Spring 2015

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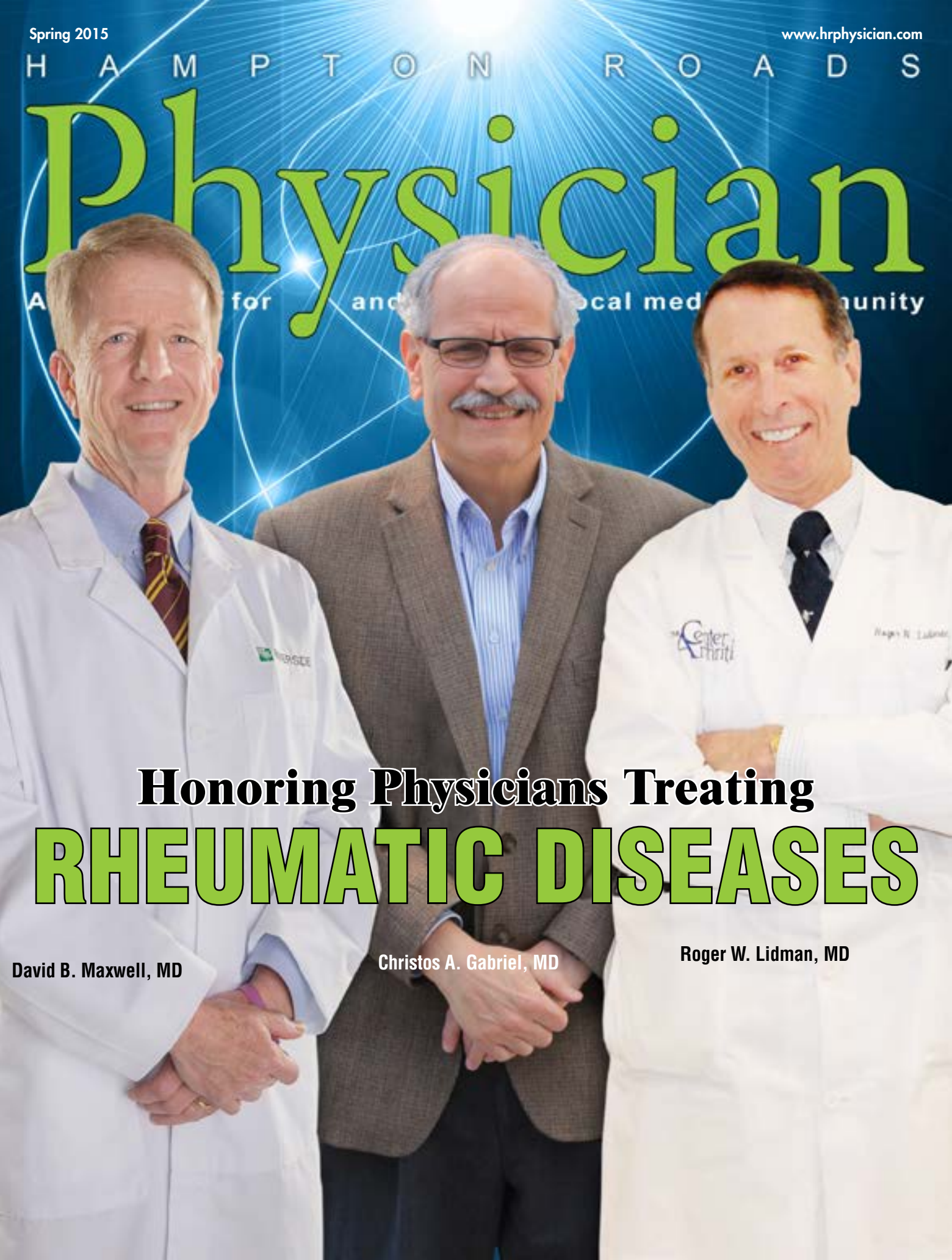

Honoring Physicians Treating

RHEUMATIC DISEASES

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HAMPTON ROADS
Physician
A publication for and about the local medical community

Spring 2015, Volume III/Issue II

Recognizing the achievements of the local medical community

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Published by
DocDirect Publishing, LLC

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Hampton Roads Physician is published by DocDirect Publishing, LLC,
7445 N. Shore Rd., Norfolk, VA 23505
Phone: 757-237-1106.

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WELCOME
to the Spring 2015 Edition

Welcome to the Spring 2015 issue of Hampton Roads Physician. If this is your first experience with the magazine, we want to welcome you as a reader, and hope you'll find the publication a worthy addition to your reading folder. If you're one of our regular readers, thank you so much for your support of the magazine.

In either case, it's probably appropriate to review our cover doctor selection process. We publish four times a year, and our topics and content are governed by a 30-member Physician Advisory and Emeritus Boards.

These physicians guide us in the selection of medical specialties to feature, read all the nominations submitted for cover doctors, and after careful review, vote on those physicians to be honored.

Holly Barlow
Publisher

The Board also recommends additional topics they believe would be of interest to our readers: in this issue, that second topic is treating allergy and asthma in Hampton Roads – and in that regard, a word of disclosure might be in order: in March and April, when these interviews were conducted and the article written, both the publisher and editor of this magazine were dealing with the effects of pollen and all the other allergens that accompany springtime in Hampton Roads. A heretofore unknown resource has given us a heads up on what to expect each day, and we happily share it with you: www.pollen.com. Plugging in your zip code will provide not just the allergen count for the day, but what's producing them. For example, as this column is being written, the count is 10.1, on a scale of one to 12, and the main culprits are maple, oak and elm.

But it's our cover topic for this issue that our Physician Advisory Board recommended most enthusiastically: the practice of rheumatology, a complex and largely unheralded specialty comprised of more than a hundred different diseases that affect the joints and connective tissues of the body. The physicians chosen to appear on our cover – Dr. Roger Lidman, Dr. Chris Gabriel and Dr. David Maxwell – represent a specialty that one Board member described as "hugely important in so many areas of medicine."

Bobbie Fisher
Editor

We're already planning our next issue: the featured topic is urology, and we'll be spotlighting physicians who practice in that field. If you'd like to nominate a colleague or partner, please go to www.hrphysician.com to download our nomination form – or if you'd prefer, call our editor at 757.773.7550 to have one emailed directly to you.

Deadline for all nominations – including cover doctors, medical professionals and good deeds is June 2.

Our secondary feature for the Summer 2015 issue will be the challenges of hospital medicine, from every perspective.

Warmest thanks and good health to all of you.

Published four times a year, Hampton Roads Physician provides a wide variety of the most current, accurate and useful information busy doctors and health care providers want and need.

Cover stories concentrate on one branch of medicine, featuring profiles of practitioners in that specialty. Featured physicians are chosen by the advisory board through a nomination process involving fellow physicians and public relations directors from local hospitals and practices.

EXCEPTIONAL PROFESSIONAL

Erin McCartney, PA

Maternal-Fetal Medicine, EVMS

By Bobbie Fisher

Erin McCartney knew she wanted to work in medicine, and was on track to apply to medical school when she overheard a conversation that changed her career track. "I was in school," she remembers, "and some girls in the class ahead of me were excited because they had gotten into PA school. I asked them about it, and what they told me made me realize that I didn't have to become a physician to do the work I wanted to do."

As a Physician Assistant, she'd still have a lot of autonomy and independence. She'd work alongside doctors, and wouldn't have to spend another seven years in school. She was eager to start working with patients, and equally compelling was that she'd have more time to spend with her family.

She enrolled in the PA program at EVMS, unsure which area of medicine she wanted to pursue. She liked the obstetrics part of OB/GYN, although her program directors advised there would be few positions working only with OB patients. During a clinical rotation, she met Dr. Bonnie J. Dattel, whom she still highly regards as her mentor, and whose own passion and expertise in the practice of Maternal-Fetal Medicine led Erin further to her decision to work in her chosen practice area. Erin's mother remembers getting a phone call from her daughter and being unable to understand what she was saying. "She was as excited as I'd ever known her to be," her mom says, "all I heard was something about red hair. I didn't know if she was laughing or crying, I just heard 'red hair.'"

Erin had just delivered her first baby: a ginger haired little girl. "When I clamped that cord, and saw the life I was holding in my hands, it brought tears to my eyes," she says today. "And it still does. Each delivery amazes me."

Graduating in 2009, she was offered a position in Maternal-Fetal Medicine, where not all pregnancies turn out as well as that first delivery: all of the women are high risk. "It can be stressful, yes," she says, "but the good outweighs the bad, and the women who experience the bad need support and care, too."

The intimacy of pregnancy often creates strong bonds between providers and their patients. Many seek McCartney out for subsequent pregnancies, whether or not they are high risk.

The expectant mother in the photograph, Danielle Mutter, had conceived her first child by in vitro fertilization. McCartney cared for her throughout the pregnancy, and assisted in her Cesarean section birth, even sewing her incision after the birth. When Danielle conceived her second child spontaneously, there was no question where she wanted her obstetric care, and from whom: so strong was their bond that they reunited, and look forward to another beautiful, healthy child.

Describing her dedication to the women she takes care of, Dr. Alfred Abuhamad, Chair of the Department of OB/GYN, says, "In a specialty known for long erratic hours, Erin's commitment is displayed by how much time she dedicates to her job. She's often one of the first to arrive at the clinic and the last to leave. This is incredible given that Erin lives in Williamsburg and commutes on a daily basis! Snow, sleet, and summer tunnel traffic are no obstacles to her. The high-risk pregnant women she cares for always take priority." ■

If you work with or know a Physician Assistant or Nurse Practitioner you'd like us to consider, please visit our website – www.hrphysician.com – or call our editor, Bobbie Fisher, at 757.773.7550.

2015 Hampton Roads Physician Advisory Board

We are honored to present the ***Hampton Roads Physician* 2015 Advisory Board.** Their input will help guide the editorial content, format, and direction of the magazine. Along with our Emeritus Board, they will select our featured physicians.

Mary A. Burns, MD, FACOG, FPMRS
Urological Surgery
Gynecology
Dr. Burns is a partner of Virginia Beach OB GYN and Mid-Atlantic Urogynecology and is past Chairperson of Mid-Atlantic Women's Care. Her primary focus is treating female urinary and pelvic floor disorders. She operates at Sentara and Bon Secours DePaul Hospitals.

Emmeline C. Gasink, MD, FAAFP, CMD
Family Medicine
Dr. Gasink serves as the full-time Medical Director for the Riverside's Warwick Forest campus in Newport News. She is Board certified in Family Medicine.

Bryan Fox, MD
Orthopaedic Surgeon
Dr. Fox joined Sports Medicine & Orthopaedic Center (SMOC) to establish an adult spinal surgery arm of the practice at Obici Hospital where he is Chief of surgery. He is an expert in minimally invasive spine surgery techniques.

Boyd W. Haynes III, MD
Orthopaedic Surgeon
Dr. Haynes is the Senior Partner at Orthopaedic & Spine Center in Newport News, VA. He is Fellowship-trained and Board certified in Sports Medicine and Orthopaedic Surgery and specializes in minimally-invasive, outpatient Joint Replacement, Sports Medicine and Endoscopic Carpal & Cubital Tunnel Release surgeries.

Jerry L. Nadler, MD, FAHA, MACP
Internal Medicine
Dr. Nadler serves as the Vice Dean for Research and the Harry H. Mansbach Professor of Medicine and Chair, Department of Internal Medicine at EVMS. He is Board certified in Internal Medicine and Endocrinology and was elected to Mastership in the American College of Physicians for excellence and distinguished contributions to internal medicine.

Paa-Kofi Obeng, DO
Internal Medicine
Dr. Obeng provides a full spectrum of health care services for adults with an emphasis on preventive care at Nansemond Suffolk Family Practice.

Michael J. Petruschak, MD
Diagnostic Radiology
Dr. Petruschak is Director of Breast Imaging at Chesapeake Regional Medical Center. He is Board certified in Diagnostic Radiology and fellowship trained in body imaging.

Michael Schwartz, MD
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Dr. Schwartz is a pathologist with Peninsula Pathology Associates and practices at Riverside Health System. He is Board certified in Anatomic and Clinical Pathology.

Jyoti Upadhyay, MD, FAAP, FACS
Associate Professor of Department of Urology and Pediatrics
Dr. Upadhyay is a staff pediatric urologist at Children's Hospital of the King's Daughters with special interests in complex genitourinary reconstruction.

Elizabeth Yeu, MD
Ophthalmology
Dr. Yeu is a partner to Virginia Eye Consultants and specializes in Cornea, Cataract, Anterior Segment and Refractive Surgery. She is Assistant Professor of Ophthalmology at Eastern Virginia Medical School.

Rheumatic Diseases

Treating Them Today and in the Future

According to the American College of Rheumatology (ACR), there are more than a hundred rheumatic diseases. These diseases can affect joints, tendons, ligaments, bones and muscles. Some rheumatic diseases may also involve internal organs such as the kidneys or lungs. Common symptoms include joint pain, stiffness, swelling and weakness. Fatigue is another common problem, caused by chronic pain and disrupted sleep. Frequently these conditions lead to loss of function, which causes an inability to carry out activities of daily living.[1]

The most common of these diseases include:

Ankylosing spondylitis. Most common in young adults, AK inflames tendons in the hips, knees, and shoulders, causing pain and stiffness.

Fibromyalgia. Millions of adults struggle with the chronic fatigue and pain of this disease, which attacks the muscles and tendons that support the joints, causing stiffness and pain as well as sleep disturbances.

Gout. Characterized by uric acid crystals in the joints, most often the big toe, causing episodes of pain and swelling.

Infectious arthritis. Some forms of arthritis are caused by viral or bacterial infections. For example, Lyme disease, which results from the bite of a tick carrying specific bacteria, may cause inflammation, pain, and stiffness of joints. Other types include parvovirus arthritis and gonococcal arthritis.

Juvenile idiopathic arthritis. The most common arthritis in childhood, JIA causes pain, swelling, and loss of joint function and may be accompanied by fevers and rashes.

Lupus. Technically systemic lupus erythematosus, lupus attacks the body's own healthy cells and tissues, causing damage to joints and organs throughout the body.

Osteoarthritis. The most common type of arthritis, OA destroys cartilage and bone, causing disability and pain.

Polymyalgia rheumatica. Often a red flag of diseased arteries (giant cell arteritis), it can lead to headaches, inflammation, unintended weight loss, and fever, damaging tendons, muscles, ligaments, and joint tissues.

Psoriatic arthritis. This painful disease affects joints of fingers and toes and creates visible changes in finger- and toenails.

Reactive arthritis. Also known as Reiter's syndrome, this disease is often triggered by an infection in the bowels, urinary tract, or other organs and causes skin rashes, sores on the mouth, and eye troubles.

Rheumatoid arthritis. RA destroys the lining of joints, causing swelling, pain, and stiffness throughout the body. Unlike other rheumatic diseases, RA symptoms tend to occur symmetrically.

Scleroderma. Literally "hard skin," scleroderma occurs when the body produces too much collagen.

Rheumatic diseases affect an estimated 46 million people in the United States of all races and ages, including an estimated 294,000 children. Some rheumatic diseases are more common among certain populations. For example, rheumatoid arthritis, scleroderma, fibromyalgia, and lupus predominantly affect women. The spondyloarthropathies and gout are more common in men. However, after menopause, the incidence of gout in women begins to rise. Lupus is more common in and tends to be more severe in African Americans and Hispanics than Caucasians.[2]

As the physicians on the cover of this issue note, diagnosing these diseases can be challenging, although treating many of them successfully has become easier with the advent of biologic therapies. Biologics have been used since 1998 and have been studied for almost 10 years. Overall, they have been given to more than 600,000 people worldwide. The ACR describes the mechanism of biologic therapy this way:

> A "biologic" drug copies the effects of substances naturally made by the body's immune system. Biologic agents are genetically engineered drugs – meaning that human genes that normally guide the production of these natural human immune proteins (i.e., an antibody to TNF) are used in non-human cell cultures to produce large amounts of a biologic drug. These drugs are given to lessen inflammation by interfering with biologic substances that cause or worsen inflammation. These new biologic agents can specifically affect some of the abnormalities of the immune system that lead to the joint inflammation and other abnormalities seen in rheumatoid arthritis and so help treat its symptoms.[3]

Unfortunately, the success seen with these biologic therapies comes at a cost. The ACR estimates that a patient can pay anywhere from $10,000 to $30,000 a year, depending on whether there is insurance that pays any of the cost.

According to the American College of Rheumatology (ACR), there are more than a hundred rheumatic diseases. These diseases can affect joints, tendons, ligaments, bones and muscles.

But it's not just the challenge of diagnosing or the cost of treating rheumatic diseases that is cause for concern.

It's also a projected shortage of rheumatologists. A 2007 workforce study indicated in part that:

> ...The number of rheumatologists for adult patients in the US in 2005 is 4,946. Assuming rheumatology supply and demand are in equilibrium in 2005, the demand for rheumatologists in 2025 is projected to exceed supply by 2,576 adult and 33 pediatric rheumatologists. The primary factors in the excess demand are an aging population, which will increase the number of people with rheumatic disorders, growth in the Gross Domestic Product and flat rheumatology supply due to fixed numbers entering the workforce and retirements. The productivity of younger rheumatologists and women, who will make up a greater percentage of the future workforce, may also have important effects on supply. Unknown effects that could influence these projections include technology advances, more efficient practice methods, changes in insurance reimbursements, and shifting lifestyles. Current data suggest that the pediatric rheumatology workforce is experiencing a substantial excess of demand versus supply.
>
> Conclusion: Based on assessment of supply and demand under current scenarios, the demand for rheumatologists is expected to exceed supply in the coming decades. Strategies for the profession to adapt to this changing health care landscape include increasing the number of fellows each year, utilizing physician assistants and nurse practitioners in greater numbers, and improving practice efficiency.[4]

The ACR has projected a decline in the number of rheumatologists beginning in 2016, based on the age distribution of its membership and the number of entering fellows. The December 2014 issue of The Rheumatologist, an official publication of the ACR, featured an article entitled, "Rheumatologists In Demand As Physician Shortages in Rheumatology Intensify," by Kurt Ullman. Ullman wrote:

> As shortages in rheumatology become more pronounced, the need to get more physicians into the field also increases. A report from 2007 indicated that there could be a deficit of more than 2,500 practicing rheumatologists by 2025.
>
> One way to generate interest is to make the most of each medical student's rotation through the specialty. Exposure to the best facets of the specialty can lead otherwise undecided students into a career in rheumatology.
>
> "Rheumatology as a field gets a relatively small percentage of those choosing careers in internal medicine," says Richard Brasington, MD, professor of medicine and director of clinical rheumatology at Washington University School of Medicine in St. Louis. "Everybody we recruit counts and really helps. Rheumatology is not a field people are automatically drawn to. Many don't know what it is, so I think it is very important that we present it to students in a way that is appealing."

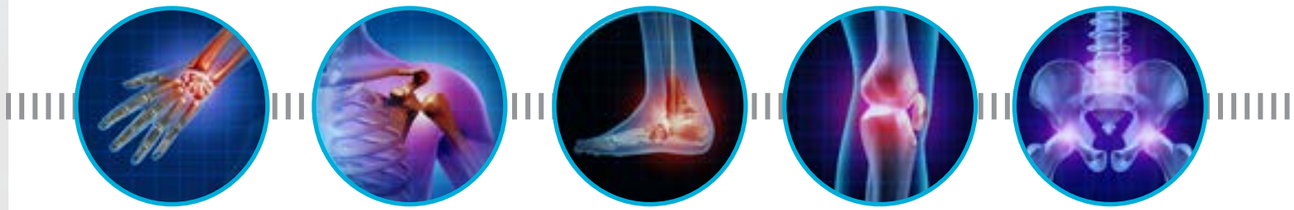
So concerned are rheumatologists about this pending shortage that the ACR has developed policy statements that are approved to serve as guides to recommendations for members of congress, regulatory entities and advocacy organizations. For 2015, the top advocacy priorities of the ACR address (a) access to rheumatology through more appropriate valuation of care provided by rheumatologists; (b) access to treatment by reining in excessive cost-sharing associated with specialty medications; and (c) continued discovery of new cures and innovative treatments through sustainable increases in funding for medical research.

One such 2015 policy statement, entitled "Shortage of Rheumatologists Endangers Health," cites the demand for adult and pediatric rheumatologists as "already exceeding supply," and states that in many areas there is already a major shortage of rheumatologists.

The Physician Advisory Board of Hampton Roads Physician recognizes this concern. As they considered the medical specialties the magazine would feature for the current year, our Board members were particularly keen to honor the rheumatologists in our area, noting that "...they get little attention, and while their numbers are few, they are hugely important in so many areas of medicine."

Indeed, there is little doubt that as the population in Hampton Roads ages, there will be an increased need for rheumatologists. As one of our featured physicians noted, "Now we just hope there will be enough coming out of training programs to replace the ones who will be retiring in the next five or 10 years." ■

[1] American College of Rheumatology, 2014 Media Guide
[2] www.niams.nih.gov/health_info/arthritis/arthritis_rheumatic_qa.asp
[3] www.rheumatolog.org/Biologic Treatments for Rheumatoid Arthritis, April 12, 2015
[4] Deal CL, Hooker R, Harrington T, et al. The United States rheumatology workforce: Supply and demand, 2005–2025. Arthritis Rheum. 2007 Mar;56(3):722–729.



Treating the Rheumatoid Arthritis Patient in 2015

Robert J. Snyder, MD

The patient who is diagnosed in 2015 with an auto-immune form of arthritis, such as Rheumatoid (RA) or Psoriatic Arthritis (PA), will most likely be treated by a team of physicians and ancillary providers. Overseen by a Rheumatologist, this multi-disciplinary team may include Orthopaedists, Physical and Occupational Therapists, Social Workers and Rehabilitation Specialists. Thankfully, these patients can be treated with an array of disease-modifying anti-rheumatic drugs (DMARD) with which their joint damage can be arrested or slowed. Today's patient may be able to delay or avoid joint replacement because of the efficacy of the new treatments available and a better understanding of the inflammatory joint disease process.

Despite all of the good news, I still see patients regularly who need joint replacement surgery due to the destruction caused by long-term erosion of the articular cartilage. Although hips and knees are the most commonly-replaced joints, patients who have rheumatic variants of arthritis can need arthroplasty of the elbows, wrists, fingers, toes, ankles, and shoulders to relieve the pain, dysfunction and deformity caused by their disease. The cervical spine may also be impacted and require surgical intervention to alleviate symptoms.

Treating RA or PA patients differs from treating patients who present with Osteoarthritis or OA. RA/PA patients have an aggressive, chronic inflammatory disease which destroys the affected joints. If their disease has progressed to the point where they require a new joint then total joint replacement is usually the only option to address the damaged joint. Partial joint replacement is not an option because of the pathology of the disease; the synovium of the entire joint is affected. In OA patients, I often am able to address limited joint destruction in the knee by performing a partial joint replacement.

Viscosupplementation is useful and approved for RA/PA patients who have involvement of the knee. Some physicians will use these hyaluronic acid injections in off-label ways and inject into joints which have not been cleared by the FDA, but I do not see evidence supporting efficacy in any joint except the knee. At best, viscosupplementation buys us time before joint replacement and allows the patient to process the reality of needing the surgery to achieve real pain relief and restoration of function.

RA/PA patients also present with significant tendon issues that also may need to be addressed. Joint damage can cause these tendons to loosen or rupture and surgical repair may be the only option to relieve pain and dysfunction. This repair is usually performed concurrently with the arthroplasty particularly around the hand and wrist. In some cases joint fusion combined with arthroplasty, is the preferred option to restore stability and alignment. ■

Robert J. Snyder, MD is a Board certified Orthopaedic Specialist with Orthopaedic & Spine Center in Newport News, VA. Voted a "Top Doc" in both 2012 and 2013, Dr. Snyder specializes in Partial and Total Joint Replacement of the knee, Direct Anterior Hip Replacement, Sports Medicine and conditions pertaining to the Foot and Ankle. www.osc-ortho.com

Christos A. Gabriel, MD

Director, Division of Pediatric Rheumatology,
Children's Hospital of The King's Daughters
Associate Professor of Pediatrics, Eastern Virginia Medical School

Physicians choose their specialties for as many reasons as there are specialties to choose from. For Dr. Chris Gabriel, it was simply a matter of seeing a need, and stepping up to fill it. He received his undergraduate degree in Environmental Health at Old Dominion University, intending to look for work in biology, but a good friend, with whom he was working at the Public Health Service Hospital, changed his path. "He told me he thought I'd make a good doctor," Dr. Gabriel remembers. "So I applied to medical school."

He earned his medical degree from Eastern Virginia Medical School, where he completed both his internship and residency in pediatrics. During his residency, he saw pediatric patients with rheumatic diseases being admitted to the hospital for treatment, and quickly realized there were no trained pediatric rheumatologists to take care of them. "They were being cared for by very good physicians," Dr. Gabriel emphasizes, "infectious disease specialists, general pediatricians, a whole host of people who were very skilled, but who didn't have specialized training in rheumatology."

Diagnosing patients with rheumatic disease can be a challenge. "Many of these disorders, such as juvenile idiopathic arthritis (JIA), are a diagnosis of exclusion."

He therefore decided to do one year of clinical fellowship in pediatric nephrology at the Children's Medical Center at Georgetown University Hospital in Washington, DC. He then completed fellowship training in pediatric rheumatology at Cincinnati Children's Hospital Medical Center, where he served an additional year as a Procter Research Scholar/Clinical Instructor in Pediatrics.

"When I left for Georgetown and then Cincinnati, it was always with the idea of coming back here. This is home to me," Dr. Gabriel says. "I have always been committed to CHKD and wanted to start a comprehensive program that offers specialized care for young patients with rheumatic and connective tissue diseases. That was really the impetus."

Diagnosing patients with rheumatic disease can be a challenge. "Many of these disorders, such as juvenile idiopathic arthritis (JIA), are a diagnosis of exclusion," Dr. Gabriel says. "While laboratory tests and X-rays are helpful, there is no single laboratory test that allows one to confirm the diagnosis. We have to rule out other possible causes of arthritis such as infection or malignancy before making the diagnosis." It's important, he says, because other causes must be eliminated: "We don't want to start these kids on powerful medication and biologics if they have some other disease, so it's important to go through that process."

Dr. Gabriel's patients range in age from infant through 21 – three years longer than many pediatricians see their patients. "These kids will probably go away to college," he explains, "so I don't want to send them to an adult rheumatologist here, only to have them move away and have to find another doctor in their new city."

The majority of his practice involves treating juvenile arthritis, followed by juvenile systemic lupus and juvenile ankylosing spondylitis. The differences between pediatric and adult rheumatology cases can be significant. "Juvenile arthritis is really a very different disease than rheumatoid arthritis, and there are various subtypes of juvenile arthritis that exist as well," Dr. Gabriel explains. "We think of adult rheumatoid arthritis as a pretty homogenous disease. With JIA, various subtypes exist. There's pauciarticular juvenile arthritis (four or fewer joints involved); polyarticular juvenile arthritis (five or more joints are involved); and systemic juvenile arthritis (joint swelling accompanied by fever and rash). The prognosis can vary depending on the subtype the patient has."

With systemic lupus and ankylosing spondylitis, there are differences between the juvenile and adult diseases, but the treatments are the same for the most part. "With systemic JIA, which we rarely see in adults, patients present with high fever and rash, and they are very ill, often requiring hospitalization," Dr. Gabriel says.

For some of his patients, the prognosis can be poor. The introduction of biologic therapies has made a huge difference in the treatment of pediatric and adult rheumatology. "Back when I was a fellow, we'd put these kids on what was basically the equivalent of aspirin or ibuprofen or Motrin and slowly watch them become crippled as their joints deteriorated," Dr. Gabriel remembers. "Now, with biologic therapy, we can treat them and keep their disease under control. They actually have the chance to live essentially normal lives."

Most of his patients with juvenile arthritis attend school, are involved in sports and do all the other things that today's kids do. "The only difference for these kids is they have to take medication," Dr. Gabriel says. "It's been a pretty remarkable revolution in terms of the biologic drugs that have allowed us to control the disease. We still don't cure it with these drugs, but they're so effective at controlling the inflammation that the patients basically are close to if not free of arthritis – as long as they take their medications."

Dr. Gabriel is excited that the program he began is expanding. CHKD recently hired another pediatric rheumatologist, and the two now see patients in satellite locations in Virginia Beach, Newport News and Chesapeake. It won't happen any time soon, he says, but, "When I'm ready to retire, I want to be sure there's a strong program in place to take care of these kids."

Roger W. Lidman, MD

President, Center for Arthritis and Rheumatic Diseases
Chief, Division of Rheumatology, EVMS

In the middle of the twentieth century, when Dr. Lidman's father was a general internist in Norfolk with a special interest in noninvasive cardiology, he didn't have the benefit of the technological advances available to today's cardiologists. "In those days, heart doctors relied on stethoscopes," he says of his father, who died in 1977. "Cardiology was still in its relative infancy."

It's been different for Dr. Lidman, who has practiced rheumatology for nearly four decades: he's seen and incorporated the tremendous advances that have been made in his specialty throughout his career.

Pursuing a career in medicine was an early and easy decision for Dr. Lidman. After earning a BS in Zoology at Duke, he took his medical training at Johns Hopkins, where, he says, "I was lucky enough to work with a true pioneer in the field of rheumatology, Dr. Mary Betty Stevens. What attracted me was the fact that we were dealing with multi-organ disease states, multi-system diseases, so we really had to know about every organ system in the body, and we needed to understand the concepts of immunology. It was an intellectual, rather than a procedure driven specialty."

At Vanderbilt, he completed his residency and internship in internal medicine, followed by a fellowship in rheumatology. During his internship, he once again had the opportunity to work with a rheumatology pioneer, Dr. John Sergent. A second fellowship at the Medical University of South Carolina followed.

Returning to Hampton Roads in 1981, he joined the Center for Arthritis and Rheumatic Diseases, where he has practiced ever since.

During those years, he has seen several advances in his field, among them the introduction of immunosuppressant drugs to treat rheumatic diseases – "with all the baggage they carry," he says, "in terms of lowering the body's resistance to infection, and in some cases, making the body more likely to develop other complications, such as cancer." Patients taking these traditional disease-modifying antirheumatic drugs (DMARDs) are at higher risk for infection.

Of the advances he's seen, he says, "The most important has been the advent of biologic therapies, the biologic response modifiers, which are used to target specific mediators of inflammation and mediators of joint damage. They may have a targeted effect on particular branches of the immune system in both rheumatoid arthritis and the inflammatory connective tissue diseases we deal with, such as lupus and scleroderma."

Dr. Lidman has participated in a number of clinical trials for medications to treat rheumatic diseases, often as principal investigator. "The newer drugs, whether they're biologic agents or so-called small molecules, are targeting either specific mediators of inflammation or tissue damage or they're acting on signaling systems within cells, which if inhibited, will decrease the production of these inflammatory or tissue destructive mediators," he explains. "And the trend that one hopes to develop in rheumatology – as in every other specialty of internal medicine – is that you target your therapy. In other words, if you have a fly, you use a fly swatter, not a baseball bat. All of the medications we use have the potential collateral damage of increased infection."

Because many rheumatic diseases have nonspecific symptoms, many patients aren't diagnosed until they seek a doctor's care for the pain associated with significant joint damage. "We do know that there are genetic markers we can test for that predict a patient's risk of developing the disease," Dr. Lidman explains, "but it doesn't mean the patient will necessarily develop the disease. There's a genetic marker that is associated with an increased risk of inflammatory back disease. There are genetic markers associated with an increased risk of rheumatoid arthritis and lupus, but then something has to trigger that, whether it's an infection or some other environmental exposure – something has to trigger the development of that condition in the appropriate genetic background."

In some cases, Dr. Lidman says, "if we can determine what mediator is driving the disease, there's testing available now of biomarkers that can help us choose the agent, whether a drug or a biologic, that's best suited for that patient, much the same way an oncologist can determine what chemotherapy regimen is best for a cancer patient. That's been a significant advance within the last five years."

"It might be possible in the future to inject something into the knee that will actually cause cartilage to regrow. Nothing does that at this point."

The ultimate goal is to be more specific in therapy. "Our goal is to do what they've done in oncology," he says, "which is to actually determine an individual's inherited risk or genomic risk of developing certain auto inflammatory or auto immune diseases and be able to target those conditions directly."

In terms of advances yet to come in his field, Dr. Lidman is optimistic. "I think one of the things coming down the road will probably be gene manipulation, gene therapy," he says. "It might be possible in the future to inject something into the knee that will actually cause cartilage to regrow. Nothing does that at this point." Today such patients' options are a cartilage transplant, or total knee replacement. And, he adds, there are rheumatic conditions that are responsive to stem cell transplants – although it may be years before that will be generally available.

Right now, like many of his colleagues in rheumatology, Dr. Lidman is more concerned with how the next advances will be paid for. But as he reminds us, musculoskeletal diseases remain the major cause of disability – and lost time from work – in the United States. ■

David B. Maxwell, MD

Riverside Medical Group

Unlike most physicians, who have a say in their chosen profession, Dr. David Maxwell believes his career was determined very early. "I learned about it much later," he says, "but apparently my grandmother wished that I would become a doctor before I was born." He remembers yearly gifts from his grandmother always included doctor kits; thus, "I soon became disillusioned of the concept of free will."

Although his father would have preferred accounting, grandmotherly persuasion won out: with a natural bent toward science, David Maxwell graduated with a degree in biology from the University of Virginia, and thereafter earned his medical degree at Eastern Virginia Medical School. "I wanted to become a family doc," he says. "My dream was to work with Dr. Rives Bailey in Yorktown, where I'd lived since the 8th grade." But at EVMS, he met Dr. Stuart Baker, who changed his mind. "He was a rheumatologist, and the smartest doctor I'd ever met," Dr. Maxwell says. "He made rheumatology, a very complex specialty, sound understandable, and doable." And, he adds, "Dr. Baker was a disciple of William Osler. Now I am as well."

Dr. Maxwell remained at EVMS for his internal medicine internship, residency and chief residency under Dr. Hershel Estep (another hero), then to the Medical University of South Carolina for his fellowship in rheumatology and immunology. In 1986, he returned to Yorktown and set up his practice. "Providence has given me my wife, Sally Harcum, who put me through medical school," he says, "and when my fledgling practice floundered, she put the organization together that allowed me to spend the next 25 years doing what I loved: taking care of patients." In 2013, he joined Riverside Medical Group and established a rheumatology division.

He describes rheumatology as "a Sherlock Holmes sort of specialty." The diagnoses are frequently obscure, but another mentor once told him that, "If you listen and observe – and are receptive – the patient will tell you the diagnosis. That's what I learned from Dr. Baker: to be intellectually and psychologically prepared."

After nearly three decades, Dr. Maxwell has seen many changes in the field of rheumatology. He explains: "Historically, the rheumatologist dealt with medical musculoskeletal issues, areas now managed by orthopedics, physical therapy and physical medicine. In fact, we're much more akin, as specialists, to the oncologists now."

Particularly in the case of rheumatoid arthritis, the excellent results achieved by the additional of biologic immunomodulation to disease modifying therapy have meant fewer referrals for orthopedic surgery. "With chemotherapeutic drugs like rituximab, cyclophosphamide and azathioprine, it's rare that we can't control rheumatoid arthritis in this day and age." The frequent limitation, he says, is insurance funding of the treatments, which are vastly expensive.

The biologics cost in the realm of $20,000 to $30,000 a year, retail. "One could control every rheumatoid for $30,000 a year for the rest of their lives," Dr. Maxwell says, "but the cost may make that an unsustainable goal. Not all insurance companies pay for biologics." Even those that do often require the patient to shoulder a great deal of the cost. He adds, "In Economics at UVA, they taught us about wartime economics: production of guns or butter; you can't afford both."

After nearly three decades, Dr. Maxwell has seen many changes in the field of rheumatology. He explains: "Historically, the rheumatologist dealt with medical musculoskeletal issues, areas now managed by orthopedics, physical therapy and physical medicine.

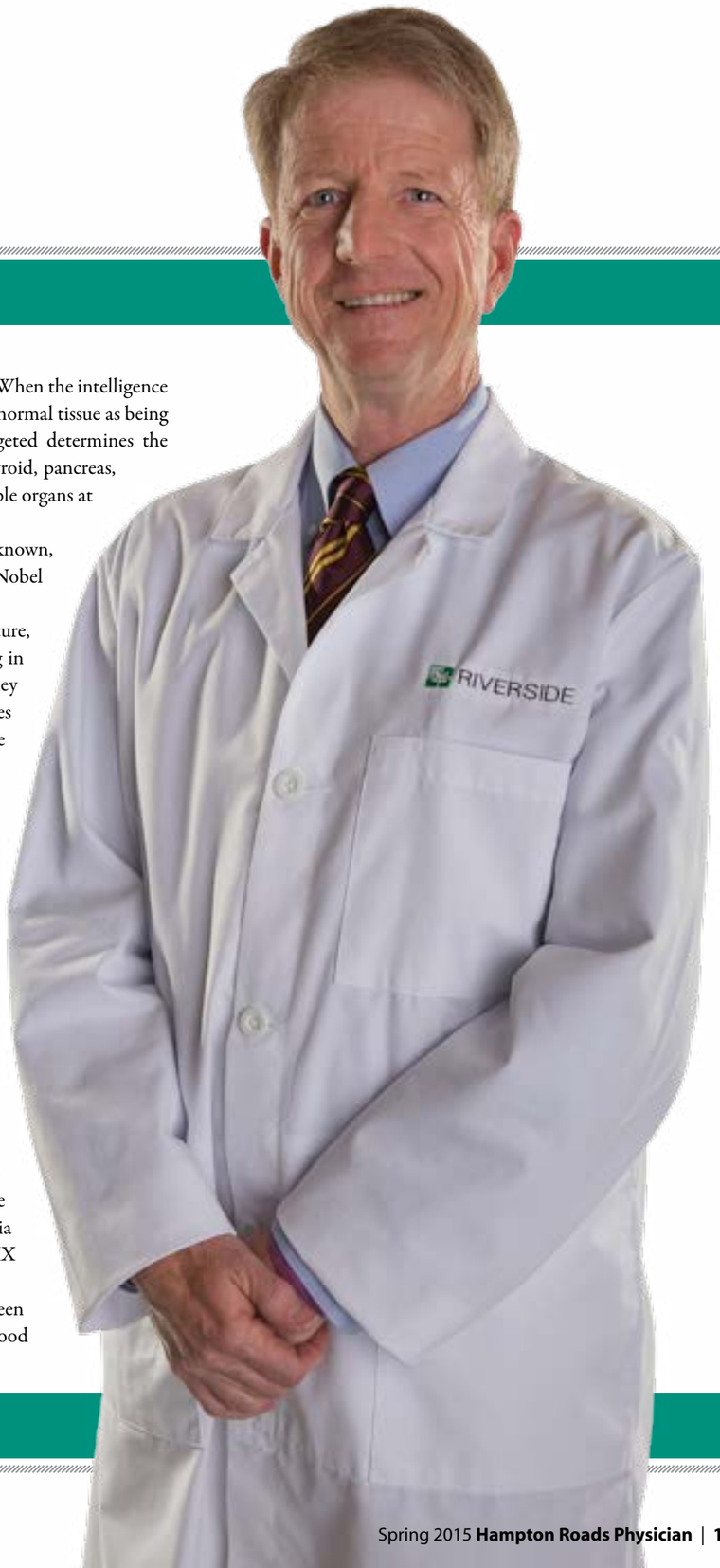
Dr. Maxwell finds the wartime analogy useful for explaining rheumatic diseases and autoimmune disorders to his patients. "I tell them to imagine an intelligence division and an armored division," he says. "The intelligence division identifies the enemy, and the armored division does the shooting. When the intelligence division makes a mistake and starts targeting normal tissue as being foreign, that's autoimmunity. What is targeted determines the patient's particular disease, whether it be thyroid, pancreas, joints, skin, lung, kidney – or when it's multiple organs at once, we call that lupus."

Why it happens in the first place isn't known, although research continues. "That's the Nobel prize question," Dr. Maxwell says.

He's hopeful that some time in the future, there may be a bigger role for genetic testing in rheumatology. "In research institutions, they can do genetic profiling and find certain genes that predispose to autoimmune diseases," he explains, "but this information is not clinically helpful at this point: now, you treat what you see. Inheriting a gene doesn't guarantee that a patient will get the disease. We treat when the disease becomes manifest."

In the scarce free time his rheumatology practice has afforded him over the last 20 years, Dr. Maxwell has been involved in the family practicing training program at Riverside, where he has an ongoing monthly clinic, and 15 or so years at the Lackey Free Clinic (Dr. Jim Shaw is another hero). An unabashed "big fan of youth," he has a long history of involvement with the Boy Scouts of America, having served variously as Scoutmaster of Troop 28 in Poquoson, as a Committee Member of the Chesapeake Bay District/Colonial Virginia Council, and as Staff Physician for the XX World Scout Jamboree in Santiago, Chile.

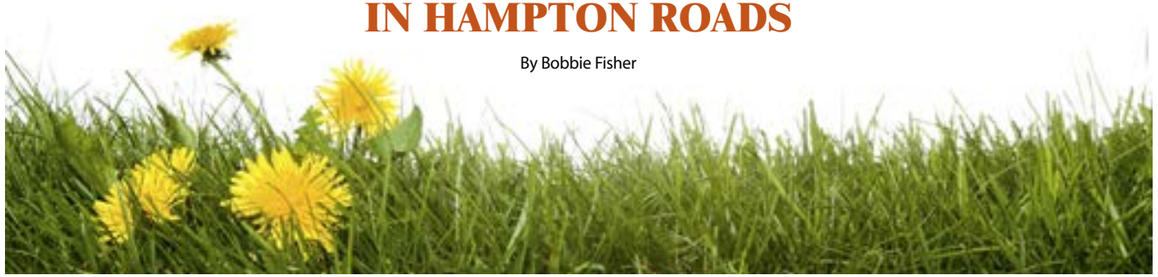
"I love young people," he says. "And I've been blessed throughout my career with really good mentors. Now I'm trying to give back." ■



TREATING ALLERGIES AND ASTHMA

IN HAMPTON ROADS

By Bobbie Fisher



After a winter that saw more snow than most years, Hampton Roads seemed more than ready to welcome spring – even that yellow pollen that collects on cars, sidewalks, creekbeds and of course, lungs. So like clockwork, rather than the cold, people are now grumbling about the allergies that accompany spring. It's a common complaint: "Hampton Roads is the worst place in the world if you have allergies!"

That's actually not true, although there is some basis for the misconception. At one point in time, about 20 years ago, Tidewater (as the area was then known) was the No. 2 area in the United States for allergy issues, although today, according to the Allergy and Asthma Foundation of America, Hampton Roads doesn't even rank in the Top Ten. The closest city in that group is Richmond, which occupies the No. 8 spot. The first appearance by a Hampton Roads city is Virginia Beach, at No. 29.

Even at that, says Himanshu D. Desai, MD, a pulmonologist with Bayview Physicians Group, he is seeing 25 percent more patients with asthma in Hampton Roads than he did in Buffalo, where he trained.

That's small comfort to those who suffer the sneezing, runny nose, watery eyes and other symptoms of the seasonal allergies that beset them every spring? And why does Hampton Roads get such a bad rap?

"It's our climate," says Gary B. Moss, MD, of Allergy & Asthma Specialists, Ltd., who is Board certified in internal medicine as well as allergy and immunology, "we live in a mild, temperate climate. The ocean has a warming effect that keeps us above freezing most of the year, so allergens don't die off. We're wet and warm and moist, so these allergens just abound. Up north, people get a break from allergies when there's so much snow on the ground for so long."

Despite our heavier than usual snowfall in this past winter, there was tree pollen present in Hampton Roads in February. In fact, when the first snow of 2015 fell, there was already a tree pollen rating of 2.3, on a scale of one to 12.

There's still another aspect to the warm, wet climate in Hampton Roads that affects and even causes allergies, says Ann P. Zilliox, MD, of Allergy & Asthma of Oyster Point in Newport News, a Board certified allergist/immunologist. "It's mold," she says, "something people don't understand particularly well. Mold will grow any place there's organic material and water. Everything that isn't stone or metal can develop mold. Patients can have problems with mold that run the gamut from severe allergic reactions to no symptoms at all."

So while Hampton Roads might not be the worst place for allergy sufferers, there are a great many tree pollens and grasses – and of course, mold – that send sufferers to their physicians for relief from their symptoms.

Making the diagnosis.

It starts with a comprehensive history and physical exam. If patients present with a green/yellow discharge, that indicates an infection. It's difficult because patients might have both an allergy and an infection that's exacerbated by that allergy. In those cases, physicians treat the infection aggressively, and if they feel better quickly, allergy is unlikely. Or if patients feel better, but symptoms recur right away, then physicians will look for an underlying allergy issue that might be triggering the infectious problems. Unlike infections, allergies are not caused by bacteria or virus.

Sometime the history and physical is all it takes to make a diagnosis. "If a patient comes in and says, 'every time a cat walks into the room, my nose gets stuffy and runny and my eyes itch,' that's kind of obvious,"

Himanshu D. Desai, MD

Angela Hogan, MD

Gary B. Moss, MD

Ann P. Zilliox, MD

Dr. Moss says. And there are lots and lots of cat allergies. In fact, there are more people seriously allergic to cats than to dogs. "Cat allergen is very light, aerodynamically stable in the air," Dr. Zilliox explains. "That's why when an allergic person walks into a house where there's a cat, they don't need to see the cat to know one's around. These people don't get beyond the foyer before they start blinking." Even when a cat leaves the house, there is measurable cat allergen hanging around in the air for an average of six months.

Of course, it's rarely that obvious, Dr. Moss says, so after taking an exhaustive history, if he believes skin testing is necessary, he'll perform those by pricking the skin with several different allergens to see what patients react to. But, he notes, "We only pick certain patients for testing, when the results can help define a treatment regimen."

Most physicians are doing fewer skin tests today, a departure from the huge numbers done several years ago. Dr. Zilliox explains, "Ultimately, when you test patients, the results of the tests have to correlate with the history; it's the only way to make the tests valid. A patient might test positive for horses, but never be around horses. And if they have symptoms all year round, but their tests only show positive to grass and pollen, that doesn't explain enough. History, symptoms and test results have to jibe."

Skin tests remain the preferred method of testing, although in certain cases – including patients on certain medications, having unstable hearts or poorly controlled asthma, or severe skin conditions – physicians use blood tests to determine antibodies in the system.

What's not understood is the mechanism that makes someone produce such antibodies.

What we do know, says Dr. Angela Hogan, an allergist/immunologist at Children's Hospital of the King's Daughters, is that we're born with all the hardware we need to become allergic in early infancy: "The allergy cell is called the MAST cell, or mastocyte, and there is plenty of histamine in them that could be released should we have an allergic reaction." Dr. Hogan has patients as young as six weeks who are diagnosed with an allergy; although, she points out, "it's usually a milk allergy, or something infants have more immediate exposure to. Environmental allergies tend to be more delayed" – but the process for allergic reaction is in place and viable.

Despite our heavier than usual snowfall in this past winter, there was tree pollen present in Hampton Roads in February. In fact, when the first snow of 2015 fell, there was already a tree pollen rating of 2.3, on a scale of one to 12.

There is a genetic component, Dr. Hogan says. "We know that allergies run in families. And we know that if one parent has allergies, there's a 50 percent chance the child will have them as well. If both parents have allergies, the child has an 80 percent chance."

But it is the child who determines the specific allergy, and a parent's allergy is no predictor of the child's, Dr. Hogan adds. Additionally, allergies are affected by birth order. The firstborn child, who tends to be kept at home a lot, is more likely to develop allergies than a child later in the birth order. The firstborn brings home infections to younger sibling(s), who gets sick – but those very illnesses might be protecting the younger child(ren) from the development of allergies.

"We still don't really understand it," Dr. Zilliox says. "I just returned from the annual American Academy of Allergy, Asthma and Immunology conference in Houston. And that's still what the conferences are dealing with: identifying what causes a person to make an allergic antibody. We're still working to answer that."

In Hampton Roads, as in the developed world, allergies and asthma are on the rise.

"There are many theories as to why that is," Dr. Zilliox says. "One is the so-called 'hygiene theory,' which essentially says that the less sick we are, and the less dirty we are, the more allergic we are." Dr. Moss agrees: "It's our clean, hygienic environment and access to medical care that keep us free of a lot of diseases that might actually predispose us to becoming allergic."

In places like South America, Southeast Asia or Africa, where people still have parasites and still have lives dealing with dirt and agriculture – which North Americans increasingly don't – there's virtually no childhood asthma, virtually no hay fever, and very few of the allergic diseases that Americans suffer.

Treating allergies and asthma.

There are three basic treatment options: "The first is avoidance," Dr. Moss says, "but that's not always possible. The second is medication, and there are many good medications on the market that work for a lot of people, both controller meds and rescue medications."

The mainstay of treatment for asthma is inhaled corticosteroids. "Patients with uncontrolled allergic asthma might benefit from omalizumab, which is an antibody to immunoglobulin E," Dr. Desai says. "New drugs are in Phase III clinical trials," he adds, including interleukins, which are showing great promise." He cautions patients and caregivers that asthma is a leading cause of death, but it is preventable, so long as medications are used regularly and appropriately.

When medications fail, the third strategy is allergy shots.

The past year has the introduction of sublingual immunotherapy. Rather than the standard subcutaneous immunotherapy, the allergen is placed under the tongue. "We've been able to do that for a number of years as an off-label treatment," Dr. Moss says, "but it hasn't been FDA-approved so insurance doesn't cover it. Two products were introduced this last year – one for grass allergies and one for ragweed."

In every case of allergy and asthma, these doctors agree, it's critical to follow medication regimens exactly. "Too often, when people start to feel better, they stop taking their medicines," Dr. Desai says. "But the allergy isn't going to go away. People need to use these medications regularly, so when they're exposed to triggers, they don't react." ■

GOOD DEEDS

Honoring physicians who are doing community service locally or outside the state or nation.

William P. Irvin, Jr., MD

Director, Gynecologic Oncology and Minimally Invasive Surgery
Riverside Regional Medical Center

In 1998, when Dr. William Irvin was a Professor of OB/GYN at the University of Virginia, he got a phone call from a man named Stan Brock. His name wasn't familiar, but he would soon play a major role in the physician's life.

Brock introduced himself as the founder of an organization called Remote Area Medical (RAM). He'd gone to Guyana as a youth, ultimately becoming foreman of the largest cattle ranch in that country. He tamed panthers, wrestled anacondas, rode bareback and came to admire the native Guyanans known as Amerindians – and developed an acute awareness of the lack of medical care available to the native community. In his book, *When All The Cowboys Were Indians,* he swore that if he was ever in a position to help these people, he would.

A Hollywood career (he was one of Marlon Perkins' sidekicks on Mutual of Omaha's Wild Kingdom) afforded him sufficient funds to return to Guyana, where he founded RAM – all volunteer doctors, anesthesiologists, nurses and others who would contribute their time to various health care needs across the world. Brock called to ask Dr. Irvin if he would help develop a cervical cancer screening program in Guyana.

Dr. Irvin knew that cervical cancer in developing countries was the leading cause of cancer related death among women of reproductive age, and that in many women, it was the number one cause of death, period. "They couldn't afford to screen," he explains. "Too often, they can't afford to feed their people, let alone screen them for illness."

Together with Brock, Dr. Irvin put together a program and began going to Guyana to screen Amerindian women in villages throughout the Amazon River basin. "We'd go in and do Pap smears in villages that had never seen white men before," he remembers. "We'd talk with the medicine men in the villages, who were directing health care for the villagers, and we'd educate them first, and they would in turn educate the women."

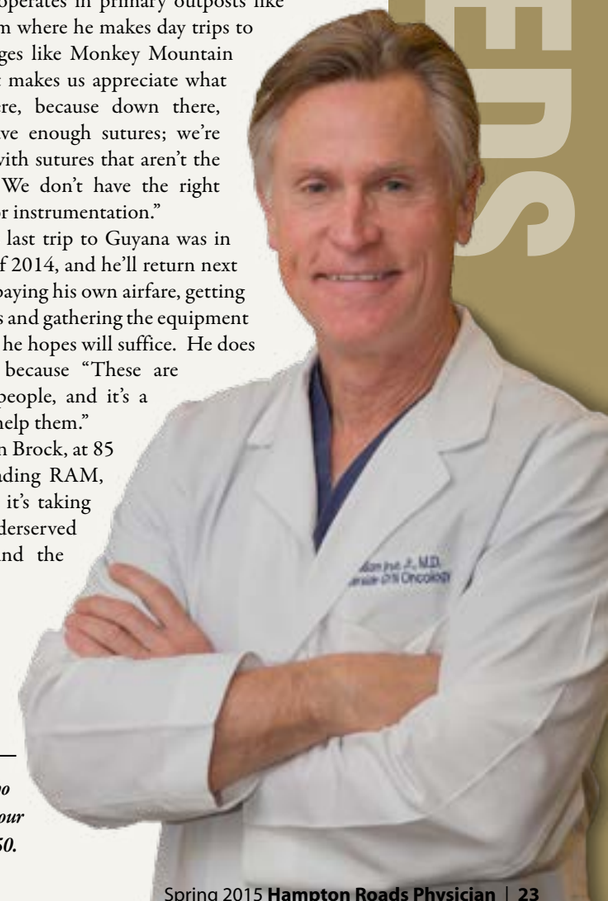
It was a challenge. Dr. Irvin and his colleagues had to devise a way to do Pap smears without women disrobing. "They were uncomfortable taking their underwear off," he says, "and their men didn't want them to." And unfortunately, not everyone in the villages understood it was in their interest to be screened. There were some villages where Dr. Irvin and his team were turned away.

The second part of the program was surgery on the women found to have cancer. Dr. Irvin remembers the primitive conditions in which he's operated: "One of the operating rooms had open windows, and I looked down to see a scorpion crawling up my leg. Right in the middle of surgery!" There was nothing to do but kill it and continue with the procedure.

Conditions today are somewhat better. Many of the surgeries are performed in Guyana's capital, Georgetown, where there is a residency program – but he still operates in primary outposts like Lethem, from where he makes day trips to various villages like Monkey Mountain or Anai. "It makes us appreciate what we have here, because down there, we don't have enough sutures; we're making do with sutures that aren't the right size. We don't have the right equipment or instrumentation."

Dr. Irvin's last trip to Guyana was in November of 2014, and he'll return next September, paying his own airfare, getting malaria shots and gathering the equipment and supplies he hopes will suffice. He does it, he says, because "These are very noble people, and it's a privilege to help them."

As for Stan Brock, at 85 he's still heading RAM, making sure it's taking care of underserved people around the world. ■



If you know physicians who are performing good deeds – great or small – who you would like to see highlighted in this publication, please submit information on our website – www.hrphysician.com – or call our editor, Bobbie Fisher, at 757.773.7550.

Dr. Samuel P. Robinson

…from the NFL to the community tennis court, helping active adults stay active – at every age

Americans are living and staying active longer, participating in sports and other vigorous activities well into their middle and later years. When they begin to encounter pain and stiffness, they may also begin to avoid physical activity because they have – or because they fear – increasing pain. Golf clubs are relegated to the closet, gardening tools to the shed, evening walks are curtailed – and thus quality of life diminished.

Rather than alleviating their pain, many people are putting themselves at risk for even more significant medical problems: cardiovascular disease, diabetes, hypertension, depression and anxiety. Fear of the surgeon's scalpel keeps many from seeking medical care.

Surgery is far from a patient's only option. Orthopedist Dr. Samuel P. Robinson has the most current specialized training, knowledge and experience to relieve or entirely eliminate joint pain – both in and outside of the operating room.

He was drawn to medicine on an Operation Smile trip to Nicaragua, where he saw the power of surgery to literally change someone's life for the better. He earned his medical degree at Northwestern University's Feinberg School of Medicine, where he was attracted to the functional outcomes in orthopedics. He served his internship at New York Presbyterian Hospital-Weill Cornell Medical Center; and completed his residency in orthopedics at New York's prestigious Hospital for Special Surgery. During that time, he served as Assistant Team Physician for the New York Giants and St. John's University's basketball team.

During his fellowship in sports medicine at the University of Pittsburgh, he spent a year learning innovative complex and technical orthopedic procedures from one of the pioneers in the field: Dr. Freddie Fu, Chairman of the Department of Orthopaedic Surgery.

Under Dr. Fu's tutelage, Dr. Robinson took care of the NHL's Pittsburgh Penguins, the University's football team and the Pittsburgh Ballet Theatre. "Football players are big and tight," he says, "and often sustain acute traumatic injuries. The ballet athletes are amazingly flexible, and have more chronic, repetitive use injuries. They may have had different injuries, but their injuries were no less painful and constituted no less a career-ending threat. I was treating both ends of the athletic spectrum."

Whenever these elite athletes sustained injuries – as they invariably did – it was his job to get them back on the field of play, or the stage, as quickly and as safely as possible, without debilitating, season-ending surgery. This meant treating trauma from high impact collisions or falls, ligament tears, shoulder dislocations and a host of other injuries. It was his job to preserve their joints, and to get these elite athletes back in the game – a job for which he had extensively trained.

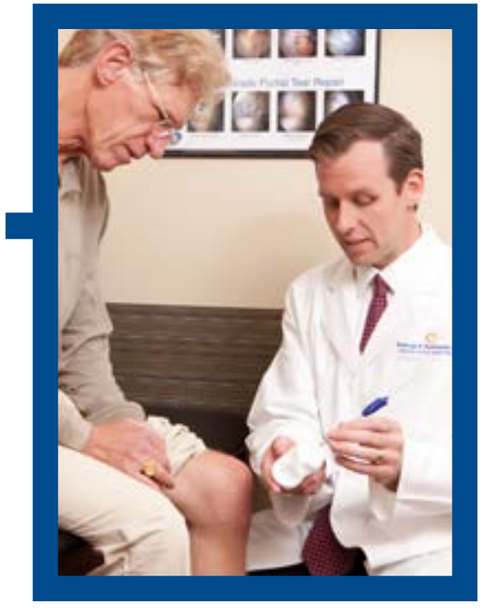
Despite offers to stay on as a permanent member of the Pittsburgh Penguins' medical team, Dr. Robinson wanted a different life, one that included the diversity of a private practice: the opportunity to help patients of every age and all orthopedic presentations – where he could fully employ all of his specialized technical training and skills.

Today, Dr. Robinson incorporates the concepts and techniques he learned taking care of professional athletes and applies them to everyday orthopedic problems, as well as more complex presentations.

Today, Dr. Robinson incorporates the concepts and techniques he learned taking care of professional athletes and applies them to everyday orthopedic problems, as well as more complex presentations.

"There are solutions for all stages of orthopedic problems that don't necessarily require surgery," he says. "We have great success with injections, physical therapy and braces. It depends on the patient and the severity of the problem. I spend a lot of time trying to help people avoid surgery."

But when his patients cannot or no longer respond to nonsurgical treatment, Dr. Robinson makes sure they understand every aspect of their procedure before he performs it – including both risk and benefit. "These are highly technical and complicated surgeries," he explains, "so I want to be sure my patients understand exactly what they can expect when their knee or shoulder needs surgery."



If these patients have no other options, joint replacement can be entirely appropriate, Dr. Robinson says. Today's joint replacements can last 20 years or longer, and in the right patient, the procedure rarely has to be redone.

"But," he says, "today I'm seeing active 40 to 55-year olds who want to stay active, patients who are developing micro-cracks in the subchondral bone, similar to stress fractures, secondary to osteoarthritis. They're in significant pain, but they're not ready for a knee replacement, either practically or emotionally." Similarly, Dr. Robinson sees 65-year olds who would be candidates for knee replacement, but other medical conditions put them at increased risk for surgery.

Previously, orthopedics had little to offer these "in-between" patients who presented with significant pain, but for whom joint replacement wasn't an option.

For Dr. Robinson's knee patients, that changed in 2014, when he perfected a new, minimally invasive procedure called subchondroplasty, which involves standard arthroscopy to debride intra-articular pathology, as well as fluoroscopically guided insertion of a bone substitute made of calcium phosphate, which sets in 10 minutes, mimics the strength of bone, and is gradually replaced with natural bone over 12 to 24 months. "It's a new and very exciting option for these patients," he says. "The biggest advantage – of the many – is that it preserves the patient's natural joint and allows a quick recovery time."

His patients report significant pain relief within a few weeks. "Subchondroplasty isn't a substitute for knee replacement," Dr. Robinson cautions, "and it's not curing the arthritis. But it has been shown to relieve pain and increase function for as much as five years; and importantly, it doesn't limit the patient's future treatment options, whether partial or total knee replacement."

Just as with his knee patients, Dr. Robinson often treats shoulder pain successfully without surgery: with injections, therapy or medications, as appropriate. When surgery is required, he can frequently preserve the shoulder joint by making many repairs arthroscopically. When the joint can no longer be preserved, a standard shoulder replacement is done; or in cases of severe damage to the joint and rotator cuff, he performs the innovative reverse total shoulder replacement, which reverses the ball and socket function within the shoulder.

Dr. Robinson helped pioneer the routine use of regional anesthesia for shoulder surgery patients in Hampton Roads, a tremendous benefit for patients both during and after their procedure. Because regional anesthesia provides excellent pain relief, less anesthesia is required during surgery and less medication required following the procedure. This eliminates or reduces the complications associated with anesthesia and post-operative pain medications and helps with recovery.

Understanding the Goal Drives the Treatment.

"When I was treating professional athletes, I understood their goals," Dr. Robinson says. "They wanted to be back playing the sport they loved. It's the same with today's patients: they may not be elite athletes, but their pain is no less real, and their desire to return to what they love is no less intense."

Dr. Robinson's goal? "I want to do everything I can to help people get where they want to be, in a way that minimizes risk and gets them the best possible result. That means really understanding what they want to accomplish." He takes the time to talk – and to listen – to them, to find out what they've been doing, what they can no longer do, and what their specific goals are. And whether those goals be retrieving the golf clubs, kneeling in the garden or just taking that evening stroll, he has the tools and the skills to get them back in their game.

"It's so exciting to have something to offer all of these patients," he says. "I always knew that if I could get LeSean McCoy back on the gridiron, I could get my everyday patients back on their field of play, wherever that might be." ■

Dr. Robinson practices with Jordan-Young Institute, 5716 Cleveland Street, Virginia Beach. 757.490.4802. www.jordan-younginstitute.com. www.facebook.com/srobinson.md.

Promotional Feature

Posterior Cervical Facet Fusion and Indirect Decompression:

A novel, minimally invasive technique to correct cervical radiculopathy

Degenerative discs in the neck often cause patients to suffer from neck pain and nerve-related pain that shoots into the arm and/or hand. These symptoms can be confused with a shoulder problem or carpal tunnel syndrome.

Although the symptoms are similar, for many of these patients, physical exam reveals that their pain is actually secondary to degenerative disk disease, or a herniated disk in their neck. In some cases, x-ray, MRI or electromyography are employed to confirm the diagnosis.

These patients are often surprised to learn that it has been their neck all along, rather than their shoulder or arm, which has caused their pain. Many respond to initial conservative treatment, which consists of physical therapy or chiropractic manipulation, steroid injections and pain medicines; but when these fail, surgical intervention is indicated.

The classic procedure is an anterior cervical discectomy and fusion, which has proved very effective for many patients, depending on where their disk is herniated and the nature of their nerve compression. Other times, an extensive posterior cervical decompression and fusion is performed.

A newer, novel technique available to many of these patients is the minimally invasive posterior cervical facet fusion, a smaller operation with fewer risks and less chance for complications. During the procedure, the surgeon makes two incisions about a half inch in length, to insert the device into the facet joints of the spine, which takes the pressure off the nerve and stabilizes that segment.

This type of posterior cervical decompression and fusion can be done in about 30 minutes, either on an out-patient basis, or when appropriate, with a one-night stay in the hospital. Most patients go home wearing a cervical collar for a few weeks, with some limitations on lifting, but are back to full activity within about six weeks. The success rate is on the order of 80 to 85 percent for reduction of arm and hand pain.

The newer procedure doesn't completely supplant the cervical discectomy and fusion, but can replace it in some patients, and is a good adjunct to it in the proper setting, again depending upon the patient's presentation. ■

Dr. Bryan Fox joined the team at the Sports Medicine & Orthopaedic Center to establish an adult spinal surgery arm of the practice at Obici Hospital. He is an expert in minimally invasive spine surgery techniques, having performed over a thousand spinal surgeries and taught several types of highly effective and innovative spine surgery procedures. smoc-pt.com

Recent Trends in RETIREMENT PLANNING

What's new in retirement planning? The following are some developments that could be of interest to medical practices that sponsor a tax-favored retirement plan or are considering starting one.

2015 Retirement Plan Limits

The maximum dollar limit on 401(k) salary deferrals has increased by $500 to $18,000 for 2015. For plan participants age 50 and older, the catch-up contribution limit also increased by $500 to $6,000.

The maximum amount that can be contributed to a plan participant's defined contribution plan account is the lesser of his or her compensation or $53,000 for 2015. This amount includes employee and employer contributions (but not catch-up contributions) as well as any forfeitures allocated to the participant's account.

The contribution limit for SIMPLE plans has increased from $12,000 to $12,500 for 2015. The catch-up limit increases from $2,500 to $3,000.

Longevity Annuity Option

One of the big challenges facing retirees centers on how much money they can and need to draw down from their retirement accounts. The fear of outliving retirement assets is very real for many retirees and those hoping to retire. However, longevity annuities, known officially as qualifying longevity annuity contracts (QLACs), can provide some assurance to people worried about having enough money to live on through retirement. IRS regulations now permit 401(k) and other qualified defined contribution plans to give plan participants the option to use plan account assets to purchase QLACs.

Now participants may opt to use up to $125,000 or 25% of their account balance (whichever is less) to purchase guaranteed income for life starting at an advanced age, up to age 85. Until distributions begin, the value of the QLAC won't be included in the participant's plan account value for purposes of calculating required minimum distributions (RMDs). (RMDs normally must begin at age 70½.) The QLAC may provide a life annuity to a surviving spouse or other beneficiary and can offer a return of premium feature.

After-tax Contributions

Some 401(k) plans allow participants who want to save more than the annual deferral limit (applicable to both pretax and Roth 401(k) contributions) to make additional after-tax contributions. After-tax contributions may become more attractive because of a recent change in IRS rules regarding IRA rollovers. Basically, when a plan participant becomes eligible to receive a distribution of his or her 401(k) account balance, the participant can have the portion attributable to after-tax contributions transferred tax free into a Roth IRA while having the portion attributable to pretax contributions transferred into a traditional IRA. (Previously, each transfer had to be treated as a separate distribution and was subject to a pro rata allocation of pretax and after-tax amounts.) Roth IRAs are attractive from a tax standpoint because there are no lifetime minimum distribution requirements and qualified withdrawals from a Roth IRA are tax free.

In connection with this change, the IRS has revised the model 402(f) notice that plans must give to participants who are receiving eligible rollover distributions.

Adding Automatic Features

Medical practices that offer a 401(k) plan may experience issues with low participation and contribution rates. Adding automatic features to the plan may be an effective way to increase participation and contribution levels. Automatic enrollment, automatic contribution increases (escalation), and an appropriate default investment fund are three plan features that can help put more employees on the path to a financially secure retirement. Qualified default investments, such as target date funds, simplify investment options for participants who may be intimidated about choosing an appropriate investment mix for their retirement accounts.

An additional benefit to adding automatic plan features is that increases in enrollment and contribution levels can potentially improve nondiscrimination testing results and permit key employees to defer more into their retirement plans. ■

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Virginia Board of Medicine Offers Guidance on Use of Telemedicine in Virginia Practices

By Laura Dickson Rixey

The use of telemedicine services offers many potential benefits to physicians and patients by providing a more convenient, flexible and accessible way to deliver care. Although many practitioners are eager to incorporate telemedicine into their practices, third party payors, regulators, legislators, and licensing boards have struggled with how to apply their laws, rules, and regulations to telemedicine services.

In general, telemedicine services refers to the use of electronic technology or media, including interactive audio or video applications like Skype or FaceTime, for the purpose of diagnosing and treating a patient or consulting with other providers about a patient's treatment and/or diagnosis. As technology continues to advance and patients continue to seek more convenient and efficient access to care, the use of telemedicine services will become more prevalent. It is estimated that the number of patients using telemedicine services globally will grow from 350,000 in 2013 to seven million by 2018.[1] Before utilizing telemedicine services in their practice, practitioners must understand the applicable laws, rules, and regulations under which they must operate.

Since the Virginia General Assembly has not yet established any type of legal framework regarding the provision and delivery of telemedicine services, practitioners must apply existing laws and regulations when delivering telemedicine services. Fortunately, the Virginia Board of Medicine (the "Board") recently released a guidance document regarding telemedicine to assist practitioners in this evolving area.[2]

The guidance document clarifies that regardless of the delivery tool or business method used by a practitioner, the practitioner must take appropriate steps to establish the practitioner-patient relationship. Accordingly, the practitioner must conduct all appropriate evaluations and document the patient history consistent with traditional standards of care. Furthermore, the Board has cautioned that "[a] practitioner is discouraged from rendering medical advice and/or care using telemedicine services without (1) fully verifying and authenticating the location and, to the extent possible, confirming the identity of the requesting patient; (2) disclosing and validating the practitioner's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine services."[3]

The guidance document also includes telemedicine guidelines the Board has adopted with respect to licensure, evaluation and treatment, informed consent, medical records, privacy and security of patient information, and prescribing practices. For instance, the Board has advised physicians to obtain written evidence documenting a patient's appropriate and specific informed consent for the use of telemedicine services. The Board has also provided guidance on prescribing medications via telemedicine services and stated that such a practice remains in the professional discretion of the prescribing practitioner and subject to existing laws and regulations.

Before incorporating telemedicine services into your medical practice, physicians should consult the Board's guidance document so that they fully understand the framework under which they must operate when delivering telemedicine services. ■

[1] Virginia Board of Medicine, Telemedicine, Guidance Document 85-12 (February 19, 2015), available at https://www.dhp.virginia.gov/medicine/medicine_guidelines.htm.

[2] Virginia Board of Medicine, Telemedicine, Guidance Document 85-12 (February 19, 2015), available at https://www.dhp.virginia.gov/medicine/medicine_guidelines.htm.

[3] Virginia Board of Medicine, Telemedicine, Guidance Document 85-12 (February 19, 2015), available at https://www.dhp.virginia.gov/medicine/medicine_guidelines.htm.

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Dr. Laura Dabney

— an MD with a unique approach to psychotherapy that helps professionals achieve success in personal relationships

People avoid seeking medical care for any number of reasons. If the problem is a physical one, they may fear the cure is worse than the illness. They may feel they don't have the time. They may even believe they can plug their symptoms into Google and learn everything they need to know. When the problem is one of an emotional nature, along with the reasons stated above, they may fear the discrimination that often follows an admission of having sought psychiatric or psychological care.

And when the patients are themselves professionals, upon whom others rely for medical, legal, financial or other expert opinions and care, it can feel unseemly to admit they need help. These professionals may feel embarrassed, or even threatened at the possibility of being discovered in a mental health caregiver's waiting room.

Privacy and confidentiality in a comfortable, professional setting.

Laura Dabney, a medical doctor Board certified in psychiatry, understands these professionals' concerns well. "Unfortunately, the stigma that's attached to getting help still exists," she says. "So I've built my entire practice – both the physical space and my administrative protocols – with a view toward zealously and meticulously protecting my patients' privacy." Established patients do not have to check in or out, are given a keypad code for a locked private waiting room adjacent to Dr. Dabney's office, and exit by a separate door.

Dr. Dabney goes a step further toward assuring her patients' anonymity: she does not work with insurance companies. This is different from most mental health practices, she explains, but adds, "It's another protection for my patients. In order to pay for treatment, insurance companies require that very personal information be faxed to them on a regular basis, something I'm very uncomfortable doing. The notes I take are for my eyes only, and are encrypted into my personal laptop, where they are seen by no one but me." Thus no file folders or other evidence of patient records are extant in any of the rooms in Dr. Dabney's suite. Basic patient information is online, but encrypted for use only by the two other staff members, and Dr. Dabney remains the sole guardian of all the other sensitive information.

In addition to understanding these professionals' concerns about privacy, Dr. Dabney understands their busy schedules. To accommodate theirs as well as her own, she affords them the opportunity to communicate with her by email or text, and even offers Skype or phone sessions when face-to-face communication isn't possible.

Her respect for their dignity and privacy is but one reason so many professionals have sought out Dr. Dabney. Another is her unique approach to her practice: she's a medical doctor who practices psychotherapy, able to distinguish between medical problems and psychological ones. And she prescribes psychotropic medications judiciously and only when absolutely necessary. "Medications can help take the edge off a lot of feelings," she says, "but psychotherapy is the most effective cure – and it has no side effects. It's important my patients understand why they're having problems. Only through understanding the reason for the problem can you make it go away. And then there is no longer a need for medication." Professional individuals, whose continued success depends on keen and unfettered focus, appreciate the opportunity to stay clear-headed and medication free.

When success is the problem.

Sometimes that very success is the etiology of their difficulties. "These professional people have spent most of their youth and all of their energy working to establish a productive, profitable career," she says, "often to the exclusion of everything else – including relationships."

This is particularly true of businessmen, Dr. Dabney notes, who now make up the majority of her patient population. "They're totally different than professional women," she explains. "Women in their 20s tend to think about how to balance grad school, career, marriage and children at every stage; they think in those big picture terms all along." Not so with men, she has found, who have a tendency to believe that like success, relationships will fall into place – when they're ready to think about it. They're so accustomed to success that they often think when they turn their mind to having a relationship, they'll be successful at that as well.

That's not always the case for either gender, Dr. Dabney says. Building and maintaining successful relationships can be challenging for anyone at any stage of life, but for professionals who have experienced difficulty forming and maintaining long-lasting personal relationships – for whatever reason – she offers a unique approach.

Helping professionals achieve successful personal relationships.

It's a familiar pattern: a man in his mid- to late 40s, highly respected and successful in his chosen field, who is freaking out because he's realizing that it's time to enjoy a relationship as fulfilling as his career, but finding it's not as easy as getting straight As in school or scoring a corner office. He may have a string of unsatisfying relationships behind him, with no idea what went wrong. Or he may have a spouse who wants more of him than he's been willing – or able – to give. And he may have no idea why. He just knows something doesn't feel right. And despite his success in other areas, he feels unfulfilled.

"In my field, we technically diagnose people who have difficulty maintaining relationships with a Personality Disorder, a phrase I don't like," Dr. Dabney says. "They're even considered untreatable by many members of my own profession."

But they are treatable, she emphasizes; it just takes time and commitment, and a willingness to work. For those who are, she develops a specifically tailored plan based on the therapy she believes is best suited to their individual needs. "Everybody is different in how much they can absorb in the beginning," she knows. "Once I know their strengths, I have the whole trajectory in mind in how much I can show them, or teach them, or push them in each session."

One of the first things Dr. Dabney does with all of her patients is establish trust. "For patients with failed relationships, my relationship with them may be the first reparative one they have," she explains. "Many of these patients are nervous when they first come in. They may have been criticized a lot, abandoned or smothered in past relationships. I make sure they know that I'm not going to do any of that.

Jenny Pfeiffer, Clinical Associate and Laura Dabney, MD

I'll always be there at our appointed time, so they learn they can rely on me. They can then use that as a basis to trust another relationship." The work can be difficult, she acknowledges, and the etiology of the problem is often outside the patient's awareness: "I'm often fighting a patient's own demons and self doubts, even (and especially) those they're not aware of." She likens it to being the referee in a basketball game. "Often the player doesn't know – or doesn't want to know – that he's stepped out of bounds. It's not that he's lying; it's just painful to admit that he stepped out of bounds. Because I'm at a distance, like the referee, I can see it, and I can help the patient identify it. Then we can begin to work on it."

Most recently, Dr. Dabney has added another option for her professional patients. Jennifer Pfeiffer, her new associate, is a life/executive coach. Life coaching involves problem solving recent or short-term problems. It can be the optimal choice for busy people who need a helping hand to reach a specific goal.

Whether the issue is personal relationships, depression, anxiety or otherwise, Dr. Dabney's training, experience and skill are available to professionals of every stripe, in a collaborative, comfortable and confidential setting – with a proven record of success. ■

Dr. Dabney sees patients at 4542 Bonney Rd., Suite D, in Virginia Beach. Her phone number is (757) 340-8800. She maintains a robust website and blog: www.drldabney.com.

Promotional Feature

Arthritis and PT Treatments:
Patient Education

By Marcia Miller, PT, MS, CHT
Tidewater Physical Therapy, Williamsburg Hand Therapy Center, Clinical Director

Wakes up. Checks phone. Runs shower water. Checks phone. Brushes teeth. Checks phone. Makes toast. Checks phone. Types quick email for work. Checks phone. Heads to the car for work.

Sound like the morning narrative of patients you treat?

Hands are one of the most used parts of the body, and it's easy for our patients to forget how often they use hands in every day life. That is, until they develop arthritis and each of those seemingly innocuous morning activities comes riddled with pain.

According to the Centers for Disease Control and Prevention, an estimated 52.5 million adults in the U.S. reported being told by a doctor that they have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia.

At Tidewater Physical Therapy's Williamsburg Hand Therapy Center, we utilize research-driven treatment protocols to get patients back to their active lives. But more than that, we utilize education.

We've comprised a list of some of daily living activities that could cause patients problems and how we, as part of a patient's complete medical team, encourage them to change their habits to keep them moving as pain free as possible.

Prepare the Hands. Prepare the Body.

Before taking on any activity, especially a long day at the computer or in the garden, patients should prepare their hands in the same way an athlete might prepare their legs for a long run.

1. Practice several stretches: thumb bends, make a fist over and over and stretch wrists.
2. Take mini-breaks throughout the day.
3. Get a "prescription" for specific exercises from a physical therapist.

Gardening.

Weeding, planting and digging are repetitive motions that can cause repetitive strain injuries. Prevent those injuries and exacerbating arthritis with these tips:

1. Wear task appropriate gloves.
2. Use good posture.
3. Use tools with padded handles to protect small joints.
4. Use long handled gardening tools to shift the pressure from hands to shoulders.

Cell Phone Use.

Even though people generally text with both of their thumbs, most people tend to put greater pressure on their dominant hand. These repetitive joint movements could eventually develop tendonitis, a condition that can be treated with physical therapy or prevented with these tips. Add in arthritis and the pain intensifies. Patients should consider the following:

1. Keep arms in front of body to minimize looking down.
2. Write extensive emails from computers, not phones. Use the "talk to text" tool.
3. Use headset or speakerphone.
4. When texting, support arms, hands and phone on a briefcase or lap.

Computer Use.

Many professions now require employees work from a computer for eight hours which can cause inflammation in the hands and wrists.

1. Take multiple three-minute breaks.
2. Maintain good posture - spine against the back of the chair, elbows resting along the sides of the body with wrists straight and typing materials at eye level. Keep neck flexible and upright to maintain circulation and nerve function to arms and hands.
3. Keep hands and wrists in a relaxed position.
4. Cut mouse pad in half to reduce the range of movement. ■

Marcia Miller, PT, MS, CHT is the Clinical Director of the Tidewater Physical Therapy Williamsburg Hand Therapy Center. Tidewater Physical Therapy features more than 30 Physical Therapy Clinics, five Aquatic Therapy Centers and three Performance Centers from Virginia Beach to Richmond. Learn more at www.tpti.com.

Uveitis
"Arthritis of the Eye"

By Alan L. Wagner, MD

As many as 38,000 people develop uveitis in the United States every year. Most importantly, almost 15 percent of all blindness in the US arises from uveitis.

It's well known that skin cancer is the most common of all cancers, and that melanoma, which accounts for only two percent of these cancers, causes a large majority of skin cancer deaths. Over the past twenty years, those cancers and deaths have increased between three and five-fold. It's less well recognized that there has been a similar increase in the incidence of melanoma of the eye and in its sequelae: from loss of vision to loss of life. Approximately 50 percent of patients with choroidal melanoma (also called uveal melanoma) will develop metastasis by 10 to 15 years after diagnosis.

Just about everyone knows someone who suffers the pain of arthritis, whether with intermittent soreness or complete immobility.

When the body's immune system attacks the eye, it can feel very much like the pain and other symptoms of arthritis. And it too can be intermittent, or cause total blindness. It's called uveitis, and it's the third leading cause of blindness in first and second world countries.

As many as 38,000 people develop uveitis in the United States every year. Most importantly, almost 15 percent of all blindness in the US arises from uveitis.

Our eye has three layers, and the middle one, just inside of the white part of the eye that we are used to seeing, is called the uvea (which is Latin for grape), because the pigmented middle layer makes the eye look like a Concord grape. We know the front part of uvea as the iris – the blue/brown/hazel of the eye. The layer of the uvea extends to the back of the eye as the ciliary body and choroid. When the uvea is targeted by the immune system, it's known as uveitis, sometimes called iritis or choroiditis.

Our bodies fight infection by sending white blood cells, antibodies, and other proteins to kill, stop, or control the offender. This response makes the area swollen and red – think what it feels like to have Strep Throat. The body's immune response to that infection is inflammation. Inflammation of the uvea, uveitis, can come from infections, or a confused immune system that attacks its own body bringing about the same sort of swelling, soreness, and redness to the eye. When those same white blood cells and proteins invade the gel filling the eye, called vitritis, our vision becomes cloudy, and we see "floaters".

Uveitis is not contagious, and most cases are not associated with any form of infection. However, some of the infections that can cause uveitis (syphylis and tuberculosis) are very contagious and must be treated to bring about resolution of the inflammation.

The symptoms of uveitis can begin slowly, or quickly. It can be a one time event, or recur frequently. The most frequent symptoms are:

- **Pain**
- **Redness**
- **Blurred/poor vision**
- **Light sensitivity**
- **Floaters**

The diagnostic process and treatment plan for a patient with recurrent or severe uveitis frequently requires a comprehensive ocular and systemic evaluation. In many cases, genetic testing is required. At the Wagner Macula Retina Center, we work collaboratively and lead a team of specialists to help the patient and their primary care giver to provide seamless, continuous, care.

Just like with arthritis, the more inflammation, the more damage. To stop the inflammation and reduce the chances for damage to the eye, uveitis treatments can range from using drops, placing steroids around or into the eye, to systemic medicines or enrolling into research studies.

Time is heart, time is brain, and time is eye. Any time vision is threatened by a recent change or for any reason whatsoever, expert evaluation is a must. ■

Alan L. Wagner, MD, FACS founded the Wagner Macula & Retina Center in 1987. He completed medical school at Vanderbilt University School of Medicine, residency at EVMS and a fellowship at Weill Cornell University Medical Center.
wagnerretina.com

(L-R) David M. Smith, MD; Theresa S. Emory, MD; John C. Maddox, MD; Michael A. Schwartz, MD

PENINSULA PATHOLOGY ASSOCIATES

Service • Technology • Experience

(L-R) Katie Simpson, PA (ASCP) and Rod Slyter, PA (ASCP)

PENINSULA PATHOLOGY ASSOCIATES

A Regional Leader in Pathology Services, Technology and Experience

By Alex Strauss

Effective medical care starts with an accurate diagnosis. An accurate diagnosis often begins with a pathology report.

The pathologists of Peninsula Pathology Associates (PPA), one of Eastern Virginia's leading independent pathology groups for more than half a century, take this responsibility very seriously. With an experienced and accessible staff and a world-class laboratory at Riverside Regional Medical Center in Newport News, the group provides the fast, reliable diagnostic information that local clinicians need, along with a level of focus and personal service that is becoming increasingly difficult to find.

"PPA is solely focused on our core mission, which is pathology," says Practice President and Lab Medical Director David Smith, MD, who specializes in genitourinary, breast pathology, and laboratory management. "Although a lot of the national labs are now branching out into other non-core medical industries, here at PPA, we maintain our laser-like focus on pathology."

Emphasis on Service

The group's emphasis on establishing and nurturing positive working relationships with the region's clinicians is another key to PPA's success.

"Because our group has been in the area for so long, we have a lot of long-term relationships with area physicians," says Dr. Smith. "We very frequently reach out to physicians and discuss cases with them, particularly if it's a challenging case. When you are dealing with difficult or unusual findings, being able to make a phone call and establish a local connection makes a lot of sense."

"We believe that you really need a great relationship with the clinicians and oncologists to get not only the best diagnosis but the best outcomes for patients, all the way from beginning to end," says Theresa Emory, MD, a nationally recognized expert in gastrointestinal and hepatic pathology.

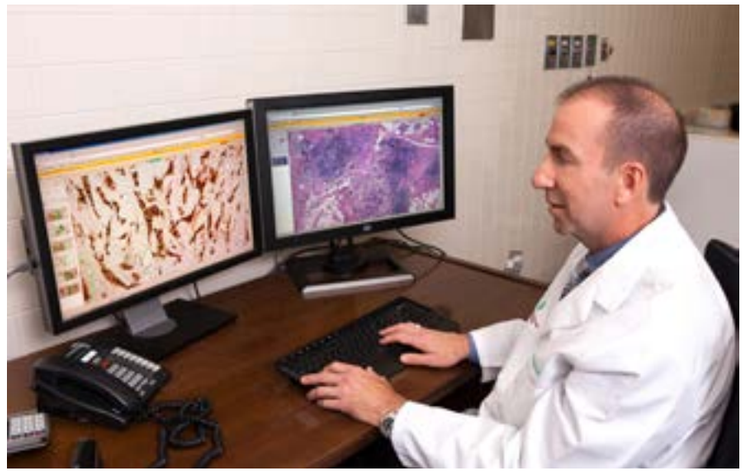
This emphasis on service for area clinicians means that a PPA pathologist is available for physician consultation 24 hours a day, 365 days a year.

"There are a lot of groups where the pathologists arrive at 9, close their office doors, and leave at 4," says Michael Schwartz, MD, whose areas of special interest and expertise include head and neck, lung, gynecologic tract, liver, cytopathology and the molecular pathology of solid tumors. "But our doors are open, we are out and about, we are interacting with our clinicians, both in the hospitals and in their offices. PPA pathologists are engaged with clinicians in a variety of settings, including participating in committees with quality improvement initiatives. It is our goal to be out there finding solutions, being proactive."

Specialty Training

PPA pathologists are uniquely equipped to help find proactive solutions to even the trickiest problems. All members of the group

> *"I have used other hospitals, but I can say without hesitation that I prefer PPA and currently use them almost exclusively for several reasons – I can always talk to a pathologist I know if questions arise, if I want to look at a slide with them I can, their turnaround time is the fastest, bar none; and I doubt any other group has their degree of gastroenterology expertise."*
>
> *– Fred Gessner, MD, Gastroenterology*



Dr. Smith analyzing a case using whole-slide digital imaging.

"I have been honored to work with PPA for 25 years. There have been great advantages in knowing the expertise and approachability of these local pathologists. When I have clinical questions about results, or even obtaining an opinion concerning patient evaluation and care, they have always been available by phone, email, or by visit to their department. I have the utmost confidence in their services and am grateful for the opportunity to work with this experienced team." – *Stanley Yeatts II, MD, Gynecology*

are Board certified (and some are nationally known) general pathologists with extensive additional education and experience in multiple subspecialty areas, giving them a level of additional insight rarely found in private pathology practices.

"Specialization like we all have is unusual for a community-based practice like ours and really makes us unique," says John Maddox, MD, a leading national consultant in the pathology of asbestos-related diseases and Board certified hematopathologist. "There is a tremendous amount of expertise in the group. Everyone here has had some level of subspecialty training, which is very unusual outside of a university setting."

"Having a group where everyone has a specialty area of expertise allows us to handle the widest variety of pathology specimens and provide truly comprehensive pathology services," says Dr. Smith.

World-Class Technology

Also unusual outside of an academic center is a laboratory as extensively equipped as the state-of-the-art laboratory at Riverside Regional Medical Center, medically directed by PPA.

Committed to staying at the leading edge of the technology revolution, PPA has formed strategic partnerships with leading equipment manufacturers including Roche/Ventana Medical Systems that have enabled them to help develop and test new equipment, procedures, and techniques.

"We often have inspectors from university hospitals who rave about our pathology department," says Dr. Schwartz. "Many comment on how advanced we are in our technology."

Thanks to their associations with manufacturers of high-end diagnostic equipment, PPA is now a Beta testing site for some of the very newest diagnostic equipment. They are leading the way in developing

Dr. Maddox and Dr. Schwartz consult with each other on a challenging case; part of the PPA pathologists routine.

The Pathologists of Peninsula Pathology Associates:

David M. Smith, MD

Practice President and Lab Medical Director, David Smith, MD, called himself a "Southeasterner, born and raised."

Board certified in anatomic and clinical pathology, the South Carolina native received his medical degree from the University of South Carolina Medical School and completed his residency in anatomic and clinical pathology at the University of Tennessee.

"I had taken some electives in pathology as a medical student and there was just something about laboratory medicine and the scientific approach that totally captivated me," says Dr. Smith.

Although he left the area for his pathology fellowship at Washington University/Barnes-Jewish Hospital, he was glad to return to the East Coast 19 years ago to join Peninsula Pathology Associates. Dr. Smith is a published author on prostate pathology, has a special interest in gynecologic pathology, and with his expertise in breast pathology, he helped the hospital win accreditation as a breast cancer Center of Excellence. "Achieving this accreditation required meeting rigorous standards, including the development of a breast cancer biomarker program," he says. "It is critical that we are standardizing the way these biomarkers are tested so that the results are reliable and reproducible."

John C. Maddox, MD

At 33 years, John Maddox, MD, has the longest tenure with Peninsula Pathology Associates of any of his colleagues.

A native of Charlottesville and a graduate of the University of Virginia School of Medicine, Dr. Maddox is Board certified in anatomic and clinical pathology as well as hematopathology. He completed a residency in pathology at Stanford University, a fellowship in oncologic pathology at MD Anderson Cancer Center in Houston, and a fellowship in hematopathology at MCV/VCU, Richmond before joining PPA in 1982.

"This position at PPA was a cut above all the other private practice jobs available in the five state area in terms of the level of technology available to someone doing anatomic pathology," says Dr. Maddox.

Although he spends much of his time on bone marrow biopsies, flow cytometry and lymph node biopsies, Dr. Maddox is also a leading national consultant on asbestos-related diseases and consults on about five percent of mesothelioma cases in the US each year.

He is a member of the College of American Pathologists, the Society of Hematology and past president of the Virginia Society for Pathology.

Theresa S. Emory, MD

A graduate of the University of Virginia, Theresa Emory, MD, received her medical degree from Eastern Virginia Medical School and completed residencies at the Mayo Clinic, where she was Chief Resident in Anatomic and Clinical Pathology, and Oakland Naval Hospital in California.

Dr. Emory spent six years at the prestigious Armed Forces Institute of Pathology as a Gastrointestinal and Hepatic Pathologist before taking a private practice position in Bristol, Tennessee. She has been with PPA since 2013.

"I was incredibly impressed by the advanced, education oriented, patient-centered approach," recalls Dr. Emory of her first visit to PPA. "They were performing really top notch immunohistochemistry and molecular testing that we couldn't in Bristol. Another thing I liked is that they were always looking to advance as medicine advanced."

Dr. Emory, who says she is "still excited to go to work every day", is the senior author of the Atlas of Gastrointestinal Endoscopy and Endoscopic Biopsies, written in collaboration with the Mayo Clinic Departments of Gastroenterology and Pathology. Pathologists and gastroenterologists around the country seek her opinions. Dr. Emory is Board certified in anatomic and clinical pathology.

Michael A. Schwartz, MD

Board certified in anatomic and clinical pathology, Dr. Schwartz received his medical degree from the State University of New York Health Science Center, Syracuse and completed his residency at the University of Pittsburgh Medical Center (UPMC) where he also served as Chief Resident and Attending Pathologist.

"I received excellent training by some of the best pathologists in the country at UPMC," says Dr. Schwartz. "At the peak, they were performing 600 to 700 liver transplants a year. We would come in on Monday morning and there would be a stack of livers that had been explanted over the weekend."

Dr. Schwartz's areas of special interest and expertise include head and neck, lung, gynecologic tract, liver, cytopathology and the molecular pathology of solid tumors. He spent time at practices in North Carolina and Ohio before joining PPA in 2005.

"As a tertiary care hospital, Riverside runs much like a university hospital. So we see virtually every type of specimen that would be seen at other prestigious medical institutions," says Dr. Schwartz. "We are fortunate that everyone here has extensive, high-level specialty training."

"After 25 years in an academic surgical practice at the Mayo Clinic, it has been a pleasure working with the PPA physicians. They are a highly skilled group of pathologists, fully informed of current and developing pathologic practice, and readily available for consultation both during an operation and whenever I stop by their offices. I have been very impressed and fully satisfied with their meticulous and prompt pathological services." – John Donohue, MD, Surgeon

Dr. Schwartz & Dr. Emory consulting on a frozen section case.

cutting-edge diagnostics that will have a profound effect on how Barrett Esophagus, a condition associated with cancer whose incidence has risen faster than any other in the last 20 years, will be diagnosed and managed in the future. In addition, PPA pathologists have developed a revolutionary telepathology/digital pathology program to transmit images electronically and view them in high definition.

"It is our goal to be on the forefront of all the diagnostic tools out there and we are very committed to this," says Dr. Smith.

To support that goal, PPA also maintains a close working relationship with NeoGenomics Laboratories who offer one of the most comprehensive molecular testing menus for cancer. The Mayo Clinic also serves as a reference laboratory for additional high-end diagnostic testing.

Specialty, Subspecialty and Expert Consultation Services

- **Gastrointestinal and Liver Surgical Pathology** including analysis for Barrett Esophagus and related dysplasia
- **Gynecologic Pathology**
- **Genitourinary Tract Pathology**
- Hematopathology including ten-color Flow Cytometry and In-Situ Hybridization evaluation of lymph nodes, bone marrow and peripheral blood specimens
- Asbestos-related disease, including Asbestosis and Mesothelioma
- Breast Pathology

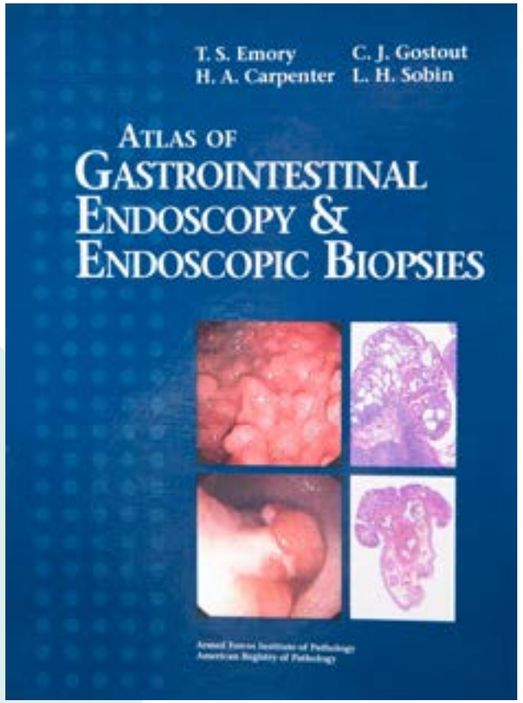
Fast, Accurate Results

Even the best diagnostic equipment and top expertise is of little use unless clinicians can be assured of fast, accurate test results. With PPA located right in Newport News, significant time can be saved in specimen transport alone, which can be especially critical when time is of the essence.

"In some cases, a specimen might arrive in an hour or less," says Dr. Smith. "Our lab's turnaround time also beats the large national labs, where a specimen might be one of thousands received on any given day. The speed at which we can give results is just another advantage of working with a group like PPA. The other advantage, of course, is that, if you need to speak to someone about those results, we are just a phone call away."

Not only are PPA pathologists accessible to clients, but they also pride themselves on learning as much as they can about the individual needs and preferences of the area physicians with whom they work – another trait not found in busy national labs.

"At the end of the day, we realize that we and our clinician colleagues are taking care of people and that is the center of everything we do," says Dr. Emory. "That drives us to want to have the best technology, the best education, and the best relationships with other doctors."



Dr. Emory is the senior author of the Atlas of Gastrointestinal Endoscopy and Endoscopic Biopsies, written in collaboration with the Mayo Clinic Departments of Gastroenterology and Pathology.

Proud Legacy, Promising Future

One name no longer on the list of active PPA pathologists is the late Jacques Legier, MD, a member of the practice from 1963 to 2010 and a prominent name in Virginia's pathology community. "He was the one who evaluated some of the first mesothelioma cases in this area in the 1960s," recalls Dr. Maddox. "Even though this is a community hospital, Dr. Legier published dozens of articles."

Legier's legacy helped set the bar high for a practice that continues to push the envelope of what a community hospital-based practice can do and be.

In addition to continually updating technology to stay on the leading edge of comprehensive pathology services, PPA has plans to bring on another pathologist, expand services to community based physician offices, and even help raise public cancer awareness.

"One of the things I'm really interested in is colon cancer screening for women," says Dr. Emory. "I would love to reach out more to women in the community, particularly when it comes to colorectal health."

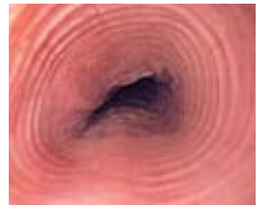
With their focus on the patient as what Dr. Emory calls "the hub of the wheel", PPA pathologists take a collaborative, team-oriented approach to each case, working closely not only with their clinician colleagues, but also with each other.

"In some groups, your case is your case, but here, we all have open doors and every day we share cases that are interesting or intellectually challenging," says Dr. Schwartz. "Everyone here is more than happy to share and look at those cases in order to ensure the best outcomes."

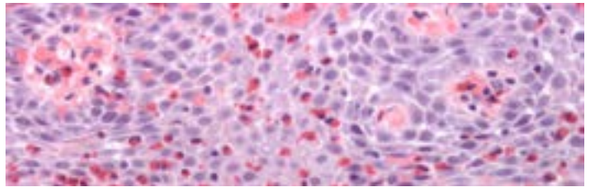
"If the patient is at the center of all your decisions, then regardless of how much things change in healthcare, the right outcome will happen," says Dr. Emory. "That's the mindset of this practice. ■

Endoscopic – Histologic Correlation of Eosinophilic Esophagitis.

Circumferential rings "felinization". The mucosa is otherwise normal.



Linear furrows with sloughing of the esophageal mucosa.



Spongiosis of the squamous epithelium with numerous intraepithelial eosinophils.

Our Services

- Surgical Pathology including all organ and specialty types along with intraoperative and outpatient frozen section evaluation
- Second opinion consultations on referred specimens
- Extensive library of Immunohistochemical and routine histochemical stains
- Molecular Pathology (Personalized Medicine) in partnership with NeoGenomics Laboratories
- Chromogenic In-Situ Hybridization (CISH) HER2 analysis in breast and gastric cancers
- Digital Whole Slide Imaging
- Gynecologic Cytopathology (Thin Prep Pap Test) with HPV testing
- Non-Gynecologic Cytopathology (including Fine Needle Aspiration of all organ systems with on-site specimen adequacy evaluation, body fluid, urinary tract and esophageal brushing analysis)
- Medical Directorship of Laboratories with expertise in obtaining College of American Pathologists (CAP) and CLIA Certifications

Dr. David Smith can be reached for questions at 757-594-2160, or for more information, please visit ppapathology.com

Promotional Feature

IN THE NEWS

Atlantic Orthopaedic Specialists opened Hampton Roads' first and only walk-in orthopaedic care center, **OrthoNow** in Chesapeake, Virginia. Extended hours and walk-in care flexibility make orthopaedic care more convenient for patients. Orthopaedic specialists at OrthoNow treat tendonitis, bursitis, hand, arm, neck, hip, knee and shoulder injuries as well as fractures, sprains and strains and sudden onset back and leg pain. X-Rays, bracing and casting are available on site.

Peter J. Bernard

Peter J. Bernard, Bon Secours Health System chief executive officer for Bon Secours Virginia, will retire from Bon Secours at the end of fiscal year which is August 31, 2015.
Bernard's retirement marks 15 years of innovation, growth and prosperity for Bon Secours Virginia. His tenure at Bon Secours brought Virginians a health care model centered on compassionate, patient-centered care combined with clinical excellence. He worked tirelessly to improve the health of the communities Bon Secours serves by providing educational programs and services designed to empower those in need.

Franklin D. Seney, Jr., MD

Bon Secours Mary Immaculate Hospital has named **Franklin D. Seney, Jr., MD,** as Chief Medical Officer, effective March 2, 2015. In his new role, Dr. Seney will provide an enhanced level of focus on patients' clinical outcomes, as well as help identify opportunities for care delivery enhancements and innovation. He will also serve as a valuable resource as the executive team works to increase collaboration with medical staff members.

Bon Secours Mary Immaculate Hospital recently acquired a **UV-C disinfection robot** to protect patients from hospital-acquired infections (HAIs). The system, Tru-D SmartUVC, can disinfect an entire room from one location. It analyzes the unique variables of the room and floods the space with the proper dose of UV-C light energy, also known as germicidal UV. Germicidal UV has a specific wavelength of 253.7 nanometers and is known to destroy bacteria, mold, viruses and other biological contaminants in the patient care environment.

Bon Secours Health Center at Harbour View - A new app helps patients at the Bon Secours Health Center at Harbour View have shorter wait times in the emergency department.

Founded by two emergency medicine physicians and full of reliable information reviewed by Harvard Medical School, **iTriage** is a free healthcare app that lets consumers quickly and easily take action. Patients can alert the emergency department at Bon Secours Harbour View that they are coming through the Bon Secours website or through the iTriage app. By submitting forms online, patients have a higher place in the queue to see a physician. However, patients are seen in order of severity.

Bon Secours Hampton Roads is proud to announce that the 2015 Bon Secours 5K for Colon Cancer Awareness presented by TowneBank raised $20,000 to help local colon cancer patients. The fifth annual Bon Secours 5K for Colon Cancer Awareness and 1-Mile Fun Walk was held on March 28. 441 racers registered for the 5K, while 69 people registered for the Fun Walk. The event also featured a race expo where attendees could receive free screenings, giveaways and learn more about their health. Proceeds are donated to the Bon Secours Maryview Foundation Cancer Fund to provide care for colon cancer patients.

Dr. Ryan Seutter

Bon Secours Heart & Vascular Institute is pleased to announce that new technology is being offered for patients with heart failure. The new cardiac resynchronization therapy-defibrillator (CRT-D) is an implantable device that features advanced technology designed to improve the pumping function of the heart and provide physicians with more options to customize the therapy for each patient's needs. Electro cardiologist **Dr. Ryan Seutter** with Bon Secours Cardiovascular Specialists is the first physician on the Hampton Roads Southside to offer this technology.

Bon Secours Heart & Vascular Institute - The Heart Healthy Academy at Bon Secours is an innovative program with a mission to teach middle school students the importance of making heart-healthy decisions early in life in order to prevent heart disease. Since heart disease manifests itself at a much older age, HHA@BS emphasizes the link between future heart disease and cigarette smoking, sedentary lifestyle and an unhealthy diet, especially when begun at an early age. A video of an open-heart surgery is shown to emphasize the link between lifestyle behaviors and their consequences. During the presentation, students are encouraged to ask questions about the disease, how it is caused, how it is treated and, most importantly, how it can be prevented. HHA@BS, which is supported through an American Heart Association grant, is free to schools and includes a heart-healthy lunch for participants.

Robert Lancey, MD

Bon Secours DePaul Medical Center has been selected to participate in Agency for Healthcare Research and Quality(AHRQ) project for the prevention of pressure ulcers. Only 10 hospitals nationally have been selected to participate. Fifteen percent of acute-care patients develop pressure ulcers. Pressure ulcers (PUs) are serious hospital-acquired conditions (HACs) that each year cost billions of dollars to treat. As a result, the Centers for Medicare and Medicaid Services (CMS) no longer pays the costs associated with treatment of a stage III or IV pressure ulcer acquired in the hospital. The goal is to help everyone to prevent and avoid the complications associated with pressure ulcers.

Bon Secours DePaul Medical Center Diagnostic Cardiac Services, located in Norfolk, Va. has been granted a three-year term of accreditation in the area of Echocardiography of Adult Transthoracic, Adult Transesophageal, Adult Stress by the Intersocietal Accreditation Commission (IAC). Early detection of life threatening heart disorders and other diseases is possible through the use of Echocardiography procedures performed within hospitals, outpatient centers and physicians' offices. While these tests are helpful, there are many facets that contribute to an accurate diagnosis based on Echocardiography testing. The skill of the Echocardiography sonographer performing the examination, the type of equipment used, the background and knowledge of the interpreting physician and quality assurance measures are each critical to quality patient testing.

Michelle Brenner, MD, IBCLC

Michelle Brenner, MD, IBCLC, a primary care pediatrician with CHKD's General Academic Pediatrics practice, completed a fellowship in integrative medicine at the Arizona Center for Integrative Medicine at the University of Arizona College of Medicine. Dr. Brenner serves as the EVMS clerkship director for pediatrics and as an associate program director of the EVMS/CHKD pediatric residency program. She is also a member of the Children's Health System board of directors.

IN THE NEWS

Dr. L.D. Britt was awarded the distinguished accolade of being recognized as a Master of Critical Care Medicine at the Annual Convocation of Fellows of the American College of Critical Care Medicine and the Society of Critical Care Medicine – the world's largest multispecialty organization for critical care specialists. Only a few physicians, in any specialty, have been bestowed this coveted honor. "To be recognized by your peers, representing every specialty in medicine, as a true master of Critical Care Medicine is one of the most humbling experiences and greatest tributes for me. I share this distinction with the colleagues I work closely with at Eastern Virginia Medical School."

Chesapeake Regional Medical Center (CRMC) will migrate to the Epic Electronic Medical Record (EMR) system over the next two years and has engaged Good Help Connections, to provide support for the implementation. CRMC is the first non-BSHSI hospital to partner with Good Help Connections for an Epic migration. While CRMC has been EMR-enabled for nearly two decades, the Epic platform has risen to the top of health care information technology, making it a smart choice for providers. The transition to Epic will better align CRMC with the local health care marketplace and improve clinician interaction and patient engagement.

(From left) Ken Deans, chief information officer and vice president, CRMC, Michael K. Kerner, CEO, Bon Secours Hampton Roads Health System, Peter Bastone, president and CEO, CRMC, Marlon Priest, MD, chief medical officer, BSHSI and executive vice president, CEO, Good Help Connections, Surya Challa, MD, chief medical information officer, CRMC, Scott Bateman, enterprise program director

CHESAPEAKE HOSPITAL AUTHORITY - Two new members have recently been appointed by Chesapeake City Council to the Chesapeake Hospital Authority. The Chesapeake Hospital Authority is an 11-member board of area citizens that oversees the operations of Chesapeake Regional Medical Center. **Robert (Robin) W. Tull, Jr.,** is founder and president of Tull Financial Group, Inc., in Chesapeake. **Larry Zoeller** has been the owner and president of Material Handling Supply, Inc. since the company establishment in 1980

Robert (Robin) W. Tull, Jr.

Larry Zoeller

Alfred Abuhamad, MD

Eastern Virginia Medical School - A group of noted obstetricians and gynecologists — including **Alfred Abuhamad, MD,** the Mason C. Andrews Chair of Obstetrics and Gynecology, Chair and Professor of Gynecology and Vice Dean for Clinical Affairs at EVMS — maintain that ultrasound is more cost-effective and safer than other imaging modalities for imaging the female pelvis and should be the first imaging modality used for patients with pelvic symptoms. Writing in the American Journal of Obstetrics & Gynecology and supporting an American Institute of Ultrasound in Medicine (AIUM) initiative, they urge practitioners to "put ultrasound first."

EVMS Medical Group announces the merger of the EVMS Aesthetic Center with EVMS Plastic and Cosmetic Center. Patients are offered both cosmetic surgery procedures and non invasive treatments with Botox, Fillers, Lasers for skin rejuvenation, Laser Hair removal, Facial Peels and more in one location. Our aesthetic team includes plastic surgeons, cosmetic trained nurses and physician assistant, as well as an aesthetician who can offer various treatments for your needs.

Mark B. Kerner, MD, Performs Two-Level Cervical Disc Replacement Surgery at Bon Secours Maryview Medical Center. Dr. Kerner was one of the first physicians in the Hampton Roads to perform this procedure. The device, the first and only cervical disc replacement FDA approved for both one and two-level applications, was the subject of a rigorous FDA Investigational Device Exemption (IDE) trial. In the FDA trial, the two-level cervical disc replacement procedure demonstrated an overall study success rate of 69.7% as compared to traditional cervical fusion results of 37.4%.

Mark B. Kerner, MD

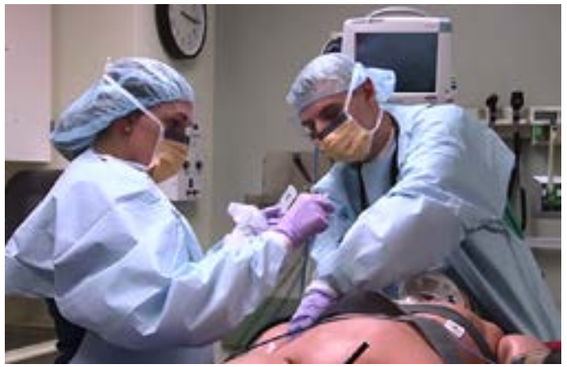
IN THE NEWS

Dr. Mark W. McFarland

Orthopaedic & Spine Center announced that **Dr. Mark W. McFarland** was the first surgeon to implant SpineFrontier's® LES® P-LIFT® Interbody Cage. The operation took place on Thursday, January 15, 2015 at Bon Secours Mary Immaculate Hospital in Newport News, VA. The procedure was an L-4-5 posterior lumbar interbody fusion on a female patient. Dr. McFarland believes it provides less invasive procedure with better results for his patients.

Reach Orthotic & Prosthetic Services opened a new office in Williamsburg, Virginia at Michael Commons. Reach O&P provides state-of-the-art orthotic and prosthetic devices and is a full service practice staffed by board certified clinicians. With offices in Newport News, Chesapeake and Gloucester, this is their fourth location. They have been in business since 2002 and are locally owned and operated.

Sentara Heart Cardiologists team up with the Virginia Zoo to provide heart screenings for two of its resident orangutan, Pepper and Schintz.. They were born in captivity as part of the national great ape breeding program designed to collectively manage the captive gene pool and to prevent extinction of the species, which is threatened by habitat destruction in the wild. Despite their healthy diet and lifestyle, the Virginia Zoo veterinary team partnered with a team of two cardiologists and one staff member from Sentara Heart Hospital to perform ultrasounds of their hearts as part of the animals' annual wellness checkups at the Zoo's state-of-the-art veterinary hospital.



Sentara Nofolk General Hospital - The Navy and The Level I trauma center at Sentara Norfolk General Hospital learned how to work better together during a helicopter training exercise. SAREX, a search and rescue drill, involved Navy and Coast Guard helicopters over the Chesapeake Bay, guided by E-2C Hawkeye radar planes and a landing at Sentara Norfolk General to deliver a 'patient' to the trauma team.

Sentara Pet Therapy - They say that volunteers are the heart of every hospital. Some of the volunteers are really a different breed - literally. Pet volunteers and their handlers work in healthcare settings throughout Sentara only after intense training and a rigorous evaluation. These volunteers wander with their handlers in search of patients who may want a four-legged visitor for a brief time. Therapy dogs can be as varied as the patients they visit. There is no specific breed for this task, just an obedient, relaxed personality willing to offer companionship and cheer. And if you happen to have a treat to share, they really like that too.

Sentara Leigh Hospital opened its West Tower as part of a larger renovation project which has the hospital reinventing itself within the footprint of a campus that dates back to the mid-1970s. Housing new patient rooms that were more than double the size of the 1970-era rooms, West Tower is the mirror image of the East Tower which opened in November of 2013. Now, all 250 patient rooms at the hospital have increased space, dedicated areas for patients and family, large bathrooms and amenities like free Wi-Fi and couches that double as sleeping space for guests.

(From left) Dr. Jennifer Miles-Thomas of Urology of Virginia, Peter Bastone, president and CEO of Chesapeake Regional Medical Center, Dr. Victor "Trey" Brugh of Urology of Virginia, Rhonda Bridgeman, Chair of the Chesapeake Hospital Authority, Dr. Michael Fabrizio of Urology of Virginia, Sharon Szalai, principal at Paul Finch & Associates architect firm and Dr. Gregg Eure of Urology of Virginia commemorate the construction of a new ambulatory surgery center in Virginia Beach.

Urology of Virginia and Chesapeake Regional Medical Center have partnered to build a three-story ambulatory surgery center that will offer patients on-site comprehensive urological and urogynecological care including minimally invasive surgeries striving to optimize the patient experience and promote quick healing. CRMC will lease space within the building to equip and operate the ambulatory surgery center. The space will include one general operating room, three cystoscopy rooms and a lithotripsy room. The center is scheduled to open in early 2016.

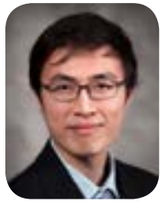
If you have News you would like to share with our readers in the spring edition, please contact the publisher at 757-237-1106 or email: holly@hrphysician.com Deadline for submissions is July 7th.

Hiba H. Alamin, MD has joined Sentara Pediatric Physicians. She earned her medical degree at the University of Khartoum, School of Medicine in Sudan, in 2001. She completed her internship in pediatrics at Hurley Medical Center, in affiliation with Michigan State University, in Flint, MI. Dr. Alamin went on to complete her residency in pediatrics at the University of Maryland Medical Center in Baltimore, MD.

Trisha Clarke Beute, MD has joined Atlantic Dermatology in Virginia Beach. She received her medical degree from the Uniformed Services University of the Health Sciences and completed her residency in Dermatology in 2007 at the Naval Medical Center in San Diego, CA. She is board certified in Dermatology by the American Board of Dermatology.

Jessica Brawley, MD has joined Sentara Family Medicine Physicians. She earned her medical degree from Virginia Commonwealth University School of Medicine in Richmond, VA. She completed her internship and residency in family medicine through the Puget Sound Family Medicine Residency program at Naval Hospital Bremerton in Bremerton, WA.

William Callaghan, MD, FACC, a board certified cardiologist, has joined Cardiovascular Specialists in Norfolk. Dr. Callaghan offers general cardiology services, interventional cardiology services and has a special interest in heart failure. He earned his medical degree from Eastern Virginia Medical School, where he also completed his residency. He completed fellowship training at Medical College of Georgia. He is board certified in Internal Medicine and Cardiology. Before joining Bon Secours, he directed a community based heart failure clinic in Georgia.



Yu Kwan Chan, MD has joined Hampton Family Practice. He received his Doctor of Medicine from the University of Maryland School of Medicine and completed his Family Medicine Residency at Mountain Area Health Education Center, Asheville, NC. He is Board Certified by the Academy of Family Physicians. Dr. Chan's clinical interests include preventative care and managing chronic conditions for the entire family.

Scott Kling, MD has joined the team at Riverside Orthopedics, Sports Medicine and Physiatry. Dr. Kling's particular areas of interests include hip arthroscopy for the treatment of femoroacetabular impingement and labral pathology; multiligamentous reconstruction of the knee; cartilage restorative surgery; meniscus surgery; shoulder instability; and rotator cuff repair.

Teresa Johnson, DO has joined the staff at Internists at Western Branch in Chesapeake. Dr. Johnson is a board-certified family medicine physician. Dr. Johnson completed her undergraduate studies at Central Connecticut State University in New Britain, Connecticut, and earned her medical degree from Edward Via Virginia College of Osteopathic Medicine in Blacksburg, Virginia, where she was the recipient of the Segal AmeriCorps Education Award and A.A. Feinstein Scholarship. She performed her residency with the Virginia Commonwealth University Riverside Family Medicine Residency program in Newport News, Virginia.

Jeffery J. Kuhn, MD, FACS has joined Bayview Physicians Group at Bayview Ear, Nose and Throat, Hearing and Balance Center. Dr. Kuhn is Board Certified in Otolaryngology-Head and Neck Surgery and Neurotology. He is a retired Captain with the United States Navy. Prior to joining Bayview, Dr. Kuhn served as an Attending Physician in the Department of Otolaryngology-Head and Neck Surgery at the Naval Medical Center in Portsmouth, Virginia.

Timothy Larkin, DO has joined the team at Riverside Elizabeth Lakes Family Practice in Hampton. Dr. Larkin specializes in family medicine and is board-certified by the American Osteopathic Board of Family Physicians. He graduated from Lincoln Memorial University and completed his residency at Riverside Regional Medical Centerwhere he received the G.S. Mitchell, Jr., M.D. Spirit of Family Practice Award.

Frances Martin, MD has joined Urology of Virginia. Dr. Martin is a Fellowship Trained Urologic Oncologist who received her medical degree from the University of Alabama School of Medicine in Birmingham. She completed her Urological Surgery residency at the University of Kentucky, Chandler Medical Center in Lexington. After her residency, she completed a fellowship and was a clinical specialist in the Department of Urologic Oncology at MD Anderson Cancer Center, University of Texas.

Hesed Mugaisi, MD has joined the staff at Bon Secours Suffolk Primary Care. Dr. Mugaisi is a board-certified family medicine physician who provides a holistic approach to medical care. He acquired his bachelor of medicine and bachelor of surgery from the University of Nairobi in Nairobi, Kenya and completed his family medicine residency at Group Health Family Medicine Residency Program affiliated with University of Washington in Seattle, Washington. He is a member of the American Association of Family Practitioners, American Medical Association and the Kenya Medical Association. Along with English, Dr. Mugaisi is fluent in Swahili.

Kristin Negaard, MD, MBA has joined Sentara Family & Internal Medicine Physicians. She earned her medical degree from Eastern Virginia Medical School in Norfolk, VA. She earned her Master of Business Administration degree at the College of William & Mary in Williamsburg, VA. Dr. Negaard completed an internship and residency through the Riverside Family Medicine Residency program, in affiliation with Virginia Commonwealth University, in Newport News, VA.

Tarita Pakrashi, MD has joined the EVMS Medical Group and the EVMS Jones Institute for Reproductive Medicine. Dr. Pakrashi received her medical degree from Topiwala National Medical College in Mumbai, India. She completed a residency in obstetrics & gynecology at the University of Cincinnati, College of Medicine. Dr. Pakrashi received a Master of Public Health (MPH) in Maternal and Child Health in 2006 from the Gillings School of Public Health at the University of North Carolina at Chapel Hill.

Holly Pierce, MD has joined Sentara Urgent Care. She earned her medical degree at Eastern Virginia Medical School in Norfolk, VA. After earning her medical degree, she began her residency in familymedicine through the Portsmouth Family Medicine Residency Program. She completed her residency through the Shenandoah Valley Family Practice Residency Program at Front Royal Family Practice in Front Royal, VA, where she served as chief resident during her final year.

Jeffrey F. Severa, DO has joined Sentara Family & Internal Medicine Physicians. He earned his medical degree from Lake Erie College of Osteopathic Medicine in Erie, PA. He completed his internship in internal medicine at West Penn Hospital in Pittsburgh, PA and went on to complete his residency in internal medicine at West Penn Hospital.

Michelle Shippert, DO has joined the staff at Western Branch Family Practice in Chesapeake. Dr. Shippert is a dually board-certified family medicine physician. She completed her bachelor of science at The University of Arizona in Tucson, Arizona and earned her medical degree from Midwestern University, Arizona College of Osteopathic Medicine in Glendale, Arizona. She went on to complete her family medicine residency at University of Pittsburgh Medical Center, St. Margaret in Pittsburgh, Pennsylvania.

Mohammad S. Siddiqui, MD has joined Sentara Internal Medicine Physicians. He earned his medical degree from Baba Raghav Das Medical College, in affiliation with Gorakhpur University, in India.. He completed his residency in family medicine at Marquette General Hospital in Marquette, MI. He went on to complete his fellowship in geriatric medicine at the University of New Mexico in Albuquerque, NM.

Jayaraman Venkatesan, MD, FACC, a board certified cardiologist, has joined Cardiology Associates. Dr. Venkatesan is board certified in internal medicine, nuclear cardiology, cardiovascular diseases and interventional cardiology. He received his medical degree from Kasturba Medical College. He completed his internship, residency and fellowships in cardiology and interventional cardiology at Coney Island Hospital. He is a fellow of the American College of Cardiology. He performs noninvasive and minimally-invasive interventional cardiology procedures, including radial artery catheterization. He is passionate about preventing tissue loss and amputation of patients who suffer from peripheral arterial disease through the use of specialized endovascular treatments.

Jaime Callaghan, FNP-BC, a board-certified family nurse practitioner, has joined the staff at Amelia Medical Associates. Ms. Callaghan earned her bachelor of science in nursing and master of science in nursing — family nurse practitioner — from Old Dominion University in Norfolk, Virginia. . She serves as a lieutenant in the United States Navy Nurse Corps and is actively pursuing her doctorate in nursing at Old Dominion University.

Jezeriah W. Cook, PA-C has joined Hampton Family Practice. He received his Bachelors of Physician Assistant Studies at Jefferson College of Health Sciences, Roanoke, VA. He partners with the patient care team led by Dr. Parker Stokes and Dr. Bobbie Sperry. Mr. Cook is Board Certified by the National Commission on Certification of Physician Assistants.

Christine B. Hardy, NP a certified family nurse practitioner has joined Pediatric Health Partners in Chesapeake, Virginia. She received her undergraduate degree from Atlantic Union College in South Lancaster, Massachusetts, and earned her master of science in nursing degree from Western University of Health Sciences in Pomona, CA.

LaKeysha Jenkins, AGPCNP-BC, a board-certified nurse practitioner, has joined the staff at Eagle Harbour Medical Associates. Ms. Jenkins received a bachelor of science in nursing from Hampton University, where she was inducted into the Honor Society of Nursing, Sigma Theta Tau International. She earned her master of science in nursing with an adult-gerontology primary care nurse practitioner concentration from Virginia Commonwealth University in Richmond, Virginia.

Colby Kohler, FNP-BC has joined the staff at Tri-Cities Medical Associates in Portsmouth. Ms. Kohler is a board certified family nurse practitioner who is passionate about wellness and preventive health care. Ms. Kohler received a bachelor of science in nursing from Old Dominion University in Norfolk, Virginia, and a master of science — with a family nurse practitioner concentration from Virginia Commonwealth University in Richmond, Virginia.

Ruth Myers, FNP-BC has joined Hampton Family Practice. She received her Master of Science in Nursing from Duke University. She partners with the patient care team led by Dr. Jennifer McCord and Dr. Amy Campbell. Ms. Myers is Board Certified by the American Nurses Credentialing Center.

Heather Westfall, CPNP, a Board certified pediatric nurse practitioner, has joined the staff at Pediatric Partners of Hampton Roads. Before receiving her master of science in nursing degree from University of Alabama at Birmingham, she worked at Children's Hospital of the King's Daughters in Norfolk, VA for 7 years as a registered nurse. She received her bachelor of science in nursing from Old Dominion University in Norfolk, VA.

Awards & Accolades

Celebrating the accomplishments of those who have received major honors

Barbara H. Amaker, MD with Pathology Sciences Medical Group –. received a distinguished physican alumni award. Dr. Amaker is board certified in anatomic/ clinical pathology and neurophathology. As a community appointed faculty member at Eastern Virginia Medical School, she teaches second-year students and provides a one-on-one elective in gynecologic pathology for third-year students.

Anthem Blue Cross and Blue Shield (Anthem) recently named Chesapeake Regional's bariatric surgery program a Blue Distinction Center and Blue Distinction Center+ (BDC/+), recognizing the program for not only its expertise, but also its efficiency in delivering patient care. Earning the blue distinction allows Anthem members to choose highly-regarded programs for their health care needs. According to Anthem, blue distinction facilities are determined based on an evaluation of "the expertise of the medical team, the number of times the facility has performed the procedure and the facility's track record for procedure results." The status also evaluates the facility's ability to meet cost measures that address patient's needs for affordable health care.

The Surgical Review Corporation has designated **the Bon Secours Surgical Weight Loss Center at Bon Secours Maryview Medical Center as a Bariatric Surgery Center of Excellence in Metabolic and Bariatric Surgery (COEMBSTM).** In addition, general and bariatric surgeons Gregory Adams, MD, FACS; Elizabeth Barrett, MD, FACS; and Eric DeMaria, MD, FACS, FASMBS with Bon Secours Surgical Specialists, have achieved Surgeons of Excellence in Metabolic and Bariatric Surgery (SOEMBSTM). These designations are synonymous with superior patient care and recognize surgical programs and associated physicians with a demonstrated track record of achieving favorable outcomes in bariatric surgery. Bon Secours Maryview Medical Center is also recognized as a center of excellence by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). This distinction makes Bon Secours Maryview the only surgical weight loss program in Virginia to have both quality designations.

Gregory Adams, MD

Elizabeth Barrett, MD

Eric DeMaria, MD

Chesapeake Regional's Breast Center recently earned the 2015 Women's Choice Award, named one of America's Best Breast Centers. The award acknowledges Chesapeake Regional Medical Center's (CRMC) dedication to providing exceptional patient care and treatment for a second consecutive year. By carrying the evidence-based designation of the Women's Choice Award seal, Chesapeake Regional's Breast Center has signified its commitment to a global mission to elevate the patient experience, specifically for women, as one of more than 315 America's Best Breast Centers. PHOTO: WCA Americas Breast Center

Deepak Talreja, MD, President of Cardiovascular Associates, has been awarded the 2015 R. Bryan Grinnan, MD Memorial Research Award by the American Heart Association. The award recognizes an outstanding individual who has served to make the community a better place through their investment of time in support of cardiovascular disease research.

DISCUSSING DIFFICULT TRUTHS[1]

Part One of a Two Part Article on Adverse Risk Disclosure

By Douglas E. Penner, Esquire

We know that medical errors occur. A prominent study published in 1999 reported that three percent of all hospitalizations involve medical mistakes.[2] But when the unanticipated outcome becomes a reality, you should realize the benefits of discussing difficult adverse events with the patient and his or her family.

Why Disclose?

It is always in your patient's best interest. When a patient experiences an unanticipated outcome of care or a medical error, he or she wants a representative from the organization involved to acknowledge the outcome or event, express empathy, assume responsibility and apologize if any error occurred, and state that corrective actions will be enacted to ensure other patients do not experience similar outcomes.

Disclosure is required by the Joint Commission standard RI.2.90.

It is the ethically responsible thing to do. AMA Opinion 8.121(3) – Ethical Responsibility to Study & Prevent Error & Harm states, in part, that "Physicians must offer professional & compassionate concern toward patients who have been harmed, regardless of whether the harm was caused by health care error. An expression of concern need not be an admission of responsibility...Such communication is fundamental to the trust that underlies the patient-physician relationship..."

There is always an opportunity to learn and improve. Unanticipated outcomes need to be investigated to prevent, if possible, a recurrence in a future patient. A thorough investigation and analysis of all possible contributing factors is the first step in identifying and correcting those system failures. Institutions that are committed to safety regard incidents as evidence that their systems have failed.

Lastly, disclosure has been proven to help avoid litigation or improve results. Several studies have found failure to provide explanations and poor communication generally are associated with litigation. Even if the patient still decides to sue, the healthcare provider will be a more sympathetic defendant and is better insulated from trial lawyer's allegation of fraud and deceit.

Note that Virginia law excludes from evidence expressions of sympathy, such as "I'm sorry for your loss." However, any admission made separately or as part of an expression of sympathy is admissible. As an example: "I'm sorry for your loss, I made a terrible mistake." The "I made a terrible mistake" part is admissible in court. Also keep in mind that a statutory privilege may be attached to some of the post-incident investigation, such as peer review and quality assurance documentation. Legal counsel should be consulted before disclosure of any of these privileged materials.

Keep these considerations in mind the next time you find yourself gearing up for a disclosure conversation. Proper disclosure can impart much needed emotional relief, lessen litigation risk, and may even offer the provider a valuable and cathartic learning experience. ■

Part Two of this article will appear in the Summer 2015 issue of Hampton Roads Physician.

[1]The information contained in this article is intended as risk management advice. It does not constitute a legal opinion, nor is it a substitute for legal advice. Legal inquiries about topics covered in this article should be directed to an attorney.

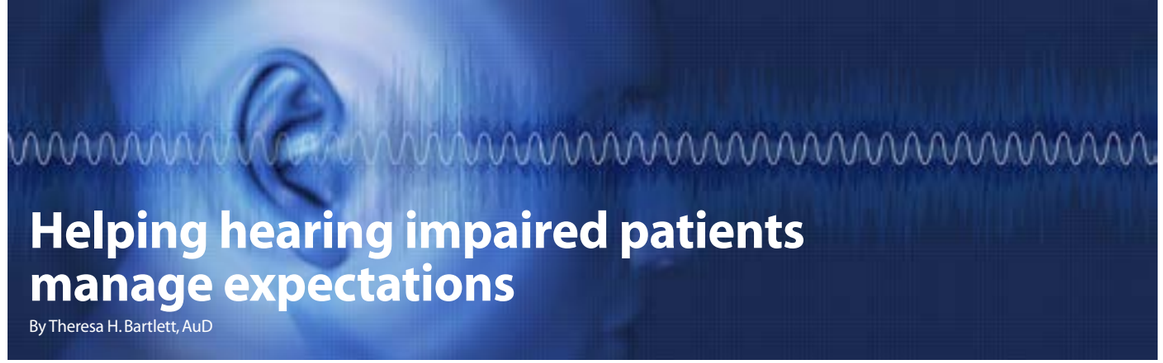
[2]Kohn LT, Corrigan JM, Donaldson M, eds. To Err is Human: Building a Safer Health System. Washington, DC: National Academy Press; 1999.

[3]"Patients and, when appropriate, their families, are informed about the outcomes of care, treatment, and services that have been provided including unanticipated outcomes."

[4]See Barnes, Janet, RN JD. A Consensus Statement of the Harvard Hospitals, When Things go Wrong, Responding to Adverse Events; 2006.

[5]See Va. Code § 8.01-581.20:1.

Douglas Penner is an attorney with the law firm of Goodman Allen & Filetti, PLLC. Mr. Penner specializes in hospital risk management, medical malpractice defense, health care law, and State Board licensing and credentialing matters. For more information, goodmanallen.com.



Helping hearing impaired patients manage expectations

By Theresa H. Bartlett, AuD

Have you ever recommended hearing aids to patients in your practice? How many of those patients follow your recommendation and purchase hearing aids? Of those who have, do you know how many of them don't wear their hearing aids? Have you ever asked your patients why? There can be one or a combination of several reasons.

Patients often have less than reasonable expectations for what technology can actually do for them. In 20 years of practicing audiology, I've seen technology come a long way: hearing aids can do more to correct hearing loss today than ever before. However, hearing aids cannot restore someone's hearing to normal – and they definitely cannot restore a patient's hearing level to what it was ten or twenty years ago.

Hearing aids are called "aids" for this reason: their sole function is to "aid" people in hearing better. People who wear hearing aids should notice a significant improvement when hearing aids are worn, but their hearing will never be perfect. Hearing aids cannot replicate what the ears could once hear naturally.

What they can do is become a very effective tool in improving people's lives.

Another reason most people stop wearing their hearing aids is that they hear too much. They often report they don't want to hear "all that other stuff." They want to hear their significant other, or their children or grandchildren, but not the background noise in the restaurant where they're having lunch. The problem is, we all hear the background noise in the restaurant. The difference for people with hearing aids is that they have to train their brains how to hear again.

I often ask patients to visualize filing cabinets: I explain that the brain has organized acoustic files for all the sounds it hears with hearing loss. These files are neatly filed away. When we put hearing aids on, the brain is bombarded with all these new auditory files. The brain has to pick up each new acoustic file, listen to it and determine where it needs to be filed. Is it an important sound that needs attention? Is it just background noise? Once all these new acoustic files have been filed away, total acclimatization will occur. For some, this is a quick process, but for others, it takes time.

It's important to make sure your patients are being fit by professionals who are trained to establish appropriate expectations. Counseling is an important tool in the successful fitting of hearing aids. I would highly recommend reaching out to audiologists in your community and familiarizing yourself with hearing aids and what they can actually do. ■

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