Not in Our House
Drug Diversion Program Seeks to Curb Risks, Enhance Awareness
You’ve often heard me say, “physicians are the leaders of the clinical care teams.” The expectation has always been that the Medical & Dental Staff sets the bar high for creating a culture of respect and well-being throughout the hospital. This type of culture is important, because the work environment must be a safe haven for everyone on our care teams. Clarity in our communication is a key skill for our success.

Language and Actions Matter

Recently, New York pediatrician Perri Klass devoted one of her blog topics to discuss physician rudeness in the hospital, and who bears the brunt of that type of behavior. Dr. Klass cited a 2015 British study called “Sticks and Stones,” which found that rude, dismissive and aggressive behavior among doctors in a hospital affected approximately one-third of all physicians several times a week, or more.

Dr. Klass also noted a recent article in the journal Medical Teacher, which tracked the effect of verbal and non-verbal mistreatment on the morale of medical students from around the country. That mistreatment was cited as a bellwether for the physician teachers, who, through their actions, may have been showing signs of burnout, depression or substance abuse.

Medical students reported that mistreatment could include:
- Public embarrassment or humiliation
- Offensive, sexist remarks or names
- Racially or ethnically offensive remarks or names
- Offensive remarks or names related to sexual orientation
- Threat of physical harm
- Unwanted sexual advances
- Required to perform personal services
- Denied opportunities for training or rewards based on gender, race/ethnicity or sexual orientation, rather than performance
- Lower evaluations or grades based on gender, race/ethnicity or sexual orientation, rather than performance

This is disturbing information, not unique to one medical school. As we are part of an academic medical center, where we have all types of learners, we must insure that any such complaints are taken seriously, investigated and brought to a positive resolution. Perception is reality, and if medical students believe verbal or other mistreatment is occurring, we must quickly address those reports.

What Works Well

One of our key endeavors has been our house-wide effort to "drill to zero" all hospital-acquired infections. It’s just as important to reinforce physician behaviors that focus on team effectiveness and positive morale.

We have a great example of how this can be done on a consistent, day-to-day basis. IMOC—our Interdisciplinary Model of Care—continually demonstrates team effectiveness and positive morale. Through IMOC,
- Everyone on the care team is acknowledged and appreciated
- Diverse perspectives are presented
- Communication between care team members demonstrates empathy and trust
- All conversations ensure mutual understanding and cooperation, and the best care for our patients

IMOC’s success in its pilot phase helped us push it through as a process to all the other care units.

What We Say, and How We Say It

Our Language of Caring for Physicians® program ensures that we focus on communication that builds relationship, earns trust, and fosters patient and family engagement and cooperation. As we continue to roll out the program modules, we will solidify our communication skills.

Our next module focuses on “Collaboration and Teamwork,” and the course objectives are very similar to IMOC principles. The strategies of focus include:
- Acknowledge and appreciate everyone involved in your patient’s care
- Open your mind to diverse perspectives
- Community with empathy in interactions with colleagues
- Transfer trust during handoffs
- Hold proactive conversations to ensure mutual understanding, harmony and cooperation

Being on the same page for our interactions with all members of the care team is a patient first endeavor, and one that all of us need to achieve. Thank you for your continuing work in this area.

Gregory J. Argyros, MD, MACP, FCCP is sr. vice president, Medical Affairs/Chief Medical Officer and Designated Institutional Official at MedStar Washington Hospital Center. Contact him at 202-877-6038 or gregory.j.argyros@medstar.net.
Evidence suggests that statins may be safely distributed as over-the-counter drugs. They are now prescribed for a broad segment of the adult population, and have been well tolerated. In fact, statins are among the safest and most effective drugs in the marketplace, much safer than aspirin or ibuprofen, to give two examples of common OTC medications.

Even with the widespread use of statins in the last 20 years, the facts are that cholesterol levels are still too high, and heart disease is still too prevalent. That makes a strong case for an even more widespread use of statins.

The Heart Outcomes Prevention Evaluation (HOPE) 3 study, published in The New England Journal of Medicine, provides convincing evidence that statins are indeed effective. In a randomized study of 12,705 participants aged 55 to 65, with at least one cardiovascular risk factor, half were given 10 mg of rosuvastatin and half were given a placebo for 5.6 years. Those who took a statin had a lower cardiovascular mortality, 3.7 percent compared to 4.8 percent. Fixed-dose treatment with low-dose statin therapy is superior to placebo, in reducing long-term cardiovascular events in an intermediate-risk population.

I believe that, on the basis of the HOPE-3 study, for middle-aged men and women, especially those with at least one heart disease risk factor such as diabetes or hypertension, availability of statin use should be significantly liberalized, including availability over-the-counter. And, for ongoing treatment (e.g., renewal of refills), patients should be able to receive that at the pharmacy level, without a new prescription.

Although some patients may choose to continue to receive medication from their healthcare provider, it is time to remove the “prescription barrier” of prescribing statins, a safe and life-saving therapy. Present policy drives up the cost of care by requiring a doctor’s visit for a simple prescription. It is time to give physicians back the time spent discussing statins in every doctor visit, and instead use that time to discuss lifestyle modifications, promoting medication adherence, and focusing on more complex cardiovascular medications.

I don’t think statins should be over-the-counter drugs. While they have been shown to be effective in lowering total cholesterol, patients still benefit from taking statins under a physician’s guidance. There is no one-size-fits all statin, and there is no one-size-fits-all dosage. They have proven safe, but there are not enough observational studies that question potential adverse side effects.

Individual factors must be taken into account when prescribing statins. For example, a patient who is HIV-positive needs a statin that has less impact on liver function, as some statins can interact with antiretrovirals, and patients should be counseled and monitored.

It’s important to select the appropriate medication and dosage. Cardiologists pick and choose among statins, based on the patient’s profile and risk factors. There should be conversations, especially with potential drug-drug interactions, including the small chance of those who love grapefruit juice and its potential to potentiate the statin effect, including some antibiotic interactions.

Also, statins, as any medication, can have side effects, and doctors need to monitor patients for those side effects. Patients need to be educated about proper statin use, and how statins can interact with other medications and even nutrients.

All in all, spending a few minutes talking about cardiac risk factors, and monitoring cholesterol levels, is time well spent with patients. Prescribing statins is a logical result of this conversation.

That said, not everyone needs statins. Lifestyle modification is a better answer for most patients, and can be very effective. The patient can take more responsibility for care, which can help to modify up to 80 percent of the chronic diseases that we treat, including diabetes, hypertension and dyslipidemia with obesity.
Not in Our House
Drug Diversion Program Seeks to Curb Risks, Enhance Awareness

“It couldn’t be happening here…not that much…could it?”

That’s often the reaction of physicians and other health care professionals when they first learn about the potential for drug diversion—the transfer of legally prescribed substances from their original purpose, usually patient treatment, for any illicit use.

Drug diversion by health care providers occurs at institutions of all scopes and sizes—nursing homes, pharmacies, urgent care facilities and hospitals, in both rural and urban environments. MedStar Washington Hospital Center is likely one of the places where it occurs.

That was the conclusion of experts from Diversion Specialists LLC, a Chicago-based consulting firm hired last year to assess the Hospital Center’s vulnerability to diversion. After spending several weeks examining and monitoring facility-wide drug handling practices and processes, the consultants reported that given the Hospital Center’s size and diverse operations, drug diversion probably occurs on a monthly basis.

“That is not something you really want to hear, even if it’s common to other large hospitals,” says Sr. Vice President/Chief Nurse Executive Sue Eckert, MSN, RN, NEA-BC, CENP, a member of the multi-disciplinary oversight committee formed to develop the Hospital Center’s Drug Diversion Prevention program. “But to not believe it blinds you to the challenges that need to be addressed.”

“We’re a good hospital, and we try to do things right,” agrees Assistant Vice President for Medicine-Psychiatry Desi Griffin, PhD, who chairs the Drug Diversion Prevention oversight committee, “but there is always room for improvement.”

Kim New, JD, BSN, RN
Greg Argyros, MD

Kim New, JD, BSN, RN
Greg Argyros, MD

Desi Griffin, PhD

Sue Eckert, MSN, RN

“Obviously, the safe care of our patients is paramount,” he says. “It’s disconcerting to think that even just one patient is not receiving prescribed medications or, worse, being treated by someone who may be impaired.”

“Anyone can be at risk,” Dr. Argyros adds. “You need to put safeguards in place, and quickly address problems as they arise.”

A thoughtful, effective plan of action

Since receiving Diversion Specialists’ report, the oversight committee, which meets semi-monthly, has moved quickly to address drug handling deficiencies throughout the Hospital Center. The committee:

• revised standards of practice to improve security and prevent diversion
• created a diversion response team, to investigate and review potential events
• formed specific workgroups focused on improving storage and security practices in Pharmacy and Anesthesiology—departments that tend to be particularly vulnerable to mishandling of drugs
• provided updates to the orientation for new associates
• created a house-wide education program for clinical and non-clinical staff that got underway in mid-March
• set up a drug diversion hotline, where anyone can anonymously report potential drug diversion events
Along with education, awareness is probably the most essential tool to combat drug diversion. Dr. Argyros says it’s particularly important for physicians to understand the processes and requirements for handling, storing and securing drugs, even if they don’t perform those tasks. For example, a patient’s persistent pain issues may not necessarily be the result of ineffective treatment.

“Physicians need to be cognizant of clinical outcomes that just don’t add up,” he says. “The problem might well be the patient isn’t getting the prescribed medication, suggesting a potential drug diversion issue.”

At the same time, the Hospital Center’s drug diversion program seeks to reinforce the level of trust that enables associates, nurses and physicians to work effectively as teams, in often hectic situations and environments.

“Team members may not be doing anything inherently wrong, but lack of standard practices and oversight may create a vulnerability in our system, that someone could take advantage of for the wrong purposes,” Dr. Griffin says.

For example, Diversion Specialists’ assessment found that interpretations of reports generated by the automated medication machines vary across the nursing staff, the result of their differing levels of experience and training. As a result, nurses are now receiving refresher training on using report data.

New adds that in addition to improved processes and increased awareness, the drug diversion program is intended to change the Hospital Center’s culture, one where staff members hold each other accountable as a measure of support, not suspicion, on top of protecting patients.

“There are multiple checks and balances that ensure potential incidents are examined fully and fairly, whether the individual in question is an entry-level associate or a senior physician,” Dr. Griffin says.

“It’s important that drug diversion be addressed with dignity and compassionate treatment,” says Anesthesiologist Daniel Perlin, MD, who has worked with physician impairment and substance abuse issues locally and nationally. “We want to protect the patients and the public, but also those whose lapses in judgment may be the result of stress or oversight, or indicative of a more serious problem.”

Dr. Perlin is also hopeful the Hospital Center’s drug diversion program will encourage self-reporting among staff members. “We will have better success finding people who are diverting drugs for illegal purposes,” he adds.

Continuing commitment

Because of drug diversion’s pervasive, ever-changing nature, the Hospital Center’s program will evolve as new or potential risks are identified. New and Diversion Solutions partner, Luke Overmire, will continue to monitor transactions involving controlled substances throughout the Hospital Center, providing an informed external perspective and guidance to the oversight committee.

“We’re just beginning to scratch the surface,” says oversight committee member Karen Jerome, MD, FACP, vice president, Quality, Safety and Risk Management. “We have a lot to learn, and it’s somewhat frustrating that we can’t implement things as quickly as we need to. Tackling drug diversion is a very complex thing to do, because so many issues are involved.”

“Drug diversion is an ongoing problem that can’t be eliminated entirely,” New says. “A sustained effort, involving education and ongoing risk assessment, is critical to success.”

Chief Operating Officer Robert Ross is hopeful the drug diversion program will be a model that can be applied across MedStar, as well as other large acute care hospitals.

“We want to do the best we can to safeguard our patients and staff,” he says. “If others can learn from what we’ve learned, that will be a bonus.”
Elizabeth Blackwell, the first woman to graduate from a U.S. medical school 168 years ago, would no doubt be pleased with the number of women who have followed her into the medical profession. Today, women account for approximately one-third of the nation’s physician workforce, with the number of female physicians and surgeons topping 239,000.

Yet Dr. Blackwell might well be disappointed to find that many women experience the 21st Century equivalent of the treatment she endured from her male peers. To be sure, outright gender-based discrimination is rare, and illegal. More common, though, are subtle forms of disrespect—acts of microaggression, dismissed opinions and “man-splaining” that don’t seem to happen to male colleagues.

Are these acts simply examples of an “old school” mentality that’s fading away? Or are they reminders that no matter how many decades have passed since Blackwell earned her degree, the path she helped blaze has progressed only so far?

Some of MedStar Washington Hospital Center’s providers share what it’s like to be a woman in medicine in 2017.

Cheryl Iglesia, MD, FACOG
Director, Female Pelvic Medicine and Reconstructive Surgery

When I was younger, I was often called “nurse,” because I’m Filipina. I generally was not bothered by that. As I have gotten older, I occasionally still feel more belittled, like the time I had to negotiate my salary. I was once told by an administrator that I was my family’s “second income.” That’s just wrong. We should be paid based on our training, expertise, job performance and what we bring to the institution.

Dealing with discrimination of any kind—gender, racial or whatever—comes from believing in yourself, and in what is just. I have a big personality, so it’s easy for me to speak up. But I’ve also seen people, both men and women, with good ideas being talked over, and ignored. Women may sense it more, but they’re not immune from doing it themselves. I’ve heard a lot of cattiness in discussions from women about other female colleagues.

I do feel that people sometimes give up too easily. It may be overwhelming, bad timing or they may decide that taking a stand would take too much energy. Our jobs have so many demands; we have to decide which battles are worth fighting, and which ones to just let go.

But if you do choose to speak up, you need to be able to back up what you say. Sure, you deserve respect as a person. But if you’re making a point and would like others to understand your perspective, have the data to back it up.

If you do feel you’ve been treated unfairly, don’t ignore it. Approach the person and tell them why you feel they’re dismissing your opinion. There will always be those who don’t change, but I think most people will be surprised about their impact, and may appreciate the feedback, especially if enough people speak up.

We’re in a high-risk business, dealing with people’s lives and well-being. We want everyone to feel like they can speak up. That will make our culture safer, and lead to better outcomes.
I've gained the most confidence: trusting my own instincts and genuine disagreement. On being a female, or on other parameters, such as personality I try to do a better job of “active listening,” and trust my gut about intentions.

It doesn’t bother me as much now as it has in the past, and again, I often find it difficult to decide if how I’m treated is based on being a female, or on other parameters, such as personality and genuine disagreement.

I try to do a better job of “active listening,” and trust my gut with respect to how someone is treating me. That’s where I think I’ve gained the most confidence: trusting my own instincts about intentions.

My perception in 2017 is that it’s still a challenge to be an assertive female physician, especially one who is African-American. In some cases, we are not allowed to have opinions. We get labeled, with non-complimentary words.

I try to listen to what others are saying, to try and see their perspectives. When I disagree with them, I try to present the kindest professional way to present my thoughts without becoming defensive. Once you allow frustration and anger to get the best of you, you become less effective.

Our environment may not be changing as fast as we’d like for female physicians and female Advanced Practice Clinicians, but we have a responsibility to educate younger women coming up behind us, to become an empowered next generation.

The APC-physician relationship has improved tremendously during the 18 years I’ve been at this hospital, so I’m sometimes more inclined to feel it’s related to being a woman. And I can’t recall ever hearing “she’s still just a nurse” from a male physician colleague.

Occasionally, at mixed-gender meetings, I may get talked over. It doesn’t bother me as much now as it has in the past, and again, I often find it difficult to decide if how I’m treated is based on being a female, or on other parameters, such as personality and genuine disagreement.

I try to do a better job of “active listening,” and trust my gut with respect to how someone is treating me. That’s where I think I’ve gained the most confidence: trusting my own instincts about intentions.

On a more intellectual level, I know that while I’m fortunate not to experience a sense of gender discrimination in overt ways, we still have a long way to go to support women in leadership roles. Most formal leadership positions are still held by men, and that limits our systems from a diversity in perspectives and contributions that would enrich our problem-solving, planning and decision-making processes.

That’s not an unusual response when a consultant is involved, but I wanted to make sure he knew I felt strongly about this particular recommendation. So I said, in what I felt was a calm but assertive voice, “As your ID consultant…” He interrupted with “Don’t #*%@! talk to me that way!”

Obviously, I was surprised, and confused, even more so when I saw him a few hours later, and he acted as if nothing had happened. I really felt bad about the incident, since there were other people in the room, and wish I’d stated clearly that the behavior was unacceptable.

Not long afterward, we were in a weekly team meeting, with many of the same people present. I brought up the case, and the attending accused me of being disrespectful by talking to the nurses. I responded that they were part of the team, and a prior colleague had encouraged me to speak with them.

The situation pretty much ended there, but afterward, some of the other women on the team thanked me for standing up to him. They added that he was a bully, and treated women poorly.

I guess it helped that I wasn’t working under him, but I wondered about the nurses and students. That’s when I realized it was a bigger problem, and not just me.

But the experience did have a profound impact on me. I’m more willing to speak up if I feel I have to. Luckily, it doesn’t happen very often. But I think as long as you’re calm and professional, it’s always good to speak up.

It also helps to think through what you might say if you found yourself in such a situation. The first time may take you by surprise—as happened with me—so you may not be ready to react. Come up with a response, and practice it, and don’t be afraid to speak with someone else about it.

We work in a profession that’s held to a very high standard. We have a code of ethics and we have the MedStar SPIRIT values. You may well help change someone’s behavior—especially if he or she doesn’t realize it’s happening—simply by giving feedback.
For someone who has just assumed the dual role of MedStar Health’s Washington Regional Chief of Plastic Surgery and Academic Chair of Georgetown University Medical Center’s Department of Plastic Surgery, David Song, MD, is remarkably accessible. And that’s the way he wants it.

Make no mistake, Dr. Song’s daily calendar is as crowded as they come. But as long as he’s been a physician, Dr. Song has enjoyed interacting with patients, even as demands on his time have grown in step with his stature as a leading expert in the fields of plastic surgery, breast reconstruction and microsurgical techniques, for conditions such as lymphedema.

Social Media Key
What’s Dr. Song’s secret for staying engaged? Social media. During those fleeting spare moments in his schedule, he’ll dash off a Tweet or Instagram post on a timely health topic, news item or, every so often, a meal recommendation.

“I’m a big foodie, so occasionally I will post something about that,” Dr. Song admits with a laugh. “But most of my posts deal with health care. To me, educating patients enriches both their individual experience and the doctor-patient relationship, which contributes to better outcomes. It really helps us both.”

Engagement is also at the heart of his approach to raising the profile of MedStar’s Plastic Surgery service throughout the Washington-Baltimore region, while also integrating those services with Podiatric Surgery, limb salvage and wound care.

The practices are not as disparate as their names might suggest, explains Dr. Song, who spent 12 years as Section Chief for Plastic and Reconstructive Surgery at the University of Chicago’s Pritzker School of Medicine, before coming to Washington earlier this year.

“It’s easy to think of plastic surgery as cosmetic,” he says, “but that’s just a very small part of what we do. When you consider other facets such as microsurgical transplants, complex reconstructive procedures and burn care, there really is a lot crossover. I see it as an institution without walls.”

Dr. Song adds that he was provided with an excellent head start on integrating and growing this “barrier-free” entity, as the key foundation elements are already in place.

“Our Plastic Surgery and Podiatric Surgery services include some of the best surgeons in the country, and the Center for Wound Healing and Limb Salvage at MedStar Georgetown University Hospital is internationally recognized,” he says.

The challenge is to have these operations work together seamlessly, both as services and across all of MedStar’s hospitals. One step toward that end is eliminating organizational “silos” that have constrained operational efficiencies and collaboration. While working better internally will benefit physicians and staff members, the ultimate beneficiaries will be patients.

“We want to improve delivery at every patient touchpoint, from admission, surgery and to post-op care,” Dr. Song says. “This is a tremendous opportunity to recruit, grow and unify.”

“To me, educating patients enriches both their individual experience and the doctor-patient relationship, which contributes to better outcomes. It really helps us both.”

**Medicine and Business**
That Dr. Song sounds as much like a CEO as a physician is no coincidence. In addition to his medical degree from UCLA and other professional training, Dr. Song holds a Master of Business Administration with an emphasis in operations management and strategic marketing from the University of Chicago’s Booth School of Business.

Once a rarity, MDs with MBAs are becoming more common, a trend that Dr. Song says makes sense, given health care’s complex and rapidly growing presence in the nation’s economy.

“The best people to manage it are the physicians who understand the doctor-patient relationship,” he states, noting that while many MBA programs are tailored with a health care focus, “I wanted to tap into other industries, to learn about and apply best practices that can help improve what we do for our patients.”

Born in Seoul and raised in Southern California, Dr. Song might well have pursued a different career path, had he not overcome his childhood queasiness at the sight of blood. Squeamishness gave way to fascination in his junior year of high school, thanks to a class presentation by a vascular surgeon.

“I was just blown away,” he remembers. “Speaking with him afterward sparked my interest in going to medical school, perhaps becoming a cardiac or vascular surgeon.”

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**David H. Song, MD, MBA, FACS**

Washington Regional Chief, Plastic Surgery

new physician leadership
Another career intervention occurred during medical school, however, when Dr. Song happened upon a late-night procedure to reattach a severed finger.

“I couldn’t help but watch, as the surgeons carefully worked with tiny blood vessels,” he says. “When a nurse told me they were plastic surgeons performing the procedure, I knew this was the discipline for me.”

Chicago Was Home
Trading the California sun after graduation for the Midwest’s often bitter winters, Dr. Song embarked on what would become a 22-year stay at the University of Chicago Hospitals. There, he completed his internship and residency in general surgery and plastic surgery, followed by a fellowship in Reconstructive Microsurgery, before joining the Pritzker School’s clinical staff in 2000.

On top of his surgical responsibilities and multiple research pursuits, Dr. Song took on administrative roles, such as Residency Program Director, and Vice-Chairman for Business and Strategy. He was named a Senior Faculty Scholar of the Bucksbaum Institute for Clinical Excellence for his achievements in promoting quality physician-patient interaction, while his academic work was recognized with the Cynthia Chow Endowed Professorship in Surgery.

But though the “Second City” had become a second home of sorts, MedStar offered what Dr. Song calls “an unbelievable opportunity that I just couldn’t pass up. And I couldn’t have asked for a warmer welcome.”

The biggest challenge facing Dr. Song may well be finding enough hours in the week to balance his administrative duties, while seeing patients and keeping up with developments in his specialty of microvascular surgery. He wants to set aside plenty of time to spend with his wife, Janie, and their three daughters, Olivia, Ava and Ella, plus—whenever possible—indulge his passion for good food and golf.

There will also be the ongoing patient interaction fostered by Dr. Song’s ubiquitous social media posts, which have attracted more than 6,200 followers to his Twitter feed alone.

“A mentor once told me that if you treat patients like family, everything will work fine,” Dr. Song says. “That’s why I try to be transparent, have frank conversations and get to know them as people, as well as patients. The Georgetown University School of Medicine’s motto, cura personalis—care of the whole person—fits with me.”
MEDSTAR CONFERENCE HIGHLIGHT

Pediatric and Adolescent Gynecology for the Primary Care Provider 2017
October 6 | Hyatt Regency | Bethesda, MD
Course Directors - Veronica Gomez-Lobo, MD and Lauren F. Damle, MD

MedStar Washington Hospital Center and Children’s National Health System are proud to be hosting this one-day pediatric and adolescent gynecology course that will focus on gynecologic care of adolescents, and young adults. This program will provide an environment complete with didactic lectures and ample room for panel discussion to cover topics including abnormal menstrual bleeding, pelvic pain, confidential services, complex contraception and gender issues. Through this course, primary care provider will increase their comfort with the evaluation and management of these conditions as well as learn when to refer a child to a specialist.

For more information, please visit cme.medstarhealth.org/Pedgyn

UPCOMING CME EVENTS

Gastric Soft Tissue Neoplasms 2017
September 23 | Park Hyatt | Washington, DC
cme.medstarhealth.org/GSTN2017

Current Issues in the Care of Dialysis and Transplant Patients
October 7, 2017 | Georgetown University Hotel and Conference Center | Washington, DC
cme.medstarhealth.org/Transplant

2017 Update on the Treatment of Heart and Vascular Disease
October 14 | MGM National Harbor | Oxon Hill, MD
cme.medstarhealth.org/uthvd

Controversies in Cardiac Arrhythmias
October 20 | The Cosmos Club | Washington, DC
cme.medstarhealth.org/CICA

Lung Cancer 2017: Progress and Future Directions
November 4 | Renaissance Dupont Circle Hotel | Washington, DC
cme.medstarhealth.org/lungcancer

Advances in Gastroenterology for Primary Care Provider
November 11 | The Ritz Carlton | Washington, DC
cme.medstarhealth.org/GIPCP

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

CME Transcripts are Available Online
You can download, print or e-mail your CME transcript. Visit cme.medstarhealth.org and click on “View Your CME Transcript” for complete instructions.
It’s been another long day of interviews here at the American Association of Colleges of Podiatric Medicine’s (AACPM) annual Centralized Residency Interview Program (CRIP), a centralized gathering near Dallas, TX. Representatives of podiatric residency programs from across the country are interviewing medical students, as part of their match process.

For the past few days, I’ve enjoyed getting to know dozens of young men and women, learning about their backgrounds and aspirations, and getting a feel for how they would approach the practice of podiatric surgery.

The process has also stirred a lot of memories. Just two years ago, I was the slightly nervous student on the other side of the interview table.

I began preparing for CRIP well before starting my final year at Kent State University’s College of Podiatric Medicine. There was little mystery about the how the interview process worked but quite a lot of unknown for how interviews would actually be conducted. I’d spoken with residents who’d been through it before, and researched the residency programs where I planned to apply. I learned that interviews were designed not so much to test my actual knowledge base, as much as they were for finding out how I’d apply it. Ultimately, the goal was to match each of us with a learning environment that affords the best opportunity to further our careers.

I knew I couldn’t “wing it” at CRIP either, because there’s little guidance about what each institution has within its interview. Some are some 10-minute “get to know you” chats, and you’re done. Most, though, last quite a while, with attendings and residents asking your thoughts on various clinical, surgical and even ethical scenarios.

I arrived at CRIP, certain I could handle most types of questions. But more than once, I was asked something that really required some careful contemplation. Though I came up with the best response I could, I sometimes left wondering what, exactly, the interviewers wanted to hear. When you’re repeatedly challenged during interviews day after day, it’s little wonder the stress among aspiring residents milling around the lobby is somewhat palpable.

Luckily, my interview with MedStar Washington Hospital Center went quite well, and I gladly accepted the opportunity to come to D.C. I was also a bit humbled when they asked me to interview prospective residents at CRIP the past two years, an experience I’ve found to be quite eye-opening.

Now in my second year of residency, I have a much clearer understanding of why we ask the questions we do. The last thing we want to do is deliberately make candidates uneasy, or stump them with a trick question. What we’re after is engaging a prospective resident’s thought process, making sure he or she can bring a holistic approach to treating patients, regardless of the condition.

It’s also important to understand what a candidate can offer both the Podiatric Surgery department, and the profession as a whole—in other words, someone we can get along with. We’re a team, and we want to find individuals who will both complement what’s in place, and also bring a unique perspective that will enrich our ability to provide quality care.

I really do wish I could tell all those young men and women to relax, and just do the best they can. Yes, finding a good residency program is every aspiring physician’s dream. But as long as they come in with confidence and poise and put forth their best effort, they will succeed.
Doctor Days
The last two days of March found members of the Medical & Dental Staff enjoying breakfast and lunch with special menus, to celebrate Doctor Days.

Joseph Choi, MD, and Peter Levit, MD, make their way through the buffet line.

David Shocket, MD, Jay Mazel, MD and Jessica Fields, MD, got together for conversation and good food.

Madeleine Caughey, CRNP, and Nnena Oluigbo, MD, enjoyed their time together.

Eighth Annual Authors Day

The MedStar Authors Bibliography, now 103 pages, represents:
- 26 MedStar Washington Hospital Center departments
- MedStar Franklin Square Hospital
- MedStar Good Samaritan Hospital
- MedStar Harbor Hospital
- MedStar Health
- MedStar Health Research Institute
- MedStar Heart and Vascular Institute
- MedStar Institute for Innovation
- MedStar Montgomery Medical Center
- MedStar National Rehabilitation Network
- MedStar Shah Health Group
- MedStar Southern Maryland Hospital Center
- MedStar St. Mary’s Hospital
- MedStar Union Memorial Hospital

The top five most prolifically publishing departments, based on the number of journal articles published, are:
- Emergency Medicine
- Maternal-Fetal Medicine
- Endocrinology
- General Internal Medicine
- Plastic Surgery (tied # of articles)

If the MedStar Heart and Vascular Institute and Cancer Services were counted as departments, they would top the list of Hospital Center departments.
## 2017 Resident Match

Both MedStar Washington Hospital Center and MedStar Health are anticipating a great FY18 for Graduate Medical Education, following a successful local and system-wide resident match.

At the Hospital Center, Medicine filled 47 or 47 preliminary and categorical positions, Emergency Medicine filled 10 of 10 positions and Ob/Gyn filled 10 of 10 positions. Surgery filled 8 of 13 preliminary and categorical positions in the Match, with the remaining 5 filled in the Supplemental Offer and Acceptance Program® process. Seven of the new residents are from the Georgetown University School of Medicine, 3 in Medicine, 2 in Ob/Gyn and 2 in Surgery.

MedStar Health had a 94 percent fill rate in the main residency match. Seventy of the students matched are from local schools, including 39 from GUSoM.

In January, the MedStar Washington Hospital Center/MedStar Georgetown University Hospital Ophthalmology Residency program successfully matched with six medical school students, for its new class that begins on July 1, 2018, after the internship year.

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### Welcome to New Members of the Medical & Dental Staff

<table>
<thead>
<tr>
<th>Name</th>
<th>Specialty</th>
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<tbody>
<tr>
<td>William Doolin, CRNA</td>
<td>Anesthesiology</td>
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<tr>
<td>Bruce Herr, CRNA</td>
<td>Anesthesiology</td>
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<tr>
<td>Kimberly Hurst, CRNA</td>
<td>Anesthesiology</td>
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<tr>
<td>Linet Kandie, CRNP</td>
<td>Anesthesiology</td>
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<tr>
<td>Catherine McLane, CRNA</td>
<td>Anesthesiology</td>
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<tr>
<td>Elizabeth Schroeder, CRNA</td>
<td>Anesthesiology</td>
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<tr>
<td>Adam Turman, CRNA</td>
<td>Anesthesiology</td>
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<tr>
<td>Ivanesa Pardo Lameda, MD</td>
<td>Bariatric Surgery</td>
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<tr>
<td>Colleen Fraser, CRNP</td>
<td>Cardiovascular Disease</td>
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<tr>
<td>Jigar Patel, MD</td>
<td>Cardiovascular Disease</td>
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<tr>
<td>Michele Zemedkun, MD</td>
<td>Cardiovascular Disease</td>
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<tr>
<td>Paloma Fernandez-Trung, CRNP</td>
<td>Cardiovascular Surgery</td>
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<tr>
<td>Leanne Carter, PA-C</td>
<td>Critical Care Medicine</td>
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<tr>
<td>Jason Chang, MD</td>
<td>Critical Care Medicine</td>
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<tr>
<td>Daniel Czarniawski, PA-C</td>
<td>Critical Care Medicine</td>
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<tr>
<td>Albertina Mindich, PA-C</td>
<td>Critical Care Medicine</td>
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<tr>
<td>Akram Zaaqoq, MD</td>
<td>Critical Care Medicine</td>
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<tr>
<td>Amy Morgan, DO</td>
<td>Family Practice</td>
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<tr>
<td>Keri Johnson, CRNP</td>
<td>Gastroenterology</td>
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<tr>
<td>Bogdan Dumitriu, MD</td>
<td>Hematology Oncology</td>
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<tr>
<td>Hussam Ammar, MD</td>
<td>Internal Medicine</td>
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<tr>
<td>Ashlyn Andres, CRNP</td>
<td>Internal Medicine Service</td>
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<tr>
<td>Judith DeBose, MD</td>
<td>Neonatology/Pediatrics</td>
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<tr>
<td>Helene Felman, MD</td>
<td>Neonatology/Pediatrics</td>
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<tr>
<td>Christine Nelson, MD</td>
<td>Neonatology/Pediatrics</td>
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<tr>
<td>Christopher Pretorius, MD</td>
<td>Neonatology/Pediatrics</td>
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<tr>
<td>Mary Denny, MD</td>
<td>Neurology</td>
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<td>Shrinal Patel, PA-C</td>
<td>Neurosurgery</td>
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<tr>
<td>Gabriel Soudry, MD</td>
<td>Nuclear Medicine</td>
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<tr>
<td>Allison Reiter, MD</td>
<td>Ob/Gyn</td>
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<td>Cynthia Shepard, MD</td>
<td>Ob/Gyn</td>
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<td>Katherine Sznejder, MD</td>
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<td>Joseclyn Wertz, MD</td>
<td>Ob/Gyn</td>
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<tr>
<td>Amy Green-Simms, MD</td>
<td>Ophthalmology</td>
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<td>Namratha Turlapati, MD</td>
<td>Ophthalmology</td>
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<tr>
<td>Rania Habib, DDS</td>
<td>Oral &amp; Maxillofacial Surgery</td>
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<tr>
<td>Fadi Kosa, DDS</td>
<td>Oral &amp; Maxillofacial Surgery</td>
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<tr>
<td>Charlie Park, DDS</td>
<td>Oral &amp; Maxillofacial Surgery</td>
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<tr>
<td>Yvette Ho, MD</td>
<td>Orthopaedic Surgery</td>
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<tr>
<td>Jillian Jewett, CRNP</td>
<td>Orthopaedic Surgery</td>
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<tr>
<td>Abha Lokhande, MD</td>
<td>Physical &amp; Rehab Medicine</td>
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<tr>
<td>Neelosh Kantak, MD</td>
<td>Plastic Surgery</td>
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<tr>
<td>Akbar Abyaneh, DPM</td>
<td>Podiatric Surgery</td>
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<tr>
<td>David Vieweger, DPM</td>
<td>Podiatric Surgery</td>
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<tr>
<td>Seth Rosenblatt, MD</td>
<td>Psychiatry</td>
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<td>Daniella Scott, PsyD</td>
<td>Psychiatry</td>
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<tr>
<td>Thomas Chang, MD</td>
<td>Radiology</td>
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<td>John Mackrell, MD</td>
<td>Radiology</td>
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<tr>
<td>Kathryn Page, PA-C</td>
<td>Radiology</td>
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<tr>
<td>Dmitry Pekarsky, MD</td>
<td>Radiology</td>
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<tr>
<td>Hesum Chegini, DO</td>
<td>Rheumatology</td>
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<tr>
<td>Sonia Nair, MD</td>
<td>Rheumatology</td>
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<tr>
<td>Belen Bekelwe, CRNP</td>
<td>Surgery</td>
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<tr>
<td>Hayley Henderson, CRNP</td>
<td>Thoracic Surgery</td>
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<tr>
<td>Maria Litzendorf, MD</td>
<td>Vascular Surgery</td>
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Chief Resident Jerry Chiu, DDS, Oral and Maxillofacial Surgery, admits that when he was a child, he didn’t like going to the dentist. The saving grace, he says, were the video games in the waiting room. But years later, when he began looking at various health care careers while in college, dentistry became a clear favorite in his search. “I realized that dentistry would allow me to use my hands and produce something,” he says.

While applying to dental schools, Dr. Chiu took a job at an oral surgeon’s office, his first introduction to the specialty. He realized it was his perfect trifecta, combining dentistry, surgery and medicine into one field. “With dentistry, you’re overseeing the general oral health of your patient. With surgery, you’re doing procedures that can range from facial trauma to jaw correction. And with medicine, we see patients who can have illnesses and medical conditions while we treat them for their dental issues, and we have to be comfortable doing that.”

Growing up, Dr. Chiu didn’t feel pressure from his family to choose healthcare. “My family members are all in business or accounting, but I had a fondness for biology, anatomy and other sciences. I looked into physical therapy, pharmacy and medicine, before I decided on oral and maxillofacial surgery. I’ve found that it’s very rewarding to see immediate results, and it’s a great opportunity to change someone’s life.”

Dr. Chiu saw how he could make a difference during a mission trip to Cambodia while at the Columbia University College of Dental Medicine. The trip was based out of Phnom Penh, but the dental students left early every morning, to travel to villages and evaluate a primarily pediatric population. “We set up the clinics in schools, so our dental chairs were wooden chairs with pillows. We had only three instruments, a dental syringe, forceps and elevator. The kids we saw had no access to dental care where they lived, and were super appreciative of what we did,” he says. “They came from hours and hours away, and waited in line for hours.”

Like many chief residents, Dr. Chiu says this year has been marked by its busyness and an incredible degree of responsibility. He has also been in awe of the knowledge gleaned from the attendings who work with him. “I’m so appreciative to be part of a larger team working together, interacting and helping and learning from each other.”

As Dr. Chiu rounds out his chief year, he plans to pursue a career in private practice. In a future professional role, he hopes to focus on jaw correction surgery, facial traumas, pathologies and implants for jaw reconstruction. “The jaw area is such an underrated part of daily life,” he notes. “We talk, chew, smile–a lot of times, it’s the first thing people see, so an oral surgeon can make a huge impact for a patient.”

While he’s open to where that next phase of where his adventure may lead, he’s eager to put down roots and become part of a community. Wherever his practice takes him, Dr. Chiu hopes it will be in a food mecca, comparable to the neighborhoods of Washington, D.C. “I’m a big foodie,” he says of his favorite pastime. “I like exploring a city for new restaurants, and finding the hidden hole-in-the-wall gem.”
Louis Dainty, MD
Gynecologic Oncology

Louis Dainty, MD, vividly recalls his first visit to a hospital—the one that drew him to medicine. For the future doctor, what appealed to him wasn’t so much technical equipment or doctors racing around in white coats. Dr. Dainty was drawn by the smell and comfort of clean hallways.

Many years later, Dr. Dainty laughs at the recollection. The precision and orderliness that made him take notice as a 12-year-old boy, were a few years later, a large part of what led him to apply to West Point. The high school senior played football at Upper Merion High School outside Philadelphia, and had been offered college football scholarships. But he sensed a need within himself.

“I wasn’t very organized, and I thought I needed more discipline,” he says of that decision. “I knew I wanted to be a doctor, and believed if I pursued a football career, I’d squander my chances for medical school.”

Dr. Dainty found that he thrived within the structured world of the military, and after spending some time in the infantry, he was accepted to medical school. He spent 30 years on multiple deployments—most recently, with an infantry battalion in Afghanistan. He rounded out his military career, teaching at Walter Reed National Military Medical Center.

Despite spending much of his career surrounded by male colleagues, Dr. Dainty’s specialty is gynecologic oncology. The Army, he explains, would sometimes deploy a neurosurgeon to be a general practitioner in the military theater. While in medical school, Dr. Dainty presumed he’d pursue orthopedics, given his past athleticism, but he found it somewhat boring. He realized during his obstetrics/gynecology training that he loved taking care of women.

“They’re tougher, and they don’t complain as much as men,” he notes wryly. He found Ob/Gyn to be a nice balance of surgery and medicine, and once within the specialty, he found that surgery was his true passion, and it soon led him to oncology.

“When someone is facing death, the relationship between doctor and patient becomes very special,” says Dr. Dainty, who is also credentialed in hospice and palliative care. “Gynecologic Oncology has a high mortality rate; so unfortunately, I take care of a lot of women during the end of their lives. Some people think it’s depressing, but it’s not at all. You see women facing bravely their cancers.”

A little more than a year into his time at MedStar Washington Hospital Center, Dr. Dainty is preparing to take on the role of regional director for Gynecologic Oncology, a role that will oversee the specialty from MedStar Franklin Square Medical Center, north of Baltimore, to MedStar Southern Maryland Hospital Center.

“We’re trying to take a more coordinated approach between doctors, in order to provide more comprehensive coverage,” says Dr. Dainty. It’s a large swath of territory, he notes, but his goal is to meet many of those doctors, and establish a more collegial relationship with MedStar’s smaller hospitals. His aim is to assure the best possible care of potential patients.

Dr. Dainty believes his 30 years in the military prepared him to be up to the task. “It’s not all that different,” he says, comparing the MedStar system with the military. “Both are very big organizations, and it takes a while to know how to navigate them.”

One thing is certain: Even as Dr. Dainty prepares to take on his new responsibility, he won’t let his patient relationships falter.

“I pride myself on very personal relationships with my patients. Being here every day of the week allows me to do that,” he says. “That’s the value we have here, and that’s the value I’m trying to leverage across MedStar: competency and consistency.”

“There is such a great energy around the hospital,” he says, “I’m happy to be here, and care for a patient population that really needs good health care.”
Female Pelvic Medicine & Reconstructive Surgery

The MedStar National Center for Advanced Pelvic Surgery (NCAPS) provides care for women with pelvic floor disorders, which may include urinary incontinence, pelvic organ prolapse, fecal incontinence, defecatory dysfunction, fistulae and other complications from childbirth.

We offer medical management, behavior modification and non-surgical therapies. If surgery is indicated, we are highly skilled at minimally invasive, laparoscopic, robotic and traditional surgical procedures, including reconstructive pelvic surgeries for prolapse and incontinence, complicated cases for vaginal mesh removal, laparoscopic fibroid and endometriosis surgeries, and repair of fistulas and lower urinary tract injuries.

For many women with complicated fibroids and symptomatic endometriosis or pelvic floor disorders, it’s important to see a specialty-trained and experienced physician, who can pinpoint the cause and offer effective treatment. Our team includes Andrew Sokol, MD; Rob Gutman, MD; Amy Park, MD; James Robinson, MD; Lee Richter, MD; Tania Marek, NP and section director, Cheryl Iglesia, MD.

The state-of-the-art technology we use helps us focus on innovation, patient safety and excellent long-term results. You might be surprised to hear that the surgical healing process for our patients has significantly improved. This is not your mother’s prolapse repair or hysterectomy: most urogynecologic and advanced pelvic surgeries are performed laparoscopically, robotically or vaginally, resulting in a much faster healing process than traditional abdominal repair. These minimally invasive processes find 95 percent of our patients go home the next morning. Their post-op nausea and vomiting is minimal. Most no longer require pain medication on the second post-op day, and one fourth never fill a prescription for narcotic pain relief.

If you have questions about referring a patient, or how we can work with you, please call us at 202-877-6526 at the Hospital Center, or 202-416-2000 at Lafayette Centre.