The MedStar Medical Group leadership team includes John Martin, MD; Brendan Furlong, MD; Richard Goldberg, MD; Bill Frohna, MD; John DeSimone, MD and James Welsh, MD.
We’re proud of the high quality and safe care that takes place every day at MedStar Washington Hospital Center. In fact, we encourage our physicians to bring clinical observers to all of our procedural/surgical areas, so they can see first-hand how we provide that care. Whether the observers are visiting physicians, Advanced Practice Clinicians, nurses, therapists, students or clinicians from professional medical organizations, we welcome them to watch our teams in action.

One thing we need to ensure, however, is the privacy and safety for our patients and for our procedural teams—which is why it’s important for everyone to understand Standard Practice 602.03, “Observers in the Procedural/Operative Areas,” which covers all clinical observers.

Clinical observers cannot take part in direct patient care activities, and must not compromise or interfere with patient care or any quality and safety standards. Observers must stay with the host/sponsor, and fall within the guidelines of the Standard Practice if they visit these areas of the hospital:

- Main Operating Rooms
- Third Floor OR
- Cath Lab
- Electrophysiology Lab
- Interventional Radiology
- Endoscopy Suite
- Women’s and Infants’ Services areas

The policy does not apply to residents or faculty applicants, who are covered under a Graduate Medical Education policy; vendors, who are covered under a separate Standard Practice, 499.04; and members of the media, who must be approved and escorted by a member of the Public Affairs & Marketing team.

Please remember that if you are the host, you are responsible for obtaining the required approvals for your observer. There are five (5) documents outlined in the SP that must be completed and returned to Caren Lewis, MSHA, BSN, BSHA, RN, vice president, Perioperative Services or the area’s appropriate leadership, at least two (2) weeks in advance of the scheduled observation. If you have a last-minute request, if all the documents are completed and approved, a special arrangement can be granted.

Your five documents include:

- Observer authorization form
- Clinical observation information sheet
- Confidentiality agreement for clinical observers
- Patient consent for clinical observer
- Occupational Health—observer health requirements

It’s important to remember to return the documents to Perioperative Services, as these records are kept for audit by our Chief Compliance Officer, Beverly Allen.

Key points to remember, if you are the host:

- You are responsible for speaking to the patient, to explain that the observer is not part of the patient’s healthcare team, and to get documented consent for the observer to be present.
- You must inform the observer that s/he cannot be in the procedural/operating area if s/he is ill.
- You must ensure that there is no physical contact between your patient and the observer, and you must accompany the observer at all times.
- If your observer fails to follow hospital policies, procedures, rules, guidelines and requirements, or becomes a threat to the health or well-being of patients, clinical team members or others, or if you cannot provide supervision for the observer, the hospital can terminate a clinical observation at any time. Should that occur, your future host privileges may be revoked.

This Standard Practice is important not only for HIPAA reasons, but for infection control in our procedural areas. As we “Drive to Excellence” for our serious safety events, and “Drive to Zero” for quality measures where we seek higher scores, this SP means we have one more tool in our arsenal, to keep our patients safe and on the road to better health.

If you have any questions about the Standard Practice, please contact Caren, at 202-877-9202 or caren.c.lewis@medstar.net. If Caren is unavailable, Nicole Bowman, administrative coordinator for Perioperative Services, can also help you, at 202-877-0290, nicole.bowm an@medstar.net.

Gregory J. Argyros, MD, MACP, FCCP is senior vice president, Medical Affairs & Chief Medical Officer. He can be reached at 202-877-7202 or gregory.j.argyros@medstar.net.
The patient, a 65-year-old woman, presented to her primary doctor with an enlarging inner thigh mass. She was referred to a plastic surgeon for evaluation. That surgeon believed the mass to be a lipoma, a common and benign soft tissue tumor. As a result of this diagnosis, no pre-operative imaging was done before her scheduled procedure. She underwent a simple excision as an outpatient procedure.

However, after surgery, the patient’s pathology report found the tumor was not benign, but was a high-grade, undifferentiated pleomorphic sarcoma (HG-UPS). This type of soft tissue sarcoma is a highly malignant form of cancer that arises in soft tissues, particularly in the extremities. Soft tissue sarcomas are very rare, representing less than one percent of all cancers that occur.

Such a rare tumor requires specialized treatment from experts with experience in sarcomas. The woman was referred to Robert Henshaw, MD, who leads the orthopaedic oncology team at MedStar Washington Hospital Center, one of the largest centers for soft tissue sarcomas in the region. Dr. Henshaw has personally operated on more than 1,500 patients with soft tissue sarcomas.

Dr. Henshaw also noted a complicating factor from her prior surgery. “The original incision was oriented in the transverse direction, instead of an extensive longitudinal direction, which complicated the limb-salvage surgery for this patient,” he explains.

Dr. Henshaw ordered complete imaging of the woman’s limb, and a systemic staging for the patient. MRI imaging of the limb showed that the prior attempted resection had contaminated multiple tissue planes. CT imaging of the lungs showed that there was no evidence of metastatic spread.

“We planned an extensive salvage limb-sparing surgery, to remove the entire site of the previous surgery and the affected tissue planes,” he states. “The skin incision was completely excised as well, with conversion of the transverse incision into a longitudinal, extensile incision.”

Unfortunately, it is not unusual for Dr. Henshaw and his team to see cases such as this. “We recommend pre-operative imaging of any enlarging soft tissue mass, to distinguish lipomas from other solid tumors,” he says. “Biopsies of suspected sarcomas should be performed under the direction of a trained musculoskeletal oncologist, as well, and surgical planning should include use of extensile incisions.” The best chance of a long term care is complete surgical removal of the entire tumor, he adds.

Following her surgery, the patient also received adjuvant external-beam radiation to her thigh, to reduce the risk of local recurrence due to her initial surgery. Two years later, she remains cancer-free, and is back to all of her normal activities without any restrictions.

“With timely diagnosis and proper treatment, many of these cancer patients can enjoy a successful outcome,” Dr. Henshaw notes.

For any question, or to refer patients to Dr. Henshaw, contact him at robert.m.henshaw@medstar.net or 202-877-3970.
MedStar Medical Group (MMG) has a compelling strategic purpose: create an aligned and engaged clinician enterprise that will design and implement a system-wide, standardized clinical care delivery model. This model is foundational to the MedStar 2020 strategy and to the population health journey now underway.

To fully integrate the wide-reaching resources of MedStar Health, MMG is fostering connectivity among all employed providers across the system, with the effort led by providers. On January 1, Richard Goldberg, MD, former president of MedStar Georgetown University Hospital, became MMG president. He formed a team with extensive practice knowledge and involvement with MedStar Health, to make the MMG vision a reality.

Involving All Providers

“This is not an organization with top-down decision-making,” Dr. Goldberg says. “We aim to involve providers to develop a seamless, connected medical group that we can be very proud of. We are acting as facilitators to galvanize provider engagement and make practice better for them and their patients.”

“Within MMG, and across MedStar, we recognize the exceedingly important role of private practice physicians in MedStar’s Distributed Care Delivery Network,” adds Dr. Goldberg. “As we advance our clinical and business priorities within MMG, we will be looking for creative, meaningful ways to engage this loyal group of affiliated physicians, talk about how we can support each other, achieve shared goals and continue to partner to deliver the very best care to our patients and our communities.”

MMG is a diverse group of providers—physicians and Advanced Practice Clinicians—both geographically and by specialty. The entire enterprise has more than 4,000 providers, making it one of the largest in the nation. Defining the size and components of the group has helped to align and sequence priorities. Internally, MMG uses designations of “MMG-A” and “MMG-B” to define the group structure. MMG-A, in general, is comprised of providers employed by a MedStar hospital. MMG-B consists of providers and practices employed by MMG.

Providers will have increasing opportunities to benefit from the experience of others, and more easily coordinate care for their patients through true connectivity with their colleagues. Patients can be assured they will receive the same high quality of care from every MedStar provider at every MedStar site, with their care fully integrated. “To accomplish this, in the next six months we will advance these important shared strategic tasks,” Dr. Goldberg says:

- Implement the new ambulatory Electronic Health Record (EHR), with the optimization phase in 2017
- Hardware best practices around business and financial operations
- Improve productivity in primary care practices
- Improve patients’ access to care, especially for referral management
- Develop specialty-specific Clinical Practice Councils

A Governing Council that includes nine physicians and one advanced practice clinician from across MedStar Health helps foster the synergy needed to fulfill MedStar’s goals for its medical group. It advises on all related initiatives, and has geographic diversity and representation by different specialties.

Council President Bill Frohna, MD, says, “This cross-pollination from different leadership groups ensures we maintain lateral connectivity among all the groups working on this. Our over-arching theme is to provide care to the right patients, at the right time, at the right place, at the right cost.”
Electronic Health Record
Brendan Furlong, MD, is vice president and Chief Medical Information Officer for MMG, and is tasked with the rollout of the new ambulatory EHR.

“Our focus this year is to move all providers using Centricity to the MedConnect platform, also known as MedConnect. Using Centricity will migrate to optimize its use. Practices not currently using Centricity will migrate to MedConnect. During the next few years, MedConnect will incorporate customizations suggested by physicians across MMG to optimize its use. Practices not currently using Centricity will migrate to MedConnect. “

Primary Care Practices
MedStar owns and operates nearly 50 primary care practices from Leonardtown, Md., to Alexandria, Va., and to Damascus and Bel Air, Md. There are also a number of hospital-based primary care practices.

James Welsh, MD, is MMG’s vice president of Primary Care. “My initial focus is to visit as many sites as possible, to work to improve operations and productivity, and to enhance physician engagement and satisfaction,” he says. “We want to find out how we’re delivering primary care throughout the system, so we can identify best practices. We won’t be dictating to anyone how to provide care; instead, we’ll be sharing best practices. A stronger primary care base benefits all clinicians.”

Clinical Practice Councils
A total of 21 specialty-specific Clinical Practice Councils will be developed, to function as forums to engage physicians in identifying best practices for clinical and business operations, Dr. Goldberg states.

“This is an opportunity for physicians to sculpt their practices through a shared synergy, which maximizes office operations and identifies best practices. This provides improved access for patients, and greater continuity of care.”

John DeSimone, MD, is one of two vice presidents of Medical Operations, working with employed providers at MedStar sites, and developing Clinical Practice Councils for 11 medical subspecialties. Each Clinical Practice Council will have a leadership group, consisting of representatives from each hospital. To form the councils, Dr. DeSimone is establishing personal relationships with department heads, to ensure buy-in. Department heads can then select a representative to the leadership group, and the group populates the committees with leaders from that specialty.

Each practice council will have set tasks to unify and align providers across the system:

- Implement information management practices
- Develop quality and safety matrix
- Decrease variations in care/establish best practices
- Develop operational efficiency
- Contribute to value analysis of equipment and supplies, when appropriate

The councils offer a special opportunity to develop trust. “Once they’ve worked together, they can trust each other and resolve any issues,” Dr. DeSimone says.

The councils will also benefit from system-wide resources. Quality personnel working throughout MedStar Health will advise councils on the development of quality and safety measures. Project managers will be available to guide and support projects that the councils undertake.

“We’re working from the bottom up, so practice councils develop their own frameworks,” Dr. DeSimone says. “The councils will align with other initiatives across the system.”

John Martin, MD, is the other vice president of Medical Operations for MMG, and is working with employed physician groups and developing Clinical Practice Councils for surgical, behavioral and rehabilitation subspecialties.

“Because many of our physician groups operate outside as well as in the hospital, this complicates clinical operations,” he says. “Much like a symphony, we need all of the players working in harmony to make it work. Optimizing business and clinical needs is a daunting challenge. To accomplish this, we need a solid foundation of policies and procedures with tangible metrics displayed in accurate user-friendly dashboards. The data needs to be actionable and trustworthy. With information, we can leverage the combined expertise of our growing organization and improve quality, while controlling costs.”

“We’re working closely with groups, to create a system of care that finds the ‘sweet spot,’” Dr. Martin continues. That sweet spot takes into account patient outcomes, patient satisfaction, finance and internal staff satisfaction. “We want to optimize those four parameters,” he states. “We think internal staff satisfaction is as important as the other measures.”

“This won’t be imposed on groups; they will be part of this,” Dr. Martin promises. “By engaging in this new system, you can build the health care system of the future. As we expand our focus from the treatment of acute events within our outstanding hospitals to management of chronic illness in both inpatient and outpatient settings, finally to the prevention of disease states in multiple creative venues, it becomes significantly more important to establish connectivity between the inpatient and outpatient arenas.”

“Our vision is to make MedStar Health THE place where patients know they will get outstanding medical care, and make MedStar Health the destination of choice for health care providers,” Dr. Frohna concludes.
It all started several years ago, when Ronald (Artie) Tekel, then living in Arizona, went to his doctor for a routine checkup. Blood tests revealed an elevated serum calcium, and he was referred to an endocrinologist for follow-up. Additional blood tests showed a marked excess in human growth hormone.

Tekel relocated to Bethesda, and saw a local endocrinologist. Still more blood tests showed abnormally high levels of other hormones, and he was referred to the team of pituitary specialists at MedStar Washington Hospital Center.

Preliminary observation by Edward Aulisi, MD, chair, Neurosurgery, an expert in pituitary adenoma surgery, confirmed an unusual condition and a marker for a pituitary disorder: acromegaly.

“The signs had been there all along, but they were subtle,” Tekel says. He had pronounced facial characteristics consistent with acromegaly. His shoe size was steadily increasing, another classic diagnostic cue.

MRI demonstrated a resectable, benign tumor. Since the patient was otherwise healthy and an excellent surgical candidate, Dr. Aulisi promptly scheduled surgery, and enlisted Stanley Chia, MD, vice chairman, Otolaryngology, to assist with gaining surgical exposure to the pituitary gland through a minimally invasive approach.

“The surgery was on a Monday, and I went home on Thursday,” Tekel, now 59, recalls. After two weeks, he was enjoying all the activities of daily living, and with more energy.

“I was very happy with the care and direction I received,” he says. “The doctors took a wider view of my body and me, to come up with the right diagnosis.”

MedStar Pituitary Center: A Team Approach to Pituitary Conditions

In the past, patients with a suspected pituitary condition had to travel from one specialist to the next, to obtain a diagnosis and then undergo treatment. Now, patients have access to a multidisciplinary team at the MedStar Pituitary Center at MedStar Washington Hospital Center. It is the region’s only fully integrated program, offering patients the convenience of a full array of diagnostic and treatment options in one location on the same visit.

The team is comprised of specialists in endocrinology, neuroradiology, neuro-ophthalmology, neurosurgery, otolaryngology and radiation oncology. A patient coordinator oversees all facets of care. The patient sees all the specialists who may be involved in his or her care in one place, often on the same day. Afterward, the team meets to discuss the patient and customize an the optimal treatment plan.
“We provide diagnosis, treatment and care for patients with all kinds of pituitary disorders,” says Edward Aulisi, MD, medical director of the Center. “We offer first opinions, second opinions, and we treat the most complicated cases.”

“This is one of only a few programs that is focused on pituitary treatment,” adds Stanley Chia, MD, who works in tandem with Dr. Aulisi to perform minimally invasive surgery. “We offer a true multidisciplinary approach.”

When surgery is indicated, a minimally invasive, endoscopic approach is often possible. The benefits of this approach are smaller incisions, less damage to surrounding tissue and a faster recovery with fewer complications. Most patients leave the hospital after 48 to 72 hours, and resume normal activities in several days.

### Brainlab Technology Used

The team has performed hundreds of pituitary resections, more than any other program in the Washington metropolitan area. Brainlab technology—high-resolution image guidance in the operating room—provides surgeons with detail and focus that is accurate to less than 1 mm, allowing for precise results. Surgeons at MedStar Pituitary Center have an exceptional depth of expertise, with the most advanced Brainlab technology currently available.

Drs. Aulisi and Chia perform two kinds of minimally invasive operations to remove pituitary tumors, depending on the tumor’s size and location.

The trans-sphenoidal approach involves opening the sphenoid sinus through an incision in the nose or under the upper lip. Dr. Aulisi then removes the tumor through the incision. In neuroendoscopic surgery, Dr. Chia makes a small incision in the back of the nasal septum, opening access for Dr. Aulisi’s insertions of an endoscope for visualization and removal of the tumor. Larger or more complicated tumors may require removal through a standard craniotomy. Patients recover in a dedicated neuro-intensive care and neuro-intermediate care units, staffed by experienced, specially-trained nurses and neuro-intensivists. Long-term follow up, typically by the Center’s endocrinologists, ensures patients remain symptom-free during their lifetime.

Some patients may require radiosurgery to remove residual tumor. The Hospital Center is the only site in the metropolitan region with EDGE™ technology, a system that uses real-time tumor tracking technology, fully integrated with motion management capabilities with superior results.

### Cutting-Edge Research

The team is actively involved in cutting-edge clinical research toward maintaining a dominant position in the field. Joseph Verbalis, MD, a prominent endocrinologist and researcher in pituitary disease, leads the Georgetown Clinical Research Center. Susmeeta Sharma, MD, new director of pituitary endocrinology for the Center, completed her fellowship at the Hospital Center, and most recently, held a staff position at the NIH division of Endocrinology, specializing in pituitary disorders.

Dr. Aulisi emphasizes that the team follows all patients closely to monitor their condition. “We focus on developing long-term relationships with our patients,” he concludes. “This ensures the best results.”
The Next Step… for Three Residents Who Have Shared Their Stories

Guillermo Rivell, MD, Internal Medicine
32, married; new dad for daughter, Carlota, born last Oct.; lives in Adams Morgan; from Augusta, Ga.
BS in Biology, Wake Forest University; MS in Biomedical Research, Universidad de Navarra, Pamplona, Spain; MD, Medical University of South Carolina

Jason Chen, Surgery
31, engaged; wedding date is Sept. 17, 2016; lives in Columbia Heights; from San Mateo Valley, Calif.
BS in Molecular Biology, University of California at Berkeley; MD, Vanderbilt University School of Medicine

Alex Shuster, MD, Emergency Medicine
29, single; lives in the U Street area; from McLean, Va.
BS, Cognitive Science, University of Virginia; MD, Georgetown University School of Medicine

In 2013, 79 fresh-faced doctors started their residencies at MedStar Washington Hospital Center. Before they arrived, three of them—Jason Chen, MD; Guillermo Rivell, MD, and Alex Shuster, MD—agreed to be interviewed about their hopes and expectations for their medical training here.

In 2014 and 2015, they again shared their insights as first and second year residents, focusing on the challenges they faced both in the hospital and in their not-so-free-time, and on their expectations for the following year.

In June, Drs. Rivell and Shuster graduate. Dr. Rivell has accepted a hospitalist position at Virginia Hospital Center in Arlington. Dr. Shuster will join the Emergency Department at Washington Adventist Hospital. Dr. Chen is taking a year off from his five-year residency, to complete a fellowship at MedStar’s Firefighters’ Burn and Surgical Research Laboratory, under the mentorship of Jeffrey Shupp, MD, director Burn Center, MedStar Washington Hospital Center. Dr. Chen will resume his final two years of surgical training in July 2017.

Third Year Changes
This, their third year, has brought greater responsibility, greater leadership and, for Drs. Rivell and Shuster, the final preparation for their new careers. As Dr. Rivell starts his job as a hospitalist, he says he goes in feeling confident in the skills he’s honed while at MedStar Washington Hospital Center.

“This hospital has the reputation as the busiest hospital in D.C., with some of the highest acuity patients,” he says, “so we are prepared to be in stressful situations and know how to react. That’s been the best part of this training. I’m confident even if I’m faced with something I’m not familiar with, I’ll know how to handle it and go forward. Other hospitals respect us for that.”

Dr. Shuster adds, “A big part of being an emergency physician is learning to think on your feet. Given the complexity of patients seen during my residency, I know that I now have the critical skills needed to succeed after graduation.”

Dr. Chen has thoroughly enjoyed his third year. In late March, he completed a five-week rotation on the Vascular Service, “working with Drs. Abramowitz, Massimi, Malik, Kiguchi and Woo,” he says.

“They are a fantastic new generation of attendings, who are approachable and strong supporters of hands-on learning in the operating theater. It has been gratifying to help people save their limbs and lives by creating arterial bypasses, removing obstructing plaques and repairing traumatic arterial injuries.”

All three say their schedules are still rigorous, but better than the second year. Dr. Shuster says, “It helps to see the light at the end of the tunnel. We are lucky that regulations have put in some safeguards about our work load, but we still work…a lot!”

Residency Challenges
The challenges all three doctors have faced during their residency haven’t changed dramatically in their time here. Knowing what to do, in what order, is the hardest part of their job. As they’ve taken on more responsibility, the challenge has grown with it.

Dr. Rivell cites the example of the 90-year-old woman who came in short of breath. At her advanced age, was it wise to perform a catheterization?

“Other institutions might say ‘no,’” he says. But the high level of the Hospital Center’s interventional cardiology program opens the door for such patients. “What mattered to me in this case,” he adds, “is, ‘what was she like at home?’ She lived independently and was otherwise mentally and physically strong, so we decided to open up some arteries, and she did fine.”

Another challenge is the need to be in multiple places at once. “I often find myself about to remove somebody’s gallbladder in the OR,” says Dr. Chen, “when I get paged to see a patient in the ED with a surgical emergency, such as dead gut. Luckily, I often have a chief and two astute interns, to help me divide and conquer the juggling act of delivering quality care.”

Dr. Shuster says his biggest challenge is balancing all the tasks. “That means learning to work faster, smarter, better, but never forgetting that you need to relate to your patients.”

Advice to Your Younger Self
If they could talk to their former selves, as new residents, what would they say?
Alex Shuster, MD, Emergency Medicine; Jason Chen, MD, Surgery; and Guillermo Rivell, MD, Internal Medicine, have shared their medical education journeys for four years.

Dr. Rivell would tell himself to “keep an open mind. You might think you’re on this path, but in the course of your residency, your world is going to turn over three times. But if something is really important to you, be persistent.”

Dr. Shuster would say, “Trust the process. During the last three years, things that were challenging are easier now, because I’ve done them so many times. Recognize when you have a weakness, get stronger at it and push yourself.” For example, he states, “intubation was really hard in the beginning. Now I’ve done so many, with different equipment and having to troubleshoot, that I’m confident.”

Dr. Chen would tell his younger self, “Make time to meet with a mentor each week, to discuss interesting cases and challenging experiences. Learn how things could have been done better.”

Advice to New Residents
To new residents, Dr. Rivell says, “Nothing is better than a smile. It might be the best medicine. You don’t need to be a rocket scientist to know that.” Dr. Shuster agrees. “As you develop your skills and knowledge base, you’ll do things faster, smarter and better, but at the same time, you have to be kind,” he says. “You can be the smartest doctor in the world, but if you can’t relate to patients, staff, your colleagues, you’re going to be sunk.”

Dr. Chen adds, “There are three A’s to strive for as a surgical resident: availability, affability and ability. Be present when called. Smile and introduce yourself warmly to the nurse, patient and family, even when you are hungry, thirsty and tired. Know the answer to the clinical problem. Sharpen your skills daily. Learn how the hospital works.”

He also adds, “You need to know that it does get better. One day, you will finally feel comfortable at the hospital, and have the answers resting in your back pocket.”

Outside the Hospital
For Dr. Shuster, things haven’t changed much during his residency. He still lives in the U Street area, spends most free time at the gym, local restaurants and bars, even though can’t remember the last time he visited a bar. He still speaks frequently with this father, an Emergency Medicine physician in Northern Virginia. They compare notes—sharing clinical tips, and giving each other perspective from the seasoned physician to the newly-minted one.

Dr. Rivell became a father last October, with the birth of his daughter, Carlota. He and his wife live in Adams Morgan. And with a baby seven months old, “Sleep is beginning to happen,” he says.

Dr. Chen continues to wear his “man-gagement” ring on a chain around his neck every day at the hospital. He will be tying the knot with his fiancée, Sarah Elizabeth Wineland, this fall in her parents’ backyard in the woods of southern Virginia. He is still on the path to becoming a community general surgeon, to serve where he is most needed in the country. But, he says, he is still open to specializing in much-needed specialties, such as Trauma and Burn surgery.
Match 2016
System-Wide Orientation for New Residents, Fellows

In March, Caitlin Sorensen waited in a large auditorium with the rest of her Georgetown University School of Medicine graduating class, to learn where she would be spending her next five years. Surrounded by family and friends, the 4th year students all opened their envelopes precisely at noon, just as 4th year medical students were doing all across the country. There was yelling and screaming and hugs and tears. For Sorensen, who matched at her 1st choice, there was joy. When she interviewed at other programs, she remembers the doctors she met always had something positive to say about MedStar. “It’s clear that the surgeons here are very well respected.”

When she begins her Integrated Vascular Surgery residency at MedStar Health this summer, Sorensen will have already experienced one of MedStar’s newest innovations. Her incoming class of residents and fellows will be the first to take part in a system-wide orientation.

New Orientation Process
In the past, each hospital handled orientation separately. In 2016, every incoming resident, regardless of hospital affiliation or specialty, will spend three days with colleagues from across the MedStar system. By the end of that orientation process, notes MedStar Health Vice President for Academic Affairs Jamie Padmore, DM, MSc, “We want them to feel an overwhelming sense of pride that they are working for a great system.”

Working for a system as opposed to an individual hospital provides residents with limitless opportunity, according to Padmore. “They have the world in their hands. The affiliation with an outstanding medical school like Georgetown offers valuable resources. It not only can help provide first-rate training in clinical skills, but can also help ensure that these new doctors become outstanding teachers themselves.”

Teaching has been a particular passion of Rebecca Evangelista, MD. Dr. Evangelista, a surgeon at MedStar Georgetown University Hospital, likes to share her own match story with her students. “I didn’t match to one of my top choices. I felt like a failure. And it was the best thing that ever happened to me.”

Dr. Evangelista has devoted a large part of her career to educating medical students. She is extending that to Graduate Medical Education (GME) in her new role, as director of GME Skills and Simulation Assessments. One of her primary goals in this newly-created position is to fully integrate GME throughout the entire MedStar family. Dr. Evangelista hopes to bring residents back together periodically throughout their training at MedStar, in a form of an inter-hospital learning cohort. “Skills such as communication and leadership are common across all disciplines. They aren’t unique to any one specialty.”

Quality & Safety are Key
The skills necessary to raise Quality & Safety to world-class levels are also necessary in every specialty. Before they set foot in a MedStar hospital, this year’s incoming residents and fellows will take part in an intensive three-day Quality and Safety boot camp, as part of the system-wide orientation. This program, based on the week-long Telluride Experience pioneered by MedStar Health Vice President of Quality and Safety David Mayer, MD, is a first of its kind.

Dr. Mayer, who matched in the only program he selected (“I may have been a little naïve”), points out that “during the last five to 10 years, residents want to be taught not only the clinical sciences, but they want to learn the best practices in Quality to provide the best care. It has been fun to see younger generations take such an interest in Quality and Safety.”

The U.S. military has a separate match. Gregory J. Argyros, MD, MACP, FCCP, senior vice president, Medical Affairs/Chief Medical Officer and Designated Institutional Official for the Hospital Center, matched at his first choice, at Walter Reed Army Medical Center.

“Residents are the cornerstone, in our goal of providing the highest quality and safest care and the best experience for our
patients and their families. Nearly 70 percent of all orders written for patients are written by residents. Their understanding of the basic precepts of our quality and safety program will be critical in our ‘Drive to Excellence/Drive to Zero’ serious quality and safety events.”

This interest in quality and safety shows up in tangible results. This past winter, Puneet Randhawa, MD, a resident at MedStar Union Memorial Hospital, was perplexed by a patient’s condition. Some digging uncovered a misunderstanding in the patient’s medications as reported by the family. Dr. Randhawa was recognized for her commitment to get to the root cause of her patient’s problems. She responded, “Empathy and perseverance are something we have learned at MedStar, and I am happy I could put it all to good use.”

From the time of the Match through the end of July, when new residents are settling into their routines, Jennifer Remington, MHSA, and her Graduate Medical Education team are particularly busy. “That’s like our Christmas season,” states Remington, who, as assistant vice president for GME at MedStar Health, has been intimately involved in all of the efforts to globalize the educational experience.

Remington and her team have worked hard to streamline the administrative side of GME. But beyond the paperwork, Remington never loses sight of the human side of GME. “The majority of our incoming residents are fresh out of medical school, and have never had a ‘real’ job. They come in as timid interns, and go on to flourish. Watching that transformation, that’s why I do my job.”

Organic Changes

Remington, Padmore and Dr. Evangelista all stress that the transformation of GME at MedStar is designed to be an organic process. Dr. Evangelista notes, “We are still feeling our way through, trying to determine what the individual program directors want and need. We don’t want to impose this from above. The program directors have been extremely enthusiastic about collaborating.”

The goal for everyone involved remains constant, to ensure that MedStar Health continues to be a world class provider of graduate medical education. As Dr. Mayer notes, “If you want to get the highest quality of medical care, you have to go to the front lines. You have to educate young doctors.”

By the Numbers: MedStar Health

- Through the main residency and fellowship matches offered by the NRMP (National Resident Matching Program) and the San Francisco match, MedStar Health will welcome 361 new residents and fellows in FY17.
- Our residency programs offered 293 positions, and our fellowships offered 80 positions through the respective matches.
- The overall fill rate was 94 percent (96 percent for residencies and 84 percent for fellowships).
- 11 residency positions were offered and filled through the Supplemental Offer and Acceptance Program® (SOAP®) process.
- Four fellowship positions were offered outside of the match.
- Seven percent of our incoming residents and fellows are graduates of osteopathic medical schools; 30 percent of our incoming residents and 34 percent of our incoming fellows are international medical graduates.
- 24 percent of our new residents are from local medical schools, including Georgetown University School of Medicine (32; 11 percent), George Washington University School of Medicine and Health Sciences (12; 4 percent), and University of Maryland School of Medicine (7; 2 percent).
- 18 percent of our new fellows are from local medical schools. The top local school is Georgetown University School of Medicine (7; 11 percent).

MedStar Washington Hospital Center

The Hospital Center offered 118 total positions in this year’s Match, with a 95 percent fill rate; 33 percent are international medical graduates.

In a separate Match process, the Ophthalmology Match results were announced in January. The incoming class of 2020, which begins July 2017, includes six School of Medicine graduates from George Washington University, Icahn at Mount Sinai, University of Mississippi, Medical University of South Carolina, Weill Cornell Medical College and SUNY-Buffalo.
Multiple New Options for Multiple Sclerosis

For his first 10 years in practice, Michael Batipps, MD, had next to nothing to offer his patients with multiple sclerosis. About the only treatment available was a course of high-dose steroids, administered after a flare-up, in an attempt to reverse some of the disease’s most recent damage. But results were short-lived, and treatments for subsequent relapses produced diminishing returns.

It was depressing.

“I watched my patients go from walking to a walker to a wheelchair. And then, to bed, where they remained for the rest of their lives,” says the MedStar Washington Hospital Center neurologist, and longstanding member of the National Multiple Sclerosis Society’s local healthcare advisory board.

Then came the mid-90s, and a wave of new drugs—interferon beta-1a, interferon beta-1b and glatiramer acetate—set off a sea-change in MS treatment and outcomes. For the first time in history, specialists had tools that could actually modify the course of the disease. While not a cure, the new injectable drugs had the potential to reduce the number of new or active central nervous system lesions, reduce the frequency of flare-ups and slow the progression of disability.

Today, they remain the first-line MS treatment, reducing relapses by 30 percent, and helping to transform MS from a devastating disease into a mostly manageable chronic condition for many, but not all. And that’s been a problem for the past 23 years.

The Newcomers

In 2010, the FDA approved the first-ever oral treatments for relapsing MS, fingolimod. That opened the floodgates for another round of new drugs—and new uses for existing ones—that holds forth hope and help for patients who either don’t improve on the older therapies, experience intolerable side-effects or have rapidly progressing disease.

Teriflunomide and dimethyl fumarate followed in quick succession, giving neurologists and their patients with intractable MS even more viable and effective options. In fact, the new orals have been proven to reduce flare-ups just as well as the injectables, and—in the case of dimethyl fumarate—even better, at 50 percent.

But all three come with a long list of serious complications. We also developed protocols to monitor patient status at regular intervals, and know when to stop treatment.

New Applications for Existing Drugs

Perhaps even more promising are some off-label uses of drugs approved for other diseases. One of them, the common epilepsy medication phenytoin (Dilantin), may offer some protection against optic neuritis, often one of MS’s earliest symptoms. Results of one study, funded in part by the National Multiple Sclerosis Society and presented at the 2015 annual meeting of the American Academy of Neurology, demonstrated that phenytoin reduced damage to the retina and optic nerve by 30 percent compared to the control group.

Another drug could go a step further by actually boosting myelination. Solifenacin, FDA-approved for overactive bladder, was shown in an animal model to coax stem
cells to differentiate into myelin-producing cells. Findings were published by the Journal of Neuroscience in early 2015.

On the least expensive and most natural end of the spectrum, vitamin D has emerged during the last few years, as an effective and well-accepted adjuvant therapy to reduce relapse rates and disability. The treatment is particularly helpful for African-Americans with MS, who, as a whole, produce lower levels of the substance than Caucasian or Asian patients.

Generating the most interest right now, however, is daclizumab high-yield process, a monoclonal antibody originally developed as a transplant rejection drug, and currently under review by the FDA for its applicability to MS. A major, phase 3 study of nearly 1,850 patients showed that daclizumab HYP performed significantly better than interferon beta-1a, with a 45 percent lower relapse rate, and 54 percent fewer new lesions. Moreover, the number of patients on daclizumab who had no evidence of disease activity two years after treatment was more than double that of the interferon group. Study findings were published in the October 2015 New England Journal of Medicine.

What’s Next
While neurologists and MS patients await the day when therapies can cure the disease and repair existing damage, the number and type of available and effective agents designed specifically for MS continue to mount. One new drug, already in clinical trials, has shown some success in blocking a specific antibody, anti-LINGO-1, that depresses myelin production. Hopes are that the therapy may actually be able to rebuild the protective nerve covering and reverse the course of the disease.

Until such time, however, specialists remain cautiously optimistic about the future of MS care.

“From my perspective, treating patients with MS is very rewarding today,” concludes Dr. Batipps. “We went from virtually no treatment in the 1980s to a range of approaches today. While we still have to face a learning curve for the new drugs, the most important message is the same: Start treating patients aggressively as early as possible. If you wait for relapse, you’ve lost the battle.”

The ABCs of MS
Altogether, approximately 400,000 Americans suffer from MS, one of the most common diseases of the nervous system worldwide. The disease eats away at the myelin sheath that shields the nerves and their electric messaging system. When that protective covering is gone, the system short-circuits, causing anything from numbness and difficulty walking to vision loss, paralysis and dementia.

Currently incurable and of unknown etiology, MS manifests itself in a wide swath of symptoms and acuity. It most often strikes adults 20 to 40 years old, with more women developing the disease than men. Individuals with an affected parent or sibling are also more likely to have MS.

Thanks to recent medical advances, there are at least 13 effective oral, injectable and infusible medications for MS today, with more in the immediate pipeline. For the best outcomes, treatment should be initiated immediately upon a definitive diagnosis by a neurologist experienced with the diseases’ subtleties and complexity.
Doctors’ Days

Celebrating physicians was an idea from a doctor’s wife, Eudora Brown Almond, who chose the anniversary of the first use of general anesthesia in surgery, March 30, as the date for the observance and recognition for physicians. The United States Senate and House of Representatives passed S.J. RES. #366, which President George H.W. Bush signed on October 30, 1990, designating the observance as a national holiday to be celebrated on March 30.

Each year, the Hospital Center takes time to thank and celebrate its providers, which includes all attendings, Advanced Practice Clinicians, residents and fellows.

Authors Day

The Medical Library celebrated this year’s Authors Day with

• 510 Journal articles
• 453 Posters, presentations, books and chapters

...which represented contributions from 18 Hospital Center departments, and others from:

• MedStar Franklin Square Medical Center
• MedStar Health Research Institute
• MedStar Heart & Vascular Institute
• MedStar Institute for Innovation
• MedStar National Rehabilitation Network
• MedStar Union Memorial Hospital
• Washington Cancer Institute

John Steinberg, DPM, FACFAS, program director, MedStar Washington Hospital Center Podiatric Surgery residency program; co-director, Center for Wound Healing at MedStar Georgetown University Hospital and professor of Plastic Surgery, Georgetown University School of Medicine, discusses the scholarly contributions with Gregory J. Argyros, MD, MACP, FCCP, senior vice president, Medical Affairs & Chief Medical Officer.
Showcasing Research: 2016 MedStar Health Research Symposium

The 5th annual Research Symposium brought nearly 500 attendees to the March event, and showcased more than 130 poster abstracts, on topics ranging from translation medicine in the emergency department to palliative care and nursing research. Each poster presented was peer-reviewed before being selected for presentation at the Symposium.

The keynote speaker was William H. Shrank, MD, MSHS, senior vice president, Chief Scientific Officer and Chief Medical Officer, Provider Innovation and Analytics, CVS Health. His presentation focused on the benefits of partnering with innovative healthcare organizations, such as MedStar Health, that rapidly adjust to better serve their patients.

A top score award was presented to Rachel Scott, MD, MPH, for her poster abstract, “Does Delivery after 40 Weeks Gestation Increase Maternal-to-Child Transmission of HIV in Well-Controlled HIV-Infected Pregnant Women?”

Welcome to New Members of the Medical & Dental Staff

Kendra Kneeskern, CRNA  Anesthesiology
Christopher Leung, AA  Anesthesiology
Vishal Patel, AA  Anesthesiology
Lisa Ramondetta, CRNA  Anesthesiology
Emity Rucker, CRNA  Anesthesiology
Chad Toujague, AA  Anesthesiology
Sheila Vibert, CRNA  Anesthesiology
Casey Zobel, CRNA  Anesthesiology
Donna Westervelt, CRNP  Cardiovascular Disease
Brian Bello, MD  Colorectal Surgery
Joshua Black, MD  Dermatology
Rachna Goyal, MD  Endocrinology
Natasa Janicic-Kahric, MD  Endocrinology
Jennilat Badamas, MD  Gastroenterology
Angela Bien, MD  Gastroenterology
Suzan Ebrahimi, MD  Gastroenterology
Alexis Gorden, MD  Gastroenterology
Rezvan Heidari, CRNP  Hematology/Oncology
Thelma Ayensu, MD  Hospitalist
Sarah Browne, MD  Hospitalist
Clyde Freeman, MD  Hospitalist
Fisseha Ghidey, MD  Hospitalist
Miriam Michael, MD  Hospitalist
Anteneh Zenebe, MD  Hospitalist
Jennifer Barnwell, CRNP  Internal Medicine
Julianne Camba, MD  Internal Medicine
Heidi Durden, CRNP  Internal Medicine
Harjinder Kumar, MD  Internal Medicine
Esteban Marquez, MD  Internal Medicine
Marie-Perez Muoghalu, MD  Internal Medicine
Ramin Pirouz, MD  Internal Medicine
Ramona Ramachandran, MD  Internal Medicine
Adrienne Collier, MD  Neonatology/Pediatrics
Jeremy Yardley, MD  Neonatology/Pediatrics
Matthew Edwardson, MD  Neurology
Nancy Judd, MD  Otolaryngology
Nitinkumar Patel, MD  Otolaryngology
Hyun Bang, MD  Radiology
Antonietta Discepolo-Chiancone, MD  Radiology/Neurology
Elizabeth Jones, CRNP  Surgical Critical Care

William H. Shrank, MD, MSHS, noted that MedStar researchers possess the ability and drive to support “real-time changes and adjustments” during the research they complete, and that these are supported by the “networked hospital and research system” that MedStar Health embraces.
Upcoming CME Conferences

26th Annual Controversies in Cardiac Arrhythmias
September 16 | The Cosmos Club | Washington, DC
Course Director - Edward V. Platia, MD
This one-day program is designed to provide clinicians with a review of selected topics for present day management of patients with cardiac arrhythmias, emphasizing new advances in the field and incorporating current guidelines and evidence-based principles of practice. The format will incorporate didactic lectures as well as case management studies and panel discussions with experts in the field.
For more information, please visit cme.medstarwashington.org/CICA

Adult Congenital Heart Disease in the 21st Century
September 23 | Omni Shoreham Hotel | Washington, DC
Course Directors - Anitha John, MD and Melissa Fries, MD
This conference will focus on several challenging aspects of CHD including the management of the adult patient with tetralogy of Fallot, transposition of the great arteries, and the pregnant patient with CHD. Specifically, the conference will address utilizing innovative imaging, medical and surgical/catheter based therapies in the evaluation and treatment of these patients.
For more information, please visit cme.medstarwashington.org/ACHD

Gastric Neoplasms: A Multidisciplinary Approach
September 24 | Park Hyatt | Washington, DC
Course Directors - Waddah B. Al-Refaie, MD; Nadim G. Haddad, MD; Dennis A. Priebat, MD
This educational symposium will update the medical community on the state-of-the-art care of gastric neoplasms while focusing on the importance of a multidisciplinary approach to the diagnosis and treatment of these rare and complicated disease entities including gastric GIST and gastric adenocarcinoma. National and international renowned guest speakers and distinguished faculty including those from MedStar Health and the Georgetown Lombardi Comprehensive Cancer Center will discuss the significant roles of targeted therapies, the use of organ-sparing surgery, the use of minimally invasive surgery and the management of advanced, recurrent and resistant GIST.
For more information, please visit cme.medstarwashington.org/GIST.

SAVE THE DATE FOR THESE ADDITIONAL FALL CME EVENTS:
October 1: Current Issues in the Care of Dialysis and Transplant Patients
October 1: Update on the Treatment of Heart & Vascular Disease
October 21: Management of ENT Conditions in Primary Care
October 29: Melanoma Biology & Patient Management 2016
November 17 - 19: 10th International Congress on Peritoneal Surface Malignancies

CME Transcripts are Available Online
You can download, print or e-mail your CME transcript. Visit http://cme.medstarwashington.org and click on “View Your CME Transcript” for complete instructions.

WEEKLY ACTIVITIES
Numerous continuing medical education opportunities, including Regularly Scheduled Series, take place each week at MedStar Washington Hospital Center.
For a complete list of CME activities, please visit: CME.MedStarWashington.org

16 PHYSICIAN | MAY/JUNE 2016
One of the quiet success stories at MedStar Washington Hospital Center is the new Discharge Hospitality Center (DHC), a safe and comfortable area with reclining chairs, snacks, a dedicated restroom and patient care technician coverage, where discharged patients can await transportation home.

“The DHC was created, as we looked at ways to support throughput when we are at full capacity,” notes Susan Eckert, MSN, BSN, NEA-BC, CENP, senior vice president and Chief Nursing Executive. “We needed a safe environment, where patients could wait for their transportation home, where they would be comfortable and have access to help, but were not lying in a bed after discharge simply because their ride had not arrived.”

The DHC was designed to assist with day-of-discharge bed management, and it has succeeded beyond initial expectations, notes Doris Medina, BSN, RN, 3C nursing director who is managing the DHC. “The number of patients utilizing the DHC has increased every month. We went from three patients per day at the start, to about 21 on average, and we continue to grow, as providers become aware of the service.”

At any given time, there are three patients in the DHC, who wait one to two hours for their ride. As they wait, they can receive their home medications from the pharmacy, and are offered free snacks and drinks. If they have questions, they can call their physicians from their cell phones, much as they would if they were already home.

If there are any emergencies, says Medina, “the PCT is there to call a rapid response, or seek whatever assistance is needed. It takes a while for everyone to feel comfortable with a new process.” Since units had grown comfortable with transporting patients to their rides, “the first few times they discharge to the DHC can seem like a strange process,” she adds.

Eckert notes that criteria for patient use of the DHC has been re-evaluated, allowing more patients to take advantage of this area. For example, diabetics can use the DHC, if they can independently monitor and treat their blood sugar. It is increasingly used by ambulatory surgery patients, because having PCT oversight and a comfortable setting provides a relaxing environment as they wait for their rides. As with all discharged patients in the DHC, ambulatory surgery patients must be alert and oriented, and able to move independently. Rides are confirmed before the patient is discharged and brought to the DHC. If no transportation has arrived by 8:30 p.m., DHC staff will follow up, to secure transportation.

Although use is growing, the DHC still has plenty of capacity, notes Eckert, saying it is designed for more patients than it currently serves. “We appreciate provider support for our patients’ use of the Center, and encourage them to educate patients and families before admission, so that they may be placed in the DHC as a comfortable location to relax and wait until they can go home.”
David Engorn, DPM, grew up in a family of four boys. Close as children, as adults, three of them now have an additional bond: they’re all known as “Dr. Engorn.”

The oldest Dr. Engorn is a board-certified pediatrician and anesthesiologist, and the next eldest is an orthopaedic surgery resident.

“It’s been exciting to have the three of us on this journey, and it has helped shape me and push me toward pursuing medicine,” says Dr. Engorn. “Seeing one brother go through residency before me helped me see the struggles and learn what to expect.”

And yet, once in his own residency, Dr. Engorn learned that no amount of brotherly observation can fully prepare anyone for being a chief resident.

“This is a role that you really don’t know how to prepare for until you’re actually in it, it’s all on-the-job training,” he says. “I’ve learned the importance of communication and transparency from a leadership standpoint, and making sure everyone sees and understands the big picture.”

Dr. Engorn notes that one of his biggest focuses this year has been to help residents adapt to an expanding residency program. It’s an evolution he knows is best for the future of the program and profession, but which understandably brings with it some bumps in the road. “It’s been nice to be a support system for the residents, and help them when they’re having concerns about their experience,” he says.

Despite having brothers in other specialties, Dr. Engorn’s decision to pursue Podiatric Surgery came in large part from spending time with an extended relative in the field, while he was a college student.

“I loved that the profession had evolved from an office-based physician to more of the busy, hospital-based surgical focus, with a wider scope of practice,” he recalls. “I could see his satisfaction and enjoyment in his work,” Dr. Engorn says of watching his mentor. “And I admired his ability to run and build his own practice.”

As a first-year medical student, Dr. Engorn participated in a medical mission to Léon, Nicaragua, that solidified his decision to pursue Podiatric Surgery. “It was an eye-opening experience for me, to see post-traumatic and congenital deformities in patients that had been left untreated, and were completely debilitating,” he says. “To watch a podiatric surgeon surgically correct them and have such a profound impact on the patients’ lives, and the gratification felt in treating those types of patients, was quite powerful.”

As Dr. Engorn’s chief year comes to a close, he has two exciting new adventures on the horizon: he’ll join his family member’s private practice, serving patients in Potomac, Md., and Northwest Washington, D.C.

“Being able to help create something—making something my own that I’ve helped establish and build—that’s pretty neat,” says Dr. Engorn.

He’ll have that opportunity to create something new in his personal sphere as well: in November, Dr. Engorn and his fiancée will be married in Mexico.

And what about that fourth Engorn brother—the one who isn’t a doctor. Does he ever feel left out?

“He’s actually an incredible musician,” Dr. Engorn says. “He’s a big joker with a great sense of humor, so he doesn’t feel the pressure to compete with us in any way!”
Lambros Stamatakis, MD
Urologic Oncology

Like many other future physicians, Lambros Stamatakis, MD, knew as a teenager that he wanted to pursue medicine. A high school advisor connected him with a local urologist. Every Friday, Dr. Stamatakis would travel to a Baltimore hospital, working as a research assistant in that specialty.

Then he went to college and forgot all about urology.

Dr. Stamatakis—now director for Urologic Oncology at MedStar Washington Hospital Center—was reminded of the specialty, when as a second year medical student, he spent a day shadowing a urologist, who invited him to perform a circumcision on a patient.

“I fell in love with it,” he says.

Call it love at second sight.

After graduating from the University of Maryland School of Medicine, Dr. Stamatakis completed his urology training at Baylor College of Medicine in Houston. While there, he often thought about a family friend who had struggled with metastatic prostate cancer. He saw the exciting therapies and other leaps in cancer treatment within this specialty that were leading to strong outcomes for patients. He decided to pursue a fellowship in Urologic Oncology at the National Cancer Institute (NCI)—but not before completing yet another fellowship in Endourology and Minimally Invasive Surgery.

“My wife was a year behind me in her plastic surgery training, so I decided to stick around Baylor for another year,” he laughs.

In fact, that training in minimally invasive surgery is now a critical part of his work at the Hospital Center. “The field of Urology has always been very advanced when it comes to technology, pioneering robotic surgeries ahead of other specialties,” Dr. Stamatakis notes. “It ultimately translates to a better patient experience.” He spends about 30 percent of his time on minimally invasive reconstruction surgeries, but increasingly, is also seeing how that type of surgery can impact oncology patients as well.

Dr. Stamatakis joined the Hospital Center a year ago, and says it has been an incredible year. “I’ve been able to work alongside my mentor, Dr. Mohan Verghese, who developed the foundation of an incredible program, upon which we’re really now just putting on the finishing touches,” Dr. Stamatakis says.

Previous to Dr. Stamatakis’ arrival, Dr. Verghese was the only fellowship-trained Urologic Oncologist within the Hospital Center, and the foundation Dr. Stamatakis describes was built during several decades. That groundwork, says Dr. Stamatakis, has allowed him, along with colleague Jonathan Hwang, MD, chair, Urology, to introduce minimally invasive surgery for an increasing number of surgeries, including robotic prostatectomies, and for treating bladder and kidney cancers.

One priority for his second year at the hospital will be ramping up clinical trials for bladder cancer, which Dr. Stamatakis focused on as a fellow at NCI, where he holds an appointment.

He also hopes to support and encourage existing efforts to create a multidisciplinary cancer center at the Hospital Center. “It’s the opposite of fragmented care,” he notes. “You have medical oncologists, radiation oncologists, social workers all coming up with a consensus for management, and then sitting down with a patient to minimize miscommunication.”

Dr. Stamatakis has two young daughters—ages 3 and 1—so most of his precious time outside of work is spent with his family. But when he gets the chance, Dr. Stamatakis loves spending time outdoors. Having grown up in greater Baltimore, he is also a deeply committed Ravens and Orioles fan.
Physicians’ Perspective

From the Desk of...
James Jelinek, MD, FACR
Chairman, Radiology

Our physicians have always read a wide spectrum of images, including imaging of the brain and spine, chest and abdomen studies, breast imaging and musculoskeletal specialty exams. We perform complex procedures, including aneurysm coiling, tumor embolization, diversion of obstructed livers and kidneys, declotting of large veins and arteries and biopsies of every organ except the brain and heart.

What began as a group of Radiology subspecialists at MedStar Washington Hospital Center has now expanded throughout the MedStar Health system. Starting in July, MedStar Medical Group Radiologists (MMG-R) will include MedStar Georgetown University Hospital. We will read studies from all of the MedStar hospitals except MedStar Franklin Square Medical Center, and we will also focus on our outpatient centers, which include surgical centers, PromptCare locations and offices.

As a 24/7 service, there will be eight physicians reading images overnight throughout MedStar Health. Our enterprise-wide system will always include second and sometimes third opinions for challenging cases, as our radiologists will have the capability to quickly confer with colleagues, even overnight. Our mantra is to have the best radiologists be able to read cases anytime, from any location.

MMG-R physicians provide acute diagnoses, from strokes to intracranial hemorrhages; obstructed airways to solid organ injuries; emergencies, such as pulmonary embolus and appendicitis, or an obstructed bowel; orthopaedic fractures and complications.

Our expertise includes specialists in MRI, CT and interventional radiology. We have experts in neuroradiology, neuro-ophthalmology, pulmonary, vascular and cardiovascular imaging, as well as subspecialists who focus on musculoskeletal and sports injuries. Others work closely with sarcoma services, our medical oncology and radiation oncology providers. We have eight women radiologists whose sole focus is in breast cancer diagnostic studies and biopsies.

As a system-wide service line, we appreciate your trust in us. If you have any questions, please contact Radiology leadership, at james.s.jelinek@medstar.net; james.spies@medstar.net or steven.h.brick@medstar.net.

James S. Jelinek, MD, FACR
Editor
Cheryl Iglesia, MD, FACOG
Associate Editor
Mark Smith, MD, FACPE
Editor Emeritus
Marge Kumaki
Managing Editor
Marlo Russell
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Gregory J. Argovas, MD, MACP, FACP
Sr. Vice President, Medical Affairs/Chief Medical Officer
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President
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