The Collective Power of APCs: Rewriting Hospital Care
**New Year, New Name**

**Medical & Dental Staff CONNECTIONS**

Many years ago, this Medical & Dental Staff publication began as MSB—Medical Staff Bulletin. MSB morphed into Physician, and for the past 18 months, we’ve been debating a name change, one that would be more inclusive for all members of the Medical & Dental Staff, and would also welcome our residents and fellows.

Informal surveys of physicians, APCs, and Physician editorial board members had one outcome: no one could agree on a word to reflect our group of almost 2,000 members.

We talked about changing Physician to “Provider,” a word you loved, hated or were completely indifferent about. We thought about going back to “Bulletin,” or using “Update,” or just “News” or “News and Information.”

Here’s the solution. At service line town halls, my message has been “We are ONE team.” Whatever your medical indicia, all members of the Medical & Dental Staff are connected.

- You are connected to each other.
- You are connected to other direct patient caregivers—nurses, patient techs, transporters, nutritionists, respiratory therapists, social workers.
- You are connected to all other associates at the hospital—environmental services, administrative staff, technicians, engineers, telecom, IS.
- You are connected to your patients and their families.
- You are connected to the regional community we serve.
- You are connected to all other caregivers throughout MedStar Health.

About eight months ago, we changed the names of the Dining Room and Business Center, to “Medical & Dental Staff Dining Room” and “Medical & Dental Staff Business Center.”

So here’s the transition for Physician: “Medical & Dental Staff CONNECTIONS.”

Rather than focus on a job category—“Physician” or “Provider”—or a news-related word, “Update” or “Bulletin,” CONNECTIONS is descriptive of your links to everyone you touch in your role as a caregiver. And as the clinical leadership for the hospital, you are linked to everyone.

Through the articles and updates we present in every issue, we demonstrate how we are connected to our readership. That readership is more than the members of our Medical & Dental Staff. CONNECTIONS is sent to our hospital leadership team, boards of directors, MedStar Health corporate leadership, and maybe most importantly to you—the regional physicians who do not have privileges here, but who could refer their patients to us.

In every issue, we make sure we have stories on our latest technology, procedures and therapies that benefit our patients.

Stories About YOU

Anecdotally, however, we hear that the articles you enjoy most are the ones that focus on what your colleagues do when they are not at the hospital:

- We’ve featured physicians who are married to other physicians in MedStar, and how that gives them the bonus of speaking the same language at home.
- We’ve featured physicians who are chefs, fishermen, photographers, writers, gardeners, beekeepers, triathletes, bicyclists, motorcyclists, knitters, marathoners, swimmers, scuba divers, singers, jewelers, artists, farmers, and vintners.
- We’ve featured physicians who go on voluntary overseas trips, to provide healthcare for less fortunate people in Argentina, Cambodia, Dominican Republic, Ecuador, Ethiopia, Haiti, Honduras, India, Kenya, Nicaragua, Tanzania, and Thailand. In this issue, you’ll read about two of our Emergency Medicine physicians who volunteer their time at Native American reservations.
- We’ve featured physicians who are married to other physicians in MedStar, and how that gives them the bonus of speaking the same language at home.
- We’ve featured physicians who take interesting vacations, to Colombia, Nepal, Philippines, Spain and Tanzania.
- We’ve featured physicians who have found the knack of the work/life balance, by coaching teams for their kids, walking, going whitewater rafting or weightlifting.
- We’ve featured vignettes on our Medical & Dental Staff members who have come to us after a career in the military—22, at last count.
- We’ve been lucky to have physicians who are writers, and pen stories such as “what it’s like to be a resident in the 21st century,” and “what it’s like to be a young married physician with two kids, and trying to buy a house in the D.C. area.”

Several stories in each issue are suggested by the 20 members of the Medical & Dental Staff who volunteer their time as Editorial Board members. A sincere “thank you” to each of them, for their time at Editorial Board meetings, for keeping us current on what’s going on in their service lines, and for letting us know the interesting things their colleagues are doing outside of work.

Please remember, CONNECTIONS is your magazine. Pediatrician Benjamin Spock often said, “You know more than you think you do.” If you have an idea for an article, whether it’s about the latest procedure or technology in your department, or you had a great patient outcome that resulted from teamwork, or you know someone who took an unusual trip, please email Marge Kumaki, who manages this publication, at marge.kumaki@medstar.net.

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Limb Salvage Surgery Saves Diabetic Patient’s Leg

When January Brown was first diagnosed with diabetes at age 16, she took it seriously. But not seriously enough, the 35-year-old D.C. resident now admits. After developing a heel wound that would not heal, she nearly ended up with a below-the-knee amputation.

Brown is unsure how she developed the wound. “I did sometimes go barefoot,” she admits. And she spent a lot of time on her feet, working for FedEx.

Fortunately, she received expert care from podiatric surgeons at MedStar Washington Hospital Center. When she first visited Katherine Rasovic, DPM, Brown was mildly concerned. “The skin around the wound was turning dark and there was an odor,” she says. “It wasn’t healing.”

Dr. Rasovic was more concerned, though. “I saw a very serious wound,” she recalls. “The patient had osteomyelitis of the calcaneus, and it needed immediate attention. The bone had become so weakened from infection that it actually fractured.”

The first step was extensive debridement of the wound. But that was only the beginning. For subsequent treatment, Dr. Rasovic outlined two options: a partial calcaneectomy or a below-the-knee amputation.

“Due to the patient’s age, I wanted to try to avoid amputation if at all possible,” Dr. Rasovic remembers. “I saw a very serious wound,” she recalls. “The patient had osteomyelitis of the calcaneus, and it needed immediate attention. The bone had become so weakened from infection that it actually fractured.”

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Fortunately for Brown, the hospital’s podiatric surgeons had devised a special procedure that could solve her problem. “We’ve developed a modified calcaneectomy procedure, so we can keep the joint surface intact while removing most of the bone below,” describes John Steinberg, DPM, chief of Podiatric Surgery. “This keeps joint stability, while removing the infected tissue, and leaving enough skin for closure with full thickness flaps.”

Brown was eager to give the procedure a try. “Dr. Rasovic explained everything to me, and I agreed that heel surgery was the way to go,” she says. “But she told me that I might end up having to have an amputation, if that didn’t work.”

The partial calcaneectomy did the trick, however. With six weeks of intravenous antibiotics, Brown’s heel healed nicely, with no complications. Less than six months later, she was walking, with the help of only a special insole in her shoe.

“Her recovery was quite remarkable, given the severity of her wound,” Dr. Rasovic says.

Brown continued to visit the Hospital Center, so her doctors could monitor her recovery. When the podiatric surgery team recommended a subsequent preventive surgery six months later, Brown agreed. Dr. Steinberg explained that skin pressure from her worsening hammertoes could lead to another wound, one that would jeopardize the success of the initial surgery.

The answer was a minimal incision-type procedure, which accomplished a flexor tendon release and flattened out the affected toes, eliminating the source of future wounds. With Brown’s consent, Dr. Steinberg proceeded with the surgery, and that recovery went well, too.

“Our program has the benefit of an interdisciplinary team of specialists,” Dr. Rasovic says. Infectious disease specialists and vascular surgeons are on hand to evaluate patients with foot disorders, so they can determine the optimal treatment strategy.

“Anywhere else, this patient would have had an amputation,” Dr. Steinberg adds. “Her combination of injury and infection was a deadly combination. The fact that we have a multidisciplinary team already identified and available, saved her leg. We were ready to do the reconstruction.”

For her part, Brown feels lucky. “The doctors did an excellent job. I didn’t realize how lucky I was to be under their care.”
The Collective Power of APCs: Rewriting Hospital Care

More than 30 years ago, Cardiac Surgeons Paul Corso, MD, and Jorge Garcia, MD, brought Advanced Practice Clinicians (APCs) into their practice. It was the first service to introduce the use of APCs and in the decades since, has helped transform care delivery at MedStar Washington Hospital Center.

“Physicians continued to bring APCs into their practices,” says Sharon Taylor-Panek, MScN, ACNP-BC, and chief APC for the hospital. “These professionals became part of the medical culture. This is the model that was established and continues today. We’ve never been under the Department of Nursing, as is the standard in many hospitals. We have been established as independent practices within specialty services, and we are full voting members of the Medical & Dental Staff,” she explains.

The role of APCs has grown; today, there are more than 300 APCs at the Hospital Center, in services across specialties. “In our world, APCs include Nurse Practitioners, Physician Assistants, Nurse Midwives, Anesthesiology Assistants and Certified Registered Nurse Anesthetists,” says Taylor-Panek. “While our specialties are different, we are one group, and the challenges we face are the same. We may have taken different routes to get where we are today, but we all deliver the same level of care.”

APCs Pull Together
That sense of collective purpose is demonstrated by the establishment of the Advanced Practice Group, a Peer Advisory Council of the APC chiefs of services—a first-of-its-kind collaboration at the hospital.

The group initially worked together to ensure that every service meets consistent guidelines of practice and clinical judgment, and achieves quality indicators that would stand up to peer review and regulatory evaluation. Now the group is taking on consistent credentialing, by creating a list of core competencies required to practice as an APC at the hospital.

“Every service requires specific skills, but there are basic skills that every APC needs to have, in order to earn privileges to care for our patients,” says Taylor-Panek. “This will become part of the hiring process for anyone seeking employment as an APC.”

The group is also increasing a sense of collaboration among all APCs through a shared intranet service, a single source of information about educational offerings and upcoming meetings. Quarterly Town hall meetings that offer all APCs an opportunity to share ideas and voice concerns are hosted by Chief Medical Officer Gregory Argyros, MD.

The group is helping to ensure that the next generation of APCs receives a high level of educational experience. A new web program is creating a central application process for clinical clerkships. “There are exploding numbers of students, and we want to develop relationships with area faculty, and place local students in the hospital for a semester of study,” says Taylor-Panek. “We hope to create a pool of potential future hires with a high level of competency.” We are encouraged by the strong support we are receiving from Dr. Argyros and Dr. Arthur West. It’s great to have the chief medical officer and the president of the Medical & Dental Staff in our corner.”

Taylor-Panek says when she travels to national meetings, she sees how the field is growing across the country. “We’re all struggling with the same issues. But I think the hospital is on the cutting edge, and we’re becoming a model for the nation.”

Setting Trends
Nationwide, numbers of APCs are increasing, and these professionals are rising to leadership roles in health care organizations. Like their physician colleagues, APCs are increasingly specialized as well, with advanced training, degrees and certification in a variety of medical subspecialties.

The one thing they are NOT is physician extenders—or mid-level providers. “We have our own roles and independent responsibilities,” says Maria Leber, PA, chief in Orthopaedic Surgery. “Ours is a unique skill set. We bill for our services, and are recognized by Medicare. In Orthopaedics, many patients who come to our offices don’t require surgery, and APCs are the front line clinicians who follow their care.”

The eight certified midwives at the hospital, known as “Midwives of MedStar,” are an independent practice, as well. “We care for women experiencing healthy pregnancies. Physicians are specialists in complex pregnancies,” explains Loral Patchen, PhD, CNM, director, Section of Midwifery. “We are also primary care practitioners who provide wellness care for women throughout their lifespans,” she adds. “I think of us as the experts in ‘normal.’ Because we specialize in healthy women, we recognize and attend to the impressive variability that defines normal.”

Increasing Numbers, Expanding Roles
Kristen Nelson, ACNP, MBA, chief APC for the Department of Critical Care Medicine, oversees 39 FTEs, including NPs and PAs who provide continuous bedside care management.

“Attending physicians may be overseeing several different intensive care units at the same time. But we are on the units all the time to provide consistency, and can pick up the important clinical clues. Care in the ICUs is so complex and device-driven that there is a real need for APCs to be geographically close to patients, so we can make diagnoses, write orders and independently manage crises,” she states.
We work with intensivists as collaborators to develop protocols, and all new hires are required to complete months of orientation, to ensure they are familiar with our practices and our sophisticated technology,” Nelson adds. “We are part of an interdisciplinary care team that includes physicians, APCs and nurses, and everyone has a role.”

As the numbers of resident physicians diminish and hours on call are reduced, APCs have become an important linchpin in hospital-based care delivery. “We’re in a growing phase right now, and our team’s role is expanding,” Nelson says.

In just the last four years, the number of APCs in Critical Care has nearly doubled. The same growth spurt has occurred in the Department of Medicine, where Sarah Sabo, ACNP-BC, serves as chief.

“In seven years, we’ve grown from four to 22,” says Sabo. “We used to work for private physicians, and weren’t collaborating with each other at all. Two years ago, I was named chief, with the goal of bringing all these individuals together. Today, we serve as APC hospitalists, working in the ED for pre-admission of patients, rounding on the medicine floor and writing care and discharge plans,” she adds.

Sixty full-time certified APC anesthetists support the needs of more than 100 daily procedures. Chief Rudy Hamad, AA-C, MS, says while they work under the supervision of an anesthesiologist, “we are at the bedside monitoring the patient throughout the process, from pre-anesthetic evaluation to post-anesthesia care. We serve a vital role.”

In Neurosurgery, one of the hospital’s busiest surgical services, APCs are involved in multiple aspects of care, from stroke rapid response to research. Their practice leads a “training dynasty” that began more than 15 years ago. “Dr. Edward Aulisi began the program in 1999 with two PAs, and today, there are 11 of us,” explains Matthew Jacobs, chief APC of the service. “Ours is a rich educational environment. There are stipends to travel for conferences, and we work closely with residents and teach each other.”

The Future

A 2011 Institute of Medicine report recommended expanding the role of Advanced Practice Clinicians, to meet the growing health care needs of the nation. To achieve that goal, APCs would need to practice to the full extent of their licenses.

MedStar Washington Hospital Center has been breaking down any barriers for decades, says Taylor-Panek. “I anticipate this trend will continue. We will need to continue to hire more APCs, to keep pace with the growing needs of our population, and to ensure speedy access to care,” she says.

The hospital is an environment where APCs feel supported and valued, explains Leber. She predicts that by 2020, there will be more full time APCs than physicians. Educational opportunities, good life-work balance, strong support and increasing reimbursement for services make APC practice at the hospital attractive. No doubt Leber speaks for most of the hospital’s Advanced PracticeClinicians, when she says, “I love what I do. It would very hard to duplicate somewhere else.”

On the cover: The Advanced Practice Clinician leadership includes (top row) Kristen Nelson, Rudy Hamad, Sarah Belna, Raichel Thornhill, Sarah Sabo; (seated) Amanda Beirne, Cindy Bither, Loral Patchen, Janeen Constantine; and Maria Leber, Sharon Taylor-Panek. Not in the photo are APC leaders Maria Lucia Deausen, Regina Ebuwai and Mathew Jacobs.
A healthy patient-doctor relationship is the cornerstone of medical practice. And effective communication is at the core of that relationship.

That’s why MedStar Washington Hospital Center has instituted a new program to facilitate communication. Called Language of Caring for Physicians (LoC-P), this program promises to help physicians communicate effectively, develop trust and foster engagement with patients, families and other caregivers. The result—better outcomes and improved satisfaction for all involved.

This effort is underscored by new realities in medical practice. As productivity assumes a greater role in patient care, doctor visits may be reduced in length. As the Electronic Medical Record (EMR) becomes a mainstay of each interaction, actual eye-to-eye contact can become an afterthought. And as payment becomes tied to patient satisfaction, the relationship may be incentivized.

Language of Caring is an important strategic objective of the hospital, and all associates—physicians, nurses and every person working in the hospital—will participate in this program, according to Kassie Savoy, assistant director, Physician Performance Improvement & Population Health. “LoC-P covers communication essentials for patient-centered care,” Savoy explains. “It promotes mindfulness, which is how to give patients your undivided attention in the present moment without judging. This is grounded in research on best practices for physicians.”

All physicians have participated in an overview of the program during departmental meetings in December. In February, each physician will be asked to complete one module every other month on the SITE L system. Each of the eight modules will take only 30 minutes to complete. Modules consist of an explanation of concepts, video demonstrations, handy tips and references.

“Doctors are trained in the science of medicine,” acknowledges Arrel Olano, MD, Internal Medicine. Dr. Olano is a LoC-P physician ambassador, tasked with helping colleagues complete the program. “There is no actual curriculum or structured training in the art of medicine. LoC-P will fill in that gap.”

Dr. Olano adds that physicians already know much of what the program teaches. He characterizes LoC-P as a “refresher course” that reminds busy doctors to be more mindful of emerging customer service requirements.

Susan O’Mara, MD, vice chair of Emergency Medicine, is another physician ambassador. “Being present with the patient
is so important,” she notes. “High quality care has got to include empathy, with the patient feeling well-cared for.”

Dr. O’Mara notes that incorporating the EMR into the patient interaction can get in the way of being fully present with the patient. “When you take into account the sheer time the EMR takes away from the patient encounter, the stakes at the bedside are even higher. It requires a more intense connection with the patient.”

This practice can improve physicians’ job satisfaction, she adds, both in terms of interactions with patients and with other team members. “In our days, we spend much of the time interacting with others in the hospital. Improving the quality of that time has got to improve morale.”

Dr. Olano also sees the program in terms of customer service. “Gone are the days when patients are willing to wait an hour,” he says. “We have to make sure we provide quality care and patient satisfaction.”

Another physician ambassador, Jonathan Patrick, MD, Cardiology, takes this a step further. “Time spent with our patients is a reminder of the nobility of our profession. Engaging patients on a personal level is important for our own satisfaction. LoC-P helps us take the time to engage with patients in a personal way.”

Dr. Patrick sees the program as a useful tool to reconnect with patients, especially given all the distractions of daily medical practice. “With our incredibly busy schedules, meaningful interaction helps us recapture why we all do this,” he explains.

At the heart of the program is the “Heart-Head-Heart™” model of communication. This model shows physicians how to engage the patient on all levels. Studies show that patients hear the rational “head” explanation more, when the physician begins and ends with caring “heart” statements.

Dr. O’Mara provides an example of this approach, in the event a patient has had to wait a long time to be seen in the Emergency Department.

Heart: “I’m so sorry you have had to wait. I’m sure you’re hungry.”

Head: “Let me find out where you are in the queue. I’ll see if I can give you a time estimate.”

Heart: “Again, I’m so sorry you have had to wait.”

The ultimate goal is improved patient and provider satisfaction, Savoy concludes. “Physicians in other hospitals who have already completed the program give it very high marks.”
A white lab coat or scrubs are standard workday wear for most MedStar Washington Hospital Center physicians. But if Ziad Deeb, MD, occasionally complements his ensemble with a Sherlock Holmes-esque deerstalker hat, no one will be surprised.

For more than four decades as a member and, until recently, chair of the Hospital Center’s Otolaryngology Department, Dr. Deeb has stressed the importance of assessing and diagnosing patients through listening and observation, much like Joseph Bell, the Scottish surgeon whose deductive reasoning skills were the inspiration for Ophthalmologist Sir Arthur Conan Doyle’s famed fictional detective, Sherlock Holmes.

“Dr. Bell said a good doctor should be able to tell what’s wrong with a patient before touching him,” Dr. Deeb says. “I tell young doctors that the CT scan is the end of the process. Listen well to the patient, and perhaps you’ll reach a deferential diagnosis before looking at the test results.”

Dr. Deeb considers his methods not only more insightful, even in an age of advanced medical diagnostics, but also, more personally rewarding.

“To me, it’s no fun if you don’t listen to the patient,” he says with a laugh. “Other physicians would miss that, if they jump right to the test results.”

Solving cases, both routine and complicated, is just one of many things that have distinguished Dr. Deeb’s long career at the Hospital Center. In addition to caring for countless patients directly or through collaborations with colleagues, he’s helped train generations of residents who have gone on around the world to emulate his example. In 2007, Dr. Deeb was presented with the Hospital Center’s Gold-Headed Cane Award, given annually to the physician who demonstrates the characteristics of the “ideal” physician—devotion to duty and patient care.

Father Knows Best
Yet none of this might have happened, had Dr. Deeb not listened to his father, Elias Deeb, who practiced family medicine in Palestine and Israel.

“My father was very influential in steering me into medicine, because he firmly believed that a good education is more important than personal wealth,” Dr. Deeb says, adding with a bit of self-deprecating humor, “I have no regrets, because I likely wouldn’t have done any better in another profession.”

Dr. Deeb obtained his medical degree from the Hebrew University in Jerusalem. When it was time for his residency, Dr. Deeb came to the Hospital Center, with the help of his cousin, an otolaryngologist in private practice here.

New Resident, Surprise Case
His first day on the job as a resident—July 4, 1970—was memorable for more than just the birthday of his newly-adopted country. Around 9 a.m., Dr. Deeb received a STAT call for a “blowout case.”
“I tell young doctors that the CT scan is the end of the process. Listen well to the patient, and perhaps you’ll reach a deferential diagnosis before looking at the test results.”

He hurried to the patient’s room, thinking he’d be treating a similarly-named bone fracture around the eye. As it turned out, a young patient with terminal cancer of the neck had experienced a rupture of the carotid artery.

“All I could think of to do was to wrap a bedsheet around his neck, and hold him until his attending physician arrived,” Dr. Deeb recalls. “It was an intimidating encounter of the first degree, as his blood was splattering on the ceiling.” Unfortunately, the patient didn’t survive, and the attending assured Dr. Deeb that there was nothing he could have done to prevent it. “He told me I’d been ‘baptized,’” Dr. Deeb says.

Hospital Center Opportunity

Subsequent milestones in Dr. Deeb’s career came and went, fortunately, with less drama. He did an extra year of training as a Fellow in head and neck surgery at the Hospital Center. After that, he joined the faculty at MedStar Georgetown University Hospital. In 1981, Dr. Deeb was appointed as chairman of Otolaryngology at the Hospital Center.

“And, as now, the Hospital Center provides a wonderful opportunity to gain experience across all kinds of diseases and patients,” he says. “You see cases here almost routinely, that some doctors never see in their entire career.”

The Hospital Center’s growth in the ensuing decades has also afforded Dr. Deeb a virtual front-row seat, to a parade of diagnostic and treatment advancements across all fields of medicine, from imaging technology and chemotherapy, to endoscopy and “free flap” skin reconstruction techniques.

What Dr. Deeb is most grateful for, though, is the opportunity to be a perpetual student, as well as a teacher. He credits the examples set by his first department chair and mentor, William M. Trible, MD, a founding member of the American Society for Head and Neck Surgery in 1970, and whose picture hangs alongside those of Dr. Deeb’s family. Other career influencers include Theodore Winship, MD, former chief of Pathology, and a pioneer in describing the nature of carotid body tumors in the 1950s; and Ralph Caulk, MD, chief of Radiation Therapy, and founding member of the first American Joint Committee for the Staging of Cancer, in 1968.

Dr. Deeb believes that the worst thing a clinician can do is not share his experiences with students, residents and peers. One of the most critical messages he has stressed to his residents is that they are doctors, not specialists.

“I tell them that they treat patients, not tests,” Dr. Deeb says, adding that because ear, nose and throat conditions are often symptoms of other diseases, otolaryngologists need to look beyond the “usual suspects,” and carefully examine a patient’s history, for clues that might point to something more systemic.

For example, Dr. Deeb once received a call from a gastroenterologist about a patient with chronic dysphagia. After asking a few questions, including when the dysphagia occurred—only in the afternoon, he was told—Dr. Deeb suspected that the patient had Myasthenia Gravis, and asked to see her right away. His diagnosis was soon confirmed.

“Other specialists had been unable to figure it out, yet I was able to diagnose the case over the phone,” he says, with complete modesty. “I’m just proud that we saved her life.”

Now, having transitioned the Otolaryngology chairmanship to Stanley Chia, MD, this past summer, Dr. Deeb considers himself “just an attending” who sees patients like any other member of the department.

“I am grateful that I will stick around for a number of years, to help the new young leadership of our department, and also pass on as much of my knowledge as possible to the young trainees and students,” Dr. Deeb says.

He also plans to take advantage of his newfound free time to keep abreast of medical progress, and write a book about the manifestations of systemic disease in otolaryngology. With a file cabinet bulging with more than 5,000 case slides, there’ll surely be no shortage of source material.

There are also Dr. Deeb’s personal pursuits, which include reading, listening to music, swimming and learning about the origin of things (“it’s a mistake to assume that all knowledge is just sitting there,” he says), and spending time with his wife, Leila, in a city they’ve both come to love.

“I tell my wife that if I hadn’t come here, I would’ve missed half the world,” he jokes. “It’s such a cosmopolitan city, and closer than anywhere else in America to Jerusalem, where I went to medical school.” Dr. Deeb recalls being able to take his four children to a different museum every weekend when they were growing up. Though none of them followed him into medicine, “they’ve given us three grandchildren so far, and we’re proud of them all.”

Back to the Future

Though he can’t imagine having spent his career anywhere but the Hospital Center, Dr. Deeb admits that he is a different person than the one who arrived for that hectic first day in 1970. And if somehow, he could offer that young resident some advice from 46 years in the future, Dr. Deeb would tell him, “Keep your eyes and ears open, listen to anecdotes from other physicians and be compassionate with your patients.”

In other words, simply be Dr. Deeb.
Geriatrician Eric De Jonge, MD, describes what he often encounters when meeting a new patient for the first time. “It’s pretty common to discover the patient is taking 10 to 15 medications. Those medications have accumulated over many years, leading to a higher burden of side effects than benefits. It can lead to a perfect storm of a medication toxicity.”

Dr. De Jonge is director of Geriatrics at MedStar Washington Hospital Center, and co-founder of the hospital’s Medical House Call Program, which provides home-based primary care and hospital services to ill elders. He spends his time overseeing the care of elderly patients, and often sees problems with medication management.

The Problem

Too many medications

Polypharmacy is the term that describes the proliferation of medications in a patient’s medicine cabinet. Often, this happens over a period of years, Dr. DeJonge notes. Doctors prescribe medications for specific reasons, and the list just gets longer. This is exacerbated by different doctors who see the patient for a single medical condition, each of whom prescribes medications separately.

Dosages are too high

As patients age, their metabolisms slow, so medications remain in the body longer and have a greater impact. “Less muscle and more fat cause the body to hold on to some meds longer,” says Lisa Peters, PharmD. “Plus, kidney function slows down, and a lot of medications that are metabolized by the liver are slower to clear.”

Side effects

As the number of medications increases, so does the risk of side effects, especially for patients in their 80s and 90s. With too many medications and “too many cooks in the kitchen,” as Dr. De Jonge says, trouble can develop, with common side effects such as constipation, confusion or low blood pressure. The problem is compounded when other medications are prescribed to treat the side effects.

Complicated regimens

A National Institutes of Health (NIH) study found that as many as 55 percent of seniors take their medications incorrectly. “Many elderly patients are on a complicated medication regimen, with doses at many different times of day. It is often best to arrange a once daily regimen,” Dr. De Jonge explains. Medications frequently have names that are easy to confuse. And, many pills look similar, which makes for more mistakes, especially for patients with dementia.

Too many negative interactions

Often inadvertently, different physicians can prescribe medications that are dangerous when mixed. For example, a patient could be prescribed an opiate painkiller from one provider, and a sedating sleeping medicine from another. Add to that a few over-the-counter (OTC) remedies, and the combination can be risky.

Too many OTC medications

Aspirin, acetaminophen and NSAIDs serve their purpose, but may do harm in elderly patients. These OTC meds can be overused, and cause gastrointestinal distress from NSAIDs, excess bleeding from aspirin or liver toxicity from acetaminophen.

The Facts

The typical Medicare beneficiary sees two primary care providers and five medical specialists in a year.

- 60% of seniors are taking three or more medications at a time.
- 66% of seniors have two or more chronic diseases.
- 25% of emergency room visits in older adults are due to adverse drug events.

—Centers for Medicare and Medicaid Services

Beware of Under-Treating the Patient

With all the valid concern about over-treating patients, providers should remember that under-treating also can occur. “Many patients can benefit from medications which they are not on,” says Dr. De Jonge.

One example is patients with congestive heart failure (CHF). “There are at least five different medications that can provide relief,” Dr. De Jonge notes. “Consider if your elderly CHF patients are getting all potential benefits from indicated medications.”

Another example is patients with severe pain. Opiates can be used safely in older patients with moderate to severe pain, in cases of severe arthritis or vascular disease, post-surgical pain or terminal illness.

“In the last years of life, it’s important that we provide comfort and relieve suffering,” Dr. De Jonge emphasizes. He finds that the vast majority of elderly patients do not develop a drug dependency on opiates; in fact, “a good number use less than they need,” he says. In the last phase of life, he notes that medications can be stopped or adjusted, to focus mainly on relief of suffering.
A Solution

Designate one primary care physician
Dr. De Jonge suggests one solution. “Older patients need one captain of the ship—a single doctor or a primary care team. That person or team then manages the whole medication list, understanding the benefits and risks of every single medicine.” Periodic review of medication lists can eliminate drugs the patient no longer needs. His mantra is, the right medication at the right dose for the right condition.

Make good use of the Electronic Health Record
Ideally, the Electronic Health Record (EHR) can help. But that would require the patient to see specialists affiliated with one hospital. That is not always the case, and even within one hospital, the inpatient and outpatient records may not be fully integrated. The MedConnect transition now occurring can help fix this problem.

Make sure patients have an up-to-date list of all medications
Patients—and their family members—can keep an up-to-date list of all medications at all times. Best of all, that list should be electronically updated, rather than handwritten. OTC medications, vitamins and herbal remedies also should be included on the list.

Start low, go slow
As patients age, they may react more strongly to medications. For that reason, “start low, go slow” is a valuable maxim. Dr. De Jonge gives an example. “For sertraline, I start patients at 12.5mg though the maximum is 200mg. I gradually increase the dosage, until the patient has a positive effect with minimum negative effect.”

Simplify the medication regimen
Dr. De Jonge often cuts the number of medications in half for a new patient, resulting in an improved clinical experience and fewer side effects. “Prescribing a medication that the patient has to take three or four times a day is asking for failure,” Dr. De Jonge adds. “Once-a-day dosing is the gold standard for adherence.”

Encourage patients to use one pharmacy
The pharmacist can identify medications that are contraindicated or duplicated, if the medication list resides at one pharmacy. “It’s ideal to have different providers using the same medical record, and talking to each other,” Dr. Peters notes. “And if patients use one pharmacy, the pharmacist can look for interactions and educate patients.”

At discharge, explain medications to patients
When discharging patients from the hospital, print out a medication list, review it with them and make sure they understand what they are taking and why. “It’s really important for the patient to be part of the decision-making process, and understand why he or she is taking these medications,” says Jennifer Brandt, PharmD.

Reconcile medication lists with Surescripts®
The Surescripts application on MedConnect allows users to access a national database that includes many drugstore chains and insurance plans. “This gives us a list to start from,” Dr. Brandt says. “We can take that list as a starting point.”

Know what medications are contraindicated for the elderly
The Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, compiled by the American Geriatric Society, is a handy resource that lists medications not appropriate for the elderly.

The list can be found online at americangeriatrics.org. A smart phone app also is available; search for AGS iGeriatrics.

Highlights from the Beers List

Drugs that generally should be avoided for the elderly
Antihistamines and other drugs that block acetylcholine (e.g., BENADRYL)
Anti-Parkinson drugs used to treat the side effects of antipsychotics
Antispasmodics (e.g., dicyclomine)
Some drugs to treat blood clots (e.g., ticlopidine)
Nitrofurantoin, an antibiotic used to treat bladder infections
Alpha-1 blockers (e.g., terazosin) for hypertension
Alpha-agonists to treat high blood pressure (e.g., reserpine)
Some drugs used to treat heart arrhythmias (e.g., amiodarone)
Digoxin at high doses, to treat heart failure
Tricyclic antidepressants
Antipsychotics, both older drugs (e.g., haloperidol) and newer ones (e.g., risperidone)
Barbiturates, such as phenobarbital
Benzodiazepine sedatives (e.g., diazepam)
Non-benzodiazepine sleeping drugs (e.g., zolpidem)
Hormones such as testosterone, “dessicated” thyroid and estrogens such as Premarin®
Narcotic meperidine
Almost all NSAIDs (e.g., ibuprofen)
Muscle relaxants, such as methocarbamol
The stark, yet hauntingly scenic desert country of the Navajo Reservation in Arizona and New Mexico is probably one of the most recognized places in the U.S., having served as the backdrop for films from *Stagecoach* to *Forrest Gump*.

It’s an area that MedStar Washington Hospital Center Emergency Medicine Attendants Dave Milzman, MD, and Jennifer Thompson, MD, frequently visit, but not because they’re movie buffs or have family nearby. They are volunteer physicians who assist Indian Health Service (IHS) professionals in caring for one of America’s poorest and medically underserved populations.

Dr. Thompson and Dr. Milzman worked together several years ago, to create and implement the attending volunteer program. They’ve never been at Gallup at the same time, with Dr. Thompson taking care of administrative work, handling the troubleshooting for volunteer physicians, and serving as clerkship director for one of the medical student Gallup electives. Dr. Milzman is committed to the medical student education aspect, as he serves as an associate dean at the Georgetown University Medical School. He takes six to eight trips to Gallup each year, and always brings six medical school students. During the past five years, nearly 80 students have joined him for the week-long experience.

**Providing Quality Care**

With approximately 225,000 members, the Navajo is the largest Native American tribe in the U.S. Yet more than 40 percent of Navajo people live below the poverty level. And compared with other Americans, the Navajo suffer significantly higher rates of Type II diabetes, cardiovascular disease and tuberculosis.

Quality health care for the Navajo and members of other nearby tribes is available at facilities such as the IHS-operated Gallup, NM, Indian Medical Center. But as with so many other rural hospitals, its resources and staffing are limited, especially in specialties such as emergency medicine.

That’s why IHS relies on volunteer physicians from across the country, providing an opportunity that, Drs. Milzman and Thompson agree, is both professionally challenging and personally rewarding.

Esperanza Sanchez, MD, chief of Emergency Medicine at Gallup Indian Medical Center, says volunteer physicians are vital to helping supplement the work of the hospital’s fulltime staff.

“It’s sometimes hard for them to believe they’re still in the United States,” she says referring to the area’s pervasive poverty. “But along with helping people in need, they’re exposed to the rich Navajo culture, one that’s different from anything else in the country.”

Dr. Milzman was already quite familiar with those needs, having volunteered extensively at IHS clinics in Montana and the Dakotas before starting regular trips to Gallup in 2011. He immediately committed himself to helping Dr. Sanchez’s staff as often as possible, even hopping a plane to Gallup after a night shift at the Hospital Center to help cover a staff shortage, then jetting immediately back home.

“Dr. Milzman has come to the rescue many times,” Dr. Sanchez says. He reports the medical school students receive what he calls “a whirlwind immersion” of culture, outdoor activities and practicing in an underserved area.

“We don’t sleep,” Dr. Milzman says. “We’re moving all the time.” If you think he’s joking, consider what Dr. Milzman describes as a “normal” schedule.

After arriving in Gallup in the early afternoon, he will work a 10 hour shift, and the students will split the ED’s 4 p.m. to 2 a.m. shift, with the relief crew responsible for bringing donuts for the departing students and nurses. A day of educational conferences is followed by another overnight ER shift, after which Dr. Milzman and crew take off for the Grand Canyon, arriving in time to see the sunrise.

That’s followed by hikes in the Bandelier National Monument, or some of the other scenic outdoor recreation areas located on and near the reservation.

**Back to Basics**

Patients the teams care for may have diabetes, or head trauma, or “things most of our ED colleagues have never seen,” Dr. Thompson says, including Hantavirus Pulmonary Syndrome, plague, rattlesnake bites and too-close encounters with cacti.

“Because the availability of specialists is limited, we do emergency medicine procedures that, at the Hospital Center, we’d hand off to other specialists,” Dr. Thompson says. “For me, that means getting to the roots of being a true emergency medicine physician.”

Lest anyone think such an environment poses a hardship to practicing medicine, Dr. Milzman says Gallup boasts “an amazing ED staff, all of whom are very dedicated, despite their limited resources and frequent staff shortages.”
Inclusive Learning Experience

Not all of the time spent by the volunteer physicians takes place in Gallup, explains Dr. Thompson. “One of the many cultural opportunities we provide is the opportunity to accompany nurses and community health workers on field visits. Diabetic education is a common reason for these visits. The experience allows our visitors to see more of the reservation, how people live and understand some of the barriers to accessing medical care in a rural setting with specific cultural beliefs about health.”

Another aspect of the learning experience, Dr. Thompson says, is thanks to volunteers, including Ted and Evie Charles. “Ted provides tours of the reservation, shares his knowledge of Navajo culture and beliefs, and hosts volunteers who want to stay in his hogan,” she states. “He and his wife help provide amazing cultural opportunities so essential to the unique experience we receive.”

The physicians receive a unique first-hand look at Navajo culture, which, unlike other Native American tribes, still flourishes. Many adults still speak Navajo. The written language is taught in schools.

There’s also the challenge of practicing medicine within the Navajo belief system. Because the mention of death can be interpreted by the Navajo as a curse, for example, physicians learn other ways to discuss it with seriously ill patients.

Dr. Thompson notes that the Gallup Indian Medical Center has native healers on staff, who will provide insights on working with certain patients or types of care.

“Interestingly, some patients go to Western medicine first, while others will prefer seeing the Navajo healers,” she says. “It’s an interesting balance of respect for their beliefs, yet making sure they receive the proper treatment.”

Volunteering Appreciated

While the satisfaction of volunteering medical skills is complemented by the area’s countless recreation and cultural enrichment opportunities, plus that postcard-perfect scenery, the volunteer physicians receive the Navajo patients’ sincere gratitude for their help.

“The patients probably don’t realize that the physicians come from so far away to treat them,” Dr. Sanchez says. “But they couldn’t be more thankful.”

And despite the hectic days in Gallup, Dr. Thompson, feels “renewed” when she returns to the Hospital Center.

“I’m able to handle the pressures of my job better, and I’m more tolerant if something’s not readily available,” she says.

Dr. Milzman hopes other Hospital Center physicians will become interested in participating in the Gallup volunteer program.

“We would love to expand beyond emergency medicine, because there is such a desperate need for specialists in internal and pediatric medicine, and family practice,” he says. “Travel costs and malpractice insurance are covered by the IHS.”

“It is an intense experience, but it’s one that helps so many people,” Dr. Sanchez agrees. “That the volunteer physicians come so far to do this for such a short time says a lot about them.”
Augusto Pichard, MD
Globe-Trotting Cardiologist Facilitates “Gorgeous” Results

For ten weeks this year, Augusto Pichard, MD, was MIA. Instead of his usual presence in the Cardiac Catheterization Lab, Dr. Pichard was in the cath labs of seven South African University Hospitals.

Dr. Pichard, senior consultant for Cardiac Innovation and Structural Disease for MedStar Heart & Vascular Institute, had a visiting professorship sponsored by the South African Society of Cardiology. He instructed hundreds of doctors in a variety of strategies related to cardiac catheterization, with the aim of enhancing acute and long term results, as well as choosing the optimal revascularization approach for patients with coronary and or valvular heart disease. Dr. Pichard was intent on guiding physicians through the steps of new technologies in the Cath Lab and transcatheter aortic valve replacement, TAVR.

Dr. Pichard was impressed by the quality of the facilities, and the energy of his new colleagues. “Their eagerness to do well and desire to learn was a most rewarding experience.” There were many physicians in training from other countries in Africa. Dr. Pichard was the fifth doctor to be selected for this prestigious opportunity from the South African Society of Cardiology, and was the only one to date who jumped in and performed procedures daily, alongside the South African physicians.

“The days were 11 to 12 hours long,” he says, “but I was happy to do it.” Dr. Pichard began each day with a morning conference, where cases were reviewed and discussed, and was quickly followed by work in the Cath Lab. An afternoon formal teaching conference was followed by dinner conferences, open to each city’s practicing and teaching cardiologists. He had the opportunity to meet more doctors and explain his vision of the best approach to patients with heart disease. Dr. Pichard also explained the positive American results of quality assurance programs, including performance measures, appropriate use criteria, process improvement and implementation practice guidelines. The South African Society of Cardiology is now planning to start implementing these programs.

In a recent email to Dr. Pichard, Helmuth Weich, MD, of the Tygerberg Hospital in Cape Town wrote, “I can safely say that we have not had a visitor who had such a profound and lasting influence on the way we operate. Your legacy will last here, and more than with just the shouts of ‘gorgeous’ that I get, whenever something works out well.”

Dr. Pichard believes the value of teaching the nuances of Cath Lab Procedures was enhanced by his time spent with new colleagues.

“Through these kinds of activities,” he says, “the good name of MedStar Heart & Vascular Institute is being spread, and even more, our good work is being shared with those who want and need it. Because South Africa is the cardiology leader, these changes will benefit many patients throughout Africa.”
A Continuing Philanthropic Connection:
Retired Pathologist Funds Cytopathology Fellowship

Physicians give generously of their time and talent throughout their careers. Some physicians choose to continue that tradition of giving after their retirement.

Pathologist Yolanda Oertel, MD, retired after nearly 40 years of practice. Actually, Dr. Oertel retired twice. In 1998, she left her post at The George Washington University School of Medicine and Health Sciences. “I flunked retirement,” she now remembers, and just several days later, started working at MedStar Washington Hospital Center.

“I was made an offer I could not resist,” she explains. “I had pioneered Fine Needle Aspiration (FNA) in the Washington metropolitan area, and I wanted to do FNAs exclusively. The Hospital Center was agreeable to this, and provided me with space, personnel and support. We confirmed the findings that better results were obtained, when the aspirates were performed by pathologists.”

She enjoyed her time at the Hospital Center. “As director of the FNA Service, it was energizing to work closely with physicians of other departments. We all shared a common goal with the institution, patient first.”

After retiring from the Hospital Center 12 years later, Dr. Oertel decided that she wanted to help the next generation of pathologists develop their skills. She endowed a cytopathology fellowship that funds one fellow each year. The program is based at MedStar Georgetown University Hospital, where there is a pathology residency program. The fellowship includes rotations at the Hospital Center, where Kenneth Burman, MD, Endocrinology section director, serves as administrative director.

“I am committed to enhancing and facilitating the use of FNA, because I believe its full potential has not been realized,” Dr. Oertel says. “We have to make sure more pathologists are comfortable doing his or her own aspirations.”

The fellowship program’s director, Mary Sidawy, MD, trained under Dr. Oertel. “She was my mentor,” Dr. Sidawy says. “Her celebrated diagnostic skills earned her the nickname ‘One Cell Oertel.’ She inspired many residents, and has trained and mentored a generation of fellows. The importance of this fellowship is that in a small way, it recognizes and honors her legacy and achievements.”

Richard Kief, the hospital’s senior vice president and Chief Philanthropy Officer, wholeheartedly agrees. “What is truly incredible is that Dr. Oertel continues to support the next generation of physicians, their education and preparation. Many members of our medical and dental staff are consistently and generously supportive of education and training while they are active. A number of physician leaders continue to be supportive in creative and important ways after they retire from practice.”

Throughout the fellowship, the fellow is continuously exposed to all aspects of cytopathology, including gynecologic, exfoliative non-gynecologic, fine needle aspiration of palpable and deep-seated lesions and consult cases. The program also includes involvement in laboratory quality management, interdisciplinary quality improvement and safety projects, peer review of scientific articles and research activities. Finally, the fellow participates in many departmental and multidisciplinary conferences, and is involved in teaching residents, cytotechnologists and medical students.

To date, two fellows have finished their fellowship. Jay Zeck, MD, completed his fellowship in 2015, during which time he published papers on thyroid cytopathology and lectured on pancreas cytopathology.

Gazal Alsaati, MD, completed her fellowship in 2016. She was active in teaching cytopathology to residents and earned certification in the thin prep gynecologic cytopathology testing. During her fellowship, she presented her research project, “Comparing Outcomes of hrHPV Positive Pap Tests: HPV 16/18 Genotypes versus non- 16/18 Genotypes” at the USCAP annual meeting, published two articles and has three more in progress.

The current fellow is Margaret Holmes, MD, who will be followed by Wei Xu, MD.
Upcoming CME Conferences

MEDSTAR CONFERENCE HIGHLIGHT

2017 Comprehensive Stroke Symposium: Continuum of Care: Acute Management to Rehabilitation
May 19-20 | Renaissance Washington, DC Dupont Circle Hotel | Washington, D.C.
Course Directors - Richard T. Benson, MD, PhD and Rocco A. Armonda, MD
Use code STROKEEB for 50% off Registration. Offer Expires February 27

MedStar Washington Hospital Center is pleased to announce the upcoming Spring conference: Comprehensive Stroke Symposium: Continuum of Care: Acute Management to Rehabilitation, taking place May 19-20, 2017 at the Renaissance Washington, DC Dupont Circle Hotel. This one and a half day symposium will equip health care providers with practical, evidence-based knowledge for early stroke identification, evaluation, treatment, transport, and management. Through lectures, interactive sessions, and open discussions, this conference will explore the critical issues surrounding the assessment and management of stroke patients. Additionally the course will review recent AHA/ASA acute ischemic stroke guidelines, cutting-edge interventions, treatment recommendations, and research. For more information and to register, please visit cme.medstarhealth.org/STROKE

SAVE THE DATE FOR THESE ADDITIONAL CME EVENTS

Kidney and Bladder Cancers: Updates on Clinical Management 2017
March 18 | Georgetown University Hotel and Conference Center | Washington, D.C.
Course Co-Directors - Michael B. Atkins, MD; Keith J. Kowalczyk, MD; George K. Philips, MBBS; Lambros Stamatakis, MD
cme.medstarhealth.org/KBC

This biennial, multidisciplinary, one-day conference will provide a clinical update on the biology, therapeutic modalities and medical management in patients with kidney and bladder (urothelial) cancers. Didactic lectures will present current science, ongoing clinical trials and future research directions including many recent advances in multi-disciplinary management approaches to patients with early stage, high risk, and metastatic disease. Interactive discussions with experts in the field will enhance the learning experience.

Advances in Liver Diseases and Transplantation 2017
April 1 | Hyatt Regency | Bethesda, MD
Course Co-Directors - Rohit Satoskar, MD; Thomas Faust, MD; and Thomas M. Fishbein, MD

cme.medstarhealth.org/LD

2017 Inflammatory Bowel Diseases and Other Inflammatory Pathologies of the GI Tract
April 29 | Ritz-Carlton | Washington D.C.
Course Co-Directors - Aline Charabaty, MD; Mark C. Mattar, MD

cme.medstarhealth.org/IBD

MedStar Associate discount available, contact 202-780-1655 for discount

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

CME Transcripts are Available Online
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Welcome to New Members of the Medical & Dental Staff

Layne DiLoreto, AA  Anesthesiology
Karen Kaiavitis, MD  Anesthesiology
Adam Khalid, AA  Anesthesiology
Sandeep Jani, MD  Cardiovascular Disease
Anil Jonnalagadda, MD  Cardiovascular Disease Hospitalist
Alison Elkins, CRNP  Critical Care Medicine
Valerie Gettys, CRNP  Hematology Oncology
Nesrine Khouy, PA-C  Hematology Oncology
Yun Oh, MD  Hematology Oncology
Osamuyimen Igbinosa, MD  Infectious Diseases
Tolawak Beyene, MD  Internal Medicine
Lawrence D’Angelo, MD  Internal Medicine
Ahmad Alkaddour, MD  Medicine Hospitalist
Nyati Jakharia, MD  Medicine Hospitalist
Rajkiran Khattra, MD  Medicine Hospitalist
Kosmas Papailadis, MD  Medicine Hospitalist
Babak Pirouz, MD  Medicine Hospitalist
Sandeep Raparla, MD  Medicine Hospitalist
Michelle Solomon, MD  Neonatology/Pediatrics
David Schidlow, MD  Neonatology/Pediatrics
Trevor Valentine, MD  Neonatology/Pediatrics
Ashley Brant, DO  Ob/Gyn
Adrienne Crawford, CNM  Ob/Gyn
Elizabeth Lamme, CNM  Ob/Gyn
Rebekah Schmerber, CNM  Ob/Gyn
Manpreet Sen, MD  Ob/Gyn
Adedoyin Shonekan, MD  Ob/Gyn
Kevin Smith, MD  Ob/Gyn
Tracy Wright, MD  Ophthalmology
Yavonne Johnson, PA-C  Orthopaedic Surgery
Oliver Tannous, MD  Orthopaedic Surgery
Savyasachi Thakkar, MD  Orthopaedic Surgery
Shankar Sridhara, MD  Otolaryngology
Nyota Pieh, MD  Psychiatry
Nicole Perras, MD  Psychiatry
Varsha Vaidya, MD  Psychiatry
Igor Trilisky, MD  Radiology
Konstantinos Loupasakis, MD  Rheumatology
Kevin Handy, MD  Surgery
Ryan Hankins, MD  Urology
Catherine Tierney, CRNP  Urology
Caitlin Cunningham, PA-C  Vascular Surgery
Lauren Storey, CRNP  Vascular Surgery
Raghuveer Vallabhaneni, MD  Vascular Surgery
Shannon Zimmerman, PA-C  Vascular Surgery

4th Biennial Moral Courage Awards

Four members of the Medical & Dental Staff—Critical Care Attending Physicians Raymond DiPhillips, MD, and Andrew Shorr, MD, and Advanced Practice Clinicians Mathew Jacobs, PA, and Autumn Ogbonbamise, NP were recipients of this year’s Moral Courage Awards. The Awards are given to recognize physicians, nurses, social workers and non-clinical associates who have exemplified the virtue of courage during difficult and ethically challenging clinical circumstances.

Chief Medical Officer Gregory Argyros, MD, and Center for Ethics Director Norine McGrath, MD, flanked award-winner Raymond DiPhillips, MD.

Andrew Shorr, MD, Critical Care Medicine, was congratulated by Dr. Argyros and Dr. McGrath.

Chief Neurosurgery Physician Assistant Mathew Jacob, PA-C, was given his award by Dr. Argyros and Dr. McGrath.
For Erin Higgins, MD, it doesn’t get much better than delivering a baby.

“It’s probably one of my favorite things,” says the Ob/Gyn chief resident.

Even though Dr. Higgins took time deliberating between a clinical career in medicine, versus pursuing a research trajectory, she always knew that if she did become a doctor, it had to be in Obstetrics & Gynecology. As a high schooler, she shadowed her aunt, a labor and delivery nurse, and witnessed a caesarean section. “I remember thinking ‘Oh my gosh, that’s the coolest thing I’ve ever seen.’”

But as a doctor who plans to hone her skills as a generalist, the field has so much to offer.

“Obstetrics and gynecology allows you to give really comprehensive care to a patient throughout her lifetime, from general well-woman care to prenatal care to management of postmenopausal issues,” she says. “It’s the best of all worlds. I get to care for patients who know me, but also be hands-on with in-office procedures and major surgeries.”

Dr. Higgins attended the University of Washington in Seattle as an undergraduate, earning a double major in microbiology and Spanish. She attended New York Medical College, before beginning her residency at MedStar Washington Hospital Center.

As a chief resident who aspires to be an academic generalist, the chief year has been one of extraordinary learning. “It’s a lot of work, but incredibly rewarding at the same time. I’ve learned how to balance patient care and clinical responsibilities, while also taking time for education with my junior residents,” says Dr. Higgins, who credits her desire to stay in a teaching role to the incredible attendings she’s worked with at the Hospital Center.

“One of the major parts of residency is who you do it with, in regards to both residents and attendings,” Dr. Higgins says. “As residents, we go through such ups and downs, and I’ve been lucky to work with a wonderful group of co-residents throughout the process. And my attendings have helped me form a solid foundation of knowledge and clinical skills. They’ve given me the inspiration for what I want to do with my career.”

Dr. Higgins will head to New York next year, for a one-year fellowship in Ob/Gyn simulation at NYU, where she will continue to hone her skills both in teaching and clinical practice.

She hopes a fellowship will give her more opportunities in the delivery room. Dr. Higgins remembers a recent delivery, when the mother was fervently hoping for a vaginal birth after caesarean (VBAC). The mom was nervous and scared, and she had been laboring for most of the night. The baby’s heart rate was dropping, and a repeat C-section was looking more and more likely. But Dr. Higgins wasn’t ready to give up on that mom’s dream.

“We were all set up to perform an operative delivery with forceps, but with the next contraction, mom pushed like a champ,” recalls Dr. Higgins. “I encouraged my attending to give her a shot with an operative delivery, but she ended up doing it on her own. It was really satisfying to advocate for her, and have such a positive outcome. I wouldn’t have felt comfortable doing that as a younger resident, but my training here at the Hospital Center has given me the skills, knowledge and confidence necessary to manage challenging situations like this one.”
**Oliver Tannous, MD**

**Orthopaedic Spine Surgery**

Dr. Oliver Tannous, MD, grew up in Bethesda, Md., and originally thought he might end up with a career on Wall Street. His strong interest in finance led him to co-found the Walt Whitman High School stock market club, where his team won the CNBC National Student Stock Tournament.

But as an undergraduate at Emory University, Dr. Tannous majored in neuroscience and behavioral biology.

“Finance lacked the human element that gave me fulfillment, so I gave it up to pursue medicine,” he says. “The field of neuroscience growing at a rapid pace, and I felt it would keep me challenged for the rest of my life.”

While at Emory, he found another passion, mission work. Throughout college, he spent his spring breaks on rural mission trips to Mexico, Greece and Alabama, where he joined homebuilding and healthcare projects.

“These trips reinforced my love for medicine and healthcare,” he says. “I felt like I was actively changing people’s lives, and this satisfaction is priceless.”

Dr. Tannous completed medical school close to home, at the University of Maryland School of Medicine. He always had a fascination with the nervous system, but also had a deep interest in the mechanics of how the body functions. He figured out early on in medical school that orthopaedics, specifically spine surgery, was the specialty for him.

He remained in Baltimore to complete his residency, at the University of Maryland Medical Center and the R Adams Cowley Shock Trauma Center, but his mission work continued. As a resident, he spent two months in Myanmar, where he worked with orthopaedic surgeons to provide care to an underserved population.

Dr. Tannous joined the Hospital Center after completing a fellowship in spine surgery at the University of California San Diego, a leading center for minimally invasive and complex spine surgery. And after all of his world travels, it truly felt like coming home.

“UCSD has one of the most established spine fellowships in the world,” Dr. Tannous says. “We did everything from minimally invasive to complex deformity and revision spine surgeries.”

“My favorite part of the job—by far—is helping my patients get better,” says Dr. Tannous. “There is nothing more satisfying than taking someone who is a good surgical candidate with a really bad problem, for whom everything else has failed, and watching that person improve.”

Emblematic of the potential for rapid results is an emergency room patient Dr. Tannous treated for a spinal cord injury, secondary to an acute, massive cervical disc herniation a few months ago.

The patient’s quality of life on Monday was completely normal, but by Wednesday, she was in the Emergency Department, and could barely walk or use her hands. Dr. Tannous performed an anterior cervical discectomy and fusion (ACDF) to remove the herniated disc and decompress the spinal cord. When his patient woke up, her strength and sensation were immediately better. She is now nearly normal again.

“It was a very dramatic and satisfying case,” he says.

But Dr. Tannous is quick to offer a critical caveat: The right procedure for the right patient.

“Technology has changed so much during the past ten to fifteen years. If you go to five different spine surgeons, you’ll get 10 different answers,” he says with a laugh, noting that he tries to stay on the cutting edge of new techniques, with an emphasis on cervical spine surgery. “I’ve trained with a lot of minimally invasive and motion-preservation techniques, and with the right patient, minimally invasive spine surgery is very effective. But it’s not the right procedure for everyone.”

For Dr. Tannous, who came home in large part to be close to family, his primary interest is diving into the local community. He lives in the Hospital Center neighborhood, and is getting to know his colleagues.
The practice of Anesthesiology has often been described as “95 percent boredom, five percent sheer terror.” That’s not true here at MedStar Washington Hospital Center. The sheer volume and diversity of our patient population ensures that our anesthesiologists are never bored, and expertise and new technology take away most of the terror.

The Hospital Center has almost 50 full-time anesthesiologists and nearly 60 full-time certified registered nurse anesthetists (CRNAs) and certified anesthesiologist assistants (CAAs). We also have anesthesiology residents and CRNA and CAA students from area hospitals who rotate through our service, as well as student CRNAs from the Georgetown program and student AA students from our own Case Western-D.C. program, based at the hospital.

Several things set our department apart, and the first is specialization. As the complexity of surgeries has greatly increased, so has our anesthesiology expertise. A great example is beating-heart surgery. Hospital Center cardiac surgeons were among the first in the nation to perform this kind of surgery. In order for cardiac surgeons to operate on a beating heart, anesthesiologists had to adapt our techniques to make the surgery safe. Today, we have nine anesthesiologists who specialize in cardiac anesthesia, even sub-specializing in complex endovascular and electrophysiology procedures.

The second is an unusual level of collaboration with our surgical and nursing colleagues. Working with orthopedic surgeons, we devised Enhanced Recovery After Surgery (ERAS) protocols that have revolutionized the care of patients. Before surgery and extending into recovery, we offer pain management protocols that have minimized the need for narcotics, reduced complications and decreased the length of stay. We are now working with other surgical specialties, to bring the same benefits to more patients.

We also focus on patient satisfaction, offering regional peripheral nerve blocks to patients with chronic pain, which has transformed their lives. We are working to expand this service to reach more patients, and are using this technology to improve pain control for patients recovering from major orthopaedic surgeries, sending them home with an indwelling catheter and disposable pump that infuses a local anesthetic, and provides three days of pain relief.

Please know that when your patients come to the Hospital Center for surgery or a procedure, they are always our highest priority.