dr. J.D. Burrow to our family of fellowship-trained orthopaedic surgeons. Dr. Burrow, a western Tennessee native, is moving to Hampton Roads with his wife, who is a primary-care physician. Dr. Burrow has trained in the most advanced surgical techniques for joint replacement and will bring that expertise to the Hampton Roads Community.

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at least 85 percent of eligible STEMI patients were treated within specific time frames upon entering the hospital. STEMI stands for ST segment elevation myocardial infarction, the most severe form of heart attack.

The Bon Secours Virginia Health System today announced it is ranked No. 8 on the 2013 AARP Best Employers for Workers Over 50 list. For this year's awards, AARP recognized 50 employers from across the country. The health system, for the first time in 2013, was honored by AARP as Bon Secours Virginia, including both Bon Secours markets in Richmond and Hampton Roads. Previously, Bon Secours Richmond was named to the list yearly since 2003.

Bon Secours Mary Immaculate Hospital has been named winner of the 2013 Pathway Award by the American Nurses Credentialing Center and the Cerner Corporation. The award recognizes a Pathway to Excellence-designated organization

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that submitted a project proposal demonstrating innovation and technology to create a positive nurse practice environment. Bon Secours' winning entry highlighted its Clinical Simulation: A World of Learning project, which illustrates how a simulation lab can advance professional practice environments.

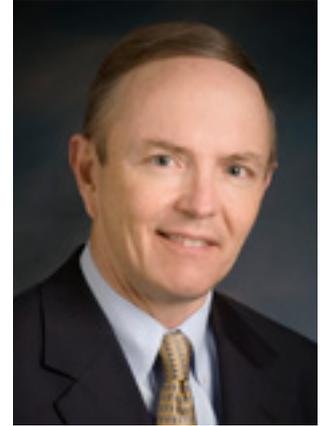
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of the best" based on extensive surveys of physicians nationwide. Ramirez practices with Chesapeake Surgical Specialists.

David A. Johnson, MD, Professor of Internal Medicine at EVMS and Chief of Gastroenterology, has been selected as a Master of the American College of Gastroenterology (ACG). The designation recognizes Dr. Johnson for his achievements in clinical gastroenterology and teaching as well as his contributions to the ACG.



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Compliance with OSHA's Bloodborne Pathogen Standard, 1910.1030

How Textile Service supports today's healthcare providers OSHA and JCAHO compliance initiatives

By Tony Acquaviva

As with any compliance issue confronting healthcare providers, there is never a shortage of research or reference material. OSHA standard 1910.1030 is no exception. OSHA, and organizations like JCAHO and the EPA provide ample 1910.1030 documentation. The subject matter ranges from the actual standards, rules and requirements, to the specific inspection procedures and citation guidelines.

If you have time, and a keen legal eye, you may be able to decipher the material and uncover the elements that are important to today's healthcare providers. Further inspection would undoubtedly lead to the conclusion that if healthcare providers try to manage 1910.1030 compliance alone, the initiative can be costly (both in dollars and time), complex, and ultimately unsuccessful.

What follows is a simple guide to help healthcare providers understand what 1910.1030 compliance really means, and how Textile Rental Service can support compliance initiatives for them, cost effectively.



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Three Principles that Health Providers Need to Understand

From a healthcare provider's perspective, there are three fundamental principles that serve as the basis for OSHA's Bloodborne Pathogen Standard 1910.1030. Oddly enough, many providers are not familiar with this information and as a result, they routinely place their employees and their practices at risk.

However, more and more providers are becoming familiar with these principles and the related risks, costs and complexities. Many have turned to Textile Service to help support their compliance efforts in a cost effective manner.

1. Provision

In basic terms, the Provision principle means that the healthcare provider, or employer, is responsible for providing staff members with Personal Protective Equipment, or PPE. Based on the occupational exposure, PPE can include gowns, lab coats, scrubs, etc.

2. Handling

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3. Laundering

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Summary

When it comes to 1910.1030 compliance, healthcare providers need to be very careful should they decide to do it themselves. While 1910.1030 compliance is based on very specific rules, it is the costs involved with purchasing, storage, replacement, processing and maintenance, that make this initiative such a serious undertaking. How to properly manage this issue within a healthcare organization starts with understanding the underlying principals of the standard.

As more and more healthcare providers become familiar with these principals and the related risks, costs and complexities, many have turned to Textile Service to help support their compliance efforts in a cost effective manner. ■



As Regional Sales Manager, **Tony Acquaviva** has over 10 years of experience in supporting cost reduction, compliance, eco-friendly and patient satisfaction initiatives via textile service. He can be reached via e-mail at acquavivaa@nixonmedical.com. For more information, please visit www.nixonmedical.com

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