Physician
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From Idea to Invention: MedStar Inventor Services

Stephen Kinsey, MS, MBA, director, MedStar Inventor Services; Mark Smith, MD, chief innovation officer, MedStar Health and director, MedStar Institute for Innovation (Mi2); Edward Woo, MD, director, MedStar Regional Vascular Program and chairman, Vascular Surgery, MedStar Washington Hospital Center; and Stephen Peterson, MD, chair, Psychiatry, MedStar Washington Hospital Center, joined forces at Mi2 to discuss the invention process.
Lennon /M cCartney, Rocky & Bullwinkle, Abbott & Costello.
Peanut butter & jelly, mac & cheese, spaghetti & meatballs.
These are all famous pairs. What do they have in common? They’re all dynamic duos.

We have our own dynamic duos at MedStar Washington Hospital Center, and their great successes as a team mean better care for our patients.

Last year, Chief Nursing Executive Sue Eckert and I began a joint initiative to establish a leadership dyad on the patient care units. This medical director-nursing director team would work together, to strengthen the professional collaboration between Nursing and the Medical & Dental Staff.

The leadership dyads are now on all 32 inpatient units, and from all reports, they are working well. Here’s one example: Nimesh Shah, MD, and Linda Conley, RN, lead the CVRR, where many disciplines interact and simultaneously co-manage patients.

“A key component to successfully manage these complicated patients is building strong relationships and fostering open communication within the SICU team, including nurses, APCs and physicians, and across disciplines,” says Dr. Shah. “Linda and Kristen Nelson, our lead for the APC group, have done a great job of fostering an environment for the staff to speak openly. Some really good solutions have come from bedside providers, who brought ideas to leadership. Having a solid relationship with other disciplines makes implementation of new ideas easier.”

Conley adds, “We meet a dozen times a day. This is a very active unit, with an extraordinarily acute patient population. We monitor and discuss tracking tools and outcomes, launch process improvement initiatives and bring new education to the CVRR. We’ve also been involved in planning the CVRRs move to the new Heart Hospital space next year.”

On 3E, Burn Center Director Jeffrey Shupp, MD, also serves as medical director, and Kathy Lee, RN, is the nursing director. They have found caregiver engagement is another aspect that their dyad has created.

“The concept of teamwork in burn care was not foreign to us, but formalizing our partnership as Nursing and Medical Director of the unit has re-energized our team,” reports Dr. Shupp. “Seeing us work collaboratively goes a long way to promote staff engagement.”

Lee agrees. “I think that it has helped me stay more focused on the vision for the unit. We talk about ideas for improvements, and what we would like to see in the future.”

Some of the original charges Sue and I gave to the dyads are:

- Developing unit-based metrics for quality, safety and engagement, to identify gaps in performance and establish corrective action plans
- Rounding on a regular basis, to evaluate patient care and regulatory readiness
- Serving as the first points of contact to address issues, including unresolved patient satisfaction concerns, safety occurrences, patient throughput and coordination of care
- Lead the patient satisfaction strategies to improve HCAHPS scores and the overall patient experience

All the MD/ND dyads meet with us on a regular basis, to share results and best practices. If you have new ideas on how these leadership teams can help your patients, please contact the MD/ND duo on the unit.

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Nimesh Shah, MD, medical director, and Linda Conley, RN, nursing director for the CVRR.

Kathy Lee, RN, nursing director, and Jeffrey Shupp, MD, medical director, for the Burn unit.
“I thought I was going to die in front of the kids.”

Instrumental music teacher Marilyn Beeson had just finished a class with 35 fourth and fifth graders who were preparing for their spring concert. As she drank some Gatorade®, she felt her throat completely close up.

“I couldn’t breathe,” she says. During the past five years, Mrs. Beeson had sporadic difficulty swallowing, “as if something was stuck in the back of my throat,” but her symptoms on May 14 were the worst she had ever experienced.

A parent volunteer in her classroom performed the Heimlich maneuver, while one fourth grader ran to get the Calvert Elementary School nurse. “I could breathe a little by then, and asked that the EMTs not use the sirens, so the children wouldn’t be upset. But then my throat closed again, which was a terrifying feeling.”

A CT revealed an aberrant right subclavian artery, at the last branch of the aortic arch. The vessel was compressing her esophagus, resulting in a swallowing disorder, dysphagia lusoria. Her condition required a specialized, multidisciplinary approach, and Mrs. Beeson was brought to MedStar Washington Hospital Center, where vascular surgeon Rajesh Malik, MD, and cardiac surgeon Christian Shults, MD, took over her care.

Aberrant right subclavian artery is the most common embryologic abnormality of the aortic arch, but affects fewer than one percent of the population.

“It’s uncommon to see a case of dysphagia lusoria, and Mrs. Beeson’s case was unusual, because most people with an aberrant artery are asymptomatic, or the condition is associated with an aneurysm of the vessel or the adjoining aorta,” explains Dr. Malik.

“Treating this condition requires a multidisciplinary approach,” adds Dr. Shults. “One of the valuable things about being at the Hospital Center is being able to collaborate, when presented with an unusual problem, and working together as a team to come up with a solution.”

“Many cases are treated endovascularly,” Dr. Malik says. “But because Mrs. Beeson had been very uncomfortable for some time and because of her relatively young age, Dr. Shults and I felt that an open approach was the better option. She is young and healthy, and this way, the artery would be resected entirely, instead of possibly causing problems for her in the future.”

The physicians presented options to Mrs. Beeson, and recommended the open procedure.

“It was a tough decision to make, but I felt I could trust Dr. Malik’s and Dr. Shults’ opinions and expertise,” says Mrs. Beeson. “They agreed I would recover well, and shouldn’t ever have to deal with this situation again.”

The surgeons went ahead with a two-stage care plan for Mrs. Beeson: a right carotid subclavian bypass, performed by

Instrumental music teacher Marilyn Beeson is all smiles now, thanks to her team of Vascular Surgeon Rajesh Malik, MD, and Cardiac Surgeon Christian Shults, MD.

Dr. Malik, and a few days later, a resection of the aberrant right subclavian artery via right posterolateral thoracotomy, performed by Dr. Shults and Dr. Malik.

As she recovered, Mrs. Beeson felt the difference immediately. “From the time I woke up, I no longer felt any kind of rubbing sensation in my throat,” she says.

“The problem with Mrs. Beeson’s artery is completely resolved,” Dr. Shults says. Dr. Malik adds, “It’s great to be able to help her feel more comfortable, and allow her to eat without worry or fear.”

Mrs. Beeson says that although her recovery has been smooth, she is still processing her experience.

“It was a frightening thing to go through, but every day is a little bit better. I had extraordinary care from the Hospital Center nursing staff. And I feel so much gratitude to Dr. Shults and Dr. Malik for their training, and for performing this complicated procedure so successfully.”

This experience also changed the career trajectory for Mrs. Beeson’s son, who is a sophomore at the University of Maryland. “Now that he’s seen what physicians can do,” she reports, “he wants to go to medical school.”
Every day, busy clinicians are confronted with poorly designed healthcare devices or bothersome obstacles to patient care. Their reaction may be, “There’s got to be a better way.” Or, “I can’t believe someone designed it this way.”

Some of those busy clinicians go a step further, and devise their own clever solutions to address the problem they are encountering. Those innovative ideas may be able to have market value well beyond the MedStar Health system.

Through MedStar Inventor Services (MIS), MedStar physicians and associates have an easy way to find out if their idea has merit in the market. MIS listens to your idea and determines if what you propose already exists in the market. If it doesn’t, MIS explores the marketability of your solution and turns those that do have marketability into a commercial product. The ultimate goal is to produce a brand new invention that helps others do their jobs better, and earns money for both you, the inventor, and for MedStar.

“Should you have an idea, we’ll help you turn it into an invention,” says Stephen Kinsey, director, MIS. “This process can be very costly and time-consuming if you do it on your own.” MIS is part of the MedStar Institute for Innovation (MI2). Launched in 2009, MI2’s job is to catalyze innovation that advances health at MedStar, and they do it in a wide variety of ways.

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“In partnership with Cleveland Clinic, MIS offers all the tools necessary to bring inventions to life,” says Mark S. Smith, MD, MedStar Health’s chief innovation officer and director of MI2. “This partnership is innovative itself—established January 11, 2011, it is one of only a handful of such partnerships within health care systems, and now includes other partners around the country.”

Two ideas are well along the path from idea to market, with licensing agreements in place and one patent actually awarded. MedStar Washington Hospital Center endocrinology surgeon Erin Felger, MD, has an invention for a surgical simulator, to teach surgeons how to perform thyroidectomies. MedStar Franklin Square Medical Center pulmonologist Bill Krimsky, MD, has invented an artificial muscle that can be attached to the diaphragm, to help patients bring in more air.

Several more ideas are in the beginning stages. Stephen Peterson, MD, chair, Psychiatry, MedStar Washington Hospital Center, has an idea for safe restraints that can minimize injuries to patients and medical staff.
“MedStar Inventor Services has been very supportive,” Dr. Peterson notes. “Whenever we have an idea, they give us feedback and help us improve that idea. So far, we’ve done a patent search and developed a prototype. The next step is to do a limited trial to see how it works.”

Edward Woo, MD, director, MedStar Regional Vascular Program and chairman, Vascular Surgery, MedStar Washington Hospital Center, has an idea for a device that can enhance transcatheter procedures, making it easier to manipulate tools within the narrow confines of patients’ arteries. “MIS helps you get through each step,” he explains. “They add substance to your ideas. It makes the whole process extremely streamlined.”

The underlying premise of MedStar Inventor Services is that everyone can be an inventor. “Innovation is all around us; you just have to look around. Many people who do not think of themselves as inventors actually are,” says Dr. Smith. “If you are a problem solver, and most physicians are, then you are an inventor.”

If MIS succeeds in bringing your invention to market, you get the satisfaction of seeing something that you created help many people, and you personally receive a very generous portion of the revenue, he adds.

### Needs Assessment
MIS helps you prepare a 10 to 12 minute presentation about your idea, which you will present to a small group of domain-expert clinicians for their assessment. In the presentation, “you will have an opportunity to tell the story behind your idea,” Kinsey says, “why you came up with this, why you came up with the solution and what problem it addresses.” The peer review panelists ask questions, and give their assessment about whether the product is unique and fills a critical need. Sometimes, they offer actionable suggestions to improve the idea.

### Viability Assessment
Business analysts at Cleveland Clinic do a “deep dive” into its marketability. “They determine its clinical indications, regulatory path and patent-ability, and share this information with you,” says Kinsey. “A decision will be made whether to continue the process, or ask you to expand or improve on the concept.”

### Enhancement
MIS files for a patent to protect your intellectual property, a process which can take two or more years to fully complete. If necessary, a prototype of your idea is developed with the help of designers and engineers. Sometimes the product is tested in a real life environment. “MedStar is a perfect clinical sandbox for this,” says Dr. Smith. “MedStar is a microcosm of health care in America—it has everything.”

The critical part at this juncture is to find a company to manufacture and distribute your product. This is where the collaboration with Cleveland Clinic Innovations comes in, as it has a long history of commercializing inventions, and has established relationships with multiple companies in many fields.

### Negotiation
MIS conducts a fair market valuation, makes sure the value of the invention is maximized and the inventors receive fair monetary compensation.

“Under MedStar’s Intellectual Property Policy, after expenses are reimbursed, inventors get 50 percent of any revenue MedStar receives from the commercial partners. In addition, 12.5 percent is given to your department, which creates an incentive for the department to support you in this process,” Dr. Smith explains. “MIS also sees you through the business and legal side of negotiations. Again, their experience stands you in good stead.”

### Translation
In this phase, MIS monitors the company, to make sure it follows through on its commitments. The MIS staff establishes due diligence milestones, to ensure the company does all the necessary patent work and navigation of the regulatory process, to bring your invention to market in a timely fashion. “We make sure they deliver,” Kinsey says. “We don’t want your product to sit on the shelf just to keep potential competitors’ products off the market. We want it out there, helping people.”

Dr. Smith adds, “Every MedStar associate has good ideas. Some of those ideas have commercial potential. But it is a long and arduous journey from having the idea to actually getting something to market. MIS substantially improves the chances that your inventive idea can be transformed into a commercial product to advance your patients’ health.”

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**INVENT**

1. **Idea Submission**
   - “Any MedStar physician or associate can submit a health-care related idea for consideration. Jot down a few sentences, send us a picture of a drawing you made on a napkin—whatever way you want to convey your idea,” explains Dr. Smith. “You can submit it via email, invent@medstar.net, or through the MI2 Website, http://mi2.org/hub/inventor-services.”
   - MIS will determine if your idea is worth pursuing, by performing a quick patent search and competitive product search to see if the product already exists, or if someone else has protected intellectual property.
   - “If your idea is potentially commercially viable, MIS will help you fill out an online Invention Disclosure Form,” says Kinsey. “That form describes your idea in more detail. Essential information includes how the product works, and who will benefit from it.”

2. **Assessment Enhancem ent**
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“Should you have an idea, we’ll help you turn it into an invention.”

MIS supports you through the INVENT process, and keeps you informed of the status of your invention along the way. Here’s how INVENT works:
In the seven years since the D.C. Sexual Assault Nurse Examiner (SANE) program began, Heather DeVore, MD, medical director of the program and an Emergency Medicine physician at MedStar Washington Hospital Center, has seen the number of patients seeking medical forensic services steadily increase.

In fiscal year 2014, the program treated 420 patients, more than double the roughly 200 patients treated when services first began in 2008. Those treated ranged in age from 16 to 77, with 10 percent of patients being male or transgender. In an earlier year, one patient receiving treatment was 100 years old.

“In my ideal world, every hospital in the District would have a specialized center to address sexual assault and intimate partner violence (IPV),” Dr. DeVore says. “I believe so strongly in this approach, and this program truly helps remove barriers to care.”

Currently, the Hospital Center is the designated hospital in the District providing free services for victims of sexual assault or IPV. Offered through the Emergency Department (ED), these services include specialized forensic exams and collection of evidence, physical evaluation for other potential injuries, preventive measures for pregnancy and sexually transmitted diseases, and professional victim advocates and case managers, who connect patients to other victim services. How much or how little services a patient receives is entirely up to the patient, Dr. DeVore says, noting that one objective of the program is to provide victims with the ability to regain and take control of their health and well-being. For some patients, that
could be as simple as requesting Plan B One-Step® emergency contraception, while others may elect more extensive services, including a head-to-toe physical exam, with collection of DNA evidence and forensic photography.

While most SANE exams take place in the Hospital Center’s ED, the program is a collaborative effort with District of Columbia Forensic Nurse Examiner (DCFNE), a non-profit community organization. It works in conjunction with other D.C. agencies and offices, including the Office of Victim Services, under the Mayor. Forensic nurses are employed as consultants through DCFNE, with two nurses always on-call 24 hours a day. Nurses are also available to travel with a “go-bag,” should a victim present at a different District hospital and be too unstable to be transferred.

**Specialized Equipment, Specialized Training**

According to Dr. DeVore, the truth is in details, which is why forensic exams utilize specialized equipment and techniques for evidence collection. One such measure is an Alternative Light Source, which can reveal injuries unseen to the human eye. Fluids are also collected for DNA testing, and patterns of bruising are meticulously documented, all critical measures important to investigations, should a victim elect to report the assault to police.

Dr. DeVore notes that as part of the 2009 reauthorization of the Violence Against Women Act, victims of sexual assault are entitled to medical forensic care without having to report the violent act to police.

“This allows us to collect DNA that otherwise would degrade and wash away, as time goes on. Then the victim has time to decide whether or not s/he wants to report this to police,” she says. “The more information we can collect and provide, the more details are present to help reconstruct a story, and the more appropriate justice will be served.”

“We don’t work for the defense or the prosecution,” she adds. “Our job is to collect and document necessary information, and provide comprehensive medical care for the patient.”

Another important focus of care is recognition and awareness of the severity and nuances of strangulation, which Dr. DeVore says occurs 75 percent of the time in IPV cases. Because classic symptoms of bruising, abrasions and swelling are often not present in patients, providers need to be aware and educate patients about potential later problems, such as voice changes, memory impairment, headaches and other symptoms of brain injury.

**Future Goals**

Currently, Dr. DeVore is working on a grant proposal that would expand forensic nursing to general trauma, noting that trauma patients who are victims of violent crimes often need similar expertise and documentation.

“This will allow our trauma physicians to do what they do best without worrying about collection of evidence,” she explains. “For those who survive a violent crime, we would be able to collect DNA, perform body mapping of injuries and take any necessary photographs.”

Plans are also underway to construct a dedicated forensic exam room in the Emergency Department, something Jeffrey Dubin, MD, MBA, chair, Department of Emergency Medicine, hopes will completed by the end of the calendar year.

“Evidence collection, taking necessary photos and careful documentation is so important because it can be used later by the judicial system,” explains Dr. Dubin. “Patients of domestic violence and sexual assault may not want to report to police right away. But if a patient later decides to make a formal complaint, having evidence collected is much better than not having any evidence, except for the written medical report.”

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**SANE services are based on patient need and circumstances and may include:**

- Evidence collection in a Physical Evidence Recovery Kit (PERK)
- Injury documentation and forensic digital photography
- Toxicology screening if drug-facilitated or incapacitated sexual assault is suspected
- Emergency contraception (Plan B)
- Medications to help prevent gonorrhea, syphilis, trichomoniasis and chlamydia
- HIV post-exposure prophylaxis

**Requirements to Become a Forensic Nurse with DCFNE:**

- Be a registered nurse with a license to practice in the District of Columbia, as well as have 12 months or more of critical care experience
- Complete 45 hours of classroom instruction, as well as clinical training, which includes:
  - participating in a mock trial
  - performing vaginal speculum exams
  - accompanying a detective in the Sexual Assault Unit on a ride-along
  - meeting with the forensic science lab
  - shadowing and preceptorship with a current forensic nurse
Today, busy physicians use one computer application to document patients who visit their offices, and another to document on these same patients in the hospital. This requires physicians to switch gears, and, worse, makes it easier to overlook important information, or even make mistakes.

Get ready for the debut of MedConnect III Electronic Health Room (MC3) for ambulatory care patients at all MedStar hospitals, clinics and physician office practices that are using MedConnect. Starting next year, Centricity™ will be left behind, and MC3, a Cerner product, will take center stage for outpatient charting. At the same time, inpatient electronic health records will phase from MedConnect to MC3.

“MedConnect III will transform the electronic medical record for ambulatory patients,” says Peter Hill, MD, chief medical informatics officer, MedStar Washington Hospital Center. “Finally, we will be able to fully integrate our major EHRs for outpatients and inpatients.”

The benefits are numerous—full integration, flexibility, ease of use, efficiency, customizability and record-sharing capability with outside physicians.

“Physicians will be able to use system-wide charting throughout MedStar,” explains Carmella Cole, MD, acting chair, Medicine, MedStar Washington Hospital Center, who is the physician champion for the outpatient MC3 application. “All the information I have for my office patients will be available for physicians caring for hospitalized patients. There will be no disconnect between inpatient and outpatient care.”

An office assistant can input information about vital signs and document medications before the physician sees the patient. Then, the physician checks the problems list, adds and subtracts problems as needed, and updates medications. Results from lab and radiology are incorporated into the chart.

All MedStar physicians who see outpatients will be affected, with one exception. Washington Cancer Institute will continue to use its own ARIA® electronic medical record.

**Full Integration**

Today, most physicians at MedStar Washington Hospital Center have to know two different systems for electronic medical records—one system for outpatients and another for inpatients. Starting next year, all records will migrate to MC3. Obviously, it is easier for busy physicians to learn and become proficient at one system, rather than two.

But the larger benefit is information sharing. “For example, if I have a patient with a potassium level of 2, that is in my chart and visible to the inpatient physician, if the patient is admitted to the hospital,” Dr. Cole says. “Physicians only have to look in one place.” This note sharing saves time and reduces errors.

**Flexibility**

All MedStar physicians will be able to access patient records and place orders from hospital computers, office computers, homes, wherever there is Internet capability. “As long as you can log onto the SERA enterprise virtual private network (VPN), you can access patient information,” Dr. Cole says.

**Ease of Use**

MC3 charting is more user-friendly and intuitive than Centricity, Dr. Cole notes. It uses Dynamic Documentation™, an interactive tool that automatically incorporates information throughout the chart to assist in documentation. Physicians can tag specific data to place in their note and add additional information as needed. The end result is “more complete, readable notes,” according to Dr. Cole.

Efficiency

The auto text feature completes common phrases for faster charting. Physicians also can create macros to facilitate documentation; for example, they can create standard wording for specialty-specific review of systems and then edit that text.
A screen capture from the MedConnect III Ambulatory pages shows great detail for the physician to consider.

as applicable. Voice recognition is another huge step into the future. The Dragon® voice-to-text dictation tool helps physicians add notes faster.

MC3 also ties into patient billing. “It gives us the ability to do outpatient billing from the EMR,” Dr. Cole says. “We can do away with paper billing. The system pulls information from the visit and imports it into the billing system.”

**Customizability**

“We’re looking at different ways to construct the chart now,” Dr. Cole states. Each specialty will be able to tailor the chart to specific needs; for example, gastroenterology will list major problems, common medications and standard tests performed by that specialty.

Further, individual physicians can tailor the chart more specifically to their own needs. “Unique practices can set up the chart for how it works best for them,” Dr. Cole notes.

“Physicians and practices can create their own templates, specific to their needs.”

Dr. Cole provides an example. “Physicians can create a list of patients with certain diagnoses. For example, I can look at all patients with blood pressure over a certain number, and then I can follow up with those patients on a regular basis.”

**Record-Sharing**

Finally, MC3 moves MedStar one step closer to an integrated medical information highway, by making it easier to share patient information with hospitals and physicians outside MedStar. The system is set up to communicate with the outside world, Dr. Cole says. It can access a database that contains fax and phone numbers for nearly every physician in the U.S., and then fax information to outside providers.

**What’s Next?**

Planning for MC3 for ambulatory care patients is still in the early stages. Because it is an enterprise-wide solution, it will be phased in, hospital by hospital, starting next year. Committees already are meeting regularly to discuss and tailor the chart to specific departmental needs.

There will be a learning curve, Dr. Cole acknowledges. But it will be well worth it. And one final point—all Centricity records will automatically populate the new MC3 charts, with problem lists, medications, allergies, immunizations, procedures, lab and radiology results, along with the last three years of office notes.
Determining whether a patient has decisional capacity to give informed consent can be among the hardest—and most important—tasks a physician faces, but there’s no sure-fire formula to follow.

Determining a patient’s decisional capacity should never be cut and dried, and sometimes it can require the services of an expert. This is especially important when the stakes are high—when there is a life-or-death decision that hangs in the balance.

Fortunately, MedStar Washington Hospital Center has a team of psychiatrists and clinical ethicists on hand to assure that patients receive the appropriate treatment. Ethicists make sure that patients are cared for in an ethical manner, protecting an individual’s autonomy for decision-making, and following the best-interests standard for appropriate treatment. When there is a suspicion that a patient lacks capacity, a psychiatrist is consulted to make a formal capacity assessment, in the context of the patient’s psychiatric condition and mental state.

Determining capacity is performed on a case-by-case basis. The nuances can be subtle, and sometimes a person’s capacity can change day by day. It is an ongoing process.

Physicians are an important part of the capacity assessment, helping to determine the patient’s physiological status as well as psychological status. Also, the physician remains in charge of patient care throughout this process, applying the best-interests standard to medical care.

The hospital’s Center for Ethics provides these guidelines for a capacity assessment:

To provide ethically and legally valid informed consent, the individual must be able to:

- Express a choice—be able to respond “yes” or “no”
- Understand the information being provided—be able to repeat back the information in his or her own words
- Appreciate the implications of the information for one’s own situation—be able to articulate what is at stake
- Reason rationally in reaching a decision—be able to demonstrate a sound reasoning process for that decision

Determining decisional capacity begins at the bedside and, worst case, can end up in the courtroom. Here’s a look at the chain of events that can occur.

The first, best scenario is the patient can meet the stated four criteria and clearly articulate the decision. When it is not clear that the patient can make his or her own decision, a capacity assessment must be performed. To determine if someone is incapacitated, D.C. law requires the agreement of one psychiatrist or psychologist plus one physician of record.

If the patient cannot speak for him- or herself or is deemed incapacitated, ideally there is a written Advance Directive (AD) that articulates that patient’s desires and names a surrogate decision maker. The AD also can be an oral statement, or can be a conversation documented by a physician in the patient’s chart. Of course, that surrogate must have decisional capacity, too.

When there is no form of AD, the search begins for someone who can speak for the patient. That surrogate must know the patient reasonably well, must be available to be present (in person or on the telephone) when decisions need to be made, and must act in the patient’s best interest. When there are multiple family members who want to be involved, D.C. law
Decision-making Capacity, or No Decision-making Capacity?

**Case 1**
A 19-year-old male is brought to the trauma unit with multiple stab wounds in the abdomen and pelvis. He is conscious and obviously agitated. The trauma team performs multiple tests to ascertain the severity of his injuries. They propose a CT scan with rectal contrast to evaluate him for internal injuries. He declines the test, saying that no one is going to insert a probe into his rectum.

The trauma team and the patient’s mother try to talk him into having this test, but he states, “I don’t want anyone messing with my butt and you can’t make me do it.” A psychiatrist determines that he is capacitated, although immature; the surgeon agrees that he is not in shock and therefore capacitated. A second physician also examines him and finds him decisionally capacitated. But the team is still uncomfortable with the case, so they call in a clinical ethicist.

“This patient has been determined to be capacitated. Also, he is over 18, so therefore has autonomy for decision-making, despite being immature. Finally, he is able to demonstrate that he is reasoning rationally regardless of whether the clinical team agrees with the reason for refusal, and is willing to suffer consequences, including death to avoid having this test. The patient is discharged after his wounds have been closed.”

—Nneka Sederstrom, PhD

**Case 2**
An 89-year-old female is living independently. When she falls, her neighbor brings her to the hospital. The neighbor reports that the woman’s home is unkempt, with no food in sight. The patient is diagnosed with a urinary tract infection, and is delirious. She also is cognitively impaired and has mild dementia.

When her infection is resolved and it is time to leave the hospital, the patient declines discharge to subacute rehabilitation. She wants to go home, but the social worker determines that her living situation is not safe and there is no one to help her at home. A capacity assessment is called.

“This patient lacked decision-making capacity. She didn’t understand the implications of going home alone. She believed that she could take care of herself, but she had clearly demonstrated that she was not capable. The hospital attorney petitioned the court for guardianship to determine the next steps.”

—Karen Johnson, MD

**Case 3**
A 43-year-old female is admitted to the hospital with elevated blood pressure and glucose levels; she also has an unspecified infection. The patient appears agitated, confused and angry. She wants to leave the hospital against medical advice (AMA). A physician requests capacity assessment due to her mental status.

A psychiatrist examines patient to ascertain that she is alert, oriented and coherent. The patient knows where she is, can describe her medical condition and treatments being offered, and understands the consequences of signing out AMA.

“This patient had decision-making capacity. She was able to reason rationally. We thought her reasons weren’t necessarily the best—she said that someone at home needed her. But just because we didn’t like her reasons, she still was reasoning rationally. Responsibilities at home represents rational thinking; if she expressed a thought that aliens were out to get her, that’s not rational.”

—Karen Johnson, MD
Mission Trips Bring Care

**Overseas** medical missions afford physicians a unique opportunity, to learn about the challenges of delivering much-needed health care in an underserved area of a country. Sometimes it’s the unexpected discovery that proves most rewarding, according to two MedStar Heart & Vascular Institute physicians, one who traveled to Argentina, and one who went to Nicaragua.

**Tartagal, Argentina**

Federico Asch, MD, associate director, Cardiovascular Core Labs and director, Cardiac Imaging Research, recently returned from a humanitarian mission to northern Argentina that he helped organize, on behalf of the American Society of Echocardiography (ASE) and the Argentinian Federation of Cardiology, together with local representatives of indigenous communities in a region called Chaco Salteño.

The team had never been together before, but “we had a goal and a mission. We fit in together from the beginning, and this group was enthusiastic.” Two physicians were from the U.S., several were from Argentina, and the volunteers also included sonographers and other caregivers.

“We paired with anthropologists who work with indigenous, isolated communities in northern Argentina,” he explains. “These communities are within the rainforest, and their people are mostly reluctant to accept care. The anthropologists coordinate an indigenous radio station, “La Voz Indigena” that is mostly run by leaders of the communities, called ‘caciques’ in Spanish, and serves as the cultural hub for these communities.”

Because coming into the communities with large Echo machines was impossible, they agreed on mounting the operations within the radio station facilities, explains Dr. Asch. “Instructing all volunteers on the costumes and culture of these communities was critical to our success, as we were able to reach a great level of acceptance from them.”

“We wanted to screen 300 people for cardiovascular disease in a four-day period, and to make sure that we had proper care available in Tartagal, Salta and Buenos Aires, depending on the escalating complexity of disease that was diagnosed, using echocardiography equipment provided by Philips Healthcare,” Dr. Asch states.

When they arrived in Tartagal, the 25 volunteers had an intense week. “We saw 650 people, more than double our original estimate, from babies through the elderly, and had good options for those who were determined to have significant heart disease. Surprisingly, we mostly found congenital heart problems, and only some cases of Chagas disease and rheumatic or tuberculosis-related disease. Overall, it happened to be a fairly healthy population.”

This was not the first time that Dr. Asch has been involved in care to remote areas. “There is a need for care, as these communities feel neglected and isolated. They live a completely different reality. I grew up in Argentina, and received my medical degree there. I try to give back to my country and people; I feel this is something I owe them.”

In working with the different indigenous communities, Dr. Asch discovered “the little effort we made had a humongous impact. On closing day, we sat together with the leaders, 90 percent of whom were female, and they were so grateful and thankful to us. It was a moving experience. Many of us left crying, thinking already on how to make this happen again. It was so rewarding, from both a medical and human standpoint.”

Dr. Asch plans to help organize future ASE mission trips in other areas of the world. “It was a great use of my time and my skills. I would describe this trip as fun and rewarding; when it ended, I was exhausted, but so happy.”

**León, Nicaragua**

Following a Cardiology Fellowship, Christy Kaiser, MD, recently joined the Hospital Center as an attending general cardiologist. She has long had an interest in Latin American culture, whether it’s cooking up any number of tasty regional dishes she’s mastered, or stepping out for some salsa dancing.

In her third year of residency at Duke University School of Medicine, she welcomed the opportunity to perform a two-month elective rotation in internal medicine at the Hospital Escuela Oscar Danilo Rosales Argüelo, in Nicaragua’s second-largest city, León.

Though León has a population of more than 200,000, the city lacks the medical infrastructure to fully care for its own citizens, let alone the thousands of low-income families from the surrounding rural areas. Even as she started preparing for her return to the U.S., Dr. Kaiser’s fascination with the variety of cases she saw already had her thinking about how and when she would return.

Near the end of her stay, Dr. Kaiser learned that a team of cardiologists from Project Health for León, a group of volunteer health care providers based at East Carolina University, was due to arrive in León for their semi-annual visit.

“Because there are no cardiac surgeons in Nicaragua, this group fills an important gap,” Dr. Kaiser says. “Medical cardiologists spend a week evaluating dozens of patients...
referred by other physicians in the region, to select the best
candidates for surgery. They’re followed by cardiac surgeons,
who may perform as many as 12 operations on those
individuals who need it the most.”

Though the Project Health visit overlapped Dr. Kaiser’s stay by
only a week, she made the most of those days, working with the
volunteers in the hospital’s clinic: “I still had a lot of medical
training ahead,” she says, “but I offered to come back and help
when I was doing my fellowship.”

That opportunity came this past February, when Dr. Kaiser
returned to León to spend two full weeks with the Project Health
team. She worked with four cardiologists and two other
cardiology fellows to evaluate approximately 300 patients, most
with valvular or congenital heart disease. Each encounter
entailed a history, physical exam, echocardiogram and treatment
decisions, including a detailed discussion with each patient.

As with many other overseas medical missions, most of the
physicians have to bring their own equipment, from
echocardiography machines to surgical supplies. But despite
the best efforts to prepare, some improvisation always seems
necessary. This year, the problem centered around a dispute
between the Nicaraguan government and the organization that
donated the replacement heart valves.

“Mechanical valves are preferred, particularly for younger
patients, because they last longer,” Dr. Kaiser explains.
“Because that brand of valve wasn’t allowed in the country, we
had to scramble for replacements. All we could find were
bioprosthetic valves, which usually last on average for only 10
to 15 years.”

In the U.S., a patient in critical need of a new valve would
receive the prosthetic valve regardless of his or her age, with
expectation being that the patient would return when it was
time for a replacement. But given the huge demand for cardiac
care in Nicaragua, there’s little assurance that a patient would
have a chance to undergo follow-up surgery.

“Until cellphones arrived, the only way physicians could reach
them, to bring them back for surgery, was by asking local radio
stations to issue announcements,” Dr. Kaiser says. Ultimately,
the surgeons decided to use the bioprosthetic valves on the
younger patients, in the hope that they would last longer than
usual, and that the patients someday would be able to receive
a longer-lasting device.

“This trip showed how important medical missions like Project
Health’s are to the people in Nicaragua, and how fortunate we
are in the U.S.,” Dr. Kaiser says. ■

Federico Asch, MD, shows children in Tartagal how to use his camera.

Christy Kaiser, MD, works with other physicians to help residents in
León, Nicaragua.
Amid the constant bustle of activity that defines daily life at MedStar Washington Hospital Center, a nexus of calm appears every Wednesday afternoon in the second-floor Cardiac Rehab Gym, across the street at MedStar National Rehabilitation Hospital. For 60 minutes, Chief Anesthesiologist Assistant Rudy Hamad, AA-C, MS, leads a small group through a form of yoga called Vinyasa, which focuses on the breath-synchronized flow of motion through a series of poses.

The students, both men and women, issue the occasional grunt of effort when they find their bodies are not quite as supple as Hamad’s. But by the end of the hour, everyone feels refreshed, physically and spiritually, and ready to return to the stresses of the real world.

It’s these and other benefits of yoga that Akron, Ohio-native Hamad discovered for himself, during his first job as an anesthesiologist assistant at Cleveland’s University Hospital in 1996. Though active in cardio fitness, he admits to leading a “crappy lifestyle, filled with soda and poor nutrition.” Yoga seemed to offer an ideal way to help manage the symptoms of gastritis and stress, and help him feel better.

Hamad felt the benefits almost immediately after his first classes, sparking what would become a lifetime interest to learn more about yoga and its various forms. His move to Washington, D.C., in 2004 to join the Hospital Center’s staff provided a double benefit—the opportunity to practice yoga four to five times a week, with some of the country’s most experienced practitioners. Seeking to further deepen his own practice, Hamad began training to become a yoga teacher himself.

Word about Hamad’s training quickly spread among his colleagues, who encouraged him to apply his new skills by teaching them. Intrigued by the idea, Hamad contacted the hospital’s Occupational Health department, and learned that its efforts to start a yoga class for Hospital Center associates had been stymied by the cost of hiring a qualified instructor.
No problem, Hamad responded. He’d teach the class for free.

“Growing up, my parents taught me the importance of volunteering,” Hamad explains. Having already donated his time to a suicide crisis hotline, the Whitman-Walker Clinic and Catholic Charities, sharing the benefits of yoga with his peers without charge was simply another way of continuing his own personal flow of serving others.

A deep knowledge about yoga and its various forms doesn’t necessarily make for an easy transition from student to teacher, however.

“In my class, I’m concentrating on the flow of poses while at the same time, describing what I’m doing so that students can follow along,” Hamad explains. “That requires an additional level of awareness, especially since individuals vary in their level of ability and experience.”

Maintaining a bifurcated focus may sound like a headache-inducing challenge, but Hamad makes it look easy, according to frequent class participant and Gynecologist Ellen Whitaker, MD.

“Everyone feels comfortable,” says Dr. Whitaker. “He’s good at instructing people who are new to yoga, or showing longtime students how to take a pose one step further, because there’s always something more that you can do.”

As for those aforementioned grunts, Hamad says one of the misperceptions about yoga is that flexibility is a must.

“It’s where you are at the moment,” he says. “Some days you’ll feel better, and can get into more advanced poses. But it doesn’t happen every time. You do as much as you can do, then move on.”

“Yoga really allows you to feel more in touch with your body,” agrees Dr. Whitaker. “I leave Rudy’s class feeling invigorated.”

Hamad hopes to eventually expand his on-site teaching program with workshops on advanced yoga poses such as inversions, where the head is positioned below the heart. Still very much a student himself, Hamad would also like to learn some of yoga’s more advanced arm balance poses.

As for his ultimate goal, Hamad says, “it’s all about improving my well-being, reducing stress and doing my job better.”

“In my class, I’m concentrating on the flow of poses while at the same time, describing what I’m doing so that students can follow along.”
Upcoming CME Conferences

14th Annual Diabetes in Pregnancy Study Group of North America
October 23-24 | Omni Shoreham Hotel | Washington D.C.
Course Directors - Oded Langer, MD, PhD; Menachem Miodovnik, MD and E. Albert Reece, MD, PhD
Internationally recognized experts will focus on new insights into the science of diabetes; glucose management; diabetes prevention; genetic underpinnings of diabetes and obesity; preconception care, nutrition, exercise, weight gain and obesity; pharmacokinetic considerations; diagnosis and consequences of diabetic fetopathy.
For more information, please visit: www.medstarwashington.org/DPSG

Update In Rheumatology 2015: New Diagnostic Tests and Treatments for Clinical Practice
October 23 | Omni Shoreham Hotel | Washington, D.C.
Course Directors - Arthur Weinstein, MD
The course is intended to provide new evidence-based strategies for the diagnosis, monitoring and treatment, including many newly approved biologic therapies and surgery of common arthritic, rheumatic and autoimmune diseases.
For more information, please visit: www.medstarwashington.org/RheumatologyUpdate

Contemporary Management of Cardiovascular Disease
October 30 | Baltimore Hilton Hotel | Baltimore, MD
Course Directors - Paul J. Corso, MD; Lars G. Svensson, MD, PhD and Ron Waksman, MD
This course delivers an update on the management of common yet complex cardiovascular conditions. Health care providers can rely on this course for critical updates and recommendations for incorporating them into your practice.
For more information, please visit: www.clevelandclinicmeded.com/live/courses/cardiomgmt

Update on the Treatment of Heart & Vascular Disease
November 21 | Gaylord National Resort and Convention Center | National Harbor, MD
Course Directors - Mun K. Hong, MD and Frederick P. Beavers, MD, FACS
This half-day educational symposium will update the practicing physician and nurse on the latest developments and treatment options in cardiovascular medicine, and provide a glimpse into the future directions of cardiology, vascular and cardiovascular surgery.
For more information, please visit: www.medstarwashington.org/UTHVD

Lung Cancer 2015: A Shifting Management Paradigm with Focus on Immunotherapy and Newer Targeted Therapies
December 5 | Capital Hilton | Washington, D.C.
Course Director - Deepa Subramaniam, MD
This symposium will clarify and define USPTF guidelines for CT screening for lung cancer and identify best practices for diagnostic and staging modalities according to IASLC/AJCC seventh edition guidelines in lung cancer that will demonstrate ways to translate the information into clinical practice.
For more information, please visit: www.medstarwashington.org/LungCancer

CME Transcripts are Available Online
You can download, print or e-mail your CME transcript. Visit http://cme.medstarwashington.org and click on “View Your CME Transcript” for complete instructions.
For the third year in a row, MedStar Washington Hospital Center has been honored as the only hospital in the Washington region with a nationally-ranked heart program recognized by U.S. News and World Report. The 2015-16 U.S. News Best Hospitals rankings identify hospitals that excel in treating patients with the most challenging medical conditions.

This is the 19th year that the Hospital Center has been nationally ranked in the top 50 by U.S. News. This year, fewer than three percent of the nearly 5,000 hospitals analyzed for the Best Hospitals listing earned national ranking in even one specialty.

U.S. News also cited three of the Hospital Center’s other specialties as high-performing: Gastroenterology & GI Surgery, Nephrology and Urology.

“A Best Hospital has demonstrated expertise in treating the most challenging patients,” said Ben Harder, chief of health analysis at U.S. News. “A hospital that emerged from our analysis as one of the best has much to be proud of.”

U.S. News publishes Best Hospitals to help guide patients who need a high level of care because they face particularly difficult surgery, a challenging condition or extra risk because of age or multiple health problems. Objective measures such as patient survival and safety data, adequacy of nurse staffing levels and other data largely determined the rankings in most specialties.

Welcome to New Members of the Medical & Dental Staff

Raihan Ahmed Chowdhury, MD  Anesthesiology
Kathleen Campos, NP  Anesthesiology
Zachary Flury, AA  Anesthesiology
Jovita Ike, NP  Anesthesiology
Klu Descalzo, NP  Cardiac Surgery
Margaret Fischer, MD  Cardiovascular Disease
Michael Gaglia, MD  Cardiovascular Disease
Michael Lipinski, MD  Cardiovascular Disease
Ghofrane Benghanem, MD  Emergency Medicine
Raichel Crist, PA-C  Emergency Medicine
Mirella Cortez, PA-C  Emergency Medicine
Kathleen Killoran, MD  Hematology/Oncology
Anila Siddiqui, MD  Nephrology
Jennifer Ballard, MD  Ob/Gyn
Louis Dainty, MD  Ob/Gyn
Ada Emarievbe, MD  Ob/Gyn
Shakira Franklyn, CNM  Ob/Gyn
Pamela Lotke, MD  Ob/Gyn
Jennifer Kim, MD  Ophthalmology
Samuel Kim, MD  Ophthalmology
Janine Smith-Marshall, MD  Ophthalmology
Erin McLaughlin, CRNP  Psychiatry
Ryan Muller, MD  Radiology
John Schneider, MD  Radiology
Tina Sprouse, MD  Radiology
Anil Taner, MD  Radiology
Ekaterini Tsiapali, MD  Surgery
Kathleen Miltner, CRNP  Surgical Critical Care
Daniel Stoltzfus, MD  Surgical Critical Care
Rachel Gopenko, PA-C  Urology
As a medical student at SUNY Stony Brook, Charlie Srivilasa gave new meaning to the phrase “continuity of care.”

At the time, Dr. Srivilasa was volunteering as an emergency medical technician and firefighter for the Setauket Fire Department. Now chief resident of Surgery at MedStar Washington Hospital Center, Dr. Srivilasa also recalls one moment when, during rounds in the ICU, his attending asked the group of medical students if anyone knew the patient’s medical history. Dr. Srivilasa volunteered to answer the question and, taking the chart, he flipped back to the notes from the EMT who brought the woman to the hospital—his notes.

Dr. Srivilasa recalls many such moments—from ambulance to emergency department to the outpatient clinic—all of which fostered in him a true sense of working within the community. It also meant he didn’t get a lot of sleep.

“There was one night where I was in the ICU for 12 hours,” Dr. Srivilasa says, “and then I went to help put out a barn fire for six hours. The next day, I was back in the ICU. A lot of my schedule was me, pushing myself. I loved being on call, and I loved the guys in the firehouse.” Dr. Srivilasa says that schedule in medical school prepared him for the long hours and frenetic pace of his role as a chief resident. Now a few months into that role, his biggest reflection from the first few months is how much more responsibility—and with it, trust—he has received from his surgical attendings.

“An attending will say, ‘What’s your opinion?’ It’s a big change in the dynamic. You’re now more of a colleague, and in a position to make actual decisions in managing patient care, while also guiding the more junior residents under you. It’s an awesome experience to teach people.”

Dr. Srivilasa majored in biomedical engineering as an undergraduate, and he brings that engineering mindset to his surgical approach. “I love finding a problem, having an algorithm for fixing that problem and then fixing it. Surgery moves at a much faster pace than a lot of other specialties, which I also love.”

Perhaps it’s not surprising, given his past experience as an EMT and firefighter, but Dr. Srivilasa immediately gravitated toward trauma surgery. “I love stabilizing patients, and the fact that you can take care of them in a medical capacity, in addition to taking them to the operating room.”

As if Dr. Srivilasa wasn’t busy enough, while in medical school he also enlisted in the United States Air Force. For him, the choice to join the military was an easy one. “I always wanted to serve. I’ve had a lot of opportunities, and I wanted to give back. Once I realized I wanted to be a doctor, I realized my best capacity in which to serve would be as a military doctor.”

Once he completes his chief year, Dr. Srivilasa will complete a trauma/critical care two-year fellowship, run jointly by the Air Force and University of Texas, San Antonio. During the first year, he will concentrate on surgical critical care, and during the following year, he will be a junior attending and trauma fellow, focusing on burn surgeries with the military.

He will likely deploy soon after the fellowship ends. “I’m looking forward to it,” Dr. Srivilasa says of his future deployment. “I joined, because I wanted to do true combat medicine and join a surgical team, to serve as much as I can.”
Z. Jennifer Lee, MD, likes to say that she grew up at MedStar Washington Hospital Center.

At the Hospital Center, Dr. Lee completed her Internal Medicine residency, a year as Chief Resident for Internal Medicine and her subsequent Gastroenterology fellowship. After those seven years of training through the MedStar Health system, Dr. Lee left to join another medical group—but her heart never really left the Hospital Center.

She soon realized how much she missed the Hospital Center’s vibrant, academic setting, and the opportunity to train and guide younger doctors in her field. A year ago, she made the decision to return to the Hospital Center.

“It’s been like coming home—a seamless transition,” Dr. Lee says. “Everyone has been so welcoming.”

That fall also saw another big transition: in October, Dr. Lee became a mother to daughter Felicity. “It’s been amazing,” Dr. Lee says. “I go home, and she’s learned three new things that day! I’m in awe when I see how much she changes in just one weekend.”

Perhaps the reason that Dr. Lee feels so compelled by the role of teacher is because she recalls just how impactful her own attendings were, when she was a medical student. She remembered the moment that she knew she wanted to specialize in gastroenterology: she was a fourth year medical student, completing her gastroenterology subspecialty. While observing a procedure, the attending looked at her, and said, “You’re up.”

“It was a minimal portion of the procedure,” Dr. Lee notes, “but just to be able to contribute a little bit was so incredible.”

After that, Dr. Lee was hooked. “I love that I can use both my cognitive skills as well as my technical skills to take care of patients,” says Dr. Lee, “and that, through our procedures, we are able to provide not only preventive care, but also diagnostics and therapeutics.”

Dr. Lee also serves as the site director for the Gastroenterology fellowship program—a partnership with MedStar Georgetown University Hospital and the Washington DC VA Medical Center.

“It’s a great honor for me,” she says. “It gives me a pretty good perspective, because I remember what it was like to be a fellow, so I get both sides. I really enjoy having the fellows with me and learning alongside me. I hope that my enthusiasm for the field rubs off on the fellows and residents I work with.”

Outside of the fellowship program and her baby, Dr. Lee admits that her time is limited. Her pre-parenthood passion was food and travel. As she and her husband get their bearings as new parents, she’s excited to start having more outings again.

“A lot of people have come to me for recommendations. I’m looking forward to getting to go out soon—I have a checklist of new restaurants to try. But at this time, I’ll take recommendations for baby-friendly restaurants.”
Urology has changed dramatically during the last 10 years. The MedStar Washington Hospital Center Department of Urology is a recognized leader in the region, and this is largely due to the vision of Dr. Mohan Verghese, former chair of urology. Thanks to Dr. Verghese’s efforts, we are now the leading hospital for minimally invasive urologic oncology surgery, and a center of excellence for urologic referrals in the region.

Dr. Verghese recognized the evolution of patient-care in our field, and became an early adopter of robotic-based surgery for prostate, bladder and kidney cancers. He emphasized the importance of keeping track of our large clinical volumes, and carried this over to presentation of our outcomes at a mid-Atlantic and national level. He also initiated creation of a clinical pathway for patients recovering from surgery.

Our outcomes are truly outstanding. Compared to traditional open-surgery techniques for prostate cancer, our patients have quicker recoveries, and in the long-term, fewer side effects of impotence and urinary incontinence. Additionally, our outcomes are superior to other centers providing urologic care in this region, and on par with the best in the country, a direct result of our years of experience.

As chairman, I will endeavor to take this program to the next level. We are positioned to increase our involvement in clinical trials and translational research. We have the tools to identify genetic abnormalities that put patients at greater risk for cancer occurrence or recurrence, which helps us identify whether patients may benefit from surgery, radiation or adjuvant therapies. With this, we can offer truly individualized care for patients with urologic cancers. One part of this continued progression to excellence is the recent addition of another fellowship-trained urologic oncologist, Dr. Lambros Stamatakis.

We also continue to expand our breadth and level of sophistication in benign urologic care. We have the first fellowship-trained physician in the region specializing in urologic reconstruction, who adds expertise in urethral and penile surgery, erectile dysfunction, as well as urologic care for patients with spina bifida or spinal cord injury.

We strive to provide the highest level and highest quality urologic care for the region. This is a very exciting time for us. Congratulations and kudos to Dr. Verghese for putting us on this path to excellence. To contact us for consultations for your patients, please call 202-877-7011.