

AXR NEWSLETTER

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December 2017

AXR Spotlight



Dr. Laudone's Practice

In my personal practice each year, I see over 300 men with newly diagnosed prostate cancer and perform more than 200 prostate cancer operations. I'm in my 30th year of doing exclusively [cancer surgery](#) and have 13 years of experience with robot-assisted surgery.

Throughout these years, my focus has been to optimize the use of this and other technology to ensure that we achieve the very best results for each and every patient.

Dr. Vincent Laudone- Chief of Surgery Josie Robertson Surgery Center (JRSC)

In the case of prostate cancer, this means treating the cancer in the most effective way possible while preserving urinary and sexual function to the maximum extent possible.

We've entered the age of what I like to call "technologically enhanced surgery." The major advance of the past decade has been the introduction of the surgical robot. Going forward, the focus is to further develop technology that will enhance what we see — and therefore what we're able to do — during surgery.

For example, I'm working with my colleagues on a method to take a three-dimensional rendering of a patient's prostate MRI and bring it into the surgeon's visual field as he or she operates. This means that surgeons will have right in front of them a real-time view of the surgical anatomy as well as a detailed MRI as a guide.

Another example involves research to develop an agent that can be given to patients prior to surgery that uses laser light to enhance visualization of nerves in order to avoid nerve injury during surgery.”

How has having JRSC changed the way our surgeons perform surgeries and what do you see for its future? JRSC has allowed us to standardize and streamline both the pre-operative and post-operative care of surgical patients. One major change has been the elimination of the traditional “recovery room”. Patients at Josie are recovered in the same room in which they stay until they are discharged. This eliminates the need to move patients and the need for them to get oriented to multiple different environments in the immediate post-operative period. It also allows the same staff to care for the patient from the moment they wake up until they are discharged. This consistency of care is not only more efficient, it is much more satisfying to both patients and staff. We also have the ability to monitor patients more closely. Post-operative patient ambulation is automatically tracked and recorded via the Versus System that is in place throughout the building. Finally, we have instituted a recovery tracker system that monitors the patient’s recovery once they have been discharged. This is done with a program of daily symptom based questions that patients receive electronically for the first 10 days following discharge.

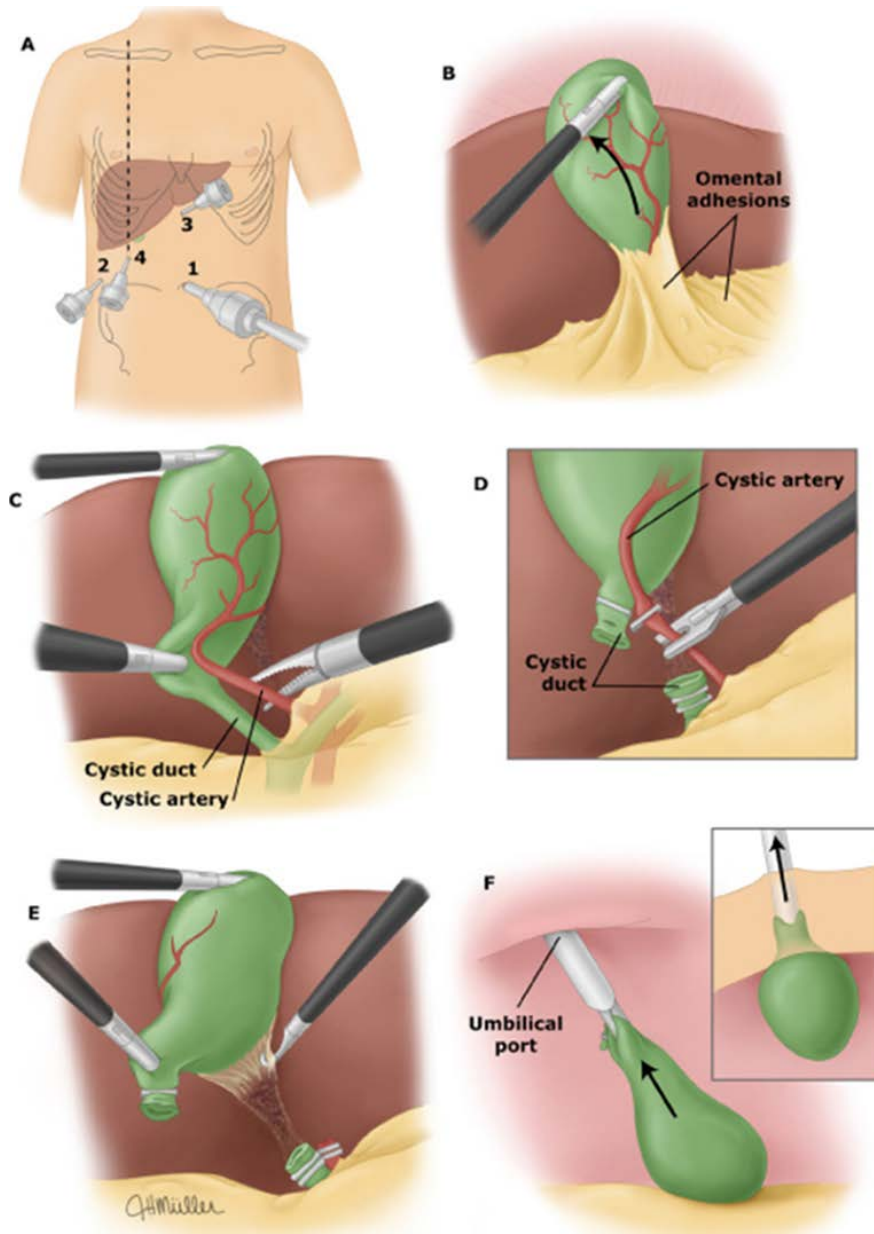
In the operating room, there are dedicated, highly skilled surgical Physician Assistants for every case. These PAs know the nuances of both the individual operation and the surgeon. The same is true for the rest of the intraoperative surgical team. We try to have the staff concentrate on a limited number of procedures to maximize their knowledge and skill level in that specific area. In addition to improving efficiency, this allows the surgeon to focus more directly on the critical aspects of each operation.

Lastly, we monitor our outcomes carefully and regularly. These metrics evaluated include length of stay, complications, conversions, transfusions, transfers, UCC visits and readmissions. It is only by knowing and consistently reviewing our outcomes that we can improve.



Josie Robertson Surgical Center (JRSC)

Laparoscopic Cholecystectomy



- A. Port placement
- B. Initial retraction of gallbladder
- C. Critical view of safety
- D. Clipping and division of cystic artery and duct
- E. Dissection of gallbladder from liver bed
- F. Extraction of gallbladder

(Taken from Uptodate)

Cholecystectomy is one of the most commonly performed abdominal surgical procedures. Laparoscopic cholecystectomy is considered the "gold standard" for the surgical treatment of gallstone disease. This procedure results in less postoperative pain, better cosmetics, shorter hospital stays and disability from work than open cholecystectomy.

Indications: Symptomatic cholelithiasis with or without complications, asymptomatic cholelithiasis in patients who are at increased risk for gallbladder carcinoma or gallstone complications, acalculous cholecystitis, gallbladder polyps >0.5cm and porcelain gallbladder.

Contraindications: are primarily related to anesthetic concerns and include diffuse peritonitis with hemodynamic compromise and uncontrolled bleeding disorders. If there is suspicion of gallbladder cancer, open cholecystectomy should be performed

Relative contraindications: include patients with previous extensive abdominal surgery, cirrhosis with portal hypertension, severe cardiopulmonary disease, active cholangitis, and morbid obesity.

Laparoscopic Cholecystectomy

Medical comorbidities – Identification of bleeding diatheses and poor cardiopulmonary reserve will help identify patients who may not tolerate pneumoperitoneum or will have higher likelihood for conversion to open operation. In patients with multiple comorbidities or acute medical problems (such as a recent myocardial infarction), a trial of antibiotics with consideration for a percutaneous cholecystostomy tube with delayed laparoscopic cholecystectomy in six to eight weeks may be preferable.

PREOPERATIVE EVALUATION

Laboratory testing in patients being evaluated for acute cholecystitis typically includes a complete blood count, liver enzymes, amylase, and lipase.

Elevations in the serum total bilirubin and alkaline phosphatase concentrations are not common in uncomplicated cholecystitis, since biliary obstruction is limited to the gallbladder; if present, they should raise concerns about complicating conditions such as cholangitis, choledocholithiasis, or the Mirizzi syndrome (a gallstone impacted in the distal cystic duct causing extrinsic compression of the common bile duct). However, mild elevations have been reported even in the absence of these complications, and may be due to the passage of small stones, sludge, or pus.

For patients with complicated biliary tract disease, abnormal tests (e.g., liver function tests, amylase, lipase) should be repeated to serve as a baseline for postoperative comparison. Coagulation tests are not routinely needed but may be obtained if there is a reason to believe an abnormality may be present.

Imaging — Ultrasonography (US) of the right upper quadrant establishes the diagnosis of gallstones or abnormalities of the gallbladder wall. The US may also demonstrate common bile duct (CBD) dilatation, stones, or evidence of acute inflammation of the gallbladder.

Magnetic Resonance

Cholangiopancreatography (MRCP) may be useful to evaluate the common duct in patients with mild elevations of their transaminases or mild CBD dilatation on US.

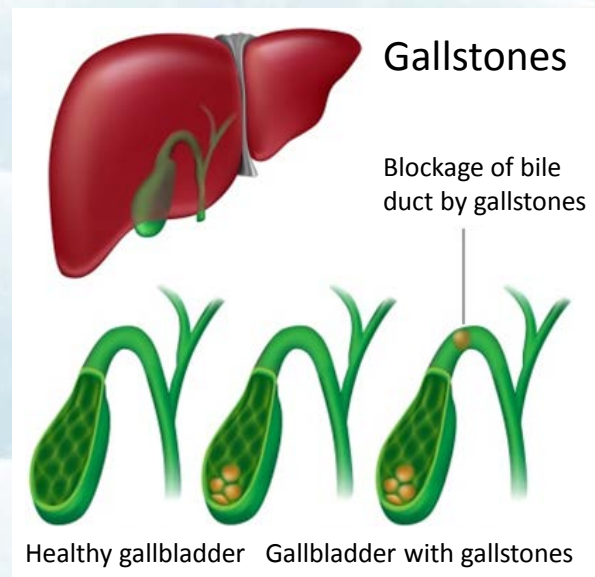
Laparoscopic cholecystectomy - patients can drink clear liquids once awake from anesthesia and their diet can be advanced as tolerated.

Most otherwise healthy, reliable patients with good home support can leave the hospital within six hours after surgery.

Patient should have no activity restriction unless the umbilical incision was particularly large. Then, limited heavy lifting for a few weeks is advisable. Most patients are able to return to work within one week. Patients follow up in clinic two to four weeks after their operation.

Most patients have some abdominal pain that resolves within two to three days after surgery and can be managed with analgesics. Occasionally, patients have referred shoulder and neck pain from the CO₂ insufflation causing diaphragmatic irritation.

POSTOPERATIVE COMPLICATIONS - Possible serious complications that can occur with laparoscopic cholecystectomy, include bile duct injury, bile leaks, bleeding, and bowel injury.



www.healthfacts.org

Laparoscopic cholecystectomy

Authors: Nathaniel J Soper, MD, FACS and Preeti Malladi, MD

Follow the link to continue reading

<https://www.uptodate.com/contents/laparoscopic-cholecystectomy>



Hepatopancreatobiliary Service

T. Peter Kingham, MD, FACS



What are the major considerations when deciding to have patients undergo laparoscopic cholecystectomy?

The majority of patients who may need to have a cholecystectomy, can have it done laparoscopically. For this, we look at indications like bad cholecystitis or a gangrenous gallbladder; these patients are often the ones on which we have to perform an open cholecystectomy, but they are the minority of patients. At MSK, some of our patients have had many prior surgeries. Many have had debulkings, for instance for ovarian cancer or colon resections, that also can factor into it. Often I will try and see if I can do it laparoscopically. Sometimes you can be pleasantly surprised, but if someone has had extensive abdominal surgery, we let the patient know that there is a real chance that we will have to do it open.

Obesity is a factor that would encourage us to do it laparoscopically. We see more and more patients with high BMIs that pushes us to try to do it laparoscopically because if we can spare a large open incision in those patients, it makes a big difference on their recovery. These patients have very high risks for wound infection and hernias; so we try everything we can so that the very obese patients undergo laparoscopy,

What are the most common complications?

This is a procedure with a very low complication rate, the biggest risk is the injury to the common bile duct; the chance of that happening is lower than 1%, but it is technically the biggest risk of the operation. The general risks are wound infection and bleeding, which are very rare for this surgery.

Postoperatively, I look to see that patients tolerate a diet; some patients have some GI discomfort when their gallbladder is out because they do not have that extra push of bile, and I also check their wounds. We do not do labs normally after this surgery.

Work with "Surgeons Overseas"

I've always known that I wanted to do surgical work in Africa. About 12 years ago, together with another surgeon who had a similar interest as mine, we started "Surgeons Overseas", trying to build up surgical training programs in West Africa. After I became a surgical oncologist at MSK, we started our 'Global Cancer Disparity Initiatives Program', which is part of Sloan Kettering and part of the international center.

I travel to Africa at least 3 to 4 times a year; we have NIH grants that are supporting our research and training work in Africa. Our program in Africa involves less surgery procedures and more research studies aimed at trying to answer questions like how can you diagnose cancer in a low resource environment and how to optimize treatments when resources are limited. It is a lot of research and training work needed in this setting. This is not a traditional mission trip where we go and do lots of surgery since the surgeons over there are excellent; it is a question on how we can help them develop their diagnostic skills and therefore better their system.

Something about yourself

I am from around New York since I grew up in Westchester County. I went to high school in the Bronx. I went to college at Yale and medical school at SUNY Stony Brook, so I have always been around in NY. My grandparents and father were all born here in Manhattan. I trained at NYUSoM and did my fellowship here at MSK where I stayed as faculty.

In my free time what I love to do is sailing; whenever I can I am out in the middle of the ocean sailing. I do long distance races for 4 to 6 days out in the ocean.

My guilty pleasure is sailing, but also exercising, going to the gym and working out is what I do for myself.



sailingbreaks.net

Hepatopancreatobiliary Service



**DeeAnn Davidson-Corbett,
MSN, AGACNP-BC**

NP responsibilities

In the hepatobiliary service, we do not participate in the operating room. We round every morning at 6AM with the fellows. We take care of patients on the floor, SACU along with the NPs in SACU, SDH PACU and UCC admissions.

We manage the day to day issues with the patients such as post-operative pain, bile leak, pancreatic leak or bleeding. The most common complication after Whipple or distal pancreatectomy and splenectomy is pancreatic leak or collection. The leaks can occur anywhere from day 2 to 10. If there is any suspicion we will perform a CT scan- we have a very low threshold to perform CT scan. If we worry that they have a pancreatic leak, we send them for a CT scan. Most of the time the attendings are either in the operating room or at clinic, therefore the NPs tend to these issues. We are in contact with the attendings but we function very independently. As an example, when a patient goes into atrial fibrillation we will start treatment. If we can't convert them from atrial fibrillation we get cardiology involved. We also admit from the urgent care center. Any patient who comes through UCC, we admit and any patient who had an embolization, ablation, any IR procedures, we admit from SDH/PACU.

We have a very good working relationship with the attendings and office practice nurses. The office practice nurses do all the pre-op teaching and set patients up for any additional testing or medical clearance that may be needed prior to surgery. When we send patients home, we send them an e-mail to let them know the patient's status on discharge such as drains or if the patients went home with any complicated issues.

Post-surgery cholecystectomy patients

The biggest issue with cholecystectomy patients is pain. We treat with Toradol, Tylenol and narcotics to control the pain. These patients typically are eating a regular diet and can go home within 24 hours if their pain is controlled and tolerate a diet. Things that we would give us reason to get keep the patient over 24 hours is pain, bile leak, bleeding, or fever. The morning after surgery we check CBC and CMP to make sure the TB is not elevated or WBC. We expect some elevation in the WBC but not gross elevation. If the patient has a leak and their bilirubin is elevated, we would wait for 48 hours to see if it will continue to rise or trend down to normal. If the bilirubin continues to rise or stay elevated we would evaluate them with a CT scan or an MRI. We want to evaluate for bile leak or retained stone.

Hepatopancreatobiliary Service NP continue

Most challenging part of the job

We have very sick population of patients young and elderly that tend to have significant comorbidities and neoadjuvant therapy prior to surgery. Half of our population presents with cholangitis prior to surgery and require biliary drain and IV antibiotics before being able to proceed with surgery. Our surgeries such as Whipple and Hepatectomies are very complicated surgeries and require extremely close monitoring after surgery. After a major hepatectomy the most significant complication is liver failure and after Whipple is bleeding from the GDA. Other complications include pancreatic leak, bile leak and delayed gastric emptying are just a few we see and require treatment.

The Hepatobiliary service

Our service includes 7 nurse practitioners, 7 office practice nurses and 6 attendings. We work 12 hour shifts - 6AM to 6PM. Overnight we have either a PA or a resident coverage. During the week the NPs take care of most everything including discharges, admissions, consults and ordering tests. We have fellows that are dedicated to the service on the weekends. We have one dedicated HPB fellow and then rotating surgical oncology fellows. Most of my NP colleagues have been on the service for 15 plus years.

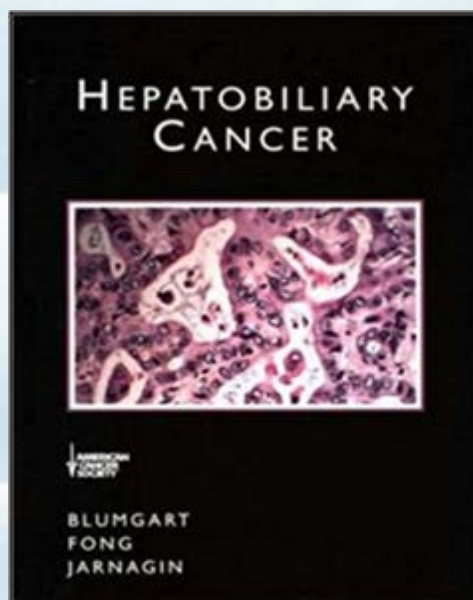
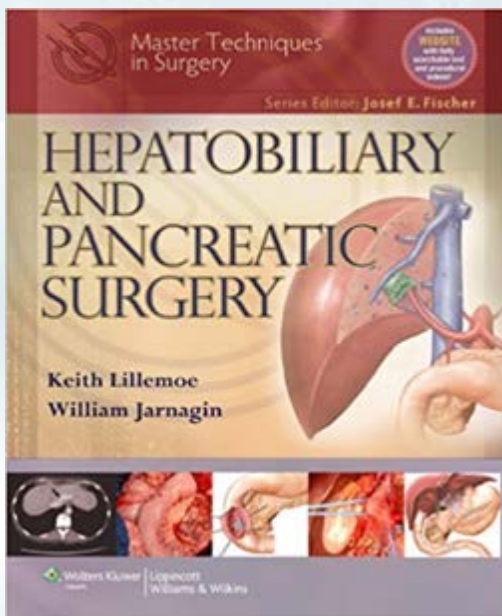
Something about yourself

I am from Southern California and have been in NY for last 15 years. I went to school at Mount St. Mary's University for undergrad and UCLA for graduate school. I specialized in the Adult Acute Care NP track.

In my free time, I go to the gym, I love the beach and I love shopping.

My guilty pleasure would be shopping. I always said that if I had to choose another profession, I would work in fashion!

Reference books for the Hepatopancreatobiliary Service



Spotlight on the Respiratory Therapy Service at JRSC



**Karin Ruiz
and
Lucien Sze**
Respiratory Therapists

What attracted you to work in Josie?

Karin: It was a unique opportunity to start in a brand new facility. There were only two respiratory therapy positions slotted for JRSC, so it was really a blank slate. Aside from monitoring sleep apnea patients, the RT role at Josie needed to be developed, which at this point in my career after 20 years was interesting to me.

Lucien: My motivation to apply for this position was essentially the same. This facility is unique, first of its kind, and I knew that it would be exciting to engage in a different type of challenge to develop a new position.

Karin: We work from the morning to the night 10am-10:30pm. We are autonomous for most of the time. Occasionally, once a week or so, we have a day when we cross over. Those days we do administrative work, work on projects, and organize research data. When one of us on vacation or have some sick time, we usually cover each other. We hand off to the Night CRNA for basic coverage, but RT night coverage is something we will be looking into for the future.

Respiratory patient's care after hours

Lucien: RT hours of operation at JRSC are usually from 10AM to 10:30PM. We currently do not have overnight respiratory therapists. All covering CRNA, doctors, and nurses have been trained to operate our devices in events of after-hour emergencies.

Karin: Our service works 24/7 at the main campus. In the event of an emergency, the night staff would call the RT supervisor at the Main Campus for support

Emergencies

Karin: We are part of our code team, thus anytime alarms go off, we rush in.

Lucien: We work through the same type of emergencies as the Main Campus but not as frequently.

Karin: There is a difference in the patient population overall. The challenging thing for us is that we have a lot of sleep apnea patients who may have not been diagnosed or are not compliant with their home devices.

When our OSA patients do come out of the OR, our job is to watch and wait to see how they will do in an unstimulated environment. Initially when the patient comes out of the OR, everybody comes and gives report and set up the patient's monitoring (EKG, BP, etc.) We stick around after the team leaves and wait to see the patient go back in deep sleep. That is when we would notice airway obstruction, desaturation, or apnea. It is challenging to tailor therapies to meet the patients' needs. We cover PACU and Pre-op. In the OR, there is the Anesthesia team covering any emergencies and they would call us if they needed to transfer anyone on a ventilator or if they have something really emergent coming out that we need to set up for in PACU.

How is it working at JRSC

Lucien: We have taken the time to build rapport and become friends with staff from all departments. It has significantly increased the level of morale and camaraderie amongst us. We're also able to spend more time with each patient to learn more about them while ensuring that they understand and retain the information from educational sessions relevant to respiratory care.

Karin: The nurses and APPs are able to rely on us the second they realize that something may be off with a patient. They call us and we respond immediately. It is a great relationship and an amazing team. It is also a nice bridge for anesthesia to know that when they bring patients down or when the patients are still a bit sedated, they will be in good hands and that they do not need to keep coming down to see these patients. Over the last year and a half since Josie opened, we have been collecting data about the OSA patients, the devices that they use and their pre-op screening. We've now completed 3 different projects along with anesthesia, all of which point to the fact that having RTs here allows a high risk OSA patient to safely have overnight or outpatient procedures versus having them admitted to the hospital.

Sleep apnea patients

Lucien: We typically receive information about high risk and diagnosed OSA patients, days in advance. Patients that have not been flagged as high risk or diagnosed OSA can sometimes exhibit symptoms of sleep apnea. When these patients arrive in PACU, we assess them and watch for events. If a patient exhibits events, then we will provide a CPAP machine for use until they fully awaken. Much of it is similar to my experience in performing sleep studies less attaching an EEG and EMG system of wires. We would follow up by reporting the findings to the patient and recommend for a sleep study. Discharge instructions would be given to reinforce the importance of confirming the findings and treating sleep apnea if needed.

Karin: We keep our machines ready to go, so they can be placed immediately on a patient and then tailored to the patient's needs. A lot of what we do at the beginning of our shift is chart review. We receive a daily list of high risk OSA patients. We have the time to go through their charts and see the level of high risk they are or if they are diagnosed with sleep apnea. We screen all of our AXR patients the same way to make sure that nobody falls through the cracks. Most of the time when the patients are coming out of the OR we come for bedside report which helps to complete the picture of how our patients' PACU stay will likely go. We see all AXR patients. It is little tricky when we are working by ourselves and we have a lot of patients, but we try to see everybody after they arrive to the floor and talk to the APP or nurse to find out if there is something going on.

Something about yourself?

Lucien: I graduated in 2011 from Long Island University at their Brooklyn campus. My first career position out of school was at Jacobi Medical Center in the Bronx. I worked there for two years before joining MSKCC. In my free time, I partake in filmmaking. My guilty pleasure is occasionally sleeping in – sometimes having that extra 30 minutes of uninterrupted sleep does wonders for me.

Karin: I graduated from Quinnipiac University in 1998, but I actually finished my RT program at the end of 1997. I have about 20 years of training in all kinds of settings. I have been at Sloan for 10 years, but have also worked at Columbia, NYU, some places in Long Island. I have done everything from intubating in the ER to managing vents in NICU. On a more personal note: I have dual citizenship in Panama and the US. I like to stay active and ran a half marathon in November. I love photography, yoga, cooking and spending time with family/friends. My guilty pleasure would be binge watching shows on Netflix with a glass of wine. Oh! And cake-all kinds-particularly with lots of icing. I cannot resist it!



Our unforgettable fellows

Gillian Stearns, MD

Urology Surgeon-Burlington, VT
Former Voiding Dysfunction Fellow

What do you miss most of NY?

I miss all the food and having my sister in the same city as me.

What do you miss of Memorial?

I miss Dr. Sandhu's clinics, of course. In every cysto that I did with Dr. Sandhu he would state at least once "Keep the lumen in the middle". It used to drive me crazy, however, now every time I go to scope or I let my residents scope I hear "Keep the lumen in the middle" in my head. I also tried to bake for all the fellows' birthdays and for our clinics.

Where are you working now and how do you spend a typical day?

I am working at University of Vermont Medical Center. I am in the OR every other Monday. The other Mondays I do Urodynamics. I am in clinic Wednesday through Friday which is a mix of everything voiding dysfunction related. Tuesdays are my academic days but now that I'm clinic director, they're usually my catch up and have meeting days.

How healthcare coverage affects how you practice?

Cost of healthcare is an issue in Vermont, but also with my patient population as they tend to have multiple comorbidities and I am not the only person who is ordering tests for them. Especially for my neurogenic bladder patients I tend to discuss what we can do in order to get the most bang for our buck, so to speak, without them feeling like a guinea pig or pincushion. With my elderly patients, a lot of the bladder medications are limited in how well insurance covers so I do have to warn them that occasionally we have to see which one the insurance is covering this week. I use compounding pharmacies for some of the meds I prescribe as it is significantly cheaper



Gillian with Dr. Sandhu at the SIU meeting, Lisbon 2017

Tell us something about yourself?

I went to medical school in Oklahoma (Boomer Sooner) and residency at SUNY Upstate in Syracuse.

What do you do in your free time and what would you say is your guilty pleasure?

In my free time, I work out, spend time with my cats and husband, take baking and cooking classes, hike and explore new areas of Vermont and the Northeast. I am a stress baker and feeding people my baked goods is probably my best guilty pleasure



Vermont

westhillbb.com

Our unforgettable fellows



Joao Casanova Goncalves, MD
GYN Surgeon Lisbon-Portugal

What I miss most of NY?

Right now, 3 months away, I am starting to miss the excitement of living and working in NY, enjoying the city over the weekend when I could relax, walking around the central park area, I miss that so much. I also miss the time that I spent there with my family,

We had our routine, would wake up early on Saturday and then would travel around the area, enjoying the area around the hospital. I miss the food so much especially the diversity of food in NY and the culture, from Chinese, Japanese, Ethiopian, Indian and Persian food. I think that only in NY you can find that.

What I miss most of Memorial?

I miss being in a place where you feel you are working for things that are bigger and better than you, you are fighting cancer and that is priceless. I miss the hectic, the adrenaline rush of being so busy every day. It kind of grows on you. When you are there, you do not like it, but when you leave, you realize that you were addicted to that kind of lifestyle. I am going miss the surgical part, the hard cases and working with some of the awesome attendings and co-fellows. Once you become an attending, you work solo and you miss sharing the hard days with the other fellows.

My fellowship lasted 2 years and started on July 1st on 2015 to July 1, 2017. Our GYN fellowship is all clinical, I used to live in the Scholar's building next door, Living so close to the hospital sometimes feels like you never leave the hospital, but sometimes is very convenient, especially when you are called to the hospital in the middle of the night.

What work do you do now?

I'm a GYN Onc Surgeon at the GYN Unit of the Champalimaud Foundation. It is an oncologic center that opened about 10 years ago. They are devoted to research. This center does not do same day discharge yet, but maybe in the future. At work, I do not have my own NP or my own nurse. We do have a specialized nurses like OR nurses, scrub nurses, midwives, but no NPs in Portugal. At my work, I do have a dedicated nurse that works with 3 surgeons and 2 assistants that work in the practice.

We have rigid work hours in Portugal, meaning that you can't work more than 40 hours a week as per law. Even if you end up working a little more than 40 hours, we do not have hectic hours. I work from 8 to 6 from Monday to Thursday, and then on Fridays, I have a light day

When I finished my fellowship in Memorial, I took 3 months to spend with my family, before starting my new job where I have been for one month.

What are the differences between Portugal and US health system?

In Portugal we have socialized medicine, a public government owned health system, and a large group of physicians work for the government. In the last 20 years, we also have private hospitals that work the same way as in America where people pay more at their own expense. We have universal coverage where people can go to any hospital if they get sick, as long as the hospital is part of the health system.

Tell us something about yourself?

In 2005 I finished my medical school in Lisbon and did my GYN residency in Porto. I also spent some time in France and Taiwan doing laparoscopy training during my residency. I worked as a junior attending for a year and then, I went to MSKCC.

When I was applying for a fellowship, there was only Memorial for international professionals that offer a training program. Only Memorial has a large volume and great surgical complexity of patients. In 2 years, I participated in about 600 surgeries. I hope that in the future, I can organize a conference in Lisbon and bring some of the attendings from NY.

What do you do in your free time and any guilty pleasure?

All of my free time I spend with my family, my wife, my daughter and my new baby boy who was born 2 weeks after I completed my fellowship making up for the time we were separated, for almost a year.

For myself, I have started to work up in the gym and started to play tennis. I love movies and trying to catch up with my friends. I love to going to dinner and relax with them



Lisbon

reflectim.com

Our unforgettable fellows

Navin Mani, MD

Head and Neck surgeon

London- England

What do you miss of NY?

New York was a great city to live in, full of energy and excitement. I miss the culture, the diversity and of course the great food!

What do you miss from Memorial?

I really enjoyed my time at Memorial and having the opportunity to work with and learn from the fantastic physicians and surgeons there. I became good friends with my co-fellows and residents who I certainly miss.

When we had time myself and the other fellows would grab a coffee at the memorial gift shop, they usually had some light jazz music playing in the background which was very relaxing!

Where are you working now?

I'm now working as an attending surgeon in Manchester, UK at an academic center specializing in head and neck surgery. My working week is divided between time in the OR, time in clinic and research. Head and neck surgical oncology in the UK is centralized, so we get a lot of referrals from other hospitals in the region.

Are there any differences between the US and UK healthcare system?

We have a national health care system in the UK, so healthcare is free for all. As you would expect there are advantages and disadvantages to this system. Healthcare in the US is run more like a business and is perhaps a more efficient system than in the UK.

I work in surgical oncology in the UK and this is a priority area for healthcare spending. So our patients requiring surgery get treated relatively quickly, but routine non-cancer surgeries may have to wait longer



Tell us something about yourself?

I attended Medical school in London and underwent residency training in Manchester. I was always interested in Head and Neck surgical oncology, and wanted to get international experience to see what practice was like outside the UK. Memorial Sloan Kettering a great reputation for Head and Neck surgery. After visiting the unit and meeting the staff, I thought it would be a great place for fellowship.

In my free time, I enjoy racket sports like tennis and squash, but my wife and toddler take up most of my free time!

Do you have any guilty pleasure?

After my time in NY, I can't resist a slice of pepperoni pizza!



Honoring one of our own



What attracted me to apply for the position?

When the NP Coordinator position was announced, I knew that I held a lot of the knowledge that could help make JRSC successful. The thought of being a leader for an established team (Main AXR NPs) and a whole new team (JRSC APPs) for a whole new building excited me. I enjoy building new programs, figuring out roles and collaborating with many different departments. In addition, I was already part of the Main AXR NP team and was working very closely with the outside consulting group that MSK hired in preparation for the opening of the Josie Robertson Surgical Center (JRSC). I had specifically contributed to the understanding of patient and health care staff perspectives that influenced JRSC design- in particular the Oasis concept.

A typical Day:

A typical administrative day includes attending meetings that request my presence for my leadership, APP, nursing, JRSC, or Periop perspective. There are several projects and programs that I lead or co-lead, which require me to collaborate with others via phone, webex, in person, or email. Some of these projects and programs include JRSC Medical Simulation Program, AP3 Program, Orderset revision requests for both Main AXR & JRSC, and MSK Nursing initiatives. I also keep tabs and follow up on the patient census, preop, intra op, and post op clinical situations at both Main AXR & JRSC. My clinical day at Main AXR or JRSC allows me to gain a fresh perspective on current workflows

Challenging aspects:

The challenging aspects of my job include remembering to take time for myself. Technology has made it too convenient to always be available. It's important to make time for space that allows creative thinking, especially as we are seeking innovative ideas. As new developments arise, it can become challenging to find ways to keep the information flowing to both teams. It can also be a challenge keeping all team members motivated and growing professionally

Advise to other APPs:

I would advise any APP who is considering an administrative/ managerial position to be active in your areas, beyond the clinical arena. Seek opportunities that showcase your strengths as a leader and communicator. Join unit based councils, nursing councils, new projects, teaching engagements, speaking opportunities, and being a superuser. Keep in mind that there are also opportunities locally and nationally, i.e., community centers, schools, local chapters, and national organizations

Can you tell us a little about yourself?

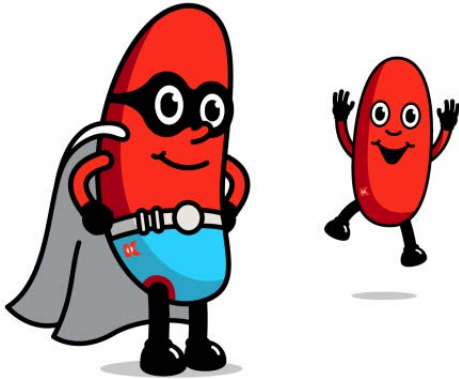
I received my Master of Arts for Adult Nurse Practitioner from NYU and my Bachelor of Science in Nursing & Bachelor of Arts in Spanish from Niagara University. One thing that I do for fun is hot yoga. One activity I wish I could do more often is go horseback riding. My guilty pleasures include reviewing on YELP & Tripadvisor, watching food shows like *The Best Thing I Ever Ate* and forensic shows like *How it really happened?* with Hill Harper and *Autopsy*



Marie, Alonzo and David in front of the Christmas lights house in Jamaica States



In the next issue...



..... it is all about
the kidney!

*Happy
New Year
From all of us at AXR*

