Making a Life-Saving Difference for a Patient
Multidisciplinary Surgical Team Joins Together For Collaborative Clinical Expertise and Treatment

Oliver Tannous, MD, Orthopaedic Surgery; Ross Krasnow, MD, Urologic Oncology; Christian Shults, Cardiac Surgery; and Mark Steves, Surgical Oncology
We’re on our way to fulfilling the bold challenge given to us a year ago, of “Five Stars in Five Years.”

Our ability to meet unexpected challenges and remain flexible has grown this past year. We’ve rallied, and adjusted, and surpassed our own expectations.

For example, we had a Code Silver activation last July. While we did not have an actual active shooter incident, we’ve developed more detailed and robust plans across the hospital, to keep everyone safe.

• The gate outside the Emergency Department entrance has been permanently locked. That gate had allowed easy entry onto our campus and into the hospital.

• The renovation for the front of the ED will begin this fall, to control access from the ED to the rest of the hospital, particularly after regular business hours.

• We have 77 entry points into the hospital. As we did after 9/11, we will be locking down the majority of our doors, with about a dozen that will be open for our associates, patients, and visitors.

• Our inpatient units will have badge access and video control, to make sure that people who come onto a patient care unit are people who should be there.

• Providers and associates in areas that may be at higher risk for workplace violence incidents have had de-escalation training. This training will roll out to all other areas of the hospital.

• On inpatient units, patients who continually disrupt care and are deemed to be competent can be asked to sign a patient safety contract, which sets behavior guidelines. Visitors who are disruptive and disregard requests from caregivers can be asked to leave the hospital.

• Our inpatient and outpatient areas now have at least one station with a red computer keyboard. Pressing the F9 and F11 keys sends an immediate signal to the Public Safety office, and an officer will respond to the call.

• Our Public Safety officers have had additional training, and the size of the department is being increased.

• All providers and associates on campus have seen the “Run, Hide, Fight” video produced by MedStar Health, and all who are employed will have an additional SITEL module on safety to complete this year.

This tremendous response to one event demonstrates the depth and breadth of what can be accomplished, as all of us work together.

I’m proud to report to you that in other areas of the hospital, we’re finding the same type of effort for quality and safety improvements. Our number of serious safety events continues to decrease, we had a 54 percent decrease in hospital onset cases of Clostridium difficile, and our ICU and non-ICU CLABSI rates dropped 27 percent. In fact, 15 patient care units were CLABSI-free during the last fiscal year.

Our market leadership is also growing:

• We were named a U.S. News & World Report top 50 Cardiology/Heart Surgery hospital

• We received a three-year comprehensive Center Accreditation for Bariatric Surgery

• We were awarded a Center of Excellence 40-year designation by the Society for Obstetric Anesthesia and Perinatology

• We were named a primary hospital affiliate and clinical partner of Georgetown Lombardi Comprehensive Cancer Center

American author Mark Twain is said to have declared, “The secret of getting ahead is getting started.” We’ve more than started on our high reliability organization (HRO) journey; we’re making great progress, and can expect to continue to do so this year.

Your input and ideas are important. Please contact me with your suggestions on how we can continue on our quality and safety journey.

Jeffrey Dubin, MD, is Sr. Vice President, Medical Affairs & Chief Medical Officer at MedStar Washington Hospital Center. Contact him at jeffrey.s.dubin@medstar.net, or 202-877-7509.
Antonio Grillo has learned and done a lot in his 72 years. But like so many other people diagnosed with a cardiovascular condition, he wasn’t quite prepared for the many lifestyle changes necessary to rebuild his health.

A lifelong resident of Washington’s Mt. Pleasant neighborhood, Mr. Grillo suffered his first stroke in March 2016, followed by two separate transient ischemic attacks several months later. An examination by his primary care physician revealed several contributing factors—atrial fibrillation, high blood pressure, high cholesterol, and later, renal failure.

Although Mr. Grillo would eventually be approved for a pacemaker to manage the AFib, his niece, Durya Durham, says difficulties in balancing multiple medications and other lifestyle adjustments slowed his recovery.

“He primary physician felt we needed a better perspective on how to proceed,” recalls Ms. Durham, who shares a home with her uncle. “He referred us to the Hospital Center’s Transitions Clinic, to learn what else we could do to improve his health.”

Part of the Nancy and Harold Zirkin Heart & Vascular Hospital at MedStar Washington Hospital Center, the Transitions Clinic helps newly diagnosed cardiovascular patients smoothly transition from hospital to home care, reducing their risk for developing more serious cardiac diseases.

“During the first month following diagnosis, a cardiology nurse practitioner, nurse navigator, and medical assistant work with the patient and family members, to develop an individualized cardiovascular management plan, including an exam, education about medications and healthy habits, and assistance with securing prescriptions or scheduling tests,” explains Nancy Bruce, RN, BSN, MBA, CENP, vice president, Operations, MedStar Heart & Vascular Institute. “Once home, patients are monitored closely for four weeks, via phone or sessions with visiting nurses.”

“Our goal is two-fold: help patients feel better, and break the cycle of hospital readmissions,” explains Advanced Practice Provider Norma Flores, DNP, CRNP. She adds that because many patient issues arise from non-compliance with physicians’ discharge instructions, “we take as much time as needed to explain how heart failure works, what these medications are for, and what will happen without them.”

The Transition Clinic is also a valuable resource for family members who often play a major role in a patient’s care. “A patient needs to have someone supportive of the recovery process, because they don’t always have the knowledge or ability to make decisions for themselves,” Ms. Durham says.

APP Flores helped Mr. Grillo get on the right track almost immediately. Along with having what Ms. Durham calls “frank conversations” about medications and nutrition, Flores discovered that a temporary change in his diuretics prescription had yet to revert to the original dosage.

“We put him on the right dose, and he felt much better,” she says.

Follow-up home visits by visiting nurses have helped Mr. Grillo conveniently continue making improvements to his heart health, including arranging access to physical rehabilitation services, and control lingering issues with chronic venous insufficiency.

Ms. Durham says Mr. Grillo’s independent streak occasionally shows itself, when he makes less-than-optimal diet decisions. But thanks to the Transitions Clinic, her uncle has made great strides in his overall health, and that “voice of reason” has benefitted her, as well.

“What Norma told him was no different from what I’d been saying, but it had that all-important element of authority,” Ms. Durham says. Though she has a college degree and a career, “to him, I’m still that 15-year-old niece. The Transitions Clinic has been in his corner, as well as mine.”
The discovery of a large left renal mass was not news that Lanford Pritchett expected to hear. The 66-year-old Smithfield, Va. native had just been diagnosed with prostate cancer, but now, a daunting shadow seen on imaging loomed over his kidney, casting a far more serious concern.

“At the time I was diagnosed with prostate and then kidney cancer, I felt completely fine, Pritchett recalls. “I had no pain, no unintended weight loss, and I was working out at the gym.”

Despite being asymptomatic, staging for Pritchett’s kidney mass revealed a tumor thrombus not only invading his left kidney and left renal vein, but extending up his inferior vena cava and into the right atrium of his heart.

“With kidney cancer, this is advanced as it gets,” says Ross Krasnow, MD, a urologic oncologist at MedStar Washington Hospital Center, who would orchestrate a life-saving operation for Pritchett. “It is very rare for a kidney cancer to present this involved.”

With no time to spare, Dr. Krasnow quickly mobilized a multidisciplinary surgical team for Pritchett. “You want to operate within two weeks when you see these patients, because the cancer can spread so rapidly,” explains Dr. Krasnow.

On Jan. 18, 2018, Pritchett underwent a complex, all-day surgery at the Hospital Center, requiring the combined expertise of oncologic, cardiothoracic, and urologic surgeons. At the time, Pritchett had no idea he would be back at the hospital 10 months later, for another complex, multidisciplinary surgery, this time involving orthopaedic spine surgery and thoracic surgery.
Case One

With thoughts of his two grandchildren, Pritchett said goodbye to his partner, Linda, and was wheeled to the operating room. After successful induction of anesthesia, Pritchett underwent a large laparotomy. Dr. Krasnow performed a left radical nephrectomy, left adrenalectomy, and exposed the vena cava. Next, Surgical Oncologist Mark Steves, MD, scrubbed into the case, in order to roll the liver off the vena cava for more exposure, and carefully divide the caudate lobe veins of the liver, a tedious, one-hour process that involved ligating 10 vessels of varying sizes.

“It's a very delicate area,” says Dr. Steves. “If you tear into the liver or vena cava, which can happen sometimes, it can cause bleeding and other problems.”

After successfully mobilizing the liver with no complications, Dr. Steves lifted the liver in a lateral to medial fashion, allowing Cardiac Surgeon Christian Shults, MD, access and exposure to the thrombus in the inferior vena cava.

Next, Pritchett was placed on venous-venous bypass. Dr. Shults opened the sac to the heart, clamped the right atrium above the tumor, and carefully teased the mass out from below. While the tumor was not adherent to the atrium, it had invaded the wall of the vena cava, requiring an approximately 5 cm area of resection that was repaired using bovine pericardium. After 57 minutes of skillful surgical maneuvering, Pritchett was taken off bypass. The operation was completed, and Pritchett was transferred to the Intensive Care Unit.

After a few days in the ICU, Pritchett was downgraded to the floor. He then spent a couple weeks at the Hospital Center with a brief readmission before returning home to southern Virginia to recover. A few months later, however, he began experiencing back pain, when he returned to the gym to exercise. He went to a local orthopaedic surgeon who ordered an MRI, where a spinal lesion was discovered. Pritchett was first treated with radiation and immunotherapy, but the mass did not respond to radiation, and was continuing to cause pain.

Frustrated with the continued, intractable back pain, Pritchett reached out to Dr. Krasnow for advice. Dr. Krasnow immediately referred him to MedStar Washington Hospital Center Orthopaedic Spine Surgeon Oliver Tannous, MD.

Case Two

In October 2018, Pritchett met with Dr. Tannous, only to learn his back pain was due to metastatic tumors located around his T11 and L1 vertebrae. “The T11 tumor was a large tumor, and was growing and compressing his spinal cord,” Dr. Tannous recalls. “He was close to paralysis.” The day before Thanksgiving, Pritchett returned to the operating room, this time with Dr. Tannous and again with Dr. Shults by his side.

“We performed a unique thoracotomy, between his 10th rib and lumbar vertebrae on his left side,” says Dr. Shults. “We had to resect a rib and then retract the diaphragm to expose the vertebral body that Dr. Tannous needed access to.”

Once access was gained, Dr. Tannous delicately removed the tumors, and decompressed Pritchett’s spinal cord. He then placed solid titanium cages in Pritchett’s spine. Two days later, Dr. Tannous performed the second part of Pritchett’s complex surgery, placing rods and screws via a minimally invasive technique.

Pritchett quickly recovered from his spinal surgery, and returned home. “As far as we can tell, he is in remission,” says Dr. Tannous. “By doing this surgery, I was able to remove the entire tumor. This will potentially expand his life by years, if not decades.”

Moving Forward

For Pritchett, while he still experiences back pain and decreased stamina, he is grateful to be alive, and for the expert care he received. His last set of full scans in February showed no signs of cancer.

“I have the utmost respect and appreciation for the whole Hospital Center team,” says Pritchett. “I was told if I did nothing, I would have six months to live. Without this care, I would be dead. There is absolutely no doubt about it.”

“I think of Dr. Krasnow not only as my doctor, but as a friend,” Pritchett continues. “He is the kind of doctor everyone should be so lucky to have. Both he and Dr. Tannous are a cut above.”

For the surgeons, they attribute Pritchett’s success to the multidisciplinary, collaborative approach.

“When you are at a center with so many specialists who communicate well and work well together, that is when we have good outcomes,” says Dr. Tannous. “And, at the Hospital Center, we have these specialists willing to tackle these complex cases.”

Dr. Shults agrees. “This was a multidisciplinary case with a very collaborative approach. We were able to tackle a novel problem, by everyone bringing their individual skills to figure out a unique situation.”

“This kidney cancer was life-threatening,” adds Dr. Krasnow, “And the metastasis to his spine required very specialized care. These surgeries definitely bought him time, and allowed him to go on with a much better quality of life.”
For decades, workers across the professional spectrum have thought of retirement in their 60s as a given, and a welcome given at that. But that notion is changing, especially for physicians. Physicians most often expect to retire at around age 60, but actually retire closer to age 70, according to a systematic review of 65 studies as reported in Human Resources for Health. Even then, retirement often is not a complete cessation of duties, but rather, a move to a lighter schedule.

Three physicians at MedStar Washington Hospital Center weighed in with their thoughts on the subject. All want to continue working as long as they are able, albeit maybe not at full tilt. When asked, they advise colleagues to retire gradually, as long as they are physically and cognitively able to practice.

George Taler, MD
George Taler, MD, is approaching 70, and still going strong. As a geriatrician, he knows better than most what aging does to the body, and how that impacts the ability to practice medicine.

“As we age, first we see mobility challenges,” he says. “Your knees and back may give out, especially if you’re on your feet doing long procedures. You also lose some flexibility. For most people, what they notice is diminishing mobility and less stamina.”

Still, Dr. Taler touts the value of experience over youthful vigor. “What is lost in speed is gained in wisdom,” he says, adding cognitive decline is not an issue for most 70-year-olds. “Short-term memory starts fading in the 40s, but there are ways to compensate for that,” he explains. “Intellect usually is not a limiting factor.”

However, Dr. Taler notes that there is a difference between physicians who are cognitive-based (Internal Medicine, Cardiology) and physicians who are procedure-based (Surgery, Interventional Cardiology). “For procedure-based physicians, it becomes a matter of physical capability.” Similarly, shift-based physicians (Emergency Medicine, Intensive Care) may experience less resilience to the demands of work, due to disruptions in their circadian rhythm.

It also can be a matter of adapting to new technology, such as laparoscopic or robotic surgery. Dr. Taler notes that the Electronic Medical Record (EMR) is touted as another reason to retire or cut back. “Some of the older docs don’t want to learn yet another new system.”

Illness for the physician or spouse is often a determining factor for retirement, Dr. Taler continues. “But most doctors are in pretty good health at 70; they’ve been active and have taken care of themselves. There is also an association between higher income and better health.”

Physicians are devoted to medicine, he adds. “Most of us like what we do, despite occasional hassles. It makes sense to cut back over time, rather than stop cold turkey.” Accordingly, he is now exploring ways to cut back, to 80 to 60 percent of his full-time schedule.

Arthur St. Andre, MD
Arthur St. Andre, MD, former chair of Surgical Critical Care, always thought he would retire at age 70, but then re-thought that notion as he approached his target age. “I’m still very interested in what I’m doing. It’s beneficial to me and to MedStar that I continue contributing,” he says.

He decided to give up his position as division chair, in favor of a reduced schedule with different responsibilities. He now works three days a week, with four days a month as a clinician in the SICUs, and the
rem aining tim e doing system  w ork for M edS tar H ealth. “I
w anted to continue to w ork clinically, as I enjoy patient care.
But I also w anted to help in other aspects of MedStar’s
Journey to E xcellence, as well as teach and mentor physicians
and other evolving leaders.”

A few years ago, Dr. S t. Andre becam e involved w ith MedStar’s
Performance Transform ation P rogram , as part of the
leadership steering com m ittee, and specifically w orking w ith
the system ’s pharm acy leaders to pursue operational
excellence. “As that program  evolved, it becam e obvious that
this was som ething where I could contribute, if I stepped aw ay
from  m y full-tim e position as clinical chair. It has allow ed m e to
be creative, and think in a global fashion, w hile also being
involved in nitty-gritty details,” he says. O ne of his key interests
is to help E M R  users have an im proved experience.

H is new role has been very gratifying, he says. “I have a better
balance of professional and personal pursuits,” he says. “I feel
m uch fresher.”

D r. S t. Andre often serves as a sounding board for colleagues
who are beginning to contem plate retirem ent. He notes that
many are looking to find ways to partially step down. He
encourages them to carefully consider how they would like to
focus their new-found time, and talk to Human Resources, to
understand the options and nuances of the practical issues of
working part-time or fully retiring. “It’s a struggle to go from
full intensity to no intensity,” he says.

Elspeth Cameron
Ritchie, MD

Elspeth Cameron Ritchie,
MD, chair of Psychiatry,
retired from the U.S. Army 10
years ago, but knew she did
not want to retire from
medicine. “Being a physician
is a satisfying, demanding,
exciting career,” she says.
“There is a lot of motivation
to stay in that career.”

Dr. Ritchie also notes that, for
female physicians who have raised families while working,
working is dramatically easier after children leave home.
“There is less juggling; it becomes easier to be a physician,”
she says. “Women often want to continue working.”

There are other factors to consider, too. “For some doctors,
medical school was so expensive, and they may have a large
amount of debt,” she says. “They may need to work longer.”

Of course, medicine is often a calling, and central to a
physician’s identity. “Many physicians are reluctant to give up
satisfying work,” Dr. Ritchie says. “They may want to cut back
on their scheduled hours, but they still want to work some.
Usually they are making quite decent money; if they stop
working, there may be a major lifestyle transition.”

She adds that it is in the hospital’s best interests to retain
physicians. “By offering flexible work hours and minimizing
work barriers, hospitals can facilitate physician retention,” she
says. “As physicians grow more senior, they can teach or
mentor younger physicians.”

If You’re Contem plating Retirement

Each physician has some advice for colleagues planning
for the future.

“Begin planning a long time before you want to actually
step down,” Dr. St. Andre advises. “Understand well what
you’re going toward. Work with someone who is a very
astute financial and life planner, to be sure you have the
resources you need.”

“Think about what you want. Build a social network
outside of work,” Dr. Ritchie advises. “Work is very social,
and you will miss that social tapestry. Look for places to
volunteer; don’t just plan to play golf.”

“As long as you maintain a sense of purpose, a feeling of
being valued and integrated into the community, and
enough money to enjoy life, you will be happy,” Dr. Taler
concludes.
A “Hands-On” Unique Experience Sharpens Skills for ED Physicians

Rahul Bhat, MD, presented a case of a patient on a ventilator

Erika Page, MD, demonstrated ultrasound to the Physician Assistant group

Jon Davis, MD, refreshed his pediatric resuscitation technique

Diana Ladkany, MD, observed Susie O’Mara, MD, at the transvenous pacing station

Nonine McGrath, MD, served as the instructor at the crash cricothyrotomy station

Beth Pontius, MD, detailed the case of a patient who needed a ventilator

Carolyn Phillips, MD, taught PAs what to look for on the ultrasound screen

Ethan Booker, MD, perfected his crash cricothyrotomy skills

Evan Baily, PA-C, learned how to test intraocular pressure

Jean Williams, MD, started the transvenous pacing work

Tina Rosenbaum, MD, began work on a pediatric resuscitation

Ryan LaDuke, PA-C, answered the quiz on radiograph interpretation
It’s the only way to save your patient: more routine methods of obtaining an airway are ineffective or contraindicated, and you must perform a crash cricothyrotomy, something you don’t do every day, every week, or even every month or year.

At any moment, providers who are part of MedStar Emergency Physicians (MEP) may have to perform a high-stakes, low-frequency procedure. But thanks to MEP Day, providers from seven Medstar Health EDs can attend a yearly set of simulation exercises, receive important knowledge updates, and practice skills refreshers.

“Very few of my colleagues across the country have the advantage of a program like this, and I appreciate it from two perspectives: first, as an emergency medicine attending who has been out of residency for a long time, the ability to stay current and to practice critical procedures that I rarely do allows me to walk in the door with more confidence each time I staff the ED, knowing my skills will be fresh no matter what emergency condition I find. And, it makes me a better teacher for our residents,” says Terry Fairbanks, MD, who also serves as MedStar’s vice president for Quality and Safety.

“I am also proud of the significant investment that MedStar continues to make in our simulation and training resources, going well beyond most academic health systems by providing major training programs like this for physicians, Advanced Practice Providers, nurses and everyone else, including environmental services associates.”

Chris Richter, MD, serves as MEP chair for MedStar Medical Group. “I have been associated with more than 50 different emergency departments, large and small, and none have had any educational program this sophisticated and robust,” he states. “This is exceptional professional development, and provides a significant benefit to our physicians, physician assistants, and ultimately to our patients. By having the best trained people, we can provide the best possible, life-saving treatment to everyone who presents to our hospitals.”

Munish Goyal, MD, is MEP Director of Faculty Education, and Jon Davis, MD, serves as Academic Chair. Both contribute to a planning team of talented faculty educators who begin planning for the next year’s MEP Day as soon as one ends.

“Our goal is to create opportunities for our colleagues, to be able to perform deliberate practice of these procedures,” Dr. Goyal says. “We also are a geographically spread-out group, so we intentionally create small groups of clinicians from different EDs, to familiarize colleagues from across the MedStar system.”

Dr. Davis notes that MEP Day has been a yearly event since 2011, and also includes opportunities for MEP physician assistants and physicians from MedStar PromptCare.

“When we first started, it was more lectures and discussion, but we decided to incorporate simulation as a component, since from a quality, safety, and risk perspective, we could more readily cover very high-risk but rarely performed procedures in the simulation setting. We strive to capture input from all stakeholders, so we can leverage feedback while the experience is fresh, and we can better meet the needs of our providers for the following year’s event.”

ED faculty serve as instructors for the day, and Beth Pontius, MD, says this year was a little different for her. “This is the first year I’ve run one of the simulation stations, and many of the physicians who came through were senior to me, and actually trained me. It was the first time I’d had the experience of teaching fellow attendings not just a specific skill, but reviewing an approach to a critically ill patient. In addition to helping my colleagues work through a complicated case, it also solidified my knowledge of the pathophysiology and available interventions.”

Norine McGrath, MD, agrees with that assessment. “I have to be the most skilled and proficient at the procedure, if I am going to have the hubris to teach my colleagues. It’s great motivation to learn and practice, and I also enjoy getting to work with other MEPs from across the system.”

Every year, those who attend feel the time at MEP Day is not just about receiving CMEs, says Tina Rosenbaum, MD. “The day was full of great refreshers—transcutaneous pacers, pediatric resuscitation—but my favorites were the peds refresher and the dermatology lecture. I used some of my newly-refreshed derm knowledge from Dr. Helena Pasieka that very night on my shift, and called a derm consult in the morning. The biggest takeaway, however, is everyone in MEP who can, should try and attend MEP Day every year.”
Dr. Paul Corso, our long-time former chair of Cardiac Surgery for MedStar Washington Hospital Center and MedStar Heart & Vascular Institute, died in early June.

Throughout his more than 40 years at the Hospital Center, Dr. Corso served his patients and colleagues with skill and distinction. His visionary leadership in cardiac surgery led to the growth and standardization of practice, allowing clinicians to proactively improve their care, research, and outreach, which formed one of the foundations for our alliance with The Cleveland Clinic Heart & Vascular Institute.

Dr. Corso came to the hospital in 1978, and recognized the need to develop an organized system of care that welcomed many new members to the physician team. His insistence on quality of care and adherence to safety throughout his career served as a hallmark of patient advocacy. Always forward-thinking, his efforts to develop the best patient care program led to our first Advanced Practice Provider team in the late 1980s, where nurse practitioners cared for post-op Cardiac Surgery patients.

Not content to focus solely on the hospital, Dr. Corso shared his talents throughout MedStar Health, serving on the board of directors for the overall organization and also for the management board of the Heart & Vascular Institute.

Dr. Corso left a permanent, enduring imprint on the care we provide at the Hospital Center. Those of us who were his colleagues and friends will remember his compassion, his surgical expertise, and his insistence on always providing the best care.

**In Memoriam**

**Paul Corso, MD**

Former Chair of Cardiac Surgery, MedStar Washington Hospital Center and MedStar Heart & Vascular Institute

“Dr. Corso was a larger-than-life individual, jumping out of helicopters to ski uncharted mountains, driving fast cars, and truly enjoying life. But at his core, he was totally dedicated to his patients. He always had time for them, and not only were his hands truly gifted, he would listen to their fears and walk them through all aspects of their care journey. And it was never about just him. He was always focused on building a cardiac team that would be world-class in every regard. He valued everyone’s contributions to patient first.

We became colleagues and dear friends over a journey of more than three decades together. We respected each other as the foundation of our special relationship and enjoyed an adult beverage or two at appropriate times, just to keep each other humble and happy.”

—Kenneth A. Samet, FACHE, President and Chief Executive Officer, MedStar Health

“Paul was passionate about the value of multidisciplinary patient care long before it become a standard practice, and constantly promoted the concept of the care team with himself a team member. However, skiing was very different. Paul reveled in the role of ‘Leader of the Pack’ on MWHC group skiing expeditions!”

—Joy Drass, MD, Executive Vice President and Chief Operating Officer, MedStar Health

“Paul and I both arrived at MWHC in the late 1970’s to begin our practices. As two ambitious young physicians looking to make our respective marks on the medical world, we naturally gravitated towards one another and ultimately developed a close professional and personal relationship that lasted for forty years. Paul was instrumental in fostering a remarkably strong and collegial synergy between cardiovascular medicine and surgery (which was by no means commonplace) that built the foundation for what has become MHWI. His focus on the quality and flow of patient care led to the development of the first nurse practitioner (now APP) teams and to the concepts of collaborative practice that have become both pervasive and essential across MHWI and MWHC. Paul’s tireless (he was immensely proud of...
being the first to arrive in the POB garage every morning!)
devotion to excellence will be missed by all, and I have lost
both a great ally and a good friend.”—Stuart F. Seides, MD,
FACC, Physician Executive Director, MedStar Heart & Vascular
Institute

“Paul Corso was a serious person who didn’t
take himself too seriously. His mind started
whirring with that first cup of Dunkin Donuts
coffee on the way in to the hospital at zero
dark thirty and by the time we met up on 4G
to start rounds he was already way ahead of
the curve. He was an expert surgeon and
thoughtful doctor – always available with
guidance, even if it meant distracting him for a
“consult” during his case. In fact, joining in the OR camaraderie
made me appreciate his humanity even more – he was never
troubled by the interruption, certainly never rattled by it – and
always maintained that ever-appealing sense of amusement that
made him “Paul.””—Anne P. Weiland, Vice President, MedStar
Health

“When Paul became chief of Cardiac
Surgery, he elevated the service by
implementing new protocols to improve the
quality of service and the quality of care. He
was an excellent heart surgeon, an engaging
person, and one of the most hardworking
people I have known. I got to visit with him
recently before I had to leave for Manila. We
talked mostly about the good old days, and
how cardiac care has evolved in the last decade. At the end of
my visit, I had to say goodbye, and we both got emotional. We
knew that it was probably the last time we would see each
other. He motioned me to get closer to him, and he
whispered, ‘We had a good ride,’ and I responded, ‘Yes,
indeed.’”—Jorge Garcia, MD, retired Hospital Center
Cardiac Surgeon

“Dr. Corso’s fundamental motivating force as
a physician was ‘we can always do better.’
Paul was instrumental in developing the
Cardiac Surgery NP program and
supporting Surgical Critical Care. The
development of expert cohesive teams was
one of his keys to programmatic success. He
vigorously pursued gathering data, assuring
its accuracy, understanding the story that emerges by
analyzing it, discussing concerns and using insights to modify
individual and programmatic behaviors to provide better care.
He said discuss, disagree but don’t argue, reach conclusions,
and take action. Take action; he was a surgeon after all.
I will remember Paul as an excellent clinician, a dedicated
husband and surgeon and one who built a fine cardiac surgery
program based upon principles that can sustain it into the
future. It was Paul’s vision, focus, stamina, dedication and
perseverance that sustained him and contributed to the success
of this man of immense and many talents.
I will miss visits to his quiet office to discuss ideas, difficulties,
frustrations and his most recent skiing adventure or forays late
in life into sports like triathlon training and golf. I am so very
thankful that our paths came together. It was an adventure.
Paul, as you, I hope that we have grasped your baton and will
‘always do better.””—Arthur St. Andre, MD, MCCM, past chief of
Surgical Critical Care

“Dr. Corso was an incredible man who
developed a highly functional, integrated
cardiac surgery team that spanned across
surgery, the intensive care units and the
cardiac surgery step-down unit. His vision
included utilizing Advance Practice Providers
to ensure cardiac surgery patients always
received consistent, high quality care. His
utilization of APPs was a model for other service lines. His
support and friendship are missed.”—Sharon Taylor-Panek,
MScN, ACNP-BC, retired Hospital Center cardiac surgery APP

“I knew Paul for more than 40 years. I first
met him when he was a fellow and I was an
ICU nurse at George Washington University.
Paul was instrumental in bringing APPs to
the Hospital Center 40 years ago, and
instituting a collaborative practice model
between the cardiac surgeons and the
APPs. This is a model that thrives to this day,
and has been adopted by services throughout the hospital. In
addition to being an astute clinician, Paul was a visionary
leader, working tirelessly to build his dream of a world-class
heart institute, which he achieved with the creation of
MedStar Heart and Vascular Institute. He had a great sense of
honor and a great bedside manner. He continued to teach us
in his final days, lessons on dying with dignity and grace, his
final gift. He is gone too soon.”—Jean Wolff, CRNP,
Interventional Radiology
MEDSTAR CONFERENCE HIGHLIGHT

**Adult Congenital Heart Disease in the 21st Century**
October 4-5 | Bethesda Marriott | Bethesda, Md.
Course Directors: Anitha S. John, MD, PhD | Melissa H. Fries, MD

This two-day program offers a comprehensive review of the evaluation, diagnosis and management of adult congenital heart disease, including the management of heart disease during pregnancy. The conference will help practitioners prepare for board certification examinations with focused attention to the long-term care of adults with CHD, imaging of congenital heart defects, and the care of pregnant patients with heart disease. We will have a detailed anatomy review of specific CHD lesions, providing a great review before the board examinations.

For more information and to register, visit [CE.MedStarHealth.org/ACHD](https://CE.MedStarHealth.org/ACHD)

UPCOMING CPE EVENTS

**Updates on the Diagnosis and Management of Pituitary Tumors**
September 11 | The Center Club | Baltimore, Md.
Course Directors: Edward F. Aulisi, MD | Susmeeta T. Sharma, MD

**The 2nd Annual MedStar Georgetown Transplant Institute Symposium**
September 14 | Washington Marriott Georgetown | Washington, D.C.
Course Directors: Thomas M. Fishbein, MD | Matthew Cooper, MD | Alexander J. Gilbert, MD | Basit Javaid, MD, MS
Stuart S. Kaufman, MD | Rohit S. Satoskar, MD

**Gastric and Soft Tissue Neoplasms**
September 21 | Park Hyatt Washington | Washington, D.C.
Course Directors: Waddah B. Al-Refaie, MD, FACS | Nadim G. Haddad, MD | Dennis A. Priebat, MD, FACP

**Autoimmune Encephalitis Post-Streptococcal Evaluation & Treatment - A Way Forward**
October 5 | The Mayflower Hotel | Washington, D.C.
Course Directors: Heidi J. Appel, MD | M. Elizabeth Latimer, MD | Earl H. Harley, MD

**Gastroenterology for the Primary Care Provider**
October 12 | Ritz-Carlton | Washington, D.C.
Course Directors: James H. Lewis, MD | Caren S. Palese, MD
Course Co-Directors: Nadim G. Haddad, MD | James C. Welsh, MD, MBA, MPH

**MedStar Heart Failure Summit 2019**
October 12 | Hyatt Regency Bethesda | Bethesda, Md.
Course Directors: Mark Hofmeyer, MD, MS | Samer Najjer, MD

**Scary Cases in Endocrine Surgery**
November 7 | Wildfire Restaurant, Tysons Corner | McLean, Va.
Course Director: Jennifer Rosen, MD

**Lung Cancer 2019**
November 16 | Washington Marriott Wardman Park | Washington, D.C.
Course Directors: Steven V. Liu, MD | Chul Kim, MD, MPH

For more information regarding MedStar Health conferences, please visit [CE.MedStarHealth.org](https://CE.MedStarHealth.org)
You’ve seen the new sign in the main corridor of the hospital: Pre-Anesthesia Testing Center (PAT), which has replaced the Admissions Testing Center.

The influx of surgical patients with chronic critical illnesses calls for more customization and an interdisciplinary team approach that includes the surgeon’s office, primary care, and other specialists, to meet patient health needs before surgery. Pre-anesthesia evaluation gives providers an opportunity to identify before surgery any chronic illnesses that need to be fine-tuned, to achieve improved post-operative outcomes for our patients.

The new systemwide PAT process and recently established regional PAT Call Center were designed by MedStar Medical Group-Anesthesia, after reviewing best practices across the system, says Emily Briton, vice president, Professional Services. “We wanted to devise a way to be more efficient, pulling resources together across the region,” she states. “From a system perspective, we have so many different settings, and we can learn from each other.”

“The intent of this process is to influence positive patient outcomes with fewer adverse surgical events, fewer post-surgery complications, and shorter lengths of stay,” says Mary Kay Grady, MD, medical director, PAT.

Here’s how the pre-anesthesia testing process works:

- A physician schedules a surgery, which auto-populates to the OR schedule in MedConnect.
- Within one to two business days, a nurse from the Centralized PAT Call Center calls the patient. The nurse reviews the patient’s past medical history, medication reconciliation, provides pre-operative instructions, and advises the patient on further testing, using the anesthesia guidelines.
- Nurses present their findings to the anesthesiologist at the PAT Call Center, to determine if the patient requires more extensive testing.
- Complex patients are triaged for an in-person visit with an Advanced Practice Provider (APP). During this visit, the APP performs a focused review of systems, compiles pertinent information, and collaborates with the surgeon and outside providers to coordinate care for any chronic illnesses that need further management. The APP also educates patients about their pre-anesthesia care, chronic condition management, and preventative health maintenance.
- On the day of surgery, the anesthesiologist has a complete record of each patient, and can safely administer anesthesia to get the surgery started on time.

With the PAT, patient safety is the primary focus, with the goal of eliminating adverse outcomes due to comorbidities. It also greatly improves communication, Briton adds.

“As an anesthesiologist, I can tell you that on the morning of surgery, when my colleagues find a complete pre-op chart, they are very happy,” Dr. Grady says. “It gets patients safely through their surgeries and helps with on-time starts.”

Chief APP Danielle McCamey, DNP, ACNP-BC, is pleased with the new process. “We’re focusing on the pre-anesthesia perspective, and making sure any medical issues are well-managed prior to the day of surgery. We get a better detailed picture of the patient and his or her health status. Our ultimate goal is to optimize each patient for surgery.”

The Hospital Center’s PAT has seven APPs; all are Masters’ prepared, and three have a doctorate in nursing practice. Their clinical practice experiences include gastroenterology, geriatrics, international primary care, internal medicine, emergency medicine and critical care.

“We all want the same thing for patients—greater safety and an enhanced experience. Our goal for our patients is that they are not just cleared for surgery, they have the best outcome post-operatively,” adds Briton.
As a young boy growing up in Detroit, Rajus Chopra, MD, remembers being fascinated by puzzles—the 1,000 piece boxes filled with cryptically similar pieces. One puzzle in particular—his hometown’s city skyline—captivated him for years. He would complete it, then break it down and put it together again, over and over.

Now Chief Resident of Internal Medicine at MedStar Washington Hospital Center, Dr. Chopra can draw an easy line between that puzzle-solving childhood and his professional specialty.

“As an internist, patients present with multiple issues,” he says. “You have to put together their signs and symptoms to form a diagnosis. It’s like a human puzzle for me.”

In his role as chief, Dr. Chopra hopes to gain exposure to new pieces of the larger puzzle of a healthcare system.

“I can’t really think of another position where you’re still under a significant amount of guidance, but at the same time, have an important role in administration. I’m looking forward to learning how to manage people, become a better leader, and work closely with residents all the way through hospital administrators.”

In particular, Dr. Chopra is excited to hone his teaching skills. “I think that the most important role will be to broaden my knowledge, to help young doctors build their foundation and knowledge of medicine,” he says.

Dr. Chopra has already hit the ground running, attending a conference with other chiefs in his specialty from across the country, to build teaching strategies, learn how to navigate difficult situations, and maximize his role. Dr. Chopra also notes that he’s received incredible guidance and support from the Hospital Center faculty.

One priority for Dr. Chopra this year is working with faculty, to develop a point-of-care ultrasound curriculum for internal medicine residents. Historically, doctors have relied on a physical exam to diagnose a patient. With point-of-care ultrasounds, hand-held or portable ultrasound devices can be used at a patient’s bedside, to get an immediate read on major organs and underlying issues, such as heart failure, dehydration, and septic shock. “If we can teach residents how to use an ultrasound appropriately, I believe it will help them diagnose better,” Dr. Chopra says.

That point-of-care curriculum will also, ideally, include echocardiograms. For Dr. Chopra, who plans to pursue a cardiology fellowship following residency, this is a particular point of interest. “Cardiology is such a fascinating field to me,” he says. “You can see a patient who is extremely ill get better in a relatively short time, because we have such good treatments available.”

And if that patient’s diagnosis proves particularly challenging, there’s no doubt that Dr. Chopra will use his puzzle-solving skills to figure it out.

When he’s not at the hospital, Dr. Chopra is taking advantage of living in the nation’s capital. “I really enjoy exploring all that D.C. has to offer, including the wonderful culinary scene and outdoor activities. One of my favorite things to do is to enjoy a Friday evening with my friends, at ‘Jazz in the Garden’ at the Sculpture Garden, at the National Gallery of Art. I’m also a big sports fan, and I thoroughly enjoy supporting the professional sports teams here.”
Ebony Hoskins, MD  
Gynecologic Oncology

Discovery has always been an orientation for Ebony Hoskins, MD. As a college student, she spent a month at the Roswell Park Cancer Institute in Buffalo, NY, drawn in by the science of the specialty, and the seemingly infinite capacity for discovery and new learning within oncology.

That interest in oncology was solidified when, as a third-year medical student, Dr. Hoskins completed a rotation in gynecologic oncology, and had what she calls her professional “aha” moment.

“I knew that practicing in the field was my calling,” Dr. Hoskins says. “It allowed the unique opportunity to perform surgeries, administer chemotherapy, coordinate cancer care, and develop long-lasting relationships with patients.”

Between completing her residency in Obstetrics and Gynecology at St. Joseph-Mercy Hospital in Michigan and a three-year fellowship at Magee Women’s Hospital of UPMC in Pittsburgh, Dr. Hoskins spent two years in a clinical research role at the National Cancer Institute. More recently, Dr. Hoskins was a physician practicing in Rockville, Md. Her decision to leave that practice for MedStar Washington Hospital Center was a difficult one, ultimately grounded in one of the core pillars that initially drew her to this specialty: the ability to form long-term, lasting relationships with her patients.

In her former role, Dr. Hoskins specialized in surgical management of gynecologic malignancies, but did not oversee non-surgical components, such as chemotherapy. “I’d complete a surgery and send a patient back to my medical oncology colleague. Most of the time, I would not see that patient again.”

In her role at the Hospital Center, Dr. Hoskins looks forward to longer relationships. “I can work with patients from initial diagnosis through the course of their treatment. It feels critical to have long-term relationships, and be able to provide compassionate care during times when patients are very vulnerable.”

Moving to a world-class, larger medical system was also a huge draw. “It’s an incredible advantage to have all treatment housed under one roof, with access to multiple specialties if necessary.” Dr. Hoskins notes the collegial environment, which ensures that her patients receive continuous and optimal care. “It’s the type of environment where we can collaborate and discuss hard scenarios with other doctors.”

While Dr. Hoskins is primarily focused on her clinical work, she is excited for the opportunity to help bring more clinical trials to the hospital, similar to those she helped conduct at the National Cancer Institute. “It benefits both providers and patients,” she says. “We serve a large patient population that hasn’t had access previously to clinical trials that offer state-of-the-art care. And on the provider side, we need access, so we can learn more about the disease.”

Dr. Hoskins also looks forward to enhancing the robotics programming for gynecologic oncology, to be able to offer more minimally invasive surgeries, for diagnoses including endometrial cancer or hysterectomies. “There’s less pain, less bleeding, and reduced hospital stay and recovery time,” she says. “We’d like to see that program grow, offering that option to more patients.”

When not at the Hospital Center, Dr. Hoskins spends her time away from work in a different mode of discovery: engaging in the exploratory wonderment of life through the eyes of her three-year-old daughter. One recent adventure took them to Baltimore, for an annual Mac and Cheese Festival.

“We call them ‘discovery trips,’” she says.
Physician’s Perspective

From the Desk of...
Ed Woo, MD
Chairman, Vascular Surgery

Vascular Surgery at MedStar Washington Hospital Center handles cases from the routine to the complex, utilizing the expertise of our care team as well as sophisticated technology. Our team consists of physicians, advanced practice providers, fellows and residents, nurses, surgical technicians and others all working together to optimize care for vascular patients.

We treat vascular disorders involving the arteries and veins of the body outside the brain and heart. Our expertise extends from the aorta and its branches to the arteries of the abdomen, neck, pelvis and upper and lower extremities.

We also treat disorders of the venous system. These conditions are as diverse as abdominal aortic aneurysm, aortic dissection, carotid artery disease, claudication, deep vein thrombosis, venous occlusions diabetic foot, mesenteric ischemia, peripheral aneurysm, peripheral artery disease, renal artery disease, thoracic aortic aneurysm, varicose veins, venous insufficiency, and more.

We make full use of MedStar Health’s systemwide distributed care delivery network. Patients can access the MedStar hospital closest to their homes. When necessary, they are transferred to the Hospital Center for surgery, and can have a follow-up closer to home. Coordination of care is maximized for the patient to allow for the best treatment while also accommodating their need to stay closer to home.

We also treat many of the patients from the surrounding region. Patients are seen, evaluated, and undergo procedures at the Hospital Center, always receiving the optimal compassionate care.

For any questions, please contact us at 202-877-0275.