Nancy and Harold Zirkin Heart & Vascular Hospital

Gathering for the dedication were Stuart F. Seides, MD, physician executive director, MedStar Heart & Vascular Institute; Paul Corso, MD, chairman, Cardiac Surgery; Augusto Pichard, MD, senior consultant, Cardiac Innovation and Structural Heart Disease; retired pioneering heart surgeon Jorge Garcia, MD and MedStar Health President and Chief Executive Officer Kenneth A. Samet, FACHE.
As we go to print, we are working our way through the first 60 days of a revised scrubs policy, “Stay On, Stay Here.” Why did we need this change in policy? Consider this story, from the AORN Journal:

An Executive Nurse’s Perspective
“Received a call from a hospital that no leader wants to receive. I was contacted by the hospital’s infection preventionist nurse and epidemiologist, to inform us that a patient we cared for at our facility was in their ICU on a ventilator, fighting for her life, as a result of a meticillin-resistant Staphylococcus aureus (MRSA) surgical site infection (SSI).

The patient was the fifth person to have surgery in our center. The source of MRSA was not from our center—the patient’s husband’s scrubs were the source. The patient’s husband was a respiratory therapist in a major trauma hospital, and worked in that hospital’s ICU.

The patient washed her husband’s scrubs with their personal laundry. His scrubs carried MRSA, and contaminated the patient and the family’s laundry.”

The Centers for Medicare and Medicaid Services (CMS) recognizes the standards set for by the Association of periOperative Registered Nurses (AORN) as one of the nationally accepted standards for surgical services.

Who was affected by the policy revision? Anyone who works in our Operating Rooms, Cardiac Catheterization Lab, Electrophysiology Lab, Interventional Radiology and Labor & Delivery. The policy is available on StarPort > Policies > Standard Practices > New.

KEY changes (not all inclusive) that began July 1:

- Scrubs MUST be hospital laundered, and NOT worn outside the building
- Scrub jackets MUST be worn in restricted areas, if not scrubbing into a case
  - Jackets must be buttoned all the way up
  - Jackets should fit tight to arms
  - Jackets should be changed daily, or when soiled
  - Jackets should be worn when performing preoperative patient skin anti-sepsis
- Head coverings must COMPLETELY cover hair, ears, scalp skin, side burns and nape of neck
  - Reusable/skull caps can be worn when covered by approved covering (i.e., bouffant hat)
  - New disposable hood-style head covers and beard covers will be available
- Do NOT remove head coverings until soiled, leaving building or donning street clothes
- All facial hair should be covered
- New surgical mask must be donned before each new procedure
  - Discard/change surgical masks when wet or soiled, filtration lasts approximately four (4) hours
  - Do NOT wear masks hanging around neck
- ID badges should be worn daily, on outermost layer of surgical attire, except for anyone who is scrubbed
  - ID badges should be cleaned regularly, using a low-level disinfectant
  - ID badges should NOT be worn on a lanyard
- Jewelry can be worn in restricted and semi-restricted areas
  - Jewelry should be contained within the surgical attire
  - If jewelry can’t be covered by surgical attire, it should be removed

You will see the “Stay On, Stay Here” poster reminders throughout all operative and procedural areas, and we expect that the revisions will soon become second nature for everyone who works in these areas.

Quality and safety are the most important factors in all areas for the patient care we provide. Revising our scrubs policy is one more step, on our road to becoming a High Reliability Organization, which will help us with our “Drive to Excellence” for quality measures, and our “Drive to Zero” for serious safety events.

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.
When urinary incontinence is so severe that a patient stops leaving her home out of fear of embarrassment, it is clearly time to seek a definitive solution.

That’s the situation in which 64-year-old Kathelia Hair found herself. A complication during a hysterectomy caused a vaginal fistula, leading to urinary incontinence.

“It was beyond leaking,” Mrs. Hair says. “I had to use a diaper and a sanitary pad and even then I would leak through. I was so embarrassed, I stopped going anywhere.”

The first strategy was to wait for the fistula to heal on its own. When it was clear that was not going to happen, she had to wait until other medical conditions were resolved before surgery would be advisable. By the time she was a candidate for a urogynecological repair, almost a year had gone by.

Then Lee Richter, MD, Female Pelvic Medicine & Reconstructive Surgery, came to her rescue. Dr. Richter carefully analyzed Mrs. Hair’s condition, and explained what needed to be done. “I got my hope up again that I would get my life back,” Mrs. Hair says.

What Dr. Richter proposed was a two-part repair. During the first surgery, she closed the vaginal fistula through a vaginal incision. Then three months later, she performed a second surgery to reconstruct the urethra, which had been damaged by prolonged use of a Foley catheter.

“I harvested a piece of fascia from the lower abdomen and used that to reconstruct the urethra, creating a new continence mechanism,” Dr. Richter explains. “Now the patient can urinate when she wants to, with no leakage.”

Fortunately, Dr. Richter had previous experience performing this unusual procedure. She had worked in Rwanda, where this kind of case is more common.

The National Center for Advanced Pelvic Surgery at MedStar Washington Hospital Center is uniquely qualified to offer this kind of tailor-made surgery. Staffed with five fellowship-trained urogynecologists and one minimally invasive gynecologic surgeon, the Center has the expertise to perform the most complicated repairs.

It is also one of the nation’s largest urogynecology services. Each year, the Center sees some 2,000 new patients, operating on almost half of those patients.

“We have the breadth, depth, skills, experience and knowledge,” says Cheryl Iglesia, MD, director of the Center. “We can handle the most complex cases.”

And Mrs. Hair could not be happier about the result. “I have my life back!” she says.

To refer patients to the National Center for Advanced Pelvic Surgery, please call 202-877-6526.
More than 300 donors, former patients, health care staff, elected officials and guests gathered at MedStar Washington Hospital Center on June 16, to witness the dedication of the area’s first cardiovascular hospital. The occasion marked the end of years of planning, design and construction, and the beginning of a new era of tightly coordinated, centralized specialty care for the most complex cardiovascular cases in the region.

“This is an extraordinary milestone for our patients,” said Stuart F. Seides, MD, physician executive director of MedStar Heart & Vascular Institute (MHVI). “Every aspect of the new hospital was designed with patients’ comfort, convenience and safety in mind as we worked to create an environment conducive to healing.”

The new four-story, 160,000 square-foot facility was built at a cost of $60 million. The result is a state-of-the-art facility that unites virtually the entire heart and vascular healthcare delivery staff—cardiologists, cardiac and vascular surgeons, nurse practitioners, cardiac care nurses and other specialized caregivers—into one cohesive team in one location, for more effective, streamlined care.

“Previously, patients with heart problems could have received care on one of 10 different nursing units,” says Allen J. Taylor, MD, FACC, FAHA, chief of Cardiology at both the Hospital Center and MedStar Georgetown University Hospital. “This new configuration eliminates variability in care, while fostering communication and collaboration among team members.”

Adds Nancy Bruce, RN, BSN, MBA, assistant vice president for Nursing, “It also makes it possible for us to ensure that the patient/family experience is seamless, and care is coordinated every step of the way.”

From admission to discharge, all aspects of the new hospital-within-a-hospital help promote that goal. Patients are on units according to condition, treatment and acuity of care, leading to increased proficiency and teamwork for staff members. Patient floors feature their own echocardiography, X-ray and other non-invasive services for faster, more convenient examinations and evaluations. Stress testing is done on the first floor of the new space. The majority of the 164 patient rooms are also private,
furnished with couches and other amenities, to increase the comfort and satisfaction levels of patients and their families.

An expanded 44-bed cardiac critical care unit (CCU) combines the functions of the previous three units into one: recovery room, coronary CCU and cardiovascular surgery ICU. A unique feature is a central boom suspended from the ceiling for medical gasses, electrical and data outlets. By doing away with the old wall mounts, the design gives staff unfettered 360-degree patient access.

“The new, cutting-edge ICU will allow surgeons, intensive care physicians, nurses and mid-level practitioners to constantly improve care, comfort and efficiency for the sickest patients in the region,” says Paul Corso, MD, chairman, Cardiac Surgery. “The unit is structured for ever-expanding, high-tech monitoring and communication among caregivers, patients and families. Cardiovascular surgery will continue to innovate and add new procedures, because of the capabilities of the new ICU. The new Zirkin Heart & Vascular Hospital is the culmination of a dream for cardiovascular care in the mid-Atlantic region.”

The physical improvements position the Hospital Center—already the third busiest cardiac surgical center in the United States, an affiliate of the world-renowned Cleveland Clinic and nationally recognized for excellence in cardiovascular care—for even more achievements in the years ahead.

For that, thanks go to Nancy and Harold Zirkin and their $10 million leadership gift. “When Nancy and I learned about the vision of MedStar Heart & Vascular Institute and its important alliance with Cleveland Clinic,” Mr. Zirkin says, “we saw this as an ideal opportunity to bring together our strong interest in better health with the region’s need for world-class heart care. We’re thrilled we were able to help make MHVI’s dream a reality.”

Dr. Seides concludes, “We’ve always been blessed with some of the most talented and dedicated physicians and nurses in the country. Now, we are providing them with an environment that allows that teamwork to flourish—and ultimately allows us to provide the best possible patient care.”

WHAT’S INSIDE

- 160,000 sq. ft. dedicated exclusively to cardiac and vascular patients
- A separate entrance, lobby and admission office
- Outpatient clinic area, including offices for cardiologists and surgeons, an enlarged Echocardiography Lab and waiting area
- An expanded 44-bed cardiovascular intensive care unit, combining cardiac surgical recovery, coronary critical care and surgical intensive care into one (2nd floor)
- State-of-the-art technology throughout, including Echo Labs on each patient floor
- Four patient units with 164 mostly private rooms, housing:
  - Cardiac and vascular surgical patients and advanced heart failure patients (3rd floor)
  - Medical cardiology and post-cardiac catheterization patients (4th floor)
On June 18, 152 physicians completed their residency and fellowship programs, and celebrated with their friends and families at the House Staff Graduation. The Editorial Board of *Physician* congratulates everyone for a job well done!

### Residents

**Burn Research**  
Jenna Luker, MD, MPH, Residency, Surgery  
St. Barnabas Medical Center, New Jersey

**Dermatology**  
Kurt Wenk, MD, Faculty, Dermatology  
Kaiser Permanente

**Dermatology/Internal Medicine**  
Ohara Aivaz, MD, Private practice, California  
Pooja Sodha, MD, Private practice, North Carolina

**Emergency Medicine**  
Kevin Blythe, MD, Fellowship, Sports Medicine  
MedStar Washington Hospital Center/MedStar Georgetown University Hospital

Kayla Dewey, MD, Fellowship, Ultrasound  
MedStar Washington Hospital Center/  
MedStar Georgetown University Hospital

Daniel Herzberg, MD, Faculty, Emergency Medicine; MedStar St. Mary’s Hospital

Rajdeep Kanwar, MD, Faculty, Emergency Medicine; MedStar Southern Maryland Hospital Center

Michael Nitzberg, MD, Faculty, Emergency Medicine; Inova Alexandria Hospital

Jessica Palmer, MD, Faculty, Emergency Medicine; MedStar Southern Maryland Hospital Center

Jessica Shackman, MD, Faculty, Emergency Medicine; Howard County General Hospital

**Mallory Shasteen, MD**, Fellowship, Sports Medicine; U of South Carolina; Greenville Health System

Alexander Shuster, MD, Faculty, Emergency Medicine; Washington Adventist Hospital

Christie Sun, MD, Fellowship, Toxicology  
U of California at San Diego

**General Surgery**  
Nchag Azefor, MD, Private practice  
Sara Chaffee, MD, Private practice

Kara Monday, MD, Fellowship, Surgical Critical Care; Baylor Scott & White Health, Texas

Naderge Pierre, MD, Fellowship, Colon & Rectal Surgery; Georgia Colon & Rectal Specialists

Charlie Srivilasa, MD, Fellowship, Trauma & Surg Crit Care; San Antonio Military Medical Center, Texas

**General Surgery, Preliminary**  
Massoud Allahyari, MD, Residency, Radiology  
SUNY Upstate

Oluwabusola Binutu, MD, Residency, Radiology; St. Francis Hospital, Illinois

Jesse Chen, MD, Residency, Diagnostic Radiology; Staten Island University Hospital

Marco Ertreo, MD, Residency, Radiology  
MedStar Georgetown University Hospital

Cody Esler, MD, Residency, Anesthesiology  
SUNY Upstate

Laura Libuit, MD, Residency, Anesthesiology  
University of Maryland

Peter O’Halloran, MD, Residency, Radiology  
Mount Auburn Hospital, Massachusetts

Anushi Patel, MD, Residency, Radiology  
Hartford Hospital, Connecticut

Luke Rasmussen, MD, Residency, Orthopaedic Surgery; University of Florida Jacksonville

Elsa Stephen, MD, Residency, Radiology  
George Washington University

Candice Thompson, MD, Residency, General Surgery; MedStar Washington Hospital Center

Stephanie Van, MD, Residency, Phys Med & Rehab; Johns Hopkins

**Internal Medicine, Categorical**  
Hanuja Agnihotram, MD, Hospitalist  
Vidant Medical Center, North Carolina

Puja Chokshi Arora, MD, Fellowship, Hem/Onc; University of Virginia

Vijaywant Brar, MD, Fellowship, Cardiology  
MedStar Washington Hospital Center

Augusto Dulantio, MD, Fellowship, Infectious Diseases; National Institutes of Health

Sarah Genet, MD, Hospitalist, Internal Medicine; New Castle, Australia

Pankhuri Gupta, MD, Fellowship, Rheumatology; University of Texas Health at San Antonio

William Hsueh, MD, Fellowship, Gastroenterology; Ruby Memorial Hospital, West Virginia

Niyati Jakharia, MD, Hospitalist, Internal Medicine; MedStar Washington Hospital Center

Anil Jonnalagadda, MD, Hospitalist, Cardiology; MedStar Washington Hospital Center

Rahul Lakhotia, MD, Chief Resident, Internal Medicine; MedStar Washington Hospital Center

Abhinav Misra, MD, Chief Resident, Internal Medicine; MedStar Washington Hospital Center

### News

**Where Did they Go?**  
2016 House Staff Graduation

Where did they go?  
2016 House Staff Graduation

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**Residents**

**Burn Research**  
Jenna Luker, MD, MPH, Residency, Surgery  
St. Barnabas Medical Center, New Jersey

**Dermatology**  
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Kaiser Permanente

**Dermatology/Internal Medicine**  
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Pooja Sodha, MD, Private practice, North Carolina

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MedStar Washington Hospital Center/  
MedStar Georgetown University Hospital

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Rajdeep Kanwar, MD, Faculty, Emergency Medicine; MedStar Southern Maryland Hospital Center

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Jessica Palmer, MD, Faculty, Emergency Medicine; MedStar Southern Maryland Hospital Center

Jessica Shackman, MD, Faculty, Emergency Medicine; Howard County General Hospital

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MedStar Georgetown University Hospital

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Hartford Hospital, Connecticut

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Elsa Stephen, MD, Residency, Radiology  
George Washington University

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Stephanie Van, MD, Residency, Phys Med & Rehab; Johns Hopkins

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Sarah Genet, MD, Hospitalist, Internal Medicine; New Castle, Australia

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William Hsueh, MD, Fellowship, Gastroenterology; Ruby Memorial Hospital, West Virginia

Niyati Jakharia, MD, Hospitalist, Internal Medicine; MedStar Washington Hospital Center

Anil Jonnalagadda, MD, Hospitalist, Cardiology; MedStar Washington Hospital Center

Rahul Lakhotia, MD, Chief Resident, Internal Medicine; MedStar Washington Hospital Center

Abhinav Misra, MD, Chief Resident, Internal Medicine; MedStar Washington Hospital Center
Anand Nath, MD, Chief Resident, Internal Medicine; MedStar Washington Hospital Center
Kosmas Papaliadis, MD, Hospitalist, Internal Medicine; MedStar Washington Hospital Center
Jigar Patel, MD, Chief Resident, Internal Medicine; MedStar Washington Hospital Center
Alexander Reisner, MD, Hospitalist, Internal Medicine; Sibley Memorial Hospital
Guillermo Rivell, MD, Hospitalist, Internal Medicine; Virginia Hospital Center
Mariam Saleem, MD, Hospitalist, Internal Medicine; University of Maryland
Amir Taefi, MD, Fellowship, Gastroenterology University of California, Davis
Olga Takshyna, MD, Hospitalist, Internal Medicine; Montefiore Medical Center, New York
Alanna Teng, MD, Hospitalist, Internal Medicine; Shady Grove Medical Center
Vipin Verma, MD, Fellowship, Geriatric Medicine; University of Maryland
Charan Teja Yerasi, MD, Fellowship, Cardiology; St. Joseph’s Hospital & Medical Center, Arizona

Internal Medicine, Chief Residents
Barinda Chana, MD, Hospitalist, Internal Medicine; University of Buffalo
Mohammed Choudhry, MD, Fellowship, Critical Care; MedStar Washington Hospital Center
Chaand Ohri, MD, Hospitalist, Internal Medicine; MedStar Washington Hospital Center
Mubarak Sayyar, MD, Fellowship, Gastroenterology; Yale University

Internal Medicine, Preliminary
Nima Aghdam, MD, Residency, Radiation Oncology; MedStar Georgetown University Hospital
Jennifer Aronica, MD, Residency, Dermatology George Washington University
Amar Bhat, MD, Residency, Ophthalmology George Washington University
Maria Braileanu, MD, Residency, Diagnostic Radiology; Emory University School of Medicine
Alyson Engle, MD, Residency, Anesthesiology Johns Hopkins Hospital
Dean Flanders, MD, Residency, Ophthalmology Eastern Virginia Medical Center
Sana Indrees, MD, Residency, Ophthalmology University of Rochester Flaum Eye Institute
Lauren Keshishian, MD, Residency, Ophthalmology; Henry Ford Health System, Michigan

Jocelyn Kim, MD, Residency, Ophthalmology MedStar Washington Hospital Center/MedStar Georgetown University Hospital
Christopher Maxwell, MD, Residency, Anesthesiology; MedStar Georgetown University Hospital
Kirsten Midgley, MD, Residency, Ophthalmology; MedStar Washington Hospital Center/MedStar Georgetown University Hospital
Elena Mrozowski, MD, Residency, Anesthesiology; MedStar Georgetown University Hospital
Matthew Ning, MD, Residency, Radiation Oncology; MD Anderson Cancer Center, Texas
Katherine Tully, MD, Residency, Diagnostic Radiology; Brigham and Women’s Hospital, Massachusetts
Michael Ullman, MD, Residency, Ophthalmology; MedStar Washington Hospital Center/MedStar Georgetown University Hospital
Kurt Wagner, MD, Residency, Anesthesiology MedStar Georgetown University Hospital
Mary Walterhoef, MD, Residency, Dermatology; University of Maryland Medical Center
Pei-Kang Wei, MD, Residency, Diagnostic Radiology; Beth Israel Deaconess Medical Center, Massachusetts
Michael Wroten, MD, Residency, Phys Med & Rehab; MedStar National Rehabilitation Hospital
Yue-Shan Yang, MD, Residency, Phys Med & Rehab; MedStar National Rehabilitation Hospital

Obstetrics & Gynecology
Sonata Cooper, MD, Attending, Ob/Gyn St. Barnabas Hospital, New Jersey
Elizabeth Coviello, MD, Fellowship, Maternal Fetal Medicine; MedStar Washington Hospital Center
Nicole Doyle, MD, Fellowship, Endocrinology & Infertility; Reproductive National Institutes of Health
Katie Friday, MD, Private practice Baptist Health Women’s Care, Kentucky
Allison Giles, DO, Private practice Henrico Doctors’ and St. Mary’s Hospitals, Virginia
Toral Parikh, MD, Fellowship, Endocrinology & Infertility; Reproductive National Institutes of Health

Jessica Sommer, DO, Private practice Arlington Women’s Center
Michelle Sutherland, MD, Private practice Healthcare for Women, Virginia
Janelle Taylor-Thomas, MD, Private practice Premier Ob/Gyn, Maryland
Jocelyn Wertz, MD, Private practice Unity Healthcare, D.C.

Ophthalmology
Amelia Fong, MD, Fellowship, Oculoplastics University of Texas Southwestern
William Grover, MD, Fellowship, Cornea Johns Hopkins
Michael Korchak, MD, Fellowship, Cornea Cornell-Weill Medical Center, New York
Chad Marciantonio, MD, Fellowship, Retina Retina Center of Ohio
Peter Murr, MD, Private practice, New Jersey
Auvni Patel, MD, Private practice, New Jersey

Oral & Maxillofacial Surgery
Oxana Kojr, DMD, Private practice Vancouver, British Columbia
Scott Martyna, DMD, Fellowship, Cleft & Maxillofacial Surgery; Dalhousie University Hospital; Halifax, Nova Scotia
Donald Pitcher, DDS, Private practice

Orthodontics
Adam Best, DMD, Private practice, Florida
Chelsea Murphy, DMD, Private practice Virginia

Otolaryngology
Lacy Adkins, MD, Fellowship, Laryngology Massachusetts General Hospital
Marceil Cunabang, MD, Private practice California
Matthew Pierce, MD, Fellowship, Head/Neck Oncology, Yale, Reconstructive Surgery

Podiatric Surgery
Arash Changizi, DPM, Private practice Virginia
Tammer Elmarzafi, DPM, Fellowship, Diabetic Limb Salvage; MedStar Georgetown University Hospital
David Engorn, DPM, Private practice Maryland and D.C.
Tiffany Hoh, DPM, Private practice, D.C.
David Vieweger, DPM, Private practice Maryland and D.C.
Thomas J. Watson, MD, FACS, seeks to make MedStar Washington’s regional surgical services greater than the sum of its parts.

If you haven’t met Dr. Watson, the new Regional Chief for the MedStar Washington Integrated Surgery Service, chances are you will soon.

Since early April, Dr. Watson has immersed himself in learning everything about the surgical departments at MedStar’s Washington-area hospitals—an important first step, in an assignment that officially calls for him “to direct the Integrated Surgery Service, which includes General Surgery, Burn, Breast, Endocrine, Trauma, Colorectal, Thoracic, Hepatobiliary and Surgical Oncology across all sites in the Washington region,” and oversee “the further development and expansion of the teaching, education and research mission of surgical services for the region.”

A complex and formidable challenge, to be sure. But as an experienced surgeon leader, Dr. Watson knew exactly where to begin—walking the halls of the MedStar hospitals to “mix” with the physicians and patients.

“That’s really part of the fun of this job,” he says. “It’s a grassroots effort, to learn about the issues and culture at each hospital—what we already do very well in terms of patient care, which is quite a lot, and what we can do better.”

New Challenge in D.C.

A graduate of Stanford University and the University of Southern California’s Keck School of Medicine, Dr. Watson came to Washington after building a national reputation in thoracic surgery over a 20-year period with the University of Rochester Medical Center in New York. An expert in thoracic and foregut surgery, he served as chief of that division, while also leading the Medical Center’s surgical residency program.

While he could have easily spent the rest of his career in Rochester, Dr. Watson was intrigued by the opportunity to cultivate an integrated surgery program, one that would serve highly diverse communities spread across a geographically large service area.

“Fundamentally, my role is simple—make us a system that’s better than what’s already available—both internally, and what’s offered by...
our competition,” Dr. Watson says. He adds that MedStar’s Washington-area organization is uniquely positioned to fulfill that goal, with two multi-disciplinary tertiary care hospitals boasting nationally-recognized programs, and a network of smaller, community hospitals.

“No other hospital system in the area has these capabilities,” he says. “That’s part of the excitement of this opportunity, and part of the reason why I came here.”

Treatm ent Close to H om e
Another advantage offered by the MedStar system, he says, is multiple points of access into the system, allowing patients to be treated for many conditions close to home.

“This is the way surgery is going as well,” Dr. Watson says. “Meeting that need requires us to distribute our services and support our care providers in the most optimal way, so that we achieve a balance across the available environments. The result benefits both our patients and our physicians.”

Dr. Watson is also the first to admit that even with those advantages, his assignment isn’t easy. Fundamental to success is integrating seamlessly the already solid platforms and well-established cultures in the surgical departments at MedStar Georgetown University Hospital and MedStar Washington Hospital Center.

“Both have tremendous strengths,” Dr. Watson says, “and I’ve been pleasantly surprised to find that under the current set-up, those strengths complement each other quite well.”

Focus on Thoracic Surgery
One facet particularly close to Dr. Watson’s heart—in more ways than one—is to build the Thoracic Surgery program at the Hospital Center, to better align with services already provided at MedStar Georgetown University Hospital. That includes hiring a chief of Thoracic Surgery, a process already underway, and constructing space for a clinic, patient care unit and operating rooms.

“How and when that timeline unfolds will depend on who we hire, and what that person determines are priorities,” Dr. Watson says.

Overseeing the integration of surgical service lines for a large, metropolitan area hospital system was hardly a career milestone that Dr. Watson might have envisioned for himself, growing up in the Midwest. Indeed, the Chicago native admits that it wasn’t until college that he took a serious interest in the sciences.

“I liked the idea of helping people, but I didn’t have much perspective,” he recalls. “When I got into medical school, I knew it was the right place for me.”

Thoracic Surgery Focus
Dr. Watson was initially drawn to general surgery, which he characterizes as a broad-based medical and technical field that can bring about immediate results. But it was the arrival of renowned foregut specialist Tom DeMeester, MD, as professor and chair of USC’s Department of Surgery in 1991, which fully sharpened Dr. Watson’s career focus on thoracic surgery.

“I spent a year with him as a fellow, then two extra years at USC getting board-certified in cardiothoracic surgery,” Dr. Watson says of his mentor, who retired in 2009. “He truly influenced me to do what I’m doing now.”

And that includes seeing patients, even with a work schedule that is already bursting at the seams.

“I can’t imagine overseeing a surgery department without being in the OR; it’s where I’ve spent so much of my life,” Dr. Watson says. Though he’s still figuring out how to balance his time, currently split between the Hospital Center and MedStar Georgetown University Hospital, “I do hope to operate at both hospitals.”

Family Matters
Dr. Watson’s already-hectic schedule will become even more crowded this summer, when his family joins him in Washington. His wife, Lisa, is a former physical therapist who recently earned an MBA at the University of Rochester. The couple has six children—a 20-year old daughter, who plays on Stanford’s field hockey team; 11-year old triplets, a nine-year old daughter and a six-year old son.

As Dr. Watson makes his managerial and medical rounds of MedStar facilities, no one should have difficulty striking up a conversation. In addition to “talking shop” and surgery, he’s equally comfortable discussing music, as he was once a semi-professional bass player, and a member of the Stanford jazz band; he still plays the piano. He also is willing to talk about the fortunes of his beloved hometown Cubs.

“I have lots of things to learn, but I’m enjoying every minute of it,” he says. “We already have first-rate surgical service lines at the MedStar hospitals, with outstanding prospects for further growth and development. I’m looking forward to finding ways to make it happen.”

Dr. Watson, playing with his Stanford college band at their 25th reunion party
Patients with advanced illnesses face a variety of indignities—the specter of their own mortality, dramatically reduced physical abilities, constant pain. But little thought may be given to that most mortal of concerns—compromised physical intimacy.

That’s why palliative care specialists at MedStar Washington Hospital Center decided to explore the matter further. Hunter Groninger, MD, director of Palliative Care, and Anne Kelemen, LICSW, Palliative Care social worker, designed a simple tool to assess sexuality and intimacy concerns among patients hospitalized with advanced conditions.

During the pilot study, 57 patients at MedStar Washington Hospital Center and MedStar Harbor Hospital were asked these questions during a palliative care consult:

1. How much has your illness affected intimacy?
2. How has your illness affected your relationships?
3. Has this been discussed before during your hospital stay?
4. Is this helpful to talk about?

The researchers presented their findings to a recent meeting of the International Society for Heart and Lung Transplantation 2016 Scientific Sessions. The presentation focused on a key subset of these patients—18 patients receiving advanced heart failure (AHF) surgical therapies. Six had undergone heart transplantation and had their new hearts for an average of 62 months, and 12 had a left ventricular assist device (LVAD) with an average of 7.6 months since implantation.

Some 72 percent said that their condition had significantly or moderately impacted intimacy. For those facing the end of life, 83 percent reported the same feelings. All said that they had never been asked these questions before. Further, they wanted more conversation on the subject with their health care providers.

Defining Intimacy

Intimacy was defined broadly, including physical and emotional closeness, affectionate contact, sexual interactions and the communication of thoughts and feelings.

“Intimacy is bigger than just sexual intercourse. It can include cuddling, holding hands or playing with children or grandchildren,” Kelemen says.

Patients’ concerns included low libido, erectile dysfunction, lack of privacy and fear. They also cited difficulties in finding and maintaining relationships overall.

George Ruiz, MD, MedStar Heart & Vascular Institute’s chief of Cardiology at MedStar Union Memorial Hospital and MedStar Good Samaritan Hospital, wholeheartedly supports the work of the palliative care team. “By getting people with different points of view to focus on the same problem, we get to see more facets of care. This is another reason why multidisciplinary care teams are the best way to deliver care to patients with complex needs. This has made our focus even crisper.”

“We had talked about the issues around intimacy, and knew they were overlooked,” Dr. Groninger says. “Then a family member brought up the issue, and we realized that it should be part of all routine palliative care consults. Patients do want to talk about intimacy, however they define it for themselves.”

Helping Patient Discussions

But patients may not know how to bring up the subject. Kelemen describes such a case:

“I had a patient who had been hospitalized a very long time, and was nearing the end of his life. His wife wanted to talk to me; she wanted to have some ‘alone time’ with her husband, but didn’t know how to ask his doctors about that.”

Both researchers noted that important biases often exist. First, clinicians often assume that intimacy only means physical
sexuality or sexual health. Second, clinicians often assume that patients with advanced conditions were too sick to be concerned with intimacy and sexuality.

“But we found that even patients at the end of life wanted to talk about these issues,” Dr. Groninger says.

Dr. Ruiz, who was an advanced heart failure provider at the Hospital Center for 10 years, also believes that intimacy is important to these patients, and should be addressed.

“Heart failure systematically steals people’s humanity, taking away their ability to engage in living a full life,” Dr. Ruiz explains. “This includes walking around the house, climbing stairs and sharing intimacy. As physicians, we are so focused on the day-to-day challenges of caring for very sick patients, that we can overlook important quality-of-life issues these patients face.”

Kelemen stresses that addressing the issue is the whole point. “This is not just about addressing their concerns with VIAGRA®, it’s about having the conversation and encouraging conversations with their partners.”

All Clinicians Can Help
It can be simple to do. “This is something any clinician can do,” Kelemen adds. “We just need to raise awareness and facilitate conversation.”

Supporting the effort is Samer Najjar, MD, medical director, Advanced Heart Failure for MedStar Heart & Vascular Institute at MedStar Washington Hospital Center. “We recognize that intimacy is important to patients at every stage of life,” he says. “This is an important part of patients’ overall health.”

Now that the results are in, Dr. Groninger and Kelemen want to study the issue further. They are planning a larger study, to include other MedStar locations and medical conditions using more specific questions.

The end result? “We hope to educate providers about how to initiate this conversation,” Dr. Groninger says.
Laurie Abrams, MD, says, “It’s always very busy in the evenings. But every once in a while it will get quiet. Usually after 4 a.m.”

Gabe Schneider, MD, refers to such unusually calm downtime as “a little strange.”

Anil Taner, MD, had been working the overnight shift at MedStar Washington Hospital Center for about six months when the blizzard of January 2016 hit. “That was the only time things were quiet,” Dr. Taner recalls. “We’d have about fifteen minutes, where there would be nothing to do.”

Drs. Abrams, Schneider and Taner form three quarters of MedStar’s overnight team, radiologists who provide immediate overnight coverage at the Hospital Center and several other MedStar facilities. The fourth member of the team, Arnold Raizon, MD, was there at the inception of the program, six or seven years ago.

“Reliance on imaging technology is much greater than it used be.”

Radiology chairman James Jelinek, MD, says the program was Dr. Raizon’s idea. Prior to instituting dedicated teams to cover the overnight hours, radiologists would generally work their normal daytime schedules, and then trade off night-time shifts. It didn’t make for the best patient care.

Dedicated Teams

Working the occasional night was very disruptive, says Dr. Raizon. There was a trend toward overnight coverage at the time. Several large practices began offering their services on a national basis. Physicians could sit in a room in Minnesota, and read films from a hospital in San Diego. Dr. Raizon’s idea was to provide such coverage on a more personal basis throughout the MedStar system.

Physician Executive Director of MedStar Medical Group Radiology, Steven Brick, MD, has first-hand knowledge of benefits and challenges of an overnight radiology service. Prior to joining MedStar, he served as medical director of Virtual Radiologic (vRad), a national teleradiology service with more than 300 radiologists providing overnight coverage to more than 2,800 facilities. “Radiology has become a critical component of patient care 24/7,” says Dr. Brick. “Building MedStar’s internal teleradiology service allows us to provide the same quality of care at 3 a.m. as we do at 3 p.m.”

And according to Dr. Abrams, the technology changed. “Reliance on imaging technology is much greater than it used be.” Imaging tests can be used to diagnose an ever-increasing number of conditions. Dr. Jelinek remembers when performing head scans at night was a rare event. Now, he says, a busy hospital might get four to five head scans an hour. Having a radiologist on hand around-the-clock to offer advice on tests, and then to read the films and scans can make a huge difference.

Overnights Help ED

Tina Rosenbaum, MD, has been an Emergency Room physician at the Hospital Center for 12 years. She says there used to be a gap in coverage in the middle of the night. “Now, we get our answers immediately.” That means many patients can be safely sent home quickly, and when they need to be sent to the Operating Room, that too happens more efficiently.

It is not uncommon, Dr. Rosenbaum says, for the radiologist to take the initiative and inform the surgical teams when it is apparent that surgery will be necessary. “They will link together all the different teams, and keep the lines of communication open. That helps everyone.”
For Dr. Raizon, that type of teamwork is the entire key to what the radiologists do. “The technical staff has always had dedicated people who work at night. It makes sense that the physicians do, too. This way, we all get to know each other, which leads to better patient care.”

**Teamwork Challenges**

The radiologists work in pairs. One will take the evening shift from 5 p.m. to 2 a.m. The other will work overnight, from 10 p.m. until 7 a.m. They work seven straight days, and then have the next seven off.

The biggest challenge is the constant pressure. From the moment they log into the Radiology platform, they have a work list that generally keeps them busy for the entire shift, and that’s on a normal night. On nights when there are multiple trauma cases, the need for both speed and accuracy becomes enormous. “Your brain is always on. There is no downtime,” Dr. Schneider says.

But that is one of the very reasons why the radiologists take such pleasure in their work. All radiologists are integral to patient care, says Dr. Tanner, but overnight, “you are often the decision point. You can make the most difference.”

**Overnight Benefits**

As for the non-traditional work hours, that can be a challenge. Coming off the overnight shift, it usually takes Dr. Schneider about three days to adjust back to normal. He says he and his wife have learned how to communicate very rapidly during the weeks when he is working. “I’ve learned to become a great napper,” Dr. Raizon says. “If you’re doing this, you’re probably kind of a night person to begin with,” notes Dr. Abrams.

But there are some lifestyle pluses to working nights. The overnight radiologists at MedStar are off 26 weeks a year. And when they are not sleeping, they have their days free, something Dr. Raizon says he never enjoyed during his previous thirty years of practice. He also loves working from home. There is no commute, which means when he logs off from the early shift at 2 a.m., he can be in bed by 2:05.

Dr. Abrams enjoys the fact that she can control her environment. There are fewer distractions, and she can play the music she likes. Her diet is better, too. “If I’m in the hospital cafeteria and I have a choice between yogurt and a cupcake, I’ll take the cupcake every time.”

Before the overnight program, MedStar hospitals were covered by five different groups, all using different computer systems. The plan now is to hire four additional radiologists, and increase coverage to almost all MedStar facilities. Dr. Jelinek says the feedback from the ED and ICU has been overwhelmingly positive, a point on which Dr. Rosenbaum wholeheartedly agrees. Having the night hawks available not only results in faster, better patient care, it also cuts down on unnecessary tests. “It’s phenomenal,” she says.

**Teamwork Critical**

Often, the teamwork between the radiologist working from home and the physician in the hospital makes all the difference in the world. Dr. Rosenbaum recalls a patient who had been transferred from another facility with a suspected dental abscess. The radiologist initially found nothing extraordinary in the scan. Dr. Rosenbaum, with the advantage of having the patient in front of her, saw evidence of trouble around the eyes and asked for a second look. Then, the radiologist was able to pinpoint a sinus infection that required immediate attention.

It’s reassuring having radiological expertise even when the situation is not quite as dire. Dr. Rosenbaum recalls calling a radiologist to ask about an intriguing finding. A chest scan had revealed a “tiny pulmonary nodule” in the lungs. The transcription software had translated this as a “tiny pulmonologist.” Both physicians were happy to confirm that there was not, in fact, a very small doctor residing in the patient’s chest.

Despite spending their evenings and nights intimately involved with some of the technologically sophisticated aspects of medicine, all four radiologists stress that the personal relationships they have developed are the single best part of the job. Dr. Raizon, who has been there from the beginning and intends to work in this capacity for the remainder of his career, makes it very simple.

“I really like the people I work with at night. It’s not just about reading X-rays. So much of medicine is about the people.”
**VIEWPOINT**

**Devastating Medical Errors Need Not Devastate Providers**

*by Stephen Peterson, MD, chairman, Psychiatry*

What happens when a doctor maims or loses a patient, especially through a serious medical error? Many doctors have made serious medical errors in their career because, after all, to err is human. At times, the consequences can be severe and lasting.

What help is available for the unfortunate physician who makes a devastating medical error? To answer this question, we must first know ourselves.

Doctors have an idealized notion of themselves as perfectionists. This perfectionist self-image can be shattered when we make serious errors. Some doctors respond with guilt, self-blame, self-doubt, self-punishment, ruminations, obsessing about how this could have been prevented and loss of confidence.

Certainly, we are taught to undergo vigorous analysis of untoward events, determine root causes and improve our performance. This is what we owe the patient. Doing so fulfills our duty as physicians, and helps us carry on the next day, when we need to get up and do our rounds.

When the outcome is catastrophic, we must accept two losses: most importantly, the patient, but also, our own perfectionism. We need to acknowledge, bear and put in the proper perspective the loss of the patient and the loss of our perfectionist self.

Talking things over with a colleague, therapist or a risk manager can help. This helps one accept loss, and also puts things in perspective. Freud described the pain of grief as “exquisite,” and is really not possible to bear all alone. The shoulder of a friend, loved one or trusted colleague is a true support, as is confiding in a priest, minister, iman or rabbi.

Everyone grieves in his or her own way, but talking it through is a wonderful help. The doctor who loses a patient might tear up in the stairwell, but doing so with someone else is better, even for the toughest among us.
Neil wore a green Hawaiian shirt, white pants and orange tinted glasses to his first session. He had a guarded look. His sister brought him, because he was hearing voices again, and had been off his meds for some months. This behavior usually resulted in hospitalizations, but she hoped Dr. Willis, a psychiatrist fresh out of training, could help.

Neil began new medication, and seemed improved after several sessions. But after two months of therapy, Neal came in, and was pale. He reported his mother was at the hospital. A lump was found in her breasts, and the biopsy was pending.

At the next session, he came late. The voices were back, and his thoughts were rambling. He was very ambivalent about taking his medication, and left without a firm commitment.

Two days later, the sister called, very worried. Neil showed up, as scheduled, for his appointment. Dr. Willis asked him to take the medication again, and Neil walked out. Dr. Willis called the sister.

The next morning, the sister called back, crying. Neil was found at the arboretum, dead. He had slashed his throat.

Dr. Willis was terribly dismayed, and his mind went red-hot with anxiety. He managed to say to the sister, “could anything more have explained his action?”

“My mom’s biopsy was positive for cancer, and the doctor said he thought it had spread.”

This loss was early in the psychiatrist’s career, and he had real trouble coping. He said, “I scourged my soul.” Dr. Willis had lost his brother to the same illness, which made it especially hard to deal with the loss of this patient.

Dr. Willis discussed the case with a senior colleague, who observed that Dr. Willis was not thinking clearly. The senior colleague firmly recommended that Dr. Willis go and talk to a professional. Later, Dr. Willis admitted that it was the best professional advice he ever received.

During therapy, Dr. Willis learned multiple insights that helped him find relief from his severe adjustment reaction. He learned that in a busy practice, when dealing with high-risk patients, the average psychiatrist could lose a patient every five years to suicide. Fortunately, suicide is rare, but in high-risk populations, it certainly happens.

He also learned that when faced with a painful event in life, such as a mother newly-diagnosed with cancer, patients with schizophrenia often go off their medications, feeling it is easier to be psychotic and hearing voices, than to face the pain of losing one’s mother.

As to why it affected him so much, Dr. Willis realized that his guilt about losing his own brother made this loss of the patient especially difficult to accept. But he was able to accept it by acknowledging the losses, bearing them and putting them in the proper perspective.

He also learned that he was not perfect. Most religions help mold this incessant drive for perfection by helping us realize that we are not perfect. It is okay to try to strive for perfection, but we cannot expect it of ourselves.

Sadder but wiser, the therapy helped Dr. Willis grow in his ability to weather such disappointment as a physician. He has saved more than a few patients since he lost this first one. He has become invested in safety, and continuously tries to improve the way he cares for his patients. This practice is what all doctors must do; it makes it possible to live with oneself, and carry the heavy responsibility of being a physician.
Upcoming CME Conferences

26th Annual Controversies in Cardiac Arrhythmias
September 16 | The Cosmos Club | Washington, D.C.
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, D.C.
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, D.C.
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: 3rd Annual Current Issues in the Care of Dialysis and Transplant Patients
October 1: Update on the Treatment of Heart & Vascular Disease
October 15: PANDAS/PANS 2016: An Update on Current Management and New Treatment Strategies
October 21: Management of ENT Conditions in Primary Care
October 28: Evaluation and Management of Common Anorectal Problems
October 29: Melanoma Biology & Patient Management 2016
November 12: Lung Cancer 2016: Progress and Future Directions
November 17 -19: 10th International Congress on Peritoneal Surface Malignancies
December 2: Thyroid Disorders 2016

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.
In Memoriam

Maureen Chua, MD
Maureen Chua, MD, a long-time member of the Medical & Dental Staff in Obstetrics & Gynecology, passed away in late June.

Dr. Chua received her medical degree from the University of the East in the Philippines. Her internship was at St. Elizabeth’s Hospital, and her residency and fellowship were completed at the Hospital Center. Dr. Chua spent her career at the Hospital Center, from 1974 until she retired in 2008.

Her former colleagues say that Dr. Chua was “committed to evidence based practice, combined with unlimited compassion. She served all her patients, whether they were homeless women or those in the highest levels of government, who were treated under the watchful eye of Secret Service agents. Dr. Chua practiced the art of medicine, and many times, clinicians from around the hospital would come to watch her during a difficult delivery.”

Donald Cooney, MD
Donald Cooney, MD, former chairman of Neurosurgery at MedStar Washington Hospital Center, passed away in late June.

Dr. Cooney received his medical degree from the University of Pittsburgh, and completed his internship and residency at George Washington University Hospital. He established and led the Washington Brain and Spine Institute, and served as a member of the Board of Directors of MedStar Health.

Neurosurgery Chairman Edward Aulisi, MD, says, “F. Donald Cooney was an inspirational leader and pioneer in the world of Neurosurgery. He was instrumental in building and leading one of the most successful Neurosurgical practices in the United States. The man was an icon in the field of medicine here in the Washington, D.C. region, and will be sorely missed by the countless number of people who called him Doctor, Chairman and Friend.”

Neurology Chairman Robert Laureno, MD, adds, “He was a strong leader with exceptional vision, for future developments in his field and how the hospital should prepare for them.”

Allen Oboler, MD
Cardiologist Allen Oboler, MD, a long-time member of the Medical & Dental Staff, passed away in early July.

Dr. Oboler’s medical degree was from Wayne State University; his internship was at Boston City Hospital; his residency was completed at Mount Sinai Medical Center and his fellowship was at New England Medical Center. Dr. Oboler had a special interest in angioplasty, cardiac arrhythmia and cardiac catheterization.

Stuart Seides, MD, Physician Executive Director, MedStar Heart & Vascular Institute, remembered Dr. Oboler: “Coming on staff in the 1970’s, Allen Oboler was one of the pioneers in the development of MWHC as the premier cardiovascular center in this region. He will be remembered for his enthusiasm, his dedication to patients, his exceptional collegiality and his overall ‘joie de vivre’—enjoyment of his professional and personal”

James Spencer Dryden, MD, Ophthalmology
James Spencer Dryden, MD, was chief of Ophthalmology at the Hospital Center from 1958-59, and also served at Walter Reed Army Hospital and the old Doctors Hospital. At the time of his death, Dr. Dryden was 106 years old. He had a private ophthalmology practice for 50 years in the District, until he retired in 1991. Dr. Dryden also served as president of the Medical Society of the District of Columbia.
Jigar Patel, MD, remembers a visceral moment from his childhood in Uganda. His grandfather had to be transported out of the country, to his homeland of India for an emergency medical procedure. He had an inflamed gallbladder—something that, in many places, might involve a routine medical procedure—but which, living in Uganda, required him to travel to another country to be assured of proper care. Later, Dr. Patel’s grandmother would suffer a debilitating stroke, receiving what he deemed insufficient care from the same medical system.

Now one of the chief residents for Internal Medicine at MedStar Washington Hospital Center, Dr. Patel realizes just how much his formative years spent in three very different countries—Uganda, India and the United States—have informed his approach to medicine.

Although Dr. Patel is ethnically Indian and speaks Gujarati and Hindi, he was born in Uganda and lived there until he was 14 years old. His family moved to Los Angeles, and he attended college at California State University, Northridge. When it came time for medical school, however, immigration issues forced Dr. Patel to look outside of the United States. And so, for the first time in his life, he lived in the country of his grandfather: India.

His medical school in India sent the top four performing students to the University of Minnesota Medical School for elective rotations, and Dr. Patel was included in that group.

While there, he was able to participate in the residency process and match with the Hospital Center.

Dr. Patel started off in medical school wanting to pursue surgery, but ultimately switched his focus, thanks to patient interactions and the desire to be more patient-centered.

"It was a transition coming from medical school in India, where most of the care is focused on primary care and prevention," Dr. Patel says. "In India, most of the cost of health care is paid by patients, so they are limited by their pocketbooks. In Minnesota, we were talking about heart and lung transplants. As a physician, that puts you at the next level of innovation and research."

And while there are many differences between his ultimate experience at the Hospital Center, there are also points of intersection.

"My medical school was in a rural setting, so our patients were mostly the underserved in India," Dr. Patel says. "At the Hospital Center, we also often work with the underserved of our community, so it’s been rewarding."

But the sheer diversity of MedStar’s patient population, Dr. Patel says, has made the learning experience “next to none.”

“Our faculty is incredibly inspiring,” he says. “The past three years have been a wonderful experience.” He credits his work with Gastroenterologist Jennifer Lee, MD, and Hepatologist Alexander Lalos, MD, with inspiring him to eventually pursue a fellowship in gastroenterology and hepatology, following his chief year.

As Dr. Patel steps into his role as chief resident, he says he is most excited about “being an advocate between the faculty and residents, and trying to build that leadership role and the skills that come with it.” The transition process, he says, has created an incredible new learning experience, and brought additional focus to his role.

"Now I’m looking at the administrative elements I was not exposed to as a resident."

But ultimately, Dr. Patel says his job is simple: “My job as a chief is to create a nurturing environment, where we inspire people to be at their best.”
James Robinson, MD, Obstetrics & Gynecology

James Robinson, MD, took a longer—and more circuitous—route to medical school than some of his peers, spending seven years working as an outdoor instructor while pursuing a master’s degree in experiential education. When he finally considered a future in medicine, he envisioned the life of an emergency medicine doctor—perhaps at the base camp of Alaska’s Denali National Park.

“Being a minimally invasive gynecologic surgeon was about as far from my initial ideal as you can get,” he laughs. But as a medical student, he was surprised by how much he loved surgery. Yet he also wanted the ability to work with patients long-term. Once he found obstetrics and gynecology, he saw the potential for the perfect marriage of both passions. His minimally invasive expertise brings him referrals from up and down the East Coast, including for conditions such as Asherman’s Syndrome, a severe scarring of the uterus.

Although Dr. Robinson has been in Washington, D.C. for a decade, his road to MedStar took the longer path as well. He joined the team after nine years of academic practice at the Medical Faculty Associates of the George Washington University Medical Center, as an associate professor and the director of minimally invasive gynecologic surgery (MIGS). In that position, he served as the founding director of a two-year accredited MIGS fellowship.

While the inception of a similar fellowship within MedStar is a few years away, Dr. Robinson states “I want to build a network of MIGS across the MedStar network, and ultimately, build a fellowship that will run parallel and cross-pollinate with our female pelvic medicine and reconstructive surgery fellowship.” In the meantime, his minimally invasive expertise brings him referrals from throughout the East Coast, including for Asherman’s Syndrome, a severe scarring of the uterus; large uterine fibroids and severe endometriosis.

Dr. Robinson is still very much a creature of nature, spending as much time outdoors as possible, white-water kayaking on the Potomac, hiking or rock climbing from time to time. He’s also raised his children to appreciate the outdoors. “If we can pitch a tent and start a fire and roast marshmallows, everyone is happy,” he says.

When asked if he misses his days working outdoors—or that dream of being an emergency doctor in the wilderness—Dr. Robinson is thoughtful: “For many years, I tried to take the thing I love and make it into my job. It turns out, you should separate your vocation from your avocation,” he says.

Dr. Robinson remembers a particularly formative experience from his pre-medicine, outdoor days—one that has stayed with him throughout his professional career: an 1,100-foot rock climb at Red Rocks, Nevada. The climb took longer than anticipated, and night was falling. Dr. Robinson was leading the way, and estimated they were perhaps only ten feet from the top of the climb, yet he couldn’t find a place in the mountain face to put his protective gear, and didn’t trust his next hold.

“I made the decision to down climb, and we figured out I was off route,” he recalls. They found a better pathway to the top, and began the eight-hour hike down the mountain.

But for Dr. Robinson, the takeaway from that experience transcends navigating a tricky mountain terrain. “You can push yourself to do things that are really challenging, but if you get into a situation where you aren’t entirely sure about, the consequences are just too high to risk it,” he says. “You need to take a deep breath, and figure out a better way. That’s good advice for any surgeon, and good advice for medicine, in general.”
From the Desk of...

Jennifer Ayscue, MD

MedStar Colorectal Surgery Program

Our surgeons provide care for a wide range of simple and complex surgical issues, including colorectal cancer, inflammatory bowel disease, anorectal disorders and pelvic floor disorders. We utilize minimally invasive state-of-the-art abdominal and transanal approaches, including the surgical robot when possible, so we can reduce post-operative pain and recovery times. The goal for our patients is to experience excellent surgical outcomes through the least invasive approach to recovery.

MedStar Washington Hospital Center hired its first colorectal surgeon, Lee Smith, MD, in 1996. In 1999, Dr. Smith and Thomas Stahl, MD, started a colorectal fellowship program. I was their second fellow and subsequently became the third colorectal attending surgeon to join the practice, which continued to steadily grow. In the fall of 2014, I became the Section Director for MedStar Washington Hospital Center. Since then, the MedStar Colorectal Surgery Program has expanded significantly, to seven board-certified colorectal surgeons and a nurse practitioner. We practice in eight sites across five hospitals, with plans to add more people in the near future, including a director for Research.

We have been fortunate to be involved in philanthropy at the Hospital Center, through a sizeable gift from The Carlyn and Lawrence Silverman Family Foundation. We are developing a program to identify and educate patients about about colorectal cancer and the importance of early screening. The goal of the program is to identify colorectal cancers at earlier stages, or possibly, even prevent those cancers through early polyp detection.

As part of our commitment to research, we are involved in two cutting-edge national clinical trials, investigating the efficacy of various treatment modalities for rectal cancer. One study focuses on the effect of preoperative chemotherapy with radiation, versus without radiation in patients with rectal cancer. The other study is investigating the efficacy of non-operative monitoring for patients with distal rectal cancers after chemoradiation.

In a further effort to improve the high quality and efficiency of care in colorectal surgery, throughout MedStar, we are partnering with our gastroenterology and oncology colleagues in a collaborative multidisciplinary approach to improve patient care across the entire MedStar system. If you have any questions, we want to partner with you. Please contact our office, at 202-877-8484.