The Radiology Operations Center:
One Point of Access for All Physicians

The leadership for the Radiology Operations Center includes Steven Brick, MD; James Jelinek, MD and Chris Wuerker, MD.
Acronyms are everywhere in healthcare, despite continuing efforts by The New England Journal of Medicine and the Journal of the American Medical Association to get everyone to stop using them. Are TAT, IMC, AMI, PCP, BID, ALL or IBD part of your daily care routine?

But there is one acronym you should be using when you round. IMOC, the Interdisciplinary Model of Care, ensures we are providing the highest quality of patient care at MedStar Washington Hospital Center. IMOC is a benefit to you, all of your care team and most importantly, your patients and their families.

IMOC creates a seamless system of care, and also creates:

- a culture where input from all team members is expected and encouraged
- opportunities for team conversations that might not be held, if rounding occurs with only an attending physician
- a deep detail of the plan of care for the patient, which provides answers about orders, so you aren’t paged as soon as you leave the unit
- an evidence based system of coordinated care
- a consistency of messaging for the patient and family, which brings the patient and family voice into the plan of care

IMOC was developed by MedStar teams for MedStar teams. One Hospital Center team that has had particular success in employing IMOC, and improving quality and safety metrics, is the physician/nurse leadership team on 4C.

4C’s Medical Directors, Teah Abashidze, MD and Giovana Olivera-Caceres, MD, and Nursing Director Rachel Watkins, RN, had a challenge. During FY 17, 4C reported nine CLABSIs, which was about ¼ of the total number of CLABSIs for the hospital. The leadership team used IMOC to focus on how care was provided for all 4C patients. I’m proud to report that as of this writing, for the first nine months of FY 18, 4C has had zero CLABSIs.

Leaders on 4C believe IMOC was the best thing that could happen on their unit.

Dr. Abashidze: “We set expectations, and defined the IMOC roles for each person on our team. We told everyone they had to participate, and it became part of our daily routine.”

Dr. Olivera-Caceres: “Our two themes were ‘engagement’ and ‘feedback.’ During our IMOC rounds, our nurses present the patient to the rest of the team. We believe it helps newer nurses develop greater clinical skills, as they learn how to see the bigger picture for patient care.”

ND Watkins: “We provide constant feedback to all team members, to make sure the plan of care is working for each patient on our unit.”

CRM Alfred: “When we discuss something like removing a patient’s lines, if the patient has a private practice physician who is not able to be on the unit during IMOC rounding, we know we can rely on Dr. Abashidze and Dr. Olivera-Caceres to help us reach the physician. It’s all about the teamwork.”

CRM Watts: “Constant communication is our theme, and it works really well on 4C.”

IMOC is an exemplary professional practice, one that benefits our patients and their families, and one that can work well into the daily routine of an inpatient unit.

Gregory J. Argyros, MD, MACP, FCCP, is sr. vice president, Medical Affairs & Chief Medical Officer, and Designated Institutional Official at MedStar Washington Hospital Center. Contact him at 202-877-6038 or gregory.j.argyros@medstar.net.

Ensuring the success of IMOC on 4C are (seated) Medical Directors Giovana Olivera-Caceres, MD and Teah Abashidze, MD; (standing) Nursing Director Rachel Watkins, RN, BSN, PCCN; Patient Care Manager Marcel Alfred, BSN, RN; Patient Care Manager Tressa Watts, RN, BSN, CMSRN; and CRM Case Manager Marquise King, RN, BSN, MS.
At 61, Brian Paul, DMD, was no stranger to neck pain. The periodontist, Navy veteran and self-described “fitness nut” suffered his share of muscle strains, injuries and deteriorating joints over the years, the result of his lifestyle and occupation. But the discomfort was something he could manage.

Until early October 2016, that is.

“All of a sudden, I had a sharp, shooting pain in my neck and shoulders,” Dr. Paul says, adding that many dentists suffer from neck problems. “Within days, it was radiating down into my hand. I couldn’t move my neck, and couldn’t sleep. Powerful prescriptions couldn’t touch the pain.”

A trip to his primary care physician and an MRI confirmed what Dr. Paul already suspected: two deteriorating cervical discs, compounded by pinched nerves. Physical therapy, more medications and steroid injections brought temporary relief, but his pain always returned with a vengeance.

“My next stop was surgery,” he says. “But I knew that the standard neck procedure, fusion, could mean the end of my career. I was desperate to find another way.”

In an online search, he found Oliver Tannous, MD, an orthopaedic spine surgeon at MedStar Washington Hospital Center.

Dr. Tannous—who recently completed advanced fellowship training in state-of-the-art minimally invasive and motion preservation techniques—believed Dr. Paul might be a good candidate for a relatively new procedure, a cervical disc replacement.

“For the past 50 years or so, anterior cervical discectomy and fusion (ACDF) has been the gold standard for treating disc degeneration,” Dr. Tannous explains. “Yet, it’s an imperfect solution. In the process of fusing two discs together, the spine is forever altered. You end up fixing one problem, but creating another. Now, orthopaedic spine surgeons have an option that preserves that motion and function, by surgically replicating a healthy disc to replace the damaged one.”

Cervical disc replacement has only been in widespread use for about a decade, and was restricted to a single degenerative disc. Recently, however, the FDA expanded its approval to cover two adjacent cervical discs, clearing the way for the more complex procedure that Dr. Paul underwent, the day after Thanksgiving 2016.

Cervical disc replacement is only an option for select patients. Those with advanced degenerative changes in the cervical spine with complete loss of disc height or with loss of cervical lordosis, for instance, still require fusion. But for those who fit the profile, cervical disc replacement offers very real benefits.

“After disc replacement, the patient typically goes home the same day without a cervical collar, and begins immediate and full range of motion of the neck. This is in complete contrast to the rigid neck brace required after fusion,” says Dr. Tannous, who estimates he’s performed about 100 of the complex cervical surgeries to date. “Other than avoiding strenuous exercise for six weeks, there are no major restrictions on movement.”

Two weeks after Dr. Paul’s replacement, he was basically pain free, and once again working out through yoga, cardio and strength training. About six weeks later, his fine motor skills returned, letting Dr. Paul completely resume the career and other activities he loves.

“At one point, I thought I’d never be able to work again, but Dr. Tannous returned me to function,” Dr. Paul concludes. “I’m glad I found him. I owe him a lot.”
Radiologists throughout MedStar Health had to figure out a way to be at nine different hospitals at the same time, so they could read images and speak to physicians about urgent studies that needed to be completed.

The solution: The Radiology Operations Center, or the ROC.

“Before, when hospital-based physicians wanted to talk to radiologists, they called them in the hospital’s reading room,” says Christopher Wuerker, MD, Emergency Medicine. “Now, all-digital technology has allowed radiologists to be remotely located. We needed a better way to communicate.”

The MedStar Communications Center, already in place for MedSTAR Transport, was a tried-and-true system that worked well. It’s now being used by physicians and radiology technologists, who call one telephone number. The system immediately contacts the appropriate radiologist, and if s/he is working on an urgent issue, the ROC finds the back-up radiologist within the same specialty. In the event of a critical finding, the radiologist uses the same telephone system to locate the ordering physician.

24/7 operations

The ROC operates 24 hours each day, seven days every week, connecting radiologists and physicians at MedStar hospitals. It is particularly useful during nights and weekends, when radiologists might work remotely and cover multiple hospitals. Part-time ROC communications service began in May 2017, and the system went full-time in November.

“The main purpose of the ROC is to support the after-hours radiology team, and have one main phone number, 301-306-2110, for all physicians across the MedStar Health enterprise,” says Physician Executive Director Steven Brick, MD, MedStar Medical Group Radiology (MMGR). MMGR employs radiologists across all MedStar hospitals except MedStar Franklin Square Medical Center. MMGR radiologists also support eight outpatient imaging centers.

“During the day, most phone calls go to individual hospitals, where radiologists are on site,” Dr. Brick says. “But after hours, radiologists are not tethered to a specific location.” After hours is defined as Monday through Friday from 5 p.m. to 7 a.m., and Saturday and Sunday from 3 p.m. to 7 a.m.

Benefits all shifts

The ROC has worked so well, that many ordering physicians now use the communication center during the day, too, says Arnold Raizon, MD, senior member of the after-hours radiology team. “The ROC does all the contact work for you,” he explains. “It works well for radiologists, physicians and technologists.”

The system is a model of efficiency at MedStar Washington Hospital Center, says James Jelinek, MD, chair, Radiology. “The ROC makes it easy for our doctors to contact the radiologist,” he notes. “But we still have important changes to make, to shorten the time it takes for physicians to speak to each other. If we have a patient with an acute stroke or a cord compression, we want to alert the ordering physician right away.”

It’s useful in less acute cases, too, Dr. Jelinek notes. “If it’s really easy to get a message to the ordering physician, the radiologist is more likely to do it. With the ROC, you don’t even have to talk to the doctor; you can be reassured they saw the report. Technologists can use the ROC to let us know there is a critical case coming up, so we can prioritize our readings.”

The centralized call service also facilitates utilization of specialized radiology services across the system. “We don’t have a neuroradiologist at every hospital every day,” Dr. Jelinek says. “The ROC allows us to better utilize resources.”

The ROC is a natural extension of the MedSTAR Transport System. “We expanded our facility and staff for the ROC,” says Dr. Wuerker, who is executive director for MedSTAR Transport. The communications center is located in Lanham, Md., and employs 32 communication specialists, with specific specialists dedicated to radiology calls. They use a

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**ROD BENEFITS**

- Tracks down appropriate personnel, eliminating time spent finding them.
- Reduces interruptions to radiology readings, improving quality, turnaround times and productivity.
- Improves ability to share specialized radiology resources across the system.
- Connects radiologist and ordering physician in event of critical finding, improving outcomes.

Arnold Raizon, MD
sophisticated call system, with speed dial and secure instant messaging.

How the system works

**Outgoing calls, from radiologist to ordering physician:**
The radiologist reads the study, and posts the report to the Electronic Medical Record for the physician’s review. When there is a critical finding, the radiologist clicks an icon in the PACS system, which alerts the ROC to contact the appropriate provider. The radiologist can continue working, while the ROC locates the physician and connects him/her to the radiologist, to discuss the results.

**Incoming calls, from ordering physician to radiologist:**
The physician may want to talk to the radiologist about what exam to order, or to discuss a previously completed study. By contacting the ROC, the system sends a secure instant message to the radiologist, without interrupting what he or she is doing.

Both the radiologist and ordering physician benefit, because they don’t have to spend a lot of time tracking each other down. There were frustrations on both ends.

With the old system, “If you had to contact the hospitalist at 10 p.m., it could take 20 minutes of the radiologist’s time on the phone,” Dr. Jelinek notes. “This interrupted the radiologist’s work flow, and prevented him or her from reading other cases.”

The reverse was also true. “If we needed to talk to the radiologist on call at night, we didn’t know who to call,” Dr. Wuerker says.

The ROC has solved both issues. “We’ve had very good success. We’re fine-tuning the system as we go along,” Dr. Brick says.

“It’s a great, great system,” Dr. Raizon agrees. “It’s a game changer for productivity.”
Because of her profound hearing loss, Edna Whitted, 90, used pen and paper or an electronic writing tablet, when she wanted others to express thoughts to her. And it was a similar communication style that Selena Briggs, MD, used to explain how a cochlear implant could help the Upper Marlboro, Md. resident hear again.

Dr. Briggs, an otologist/neurotologist and lateral skull base surgeon in the Department of Otolaryngology at MedStar Washington Hospital Center, used a computer screen set with a large-sized font. She typed answers to Ms. Whitted’s questions, and explained the risks and benefits of the small, surgically implanted electronic device.

Amelia Stewart, Whitted’s granddaughter, reports it took very little convincing before the fiercely independent grandmother was on board. “She loves learning things, and she loves talking about current events,” says Stewart, who was by Whitted’s side during the entire process. “Before the implant, she had to be outside of a conversation, and she would get really upset.”

Unlike hearing aids, which amplify sounds, cochlear implants provide signals to the brain by stimulating the auditory nerve. The brain then recognizes these signals as sounds, allowing for clarity and understanding. Dr. Briggs says implants can be used for any individual with profound sensorineural hearing loss, and there is no age limit. Advances in technology also allow for implants to be beneficial to patients with even more residual hearing, at the low to mid-frequencies of sound.

Dr. Briggs adds that while cochlear implants are well known for use in the pediatric population, only about five percent of adults who are candidates for implants receive one. “Many older adults just don’t realize it’s an option,” says Dr. Briggs, who notes that both insurance and Medicare covers the cost of the procedure. Additionally, cochlear implants also relieve tinnitus, or the perception of noise or ringing in the ears, in about 75 percent of patients.

Following an initial evaluation, patients meet with an audiologist, who assesses the extent of hearing loss. Imaging of the ear is also needed, to ensure a patient’s anatomy can accommodate the implant. The surgery typically takes one to two hours, with an internal part with an electrode placed in the inner ear, and the body of the device placed under the skin and secured to the skull.

“It’s a safe and easy procedure,” says Dr. Briggs. “People love having them, and it’s simply life-changing for them.”

That was indeed the case for Ms. Whitted, who received her left-sided implant last December, just two months shy of a surprise 90th birthday party. Following several appointments with Audiologist Lauren Evans, Au.D., CCC-A, which included activating and optimizing the implant, Ms. Whitted was soon on her way to hearing again.

“I worked with her a lot,” says Ms. Stewart, who explains that part of the success of the implant involves re-training the brain to correlate and understand words and sounds. “I would say words with my back turned to her, so she couldn’t lip read, and have her repeat the word the back to me.” Ms. Stewart also had her grandmother watch television with subtitles, to encourage the connection between sound and understanding.

“People don’t realize the things they have been missing,” states Dr. Briggs. “Cochlear implants can help older adults stay active and engaged. I have never had a single patient say they regretted getting one.”

Ms. Whitted can be included in that group. “This has improved my grandmother’s quality of life so much,” says Ms. Stewart. “You can tell how happy she really is, and at her birthday party, we sang ‘Happy Birthday,’ and she heard every word, loud and clear.”
The saying “physician, heal thyself,” is as old as the Bible, so the reluctance among clinicians to care for ourselves the way we care for patients has been around for a while. Even in the 21st century, medical professionals often drag their feet when it comes to seeking our own health care – because we know what it will entail, because we’re too busy...because we have 1,000 excuses.

That certainly applied to me. As a former competitive speed skater and basketball player, my knees took a beating early in life. This was not helped by more than 35 years on my feet as a nurse, rounding as a leader and chasing three boys through multiple sports and life events. This December, however, the pain in my left knee was causing me to compensate, and harming other joints. It was time to heal myself.

I often tell Hospital Center board members that I would not go anywhere else for my care. I believe completely that our clinical expertise is world class. As I contemplated knee replacement surgery, I knew I would have the procedure done here, because I know intimately that we have excellent resources and extraordinary physicians and surgeons. I knew I would have a good outcome.

Moving from the executive suite to the operating suite is humbling. I went from being responsible for the minute details of 2,400 clinical associates providing patient care in 900 beds, to being unable to comprehend completely what was happening to me as I lay in mine. Between the recovery from anesthesia to the grogginess and pain that accompanied my first steps only hours after surgery, I was dependent on others. I needed clinicians to advocate for me, to communicate with me and to educate me about what was happening.

It required repetition that I know is difficult to do consistently and well. It required physicians who appeared frequently to check in, assess my progress with expertise and patience, then reassure me that all was moving according to their plan. Then it required the nurse to explain to me, again, what the physician had just said.

No doubt I received significant attention thanks to my role here. I was grateful, because each interaction with your physician feels enormously important and reassuring, when you feel vulnerable and disoriented. The care my surgeon took, checking in frequently and following up during recovery, was key to my sense of well-being and my experience overall.

I was reminded, too, that little things matter more than we think, as we spend so much time and energy directing and managing care for large patient populations. Watching the expertise of a top notch surgeon, dedicated anesthesiologists and competent nursing staff work in concert before the surgery mitigated my anxiety, and enhanced my sense that everybody in this facility puts patients first. I felt a sense of relief, as my team coordinated my care throughout my stay. I especially appreciated the smooth transitions of what was an incredibly complex series of steps to get me successfully through surgery, into a room, out of pain and then on my way home in less than 30 hours.

The Hospital Center is indeed a top tier facility, and thanks to so many here, I am well on my way to dancing at my son’s wedding, only a few months after my surgery. For anyone who has clinical issues to resolve, I highly recommend taking the steps to care for yourself, because the results feel very good. Like me, you also just might renew your appreciation for what we accomplish, working together, every day.
On the morning of June 14, staff in MedSTAR Trauma received a “Code Yellow” alerting them of an incoming emergency. Their rather routine day was turned inside out, when Rep. Steve Scalise and Capitol Hill Police Officer Crystal Griner arrived via helicopter, wounded in a shooting on a baseball field. Below are the recollections of some of the Trauma team members who were working that day.

At the bottom of the page is a time-line of Rep. Scalise’s treatment at the hospital.

A “Code Yellow” (incoming emergency) was called for a gunshot wound arriving by helicopter, and minutes later the pilot wheeled an intensely bloodied stretcher toward the door.

Anthony Shiflett, DO, met the patient as his stretcher rolled into one of the eight “bays,” or procedure areas, in the MedSTAR Trauma Unit.

As the patient arrived, Dr. Shiflett started his assessment, just as he would for any patient. “I didn’t know who the patient was. My priority is to make sure the person is breathing, and to stop any bleeding.”

Looking at the patient, recalls Dr. Shiflett, “my first thought was ‘this is not your average gunshot wound.’ It was apparent that he had significant internal damage and did not have an exit wound.”

Christine T. Transkiem, MD, immediately called the Blood Bank to institute Massive Transfusion Protocol, a process to rapidly replace blood in a patient obviously in shock from blood loss.

With years of experience treating gunshot wounds, Dr. Shiflett knew immediately that Rep. Scalise needed urgent surgery to save his life.

As he transported the patient to the operating room, he called Trauma Director Jack Sava, MD, who arrived and led the operation.

During the initial surgery, the team fought to control the life-threatening bleeding. At times, Rep. Scalise was perilously close to cardiac arrest. Once the visible bleeding was
under control, the surgeons moved Rep. Scalise to Interventional Radiology (IR), so Arshad Khan, MD, and his team could use x-ray visualization and techniques applied through a catheter, to reach hard-to-see locations and stop additional bleeding.

The procedures stabilized Rep. Scalise, and he was moved to Critical Care, where a team of specialists closely monitored his condition, which remained critical for several weeks. Surgeons, including Orthopaedic Trauma Specialist Robert Golden, MD, and Plastic and Reconstructive Surgeon Derek Masden, MD, assembled to assess the massive damage to blood vessels, bones and organs in the pelvic area, and to plan next steps for reconstruction and continued improvement.

In his two months at the Hospital Center, Rep. Scalise had seven trips to the operating room and two stays in intensive care.

Finally, fourteen weeks after the shooting, including almost two months of intensive rehabilitation, Rep. Scalise made an emotional return to the House floor, walking to his seat as his colleagues greeted him with rousing cheers and a standing ovation. In his first remarks, Rep. Scalise thanked the MedSTAR team that “gave me a second chance at life. Through many, many surgeries, where my life was truly in the balance, they did a wonderful job of making sure I was well taken care of and, ultimately, made it through.”

Orthopaedic Trauma: Putting the Puzzle Pieces Together

After the first life-saving surgery on Rep. Steve Scalise, Orthopaedic Trauma Surgeon Robert Golden, MD, began planning the subsequent surgeries that would repair bones damaged in the June 14 shooting.

From the initial imaging, it was clear the femur (main thigh bone) and acetabulum (hip socket) needed surgical repair, notes Dr. Golden. “Our first goal was to stabilize the femur, because patients do better overall if you fix femurs early.” A short time later the team repaired the hip socket, which had been badly shattered.

“This is part of why you go into trauma: each break is different and every patient is a puzzle you need to figure out,” says Dr. Golden, who, as an undergraduate engineering student working as a volunteer paramedic, would bring trauma patients to the Hospital Center. These days, “I get the satisfaction of seeing the patient’s x-rays after I have intervened, with the bones realigned.” And, in this case, watching from the gallery as Rep. Scalise walked back to his seat in the House of Representatives.

7/5 through 7/16
Scalise is moved back to ICU due to concerns for infection. Condition downgraded to Serious.
Over the next two weeks, Dr. Golden treats left and right hip for shrapnel-related infection.

Monday, 7/17
Scalise transferred back to 3E, trauma step-down unit, working on physical and occupational therapy.

Tuesday, 7/25
Scalise is transferred to MedStar National Rehabilitation Hospital for continued physical and occupational therapy.

Wednesday, 9/13
Scalise takes first weight-bearing steps, using a safety harness to prevent falls.

Thursday, 9/28
Scalise receives a standing ovation as he walks to his seat in the House for the first time since the June 14 shooting.
It should come as no surprise that Norman Lester, MD, has an ear for music. He is, after all, an attending otolaryngologist at MedStar Washington Hospital Center, and chief of Otolaryngology-Head and Neck Surgery at MedStar Southern Maryland Hospital Center. While he has no illusions about his own musical talent, Dr. Lester does admit to occasionally plucking a bass guitar with a friend’s garage band.

But Dr. Lester has found another way to make music—with his hands. Drawing on his skills in woodworking, Dr. Lester has built a number of custom guitars for friends and associates, as well as professional musicians, such as legendary “power-pop” guitarist and Bethesda native Tommy Keene, who died unexpectedly in December.

Though he’d always wanted to be more than a just consumer of music, Dr. Lester had never considered becoming an amateur luthier until he was recovering from surgery for acoustic neuroma—a condition he diagnosed himself, “and probably the only ear, nose and throat doctor to do so,” he says with a laugh.

Having already built furniture and cabinets for his family, Dr. Lester was looking for a new project, when a musician friend offered to share some books on making guitars.

“He knew everything about guitars, and I had most of the tools and woodworking experience,” Dr. Lester says, “so we combined our skills, and started building.”

The initial efforts proved successful, and popular. Word spread, and Dr. Lester began receiving requests to do more.

“Guitars, like music itself, are very personal,” explains Dr. Lester, who makes only solid-body and semi-hollow electric guitars. “Many musicians like idea of customization, with inlays and other things that you can’t get with off-the-shelf guitar. There’s something special about having an instrument built by hand.”

But it’s also quite labor-intensive. Each guitar takes an average of 150 hours of work, plus extended periods necessary for finishes to fully set. Because free time is a rare commodity for a busy physician, Dr. Lester limits his luthier activity to perhaps one or two guitars every few years.

Even then, “I’m picky about what I build,” Dr. Lester adds. He’s not interested in novelty designs or making exact replicas of famous guitars. He also stays away from materials and finishes that experience has taught him to be particularly troublesome.

Wood is the hardest part, he says, as many types of trees long favored by luthiers are increasingly endangered, so Dr. Lester relies on specialty lumberyards that cater to builders of musical instruments.

Dr. Lester, playing one of his custom-made guitars, during a local concert
“I also try to use wood that’s responsibly-sourced,” he says, adding that weight is often a consideration. “Many people like the look of flame maple, though it tends to be rather heavy. Mahogany can be tricky, as it may vary in weight from one subspecies to another.”

Weight and comfort were considerations for the guitar Dr. Lester built a few years ago for Keene, who had back issues.

“Tommy loved the look of Les Paul Junior models,” Dr. Lester says. “But from a playing perspective, he liked the slimmer necks of Telecaster® guitars.”

What ultimately came out of Dr. Lester’s shop was a hybrid of sorts—a smaller Les Paul Junior-influenced body with a slim neck, equipped with pickups and other manufactured parts Dr. Lester typically sources from boutique suppliers.

Though he strives to do his best work, regardless of customer, “I got a real kick out of seeing a published photo of Tommy playing my guitar,” Dr. Lester says. “Musically, he was a huge deal for me for the last 35 years, so much so that when I told my kids that he was coming to visit, you would have thought that Bruce Springsteen was coming to our house. I contacted him, because I wanted to build him something special, as a gift to show my appreciation for someone who has always received critical acclaim, but never had major commercial success.”

After working on the guitar for a year and a half, Dr. Lester shipped it to Keene, who was rehearsing with his band for an upcoming tour. “When I found out he was using the ‘TK Jr.,’ as we called it, to play the three opening songs and the encore for every show, I was so happy. To see him play it in person was truly one of the great moments in my life, and getting a ‘thank you’ in the liner notes of his last album was wonderful, too.”

The other “big name” he knows of with one of his guitars is Dallas Molster, rhythm guitarist for Philadelphia-based “pop punk” band, Grayscale, and the son of a high school classmate.

“I believe he is under contract to use a specific brand of guitars on stage,” says an understanding Dr. Lester, “but I hope that perhaps he picks up the one I made, to practice with from time to time.”
MEDSTAR CONFERENCE HIGHLIGHT

MedStar Georgetown Transplant Institute Symposium
May 19 | Bethesda Marriott | Bethesda, Md.
Course Co-Directors: Thomas Fishbein, MD | Matthew Cooper, MD
Basit Javaid, MD, MS | Stuart Kaufman, MD | Rohit Satskar, MD

This educational program will consist of three parallel tracks navigating the diagnosis and treatment options for kidney, pancreas, liver, and intestines requiring a transplant. These tracks include: Advances in Liver Diseases and Transplantation, Current Issues in Kidney and Pancreas Transplantation and Dialysis, and Update on Transplantation for Children. The Liver track will cover topics such as chronic liver diseases, understanding the liver transplant process, and hepatocellular carcinoma. Through the Kidney and Pancreas track, the learner will gain a better understanding of the new kidney allocation system, post transplant care, managing the wait list, and living donor transplantation. The third track, Update on Transplantation for Children, will examine updates on intrahepatic cholestasis syndromes, pediatric intestinal transplantation, and the transition from pediatric to adult intestinal failure and transplant care. MGTI 2018 offers an educational experience for attendees to interact in an interprofessional learning environment with designated tracks, lectures and panel discussions.

For more information and to register, visit CME.MedStarHealth.org/MGTI

UPCOMING CPE EVENTS

Abdominal Wall Reconstruction Conference
June 7-9 | Grand Hyatt | Washington, D.C. | www.AWRconference.com
Course Director: Parag Bhanot, MD

3rd World Bronchiectasis Conference 2018
July 12-14 | Georgetown University Hotel and Conference Center | Washington, D.C. | www.WorldBronch.com
Course Chair: Anne E. O’Donnell, MD
Course Co-Chair: Timothy R. Aksamit, MD

5th Annual Gastric and Soft Tissue Neoplasms 2018
September 29 | Park Hyatt Washington | Washington, D.C. | cme.medstarhealth.org/GSTN2018
Course Directors: Waddah B. Al-Refaie, MD, FACS | Nadim G. Haddad, MD | Dennis A. Priebat, MD, FACP

The 13th Annual Georgetown Meeting on Gastrointestinal Endoscopy & Pancreatobiliary Surgery
October 20 | The Ritz-Carlton | Washington, D.C. | cme.medstarhealth.org/GIDISEASE
Course Co-Directors: John E. Carroll, MD | Thomas M. Fishbein, MD | Nadim G. Haddad, MD

SAVE THE DATES

State of the Art Mental Health Care for Emerging Adults
September 28 | Venue: TBA
Course Directors: Matthew G. Biel, MD | Course Co-Director: Aditi Vijay, PhD

Thyroid Disorders 2018: New Diagnostic Tests and Treatments for Clinical Practice
December 7 | Kellogg Conference Hotel at Gallaudet University | Washington, D.C.
Course Co-Directors: Kenneth D. Burman, MD | Jason A. Wexler, MD

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

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You can download, print or e-mail your CME transcript. Visit cme.medstarhealth.org and click on “View Your CME Transcript” for complete instructions.
Doctors’ Days at the Hospital Center

In the United States, National Doctors’ Day is celebrated to recognize and honor the service of all physicians. The date chosen, March 30, was the day that anesthesia was first used in general surgery. President George H.W. Bush signed the proclamation in 1991 that established the official recognition of the day. At MedStar Washington Hospital Center, we traditionally celebrate the Thursday and Friday closest to March 30, with breakfast and lunch in the Medical & Dental Staff Dining Room.

Welcome to New Members of the Medical & Dental Staff

Ranya Antony, CRNP
Anesthesiology

Michael List, CRNA
Anesthesiology

Rivka Schwarz, CRNA
Anesthesiology

Jordan Smedresman, MD
Emergency Medicine

Benjamin Kenigsberg, MD
Hospitalist Service – Cardiology

May Wheelwright, CNM
Obstetrics & Gynecology

Vincent DiFabio, DDS
Oral & Maxillofacial Surgery

Jason Marrazzo, DDS
Oral & Maxillofacial Surgery

Leonel Perez, DDS
Oral & Maxillofacial Surgery

Armondo Retana, DDS
Oral & Maxillofacial Surgery

Emily Fischer, CRNP
Orthopaedic Surgery

Azuka Oele, DPM
Podiatric Surgery

Benjamin Raatjes, MD
Psychiatry

Rend Al-Khalili, MD
Radiology

Jill Bruno, DO
Radiology

John Cardella, MD
Radiology

Dimitri Merine, MD
Radiology

Adnaan Moin, MD
Radiology

Rafia Raza, MD
Radiology

Jan Skrok, MD
Radiology

Alexander Somwaru, MD
Radiology

Judy Song, MD
Radiology

David Widlus, MD
Radiology

Alexa Milano, PA-C
Surgical Critical Care

Kathryn Gall, CRNP
Vascular Surgery

Vascular surgeons Tareq Massimi, MD, and Rajesh Malik, MD, enjoyed their Doctors’ Days breakfast before heading to the OR.

Sarika Rao, DO, Endocrinology; Hassan Amer, MD, PGY-2, Internal Medicine-Primary Care and Rudy Hamad, CAA, Anesthesiology, lined up for the lunch buffet.

Cardiologists Christy Kaiser, MD, and Steven Goldstein, MD, took lunch to go for Doctors’ Days.

Jessica Fields, MD, MHA, MBA, physician advisor, discussed with Danielle Coates, Medical Affairs, whether she should select the blue duffel bag as her Doctors’ Days gift.
For Ophthalmology Chief Resident Jacqui Weber, MD, caring for eyes means being part of the family business. Her late grandfather worked as an optician and started his own business, making and grinding the glass for prescriptions. Her father followed in his father’s footsteps, and became an optometrist. Dr. Weber grew up in her father’s optometry office, working first as a secretary and then as a technician, helping patients learn how to put in contact lenses.

Dr. Weber was sure that, she too, would become an optometrist. As an undergraduate at Gettysburg College, she enrolled in a combined optometry program that would lead to her degree in optometry. Then, in her senior year of college, a trip to Baltimore changed everything.

Dr. Weber shadowed an ophthalmologist, who offered the college student a chance to shadow him in the operating room.

“It was my first time in an operating room,” Dr. Weber recalls, a smile forming at the memory. “I watched a few cataract surgeries, and absolutely loved it.”

She came back from that winter break trip with a new plan: medical school. Dr. Weber added additional pre-med courses, took the MCAT and applied to medical schools. Once in school, she tried to keep an open mind about specialties, but the draw to working with eyes remained a powerful one.

“I kept coming back to wanting to do surgery, but also wanting to see and treat families over the long-term,” Dr. Weber says. “Ophthalmology provided that great balance.”

As Dr. Weber rounds out the second half of her year as chief, she notes that, as someone who plans to go into private practice eventually, the role has provided invaluable professional development.

“The administrative side of medicine has been something that I didn’t have a lot of experience in, so learning more details around billing, coding and scheduling—detailed knowledge around reimbursements or the most effective way to schedule patients—it’s the nitty gritty and less-glamorous side, but those are all the things I need to know, as I go forward in my own career.”

Dr. Weber will leave MedStar Washington Hospital Center this summer, and head for a colder part of the country. She’s been accepted for a one-year fellowship in Cornea and External Disease at the University of Minnesota. The fellowship emphasizes medical and surgical treatment of a full range of diseases, along with specialized transplant and ocular surface surgeries.

“It’s a great fellowship for private practice, because you can expand your surgical skills for cataracts and anterior segment disease, while still offering other procedures, such as corneal transplants,” Dr. Weber says.

Long-term, Dr. Weber thinks about going into business with her father—a prospect that feels like coming full circle from those early days as a secretary in his office. She and her husband are both from the mid-Atlantic region, so they plan to settle somewhere on the East Coast—after, she says, they survive one really cold winter.

In the final months in her position as chief resident, Dr. Weber says there is one more priority that she keeps top of mind: supporting her younger colleagues. “I had incredible residents who helped me tremendously. Paying that forward has been a very rewarding experience this year.”
As a high school student in Jordan, Saher Sabri, MD, had to make a choice about a profession at an early age. Well before he knew anything about Interventional Radiology as a specialty, he knew he was fascinated by the idea of being a doctor, and helping people.

As he earned his medical degree at the University of Jordan, his path began to crystalize—a path that led him to MedStar Washington Hospital Center last July, as the new director of Interventional Radiology.

As a young clinician, Dr. Sabri found himself intrigued by imaging, and looking at the human anatomy. He also discovered a passion for traveling to other places, in search of best practices for his field.

The desire to seek out cutting-edge research and dynamic clinical practices led Dr. Sabri first to the University of Iowa for a residency in Diagnostic Radiology, and later, to the University of Virginia Medical School for his fellowship.

“Iowa was an excellent place to train,” Dr. Sabri says. “I saw new technologies being used, attended as many conferences as possible and learned from the pioneers in the field.”

His mentors at Iowa encouraged him to apply for UVA’s fellowship in vascular and interventional radiology, since the program was at the forefront of interventional radiology.

That time at UVA proved formative. It included his fellowship, and later, nine years as a faculty member, with mentors helping Dr. Sabri gain national exposure and a network of partners, nationally and internationally. He served on several national committees and held leadership positions such as the president of the Association of Program Directors in Interventional Radiology.

“I learned clinical applications of minimally invasive, image guided procedures to give patients the most options, and was able to share that information with others.”

Dr. Sabri calls the sharing of experiences and collaboration with others in the medical community the “best part of medicine.”

At UVA, Dr. Sabri served as an associate professor of Radiology and Surgery, the vice chair of Education, and the residency program director for the Department of Radiology and Medical Imaging.

“It was time to spread my wings and take on different challenges,” says Dr. Sabri, who notes that, while at UVA, he was focused mostly on education and the school’s residency program. “I’m excited to take on more administrative responsibility and contribute to the operational side. MedStar is a great organization, and the idea of having a regional role integrating interventional radiology across different parts of MedStar was intriguing.”

In that role, Dr. Sabri says he aims to create a more uniform and systemized approach to interventional radiology across the system. “My goal is to offer our patients the option for minimally invasive, image guided procedures at all of our MedStar sites, creating centers of excellence, so that patients have all the best options, close to where they live.”

As the Hospital Center’s director of Interventional Radiology, this means improved workflow, training, patient education, as well as the education of referring physicians—in addition to getting the best equipment available. “There’s a structural component, in addition to hiring the best and brightest, to come join us and bring their expertise,” he says.

Ultimately, Dr. Sabri says this all comes back to collaborating with other specialties, which he sees as one of the greatest opportunities MedStar has to offer. “I want to make sure we work together to improve patient care, and that our diversity of experiences benefit the patients—to bring together all of our expertise, regardless of specialty.”

Even as Dr. Sabri lasers in on the MedStar network, he remains passionately devoted to furthering a shared learning of best practices internationally, which was forged from that early desire to spread knowledge and learn from others. He helped establish, and continues to run, an annual conference for the Pan Arab Interventional Radiology Society (PAIRS), which supports intervention radiology education and research in the Middle East. He also volunteers to perform interventional procedures in the Middle East, and works with practitioners in the region, to advance the field.

Away from the hospital, Dr. Sabri is an avid sports fan. His teams include Iowa football, UVA basketball, Wizards and the Nationals, although he has not yet warmed up to the Redskins. “I am blessed with two kids who are into sports, and like to go to the ballpark and arena for games. We love that D.C. is a great sports city.”

Dr. Sabri and his wife are enjoying their new home, and frequently attend cultural events that reflect the diversity of the city. They also like to try different restaurants, and have enjoyed the food scene, including street food. “Nothing beats a good falafel sandwich on the way home, after a long work day,” he says.
Physician’s Perspective

From the Desk of...
Stanley Chia, MD
Chair, Otolaryngology

For conditions ranging from routine to complicated, our team of highly specialized otolaryngologists at MedStar Washington Hospital Center offers the latest in treatment options. Physicians in our department bring an array of exciting new procedures to patients in the metropolitan region.

In the area of ear and balance disorders, new advancements in our department include the placement of cochlear implants in geriatric patients. Severe hearing loss is very common in this aging population. Cochlear implants can restore significant quality of life, and the procedure is often covered by insurance. Interestingly, hearing aids usually are not a covered benefit. In addition, for patients experiencing Eustachian tube dysfunction causing hearing loss and ear discomfort, a small balloon can be placed endoscopically through the nasal cavity, to dilate the Eustachian tube and improve symptoms.

Laryngology procedures to improve voice quality are performed at the Hospital Center on an outpatient basis when patients are awake, resulting in less risk and trauma. These procedures include vocal cord injections to treat patients with paralyzed vocal cords, and laser treatment of benign lesions. Salivary gland disorders can now be treated through a minimally invasive endoscopic technique called sialendoscopy. In this procedure, a very narrow camera is placed into a salivary gland duct, to remove stones or dilate the duct. This procedure is effective in treating patients with a wide range of problems, such as narrowing of the salivary duct, or chronic salivary dysfunction after radioactive iodine treatment.

We offer a novel treatment for sleep apnea patients who are unable to tolerate the CPAP device to treat obstructive sleep apnea. A pacemaker-like device called a hypoglossal nerve stimulator is placed, to stimulate tongue movement and open up the airway while sleeping. We have performed more of these procedures than any other center in the region.

In addition to providing the best treatment for our patients, we are also looking to provide the best patient experience possible. As a result, we are expanding our department, by moving into a new location in the North Tower of the Physician Office Building within the next year. We are excited about the future of our department, and are looking forward to sharing our experience with you. Please call 202-877-3647 for a consultation.