Doctors Treating Doctors:
The Art of Practicing Medicine
When Colleagues Are Patients

David Shocket, MD; Marc Bolavert, MD; and Rafael Convit, MD, are physicians who treat physicians in their practices.
Where We Are, Where We’re Going: One Team, Moving Forward Together

We often joke that there is a different regulatory agency here every day. But during one week in late May, there were four different surveys taking place. While the national surveyors represented various organizations and were looking at different service lines, they reported one thing in common: They noted how well we collaborate together and work as a team.

The Joint Commission’s Comprehensive Stroke Center re-certification surveyors may have said it best:

• “You’ve taken research, and brought it directly to the patient, your community and to the world—and we share your practices with other hospitals we survey.”

• “You are empowering the community you serve to learn to care for themselves.”

• “You are a wonderful team, with great administrative support.”

• “You provide ‘best in the nation’ care, because of your team approach.”

That word—TEAM—sums up how we will continue our way forward.

When we speak with one voice, we create a powerful synergy among team members, which results in compassion as well as clinical excellence, for our patients and their families.

When we speak with one voice, we are using the Interdisciplinary Model of Care principles of collaboration and enhanced communication and applying them to our routines, providing the highest quality, safest care every day.

When we speak with one voice, we enhance medical education, improve outcomes and use the best practices in social dynamics to prevent provider burnout.

When we speak with one voice, we create an intoxicating energy that can help us refresh, renew and recharge our commitment for our journey as a high reliability organization.

For all the work you have done this year, you have my professional and personal thanks. We will continue our quality and safety improvement projects as priorities for FY 19.

And for my last Chief Medical Officer’s column for Connections, I wanted to focus on some successes for this fiscal year, which you can share with other members of your teams.

Improving the Rate of Hospital Acquired Infections (HAI)

- The MedStar Health all-system target rate for hospital onset *Clostridium difficile* (C.diff) is <7.0 per 10,000 patient days. We began our performance improvement project for C.diff at the beginning of this fiscal year. The rate for Q1 was 8.9; Q2 was 6.3 and Q3 was 4.9. We changed the MedConnect algorithm for diagnostic stewardship for C.diff, to help providers understand that in patients at risk for C.diff, most diarrhea is not caused by C.diff, and many patients are only colonized.

- Our Central Line Associated Blood Stream Infection (CLABSI) rate has shown similar improvement, with the MedStar Health target is ≤ 0.9. For FY 16, the rate in our ICUs was 1.5 per 1,000 cath days; 1.0 in FY 17 and to date for FY 18, it’s 0.8. For the non-ICU settings, the FY 16 rate was 1.3, the FY 17 rate was 1.0 and to date for FY 18, it’s 0.9.

- We’ve made progress in our CAUTI rate—for catheter associated urinary tract infections. We have an ongoing project to reduce inappropriate culturing, and have instilled a sense of urgency to remove Foleys as soon as possible. Please note, nurses on your team do not have to get your permission to remove these devices; we are relying on their good clinical judgment to know when a patient no longer needs a catheter.

- The number of surgical site infections continues to drop. We’ve standardized the practice of nasal swabbing in Surgical Holding, and we are cohorting “clean” patients on post-operative orthopaedic surgery units.

- For sepsis, our hospital-wide times to identify and treat sepsis have dropped, thanks to our Sepsis Response Team. Our initial lactate draws in January 2017 took 51 minutes; we are now down to 27 minutes. Antibiotic administration begins within the hour and a half after a patient is identified as septic.

- For hand hygiene compliance, we are just about at our FY 18 goal of 75 percent compliance. Remember, hand hygiene plays a role in all of our HAI reduction efforts.

Our ongoing focus on reducing hospital acquired infections has made a difference in the care we provide. Thanks to you and your teams for continuing this work.

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Many years after her original aortic valve replacement surgery, the patient was running out of options. Her surgical bio-prosthetic aortic valve was failing, leaking severely and she was in heart failure.

“Another surgery was not an option as she was just too unwell,” says Toby Rogers, MD, PhD, an interventional cardiologist at MedStar Heart & Vascular Institute at MedStar Washington Hospital Center. “Because of the patient’s unique arterial anatomy, TAVR—transcatheter aortic valve replacement—posed an even higher risk.”

The patient’s CT scan showed that she was at high risk of coronary artery obstruction, one of the most feared complications of valve-in-valve TAVR. The often fatal condition is caused by mechanical displacement of the old valve’s leaflets.

Fortunately, the patient was in the right place at the right time. She would become a medical pioneer of sorts, and the first patient at the hospital Center to benefit from an innovative catheter technique called BASILICA.

BASILICA, Bio-prosthetic Aortic Scallop Intentional Laceration to Prevent Iatrogenic Coronary artery obstruction, employs an electrified guide wire threaded through a catheter, to slice the leaflet of the patient’s failing bio-prosthetic aortic valve. Cutting the leaflet before TAVR allows blood to flow through the split leaflet into the coronary artery, when the new valve is deployed.

Dr. Rogers states. “They may want to have TAVR, but we have found that a small but significant minority are at high risk of coronary artery obstruction, due to the type of surgical valve they have, and their own anatomy.”

Before the development of BASILICA, the only alternative for these patients was deployment of a stent in the ostium of the threatened artery to hold the leaflet away, as the TAVR valve was deployed. “But this was a short-term solution, with a number of complications,” Dr. Rogers adds.

Dr. Rogers was part of the team at the National Heart, Lung and Blood Institute (NHLBI) that conducted the research that led to the BASILICA procedure. The first-in-human BASILICA procedure was performed at the University of Washington in the summer of 2017, with Dr. Rogers in attendance. To date, more than 25 BASILICA procedures have been performed worldwide. Now Dr. Rogers’ patient is among the growing number of people to benefit from the lifesaving innovation.

“We performed the BASILICA procedure to prevent the leaflet of her failing valve from blocking the left coronary artery. The procedure was a success, and she was discharged a few days later, and continues to do well,” he says.

Critical Clinical Trial

“We believe we can predict fairly well through multimodality imaging who is at risk for this potentially fatal complication,” Dr. Rogers says. “But we would like to gather additional data from a larger patient population. This is why we initiated an FDA-approved Early Feasibility Study sponsored by the NHLBI. MedStar Washington Hospital Center is one of just five medical centers in the U.S. that will be participating.”

“The BASILICA interventional procedure uses an off-the-shelf technology in a very novel way,” adds Stuart Seides, MD, physician executive director of MedStar Heart & Vascular Institute. “It is the kind of inventive thinking that is fueling the development of percutaneous treatment options for structural heart defects, which is helping to meet the needs of a growing patient population.”
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Years ago, physicians used to treat each other with “professional courtesy,” a practice in which doctors provided services to each other at little or no cost. Those days are gone, and the interaction is now more like any other physician-to-patient interaction, with a healthy dose of real-time professional courtesy.

Conversations with three MedStar Washington Hospital Center physicians—Gastroenterologist David Shocket, MD; Breast Surgeon Marc Boisvert, MD; and Plastic Surgeon Rafael Convit, MD—yielded these insights about physician-to-physician care in the 21st century. A few other physicians who treat colleagues did not want to comment on the care they provide, citing potential confidentiality issues.

Scheduling Appointments
Physicians have fully-scheduled days, so the times they can break away for their own doctors appointments can be limited. Your colleagues know this, and make every effort to fit you in their packed schedules.

“I try to be accommodating,” Dr. Shocket says. “If a doctor calls and asks if I can fit them in, I make every effort to do so.”

Dr. Boisvert agrees. “I can fit them in at odd times, and I may be willing to come in early or stay late to fit them into my schedule. I facilitate it, because I know they are busy. They are part of our brotherhood.”

Dr. Convit has an additional challenge, especially when it comes to physicians who want cosmetic procedures. “They want to come when they want to come,” he says. “Confidentiality is of the utmost importance.”

Performing Tests and Physicals
Physicians often act as their own primary care physicians, and screening guidelines can easily fall to the wayside.

Dr. Shocket has seen many physicians who have put off colonoscopies. That said, he might schedule a colonoscopy without an office visit, which he typically requires for non-physician patients. “But if there’s rectal bleeding, I don’t cut corners,” he adds. “I do a physical exam.”

Similarly, Dr. Boisvert has had to accommodate physicians’ schedules for breast cancer workups. “Workups can get a little delayed,” he says, “due to busy schedules. Physicians may be harder to pin down. They’re like high-powered corporate executives, and they can tend to let things slide.”

Outlining Treatment Options
Physicians don’t expect other physicians to know their specialty in detail. In the world of hyper-specialized medicine, you can’t keep up to date with every branch of medicine. That’s why all three doctors interviewed take pains to discuss treatment options.

Dr. Convit explains in detail every surgical and non-surgical option. “Physicians usually want more subtle cosmetic changes. “They are usually very busy, and don’t have a lot of down time. They also are more realistic about the outcome.”

“There’s a temptation to let a few things slide,” Dr. Boisvert notes, referring to explanations. “You have to be careful not to do that. It’s unfair to patients, and interferes with optimal care.”

He notes that physicians may want more discussion about treatment options. “They may want more detail. In the end, they say, ‘You’re the doctor, I’m the patient. Tell me what to do.’”

“Most physicians know what the treatment options are,” Dr. Shocket says. “Still, you have to explain options in detail. If you have a good relationship, they trust you. They are already getting more than one opinion.”

Still, making the final treatment decision can be tricky, he adds. “Sometimes you can’t convince another doctor to do what you might push someone else to do.”

In some instances, Dr. Shocket may spend more time discussing treatment with physicians who understand the nuances of medical treatment. “For example, with inflammatory bowel disease patients, it can be more an art than a science, for how we approach it and what medicines we choose.”
Delivering Bad News

Both Drs. Shocket and Boisvert have been in situations when they’ve had to deliver bad news to physician-patients. “They react exactly the same as anyone else,” Dr. Boisvert says. “Sometimes with shock, or they intellectualize it. It all depends on their personality.”

Dr. Shocket adds that often physicians have a good idea that bad news is coming. They may have tried to ignore warning signs, and delayed a doctor visit.

Following Treatment Plan

Just like anyone else, some physicians are better at complying with screening guidelines and treatment plans.

“Physicians don’t always do what you recommend,” Dr. Shocket notes. He gives an example of one physician who had a colonoscopy during working hours, and then—against doctor’s orders—put on his white coat and went right back to work. “That physician didn’t remember anything done during the rest of the day.”

Physicians may also want to retain their sense of control. “I’ve had physician-patients who don’t want to be sedated during their colonoscopies. They want to know everything that is going on.”

Dr. Convit offers the same informed consent to physicians as he offers to any other patient. The difference is that doctors understand the importance of following instructions. “I don’t want doctors removing their own sutures,” he says. “But, in general, physicians have more realistic expectations. They understand the healing process, and know they can’t go to the beach the next day.”

Dr. Convit notes that physicians also are quick to pay their bills. “Physicians tend to be far more straightforward regarding payment. They don’t try to negotiate prices,” he says. “They always pay their bills before they are asked.”

Do Unto Others

In the end, the Golden Rule applies. Dr. Boisvert notes that most physicians want to be treated like every other patient. “They respond well to that. Rarely do they not want to be treated like other patients.”

All three make one final point: They are honored when their colleagues come to them for care.

“It’s always a vote of confidence, when medical people come to you for their care,” Dr. Convit says. “It means a great deal to me.”

Dr. Boisvert echoes that sentiment. “I always find it a privilege when someone chooses me to be their surgeon, especially when it is another physician.”

“It’s humbling when a colleague asks you to take care of them or a family member,” Dr. Shocket says. “I’m happy to do so.”
Every year, more than 100 residents and fellows successfully complete their training programs at MedStar Washington Hospital Center. Some go on to fellowship programs, some begin their careers as attending physicians, some become fulltime research physicians and others combine many aspects of physician life. Connections spoke to a few recent graduates, to get their thoughts on how training helped them.

Sham Mailankody, MBBS
Residency program:
Internal Medicine, completed in 2012; Hematology/Oncology fellowship at National Cancer Institute at National Institutes of Health, completed in 2015

Where I’m working now:
I joined the staff at Memorial Sloan Kettering Cancer Center (MSKCC) in New York in 2015. My clinical focus is multiple myeloma, and I’m conducting clinical trials of a drug that stimulates immune system response.

Why I chose that environment:
My mentor from NIH moved to MSKCC, so I came here to interview. This was a good fit for me; it has worked out very well. It’s given me the opportunity to work at a high-quality medical center, with a good balance of clinical and research activities. It’s also a good place to pursue my interest in health policy.

How residency prepared me for practice:
When I came to the Hospital Center, it was my first foray away from Bangalore, outside of my comfort zone. To begin with, I had a steep learning curve, and I had a fantastic program director who was instrumental in guiding me. My colleagues, mentors and faculty members made sure I made the most of every opportunity. I was incredibly blessed to work there, and I still have many friends at the Hospital Center.

What advice I’d give residents:
There’s not one single path to achieving what you want. Look for opportunities early on with program directors, senior residents and researchers. If you work hard and do your job diligently, there are a lot of people who will support you. Current trainees are very lucky to be training at the Hospital Center. You will do well, and be very successful.
They Doing?

Patricia Wehner, MD  
*Residency program:* General Surgery, completed in 2012; Breast Surgery fellowship at the University of Southern California, completed in 2013  
*Where I’m working now:* I’m now in practice with the MedStar Regional Breast Health Program, with offices at the Hospital Center and at MedStar St. Mary’s Hospital. I wanted to join an established, respected breast program, and I found that with the MedStar Breast Health Program. I felt very comfortable accepting a position at the Hospital Center, where I already had positive relationships and connections established.  
*Why I chose that environment:* My family is in Baltimore, so I was looking mainly to locate on the East Coast. I had a bunch of job offers, but I wanted to be in a city. At the Hospital Center, I get to work in an established breast center, plus this is an academic setting, where I get to work with fellows and residents. We have access to current clinical trials, so I can offer patients advanced treatment options.  
*How residency prepared me for practice:* My general surgery residency offered me the chance to work with a high volume of patients from diverse backgrounds. As I rotated through breast surgery, the multidisciplinary approach of breast care appealed to me.  
*What advice I’d give residents:* Residency is such a small blip in time. You learn so much, get so facile at so many things. When you’re going through it, you feel it’s never going to end. Just soak it up—get through the not-great parts, and enjoy the great parts. It’ll be over before you know it, and you’ll be a much stronger physician for it.

Matt Wilson, MD  
*Residency program:* Emergency Medicine, completed in 2014  
*Where I am now:* I’m now an attending physician at MedStar Washington Hospital Center, in the Emergency Department. I’m also an assistant professor at Georgetown University, and work in the pediatric ED at MedStar Franklin Square Medical Center and in the ED at MedStar Southern Maryland Hospital Center.  
*Why I chose my current environment:* I wanted to keep working for good bosses—my residency director and department chair were great mentors. I’m also doing some research with Munish Goyal, MD. This gives me the opportunity to practice clinical medicine, still be associated with an education mission and participate in a wide variety of research efforts to improve care in the Emergency Department.  
*How residency prepared me for practice:* The Hospital Center is a big, busy hospital. There are only a few places like this in every region, and it prepares you to work anywhere. Also, our residency program does a conscientious job on the academic, quality improvement and research sides of emergency medicine. I wanted to stick around, to be part of that. It’s incredibly satisfying to make important decisions, and be confident that I know how to do the right things.  
*What advice I’d give residents:* On your first overnight shift, remember that the sun always rises. You’re in it for the long haul. Every special moment provides something to learn from. Find bosses you like working for, and work hard for them.
Having the Difficult Conversation: When Should Compassionate Care Begin?

George Taler, MD, is a geriatrician and co-founder of the Medical House Call Program at MedStar Washington Hospital Center. In addition, he is Vice President for Medical Affairs of MedStar’s Home Health Visiting Nurse Association. He has practiced in the field of geriatrics for 38 years.

There are only so many ways we can die, and we all are going to die. Medicine, too often sells a delusion that life can last forever or that every illness can be overcome or conquered.

The trap that we as physicians and medical providers get ourselves into is that we are acute-care oriented. We live in an “I can fix that” type culture. Often, we can fix those acute, specific problems, such as treating pneumonia or a urinary tract infection. But often times, death comes disguised as an acute event. We need to recognize that some illnesses may be the beginning of the end.

My parents are deceased. They both died at home in their own bed, which is not common and both my parents telegraphed months before that they were going to die.

My parents’ approaches to dying, however, were completely different. My Dad thought he was never going to die, and it took him a few months after hearing that no acceptable interventions were available that he acquiesced to hospice care. They were wonderful in helping him cope and to die in peace. My Mom was just the opposite. She thought she was going to die years before she was even close; when her time came, she was ready! She arranged everything and called her friends to “save the date” for her impending funeral. Both my parents died of old age and heart failure. They were 89 and 93, and in many ways, I am unusual and fortunate that my parents lived long, full lives.

On average, only one of 10 people are fearful of dying as they reach old age, but the opposite may be true for us as their families. Because of this, people make desperate and poorly-informed decisions. As physicians, we need to be mindful of this fact, for both our patients and especially in our own families. It is not unusual for other family members to turn to us for advice, because of our profession and training. One of the most kind and compassionate things we can do for our loved ones—and for our patients—is to be aware of the excesses that medicine has to offer.

It takes a lot of courage to ask, “Is this the right thing to do?” or when to say “enough.” Until very recently, physicians have not had sufficient training in end-of-life care. Palliative care is still a relatively new field, and unless you seek it out, it’s often not readily available outside the hospital.

You don’t have to be on death’s door to talk about death. Open the discussion. Holiday seasons are a good time to do this, as families are often gathered together. Take those opportunities to start a conversation. It starts with a simple question: “What if?”

I know it’s not easy to bring up this topic. But in many ways, it is the unexpected event that leaves people unprepared and reacting, without taking the time to think things through. Have the discussions about advance directives, and who in the family will make the medical decisions. Talk it through. Have these important conversations in your own family. And it will help you encourage your patients to have these conversations, too.
In the spring of 2013, three incoming residents were randomly selected to be interviewed for a story in Connections about their upcoming year and their long term goals. They were Jason Chen, MD, Surgery; Guillermo Rivell, MD, Internal Medicine; and Alex Shuster, MD, Emergency Medicine. At the end of each year, they shared candid thoughts about their experience of the previous year. Drs. Rivell and Shuster graduated, and started their careers. Dr. Chen, in a five-year surgical program with a year off for a research fellowship, is now a fourth-year surgical resident at MedStar Washington Hospital Center, and agreed again to reflect on his year.

Last year, Dr. Chen completed MedStar’s Firefighters’ Burn and Surgical Research Laboratory fellowship, under the direction of Burn Center Director Jeffrey W. Shupp, MD.

“The grass is always greener on the other side. As I struggled to get my experiments to work during my research year, I missed taking care of patients and operating. Now that I’m back to working clinically, I miss my research time and my laboratory colleagues.”

But his research year helped him recognize that his calling is the clinical practice of medicine. “I love the daily relationships that I develop with patients—assuaging them before surgery, explaining their disease process and operation into concepts that they can grasp, and going through their discharge instructions when they are ready to leave. It is heartwarming to be recognized by patients, who make a point to show their appreciation for how you have impacted their life.”

Trauma
When this story was written, Dr. Chen was on his final five week block on the Trauma service.

“I have the upmost respect for the trauma surgeons that I have the privilege to work with. The long hours do not compare to the emotional toll that comes with the work,” he says. “I recently lost a patient to multiple gunshot wounds. We were able to restore his pulse in the trauma bay, but he ultimately died in the operating room. It hurt, to fail to save the life. It hurt even more, to tell the mother that her son is dead. Although I am well aware of the limits of modern medicine, I know that we can do more as a country.”

Fine-tuning
During his time here, Dr. Chen’s aspirations have taken a few turns. He admits to loving every rotation he is on, and wishing he could specialize in each field. At one point he was interested in breast oncology, then burn and trauma surgery, but now, has decided to pursue a career in colorectal surgery.

“I really love the breath of practice in colorectal surgery. There are large, complex open abdomen cases,” he says, “but also incredible innovative: minimally invasive cases, using a combination of robotics, laparoscopic and endoscopic surgery. I find it fun and challenging at the same time.”

Colorectal surgery will require a fellowship, so he and his wife, Sarah Wineland, have discussed locations. “It’s only one year of my life, so I want go where I can get the best training, and be in a city where my wife can continue her work as a consultant.”

Advice to Younger Residents
Reflecting on his five years at the Hospital Center and what has helped him succeed, Dr. Chen offers this advice to newer residents: Find a study buddy.

“Eugene Wang and I started our residencies together. We enjoy text messaging each other good questions, and meeting to go over mock oral exam topics. We’re like brothers, going through the ups and downs of residency together.”

Another bit of advice is The Three As: Affability, Availability, Ability. “I try to go over this concept with every medical student or junior resident that I work with,” he says. “Be polite. Don’t be a jerk. Learn people’s names. Being affable can help you get the CT scan you want first, instead of fifth on a list of twenty orders. Always be available to help in a case or on the surgical floor. Be early for rounds and conference. The mantra of being the first to arrive and last to leave each day will help you know your patients better, and take ownership over patient care. Ability refers to working on your knowledge and skills. Stay on top of the literature and commit to read at least 30 minutes a day, if not a few hours on your time off.”

“You have to have to want to be better, desire to deliver the best care possible,” he adds. “Those in my generation will get the reference that has become my mantra. It’s from Pokémon™: ‘I wanna be the very best.’ I hold on to that.”
The Patient Safety/Risk Management Team is adept at storytelling. But instead of starting at the beginning, members begin at the end. The team’s ultimate goal is to rewrite the story, and improve patient safety for the next patient.

The four-member team mitigates risk and enhances patient safety for one of the largest and highest patient acuity hospitals in the region. They analyze information from more than 8,000 submitted patient safety events a year, and also provide multiple consultations every week for physicians, every level of hospital associate, and leaders whose work intersects with patient care.

“It’s important for providers to understand that when they are involved in unanticipated outcome events, they should immediately call 202-877-6145, and complete a patient safety event report (PSE),” says Melanie Osley, RN, MBA, CPHRM, director, Patient Safety & Risk Management. “Our team has analytical minds that spot trends and dig deep into events, to identify gaps that may contribute to medical errors. We collaborate with leaders and associates, to create ways to close those gaps.”

“We are proactive,” Osley adds. “We examine information from multiple sources to find ways to improve care delivery, by identifying issues and working with care providers to develop ways to avoid error, improve safety, and minimize exposure to risk. It’s a two-way street in that we develop relationships with staff over time, and also call them for their perspective on issues we are examining.”

24-7 Availability
Each member is assigned certain clinical service lines to build a level of trust and comfort with physicians and associates. And one member of the team is on-call 24/7 to respond to all inquiries.

“We receive several inquiries each week,” explains Kevin McGraw, RN, CPHRM, senior risk management consultant. “Physicians and associates call or drop by the office, to review some challenge they are facing, anything from a difficult family situation to a conflict between services. They want to prevent confrontation, and come to us because of our experience with a wide variety of situations.” What is unique to many providers is probably something the risk team has previously addressed.

Sharing Information
Betsy Gardner, RN, patient safety consultant, teaches High Reliability Organization principles at every New Associate Orientation. This one hour program covers a broad range of issues, but focuses on basic tools that support safe practice. The set of Error Prevention Tools discussed promote the individual and collective vigilance that is so important to safe care.
When Mohan Verghese, MD, first visited MedStar Washington Hospital Center in May 1980, he was excited to find an active learning environment, staffed by impressive surgeons. When he retired in January 2018, he had made a huge impact on the hospital's direction, and earned a reputation as one of those impressive surgeons himself.

Newly arrived from medical school in his native India, in 1979, Dr. Verghese had begun a residency in general surgery at Baystate Medical Center in Springfield, Mass. But he found he liked urology, with its variety of intricate surgeries and the ability to develop long-term relationships with patients.

He hasn’t looked back. In 1980, he interviewed with Mitchell Edson, MD, then chair of urology, and also met Dabney Jarman, MD, the hospital’s first chair of urology and a pioneer in urologic surgery.

After Dr. Verghese finished his urology residency, he joined Dr. Jarman’s practice. Later, he pursued a fellowship in urologic oncology at Roswell Park Comprehensive Cancer Center in Buffalo. It was an easy decision to return to the Hospital Center to continue his practice, for two important reasons: The hospital was getting ready to open Washington Cancer Institute, and asked him to become its first full-time director of urologic oncology. The other reason was more personal: his wife was practicing pediatric anesthesiology at Children’s National.

Dr. Verghese was instrumental in bringing the newest advances in urology to the hospital, and then training the next generation of urologists. When he started practice, open surgeries were the norm. Then came the era of non-operative surgery for stone disease, followed closely by the advent of laparoscopy, in the 1990s. Robotic surgery replaced most laparoscopic procedures, providing excellent outcomes in the most complex cases. Dr. Verghese wisely saw the future for Urology, and before it was the norm, brought in a surgeon to specialize in robotics. That surgeon, Jonathan Hwang, MD, is now chair of the department, building on Dr. Verghese’s legacy. (see “Physician’s Perspective” on the back cover)

“Our program’s success is due to a combination of great surgeons, nurses, intensivists and anesthesiologists. I’d like to give credit to our three nurse coordinators: Elizabeth Gardner, RN; Bernadette Denis, RN; and Claudette Lamothe, RN. They've played an important role supporting me and our patients.”

The Hospital Center is now the top referral center in the region for complex urologic surgery, thanks to Dr. Verghese’s efforts. By the time he left the Hospital Center earlier this year, he had recruited top urologists and built a program that offered the most advanced surgeries for the most complex patients, along with a robust training environment.

“I feel very grateful of what we’ve been able to accomplish. We have an amazing group of talented, committed surgeons, and I expect the program to continue to excel.”

From 1992 through 2006, Dr. Verghese remained as director of urologic oncology, and then became the hospital’s chair of urology in 2006. Those years saw dramatic changes in the specialty. The combined programs of MedStar Georgetown University Hospital and the Hospital Center created a robust teaching environment.

“I’ve lived more than two-thirds of my life at the hospital. It’s a place I have so much association with, and love for. Everything you want in a great hospital, we have. It’s a unique place, where people love to come to work.”
MEDSTAR CONFERENCE HIGHLIGHT

**3rd World Bronchiectasis Conference 2018**

**July 12 | Georgetown University Hotel and Conference Center | Washington, D.C.**

**Course Chair: Anne E. O’Donnell, MD | Course Co-Chair: Timothy R. Aksamit, MD**

The Conference is a focused, cutting-edge gathering of the world’s experts on bronchiectasis and nontuberculous mycobacterial lung infections. Highlights include presentations of the most up-to-date research on disease mechanisms in bronchiectasis, including new understandings on the role of inflammation, infection and the microbiome. Clinical topics will include sessions on the diagnosis and treatment of bronchiectasis and NTM infections, including small group, case-based presentations specifically aimed at understanding the role of airway clearance, anti-inflammatory treatments and antibiotics. Saturday morning, July 14th will be focused on the management of patients with nontuberculous mycobacterial lung infections and will be of particular interest to pulmonologists and infectious disease practitioners who treat patients with these challenging infections. The meeting brings together the expertise of the US Bronchiectasis Research Registry and the European Bronchiectasis Registry (EMBARC) principal investigators as well as experts from Canada, Asia, Australia and New Zealand. This program will benefit the entire healthcare team who care for patients with bronchiectasis and NTM infections including pulmonologists, infectious disease physicians, pharmacists, nurses and respiratory care practitioners.

For more information and to register, visit [WorldBronch.com](http://WorldBronch.com)

UPCOMING CPE EVENTS

**Mental Health Care for Emerging Adults**

September 28 | National Union Building | Washington, D.C.

Course Directors: Matthew G. Biel, MD | Course Co-Director: Aditi Vijay, PhD

**5th Annual Gastric and Soft Tissue Neoplasms 2018**

September 29 | Park Hyatt Washington | Washington, D.C.

Course Directors: Matthew G. Biel, MD | Course Directors: Waddah B. Al-Refaie, MD, FACS | Nadim G. Haddad, MD | Dennis A. Priebat, MD, FACP

**Melanoma: Biology & Patient Management 2018**

October 13 | Omni Shoreham Hotel | Washington, D.C.

Course Director: Michael B. Atkins, MD | Course Co-Directors: Waddah B. Al-Refaie, MD | Geoffrey T. Gibney, MD

**Advanced Heart Failure Summit: 30th Anniversary Celebration of Ventricular Assist Device and Heart Transplantation**

October 13 | Martin’s Crosswinds | Greenbelt, Md.

Course Director: Samer S. Najjar, MD | Course Co-Directors: Mark R. Hofmeyer, MD

**The 13th Annual Georgetown Meeting on Gastrointestinal Endoscopy & Pancreatobiliary Surgery**

October 20 | The Ritz-Carlton | Washington, D.C.

Course Director: John E. Carroll, MD | Reena Jha, MD | Course Co-Directors: Thomas M. Fishbein, MD | Nadim G. Haddad, MD

**ENT for the Primary Care Provider 2018**

October 20 | Omni Shoreham Hotel | Washington, D.C.

Course Director: Selena E. Briggs, MD | Course Co-Director: Michael J. Reilly, MD

For more information regarding MedStar Health conferences, please visit [CME.MedStarHealth.org](http://CME.MedStarHealth.org)

CME Transcripts are Available Online

You can download, print or e-mail your CE transcript. Visit CME.MedStarHealth.org and click on “MY CE” for complete instructions.
2018 Patient Experience Week

Jeffrey Brady, MD, MPH, addressed leaders and associates at MedStar Washington Hospital Center, as part of the hospital’s Patient Experience Week activities. Dr. Brady, Rear Admiral and Assistant Surgeon General for the U.S. Public Health Service, and director of the Center for Quality Improvement and Patient Safety, gave this piece of advice to caregivers: Encourage their patients to ask questions to make sure they understand diagnosis and treatment options and plans; speak up about risks and problems they may encounter and express their values.

Resident Match

For the 2018 Resident Match, MedStar Health had an overall 96 percent fill rate, with MedStar Washington Hospital Center at a 94 percent fill rate. International medical students comprise 39 percent of the new interns. At the Hospital Center, 21 incoming residents are from local schools, with 12 from Georgetown University School of Medicine.

For the third year, all MedStar Health residents will join together for a two-day orientation, before going to their “home hospital” for orientation.

Congratulations to Trauma Services

Trauma Services received re-verification as a Level 1 Trauma Center from the American College of Surgeons (ACS). The onsite review by the ACS Verification, Review and Consultation program included a team of trauma experts, who completed an on-site review of the hospital. The team assessed relevant features of the Trauma program, which included commitment, readiness, resources, policies, patient care and performance improvement.

“We appreciate the 24/7 efforts by everyone in Trauma Services, which include physicians from multiple specialties, nurses, Advanced Practice Clinicians, and our program manager, trauma coordinator, data specialist and injury prevention coordinator,” said Jack Sava, MD, director, Trauma. “The interdisciplinary team has an unwavering commitment to the care of the injured patient, and this teamwork allows us to provide the best trauma care in the region.”

Welcome to New Members of the Medical & Dental Staff

Addisalem Bitew, CRNA Anesthesiology
Previtha Mathews, CRNA Anesthesiology
Norman Robert, CRNA Anesthesiology
Rivka Schwarz, CRNA Anesthesiology
Kimberly O’Dell, CRNP Anesthesiology/ATC
Lindsay Barnes, MD Gastroenterology
Beje Thomas, MD Gastroenterology
Maya Beplat, CRNP Hematology/Oncology
Helene McHale, CRNP Hematology/Oncology
Afnan Mossaad, MD Hospitalist Service/Cardiovascular Disease
Caroline Argyros, PA-C Hospitalist Service/Internal Medicine
Michelle Baker-Welch, CRNP Internal Medicine
Yue-Hin Loke, MD Neonatology/Pediatrics/Cardiology
Tracey-Ann Samuels, MD Obstetrics/Gynecology
Daniel Robertson, MD Orthopaedic Surgery
Steven Svoboda, MD Orthopaedic Surgery
Tammy Lamb, MD Radiology
Anathea Powell, MD Surgery

LGBTQ Healthcare Equality Top Performer Status

MedStar Washington Hospital Center received the “Top Performer” status from the Human Rights Campaign Foundation’s Healthcare Equality Index (HEI). The Hospital Center was given a score in four criteria: foundational elements of LGBTQ patient-centered care, LGBTQ Patient Services and Support, Employee Benefits and Policies, and LGBTQ Patient and Community Engagement. More than 600 healthcare facilities participated in the survey, and the Hospital Center was among 95 to receive “Top Performer” status.
When Mohamed Abdel Hakim, DDS, was a child growing up in Egypt, he soaked up movies that highlighted American culture, the hustle and bustle of New York City, and a way of life that felt wholly different than in his native country. More than just entertainment, the movies left him with the seeds of a dream: to one day move to the United States, and pursue the simple, yet sacred tenets of “life, liberty and the pursuit of happiness.”

“Despite growing up elsewhere, I believed in America as an ideal,” says Dr. Hakim, chief resident for Oral and Maxillofacial Surgery at MedStar Washington Hospital Center. Dr. Hakim was determined to make his dream of being an American and a doctor a reality. At the age of 22, he arrived in New York City with a dental degree. But within a year, he enrolled at the NYU College of Dentistry to begin his dental education again—this time, from an American perspective.

“I moved here to become an American, not just someone who comes to benefit from the privileges of this country,” says Dr. Hakim, chief resident for Oral and Maxillofacial Surgery at MedStar Washington Hospital Center.

Dr. Hakim was determined to make his dream of being an American and a doctor a reality. At the age of 22, he arrived in New York City with a dental degree. But within a year, he enrolled at the NYU College of Dentistry to begin his dental education again—this time, from an American perspective. His new degree gave him far more than additional education and training. “It provided me with a foundation in this country. I have friends and a network of connections. I learned how to interact with patients the American way, through my friends and school environment.”

Between graduating from dental school and beginning his residency at the Hospital Center, Dr. Hakim spent one year at the University of Connecticut School of Dental Medicine, as an oral and maxillofacial surgery resident. That experience offered still another formative stepping stone: “I realized there is New York City—and there is the rest of the country. Completely different, and yet I love them both.”

Dr. Hakim chose maxillofacial surgery because of its unique bridge between medicine and dentistry—giving him the ability to complete routine medical procedures while solving more severe concerns, including mouth rehabilitation, facial deformities and injuries from major traumas and disease.

For Dr. Hakim, one moment perfectly encapsulates the impact the Hospital Center has had on him, as both a student and a future teacher. An attending jokingly asked him if he thought he’d ever be as good as chairman, George Obeid, DDS, whom Dr. Hakim calls a “phenomenal doctor and educator.”

Playing along, Dr. Hakim didn’t skip a beat: “Yes, absolutely.”

The attending then turned to Dr. Obeid and said, “George, Mo thinks he can be as good as you are.”

Dr. Hakim braced himself for his mentor’s reaction. Dr. Obeid smiled, and then said, “He should be better than me.”

For Dr. Hakim, that response prompted months of reflection. “I always admired how good of an educator and what an empowering leader Dr. Obeid is,” says Dr. Hakim. “After that conversation, I realized that in order for me to be a true educator, I have to want those I am teaching to become better than I am,” he says. “I’ve always felt keen about teaching people everything I know, but Dr. Obeid’s response put it into perspective.”

Dr. Hakim now moves into the next two major roles of his life: fellow and father. He will move to Boston, for a fellowship in Endoscopic Maxillofacial Surgery at Harvard Medical School and Massachusetts General Hospital. He and his wife will welcome their first child this summer.

As Dr. Hakim winds down his year as chief, he is looking forward to returning to Egypt for the first time in many years, for his sister’s wedding. Perhaps as emotional as the return to his homeland will be the additional title he’ll bring with him: American citizen. Dr. Hakim took the citizenship oath this spring, surrounded by family and friends, the culmination of his American dream.

“I’ve considered myself an American for as long as I could remember,” he says. “Now America considers me one.”
When just starting out in a chosen profession, sometimes a person is lucky enough to stumble upon someone who becomes a prized mentor, and receives as much wisdom and knowledge as possible.

If a person is very lucky—and very talented—sometimes that person has the opportunity to find that mentor again, this time, as a colleague, as was the case for John Lazar, MD, director of Thoracic Robotics at MedStar Washington Hospital Center. In his new role, Dr. Lazar has reunited with his former mentor, Thomas Watson, MD, MedStar Health’s Regional Chief of Surgery.

“I came to the Hospital Center specifically to work with Dr. Watson, as well as for the opportunity to do more complex cases, and help build up our robotics program,” Dr. Lazar says. At the University of Rochester, Dr. Lazar had two years in a fellowship role with Dr. Watson. “I didn’t feel satisfied with the two years that I spent with him, so I felt as though I could continue that education.”

Since joining the thoracic team in January, Dr. Lazar is also enjoying an evolved relationship, one informed by years of Dr. Lazar’s own study and growth. It’s a relationship, he says, which now feels like a wonderfully collaborative friendship.

“When you’re a fellow, you just put your head down and do the work, and it’s a little bit harder to question why you’re doing something,” he says. “Now, it’s more interesting, because I’m bringing Dr. Watson cases, and I can ask: ‘Have you thought about doing it this way?’ and I can ask him questions that never would have occurred to me five years ago. In many respects, he’s a bigger resource now than he was then.”

After Dr. Lazar’s fellowship, he sought out more training around thoracic robotic surgery, reaching out to another surgeon, whom he saw as a pioneer in the field in New York City. The two collaborated around what Dr. Lazar has coined a “super fellowship.”

“You’re not exactly an attending, but you’re not a fellow anymore—it really felt more like an apprenticeship.” Dr. Lazar jokes that he followed that doctor around “like a puppy dog,” not leaving his side for twelve months.

“I was in every case,” he recalls. “We did more than two hundred cases together, and when I finished, it felt more like nine-and-a-half years of training.” Dr. Lazar felt ready to return to his residency location, University of Pittsburgh Medical Center/PinnacleHealth in Harrisburg, Pa., to build the robotics program and train surgeons, ultimately becoming the system’s robotics director.

Dr. Lazar believes that his work building up that program made him the “right guy at the right time” to move Dr. Watson’s vision forward at the Hospital Center.

For his part, Dr. Lazar is excited to do everything he can to help realize his mentor’s regional vision for the work, one that is grounded in technological advances and breaking down silos. “The practitioners all know each other, and there’s a collaborative spirit,” Dr. Lazar says. “Dr. Watson’s goal was to innovate MedStar with technology, and I understand the idea of orchestrating different facilities, but still working together in concert.”

Dr. Lazar also feels passionately about educating residents, particularly around clinical-based research and healthcare disparity. In his role, he’s enjoyed partnering with Waddah Al-Refaie, MD, MedStar’s Chief of Surgical Oncology, to explore population health in the Washington, D.C. metro area, especially those with very little to no healthcare benefits. In addition, Dr. Lazar is teaming with Pulmonary Medicine and Oncology, to develop MedStar Washington Hospital Center’s lung cancer screening program and the pulmonary nodule clinic.

As busy as he has become at the Hospital Center, Dr. Lazar still finds he is able to volunteer some time outside of surgery, as a lacrosse coach for his daughters. He has also coached and mentored disadvantaged youth in Harrisburg, by using lacrosse as a pathway for those young people to attend college.
MedStar Washington Hospital Center’s Department of Urology is the region’s best answer for patients requiring complex surgeries. Under the leadership of our former chair, Mohan Verghese, MD, our department recruited the best and brightest urology specialists.

Ross Krasnow, MD, and I specialize in urologic oncology, using robotic-assisted, minimally invasive technology for the best outcomes in cancer care. Lambros Stamatakis, MD, completed two urologic oncology fellowships, enabling him to offer a variety of surgical options and clinical trials for advanced bladder cancer. Krishnan Venkatesan, MD, directs our reconstructive surgery program, with expertise in complex genitourinary reconstruction. Daniel Marchalik, MD, leads our comprehensive kidney and bladder stone center. George Chang, MD, is a general urologist with decades of experience at the hospital, and is assisted by a nurse practitioner.

Our minimally invasive urologic oncology team uses the latest robotic technology for the most complex cases. For patients with prostate cancer and prior abdominal surgery, morbid obesity or other surgical co-morbidities, we offer robotic prostatectomy, thanks to our extensive experience. We also offer a robotic-assisted approach for patients with bladder cancer who have more complex and advanced disease, especially following radiation.

For kidney cancer, we perform a highly specialized surgery in cases of vascular invasion, often in collaboration with our vascular surgery team. For patients with kidney stones, we offer a mini- percutaneous surgery, allowing us to remove bigger stones with a very small scope. We also perform metabolic workups and medical management to prevent stone recurrence.

For patients who require reconstruction of their ureter or urethra, we harvest buccal mucosa tissue from inside the mouth. We also offer advanced prosthetic techniques to perform procedures for patients with failed prior sphincters and prostheses.

Our combined residency program with MedStar Georgetown University Hospital is one of the best and most competitive in the country, offering unparalleled clinical experience and diversity of cases. We are also proud to have an active clinical research program, where close to a dozen abstracts are accepted each year for national and regional meetings, with the same number of articles published in peer-reviewed journals.

To discuss patient options, or for referral information, please call 202-877-7011.