

## Making Personalized Care Work for Patients


**A**ccess to health care is one issue receiving a lot of face time in the media as the country wrestles with reducing health-care costs. For patients who are trying to navigate a complex health-care system, however, coordination of care may be an issue of equal or greater importance.

At one time or another, primary care, episodic specialty and/or emergency care, and chronic specialty care will probably play a role in a patient’s lifetime medical experience. Although it is critical to align the needs of the patient with the appropriate resources to ensure a team-based practice environment functions effectively, a fundamental question begs an answer.

Who takes the lead for managing a patient’s medical needs? The primary-care provider? The specialist? The emergency room?

Although there is consensus that the emergency room is definitely not the answer from a continuity-of-care or cost-effective perspective, there is no simple answer. One size of medical care – one particular model – doesn’t work for every patient. There are too many variables that preclude one approach from being optimally effective for everyone.

In this issue of *Physicians Practice*, we look at two case studies that present two models of care. In the first study by **John W. Henson, M.D.**, director of neurology at Swedish Neuroscience Institute, the patient is best served by the “traditional” primary-care model in which the primary-care provider takes the lead and the specialist provides specific diagnosis and treatment services, and follows up periodically as needed. The second study, by neurologist **Lily Jung Henson, M.D.**, presents an alternative model that may be better suited for a patient who requires regular, chronic specialty care. As an expert in multiple sclerosis, Dr. Jung Henson assumes a more prominent role in the daily medical needs of her patient. These two models may approach the coordination of care from different perspectives, but the relationships between the specialists and the patients’ primary-care providers are equally critical to a smooth medical journey for the patients. The key is finding the model that works best and making a commitment to communicate effectively with other team members.

In the end, it’s the individual needs of the patient – not a predefined model – that produces personalized care. 

<sup>1</sup> The American Association of Medical Colleges Center for Workforce Studies.

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# Episodic Specialty Care: A Case Study of Shared Responsibility

John W. Henson, M.D., FAAN, Director of Neurology, Swedish Neuroscience Institute

## Diagnosis: Low-grade oligodendroglioma

A 29-year-old account manager from a local firm was brought to a nearby emergency room late one rainy afternoon after office colleagues witnessed a two-minute episode of confusion and altered speech. One of his friends said they thought he was having a stroke.

On evaluation in the ER, he was back to normal, but a CT scan revealed a region of low attenuation in the left frontoparietal region, which was suggestive of a tumor, rather than an infarct.

The patient was transferred to the Inpatient Neurology Team at Swedish Cherry Hill where an MRI with gadolinium contrast showed a nonenhancing mass lesion in the left frontoparietal junction (see Figure). His past medical history was significant for juvenile diabetes mellitus, which was under active management by his primary-care doctor.



Neurosurgeons and I determined an aggressive surgical resection was inadvisable. We proceeded to a stereotactic needle biopsy, which revealed low-grade oligodendrogloma

with a labeling index of 1 percent and loss of heterozygosity of chromosomes 1p and 19q (respectively, an estimate of the tumor's proliferative potential and genomic changes, predicting relatively benign behavior and good response to treatment.) The patient was on the glucocorticoid dexamethasone for several days after the biopsy, with his primary-care physician managing his insulin requirements.

Despite these good prognostic factors, the patient began to have two to three partial complex seizures each week. As a result, he was unable to drive, which put his job at risk. The epilepsy specialists at Swedish Neuroscience Institute (SNI) became involved in aggressive management of his anticonvulsant regimen.

This patient's diagnosis and treatment plan has required an active, ongoing collaboration among the patient, his primary-care doctor, and me, as his neuro-oncologist at SNI.

When the patient's treatment team determined the need to administer a 12-month course of oral chemotherapy in an attempt to improve seizure control, his primary-care doctor was crucial in discussions about psychological and reproductive issues. Throughout the course of treatment, the patient's diabetes has remained under good control. Approximately three months into chemotherapy, the tumor showed shrinkage and the patient's seizure activity began to improve.

Currently the patient is 18 months out from the time of diagnosis, is seizure free, and working full time. I see him every six months with a new MRI scan of the brain. ☺



## About the Author

John W. Henson, M.D., FAAN, is director of neurology at Swedish Neuroscience Institute.

He is a neuro-oncologist at SNI's Ben and Catherine Ivy Center for Advanced Brain Tumor Treatment. Dr. Henson received his medical degree from Loma Linda University School of Medicine in Calif., and completed his neurology residency at Vanderbilt University Medical School in Nashville, Tenn. He completed fellowship training in neuro-oncology at Memorial Sloan-Kettering Cancer Center, and in neuroradiology at Massachusetts General Hospital in Boston. He is board certified in neurology. Dr. Henson is editor of *BrainWaves*, the professional journal of the Swedish Neuroscience Institute, and is the current president of the Washington State Neurological Society. His clinical interest is in neuro-oncology. To refer a patient or consult with Dr. Henson, please call 206-320-2300. ☺

*These case reports are presented for educational purposes. They have been modified to protect patient privacy.*

## Specialty Takes the Lead : A Case Study in Managing an MS Patient's Care

*Lily Jung Henson, M.D., MMM, FAAN, Neurologist, Swedish Neuroscience Institute*

TS is a 46-year-old female with remitting relapsing multiple sclerosis to whom I have provided care for the past eight years. Her disease has been fairly active and I have now switched her disease modifying therapy for a second time. She has been falling, has had frequent urinary tract infections and, like many multiple sclerosis patients, complains of fatigue and migratory paresthesias. She has otherwise been healthy. She is single, has no children and does not have a primary-care doctor. She smokes tobacco and has a family history of breast cancer in her sister and mother. Because of her active disease, she has been treated numerous times with intravenous steroids for exacerbations.

Taking care of a complicated MS patient involves treating the underlying disease, as well as the exacerbations and associated symptoms. It also means taking care of an individual who needs her overall health reviewed regularly. I monitor this patient's clinical course and order regular imaging studies to assess her disease. Consequently, I help her make decisions about disease modifying therapies she should consider.

Additionally, as part of the ongoing care I provide, I collaborate with a physiatrist and physical therapist to reduce her risk of falls and subsequent injuries, and because of her history of urinary tract infections, I order urinalyses when she has increased symptoms.

In response to her complaints of fatigue, I ordered a complete blood count and thyroid function studies, and a fatigue scale by a sleep specialist. When the results of these studies came back in the normal range, I prescribed

amantadine, which has been known to be effective in treating chronic fatigue in patients with MS. I also prescribed an anticonvulsant for the sensory symptoms and monitor the drug to make sure it doesn't make her fatigue worse as a side effect.

In the course of caring for TS, I cautioned her that smoking can make her MS worse and might also aggravate her risk for osteoporosis, particularly given her frequent steroid use. I strongly recommended she get the flu vaccine every fall to reduce the risk of exacerbating her MS if she were to get ill.

Although I regularly see her and address many routine medical conditions that may affect her MS, I am not a substitute for a primary-care doctor. She needs recommendations for management of her breast cancer risk and should have a pap smear, which she has not had since her gynecologist retired several years ago. I refer her to a primary-care provider to help me care for these and other potential issues, just as a family physician or an internist might refer a patient to me for a neurology consult on the management of a patient with hypertension, hyperlipidemia and coronary artery disease who has previously been on aspirin therapy and has recently suffered a transient ischemic attack. The primary-care provider doesn't need or want me to take over complete care of the patient; he or she wants me to provide recommendations. Similarly, I am probably best able to manage most of the health-care needs for my MS patients, but they also will have periodic concerns that will benefit from a primary-care provider's expertise. ☺



### About the Author

Lily Jung Henson, M.D., MMM, FAAN, is a neurologist who specializes in caring for patients with multiple sclerosis.

She received her medical degree from the Feinburg School of Medicine at Northwestern University in Chicago, and her master's degree in medical management from Tulane University School of Medicine in New Orleans. She completed her neurology residency at the University of Washington School of Medicine.

The National Multiple Sclerosis Society recognized Dr. Jung for her work on behalf of multiple sclerosis patients by inducting her into its Multiple Sclerosis Advocacy Hall of Fame.

Dr. Jung is board certified in neurology. Dr. Jung sees patients at the Redmond Campus and at the new neurology clinic at Swedish/Issaquah.

To refer a patient or consult with Dr. Jung Henson, please contact her at 425-313-7070 or [lily.junghenson@swedish.org](mailto:lily.junghenson@swedish.org). ☺

## Swedish Supports MS Bike Ride

The Swedish Smyelin Babes bike team is participating in the MS Bike Ride Saturday and Sunday, Sept. 10-11 in Mount Vernon, Wash., to help raise money for the National Multiple Sclerosis Society (NMSS). For more information, to join a team or make a donation, go to [www.nationalmssociety.org](http://www.nationalmssociety.org) or contact Lily Jung Henson, M.D., at [lily.junghenson@swedish.org](mailto:lily.junghenson@swedish.org). ☺

## Swedish Adds Third da Vinci Si HD Robot to Increase Robotic-Assisted Surgical Services



In late 2008, Swedish upgraded its da Vinci® robot equipment by purchasing two of the latest generation da Vinci robotic-assisted surgical systems. At the same time the hospital also opened the world's first integrated operating room specifically outfitted for the da Vinci Si HD robot. Since then Swedish has added a third da Vinci Si HD robot to advance its pioneering use of robotic-assisted surgery for patients.

“As the most experienced robotic-assisted surgery center in the Pacific Northwest, our use of the device has increased significantly enough that a third system is required to support the demand for this type of minimally invasive surgery at our hospital,” says **James Porter, M.D.**, medical director


of the Robotic Surgery program at Swedish and a prostate cancer survivor who himself underwent robotic-assisted surgery.

Swedish has been utilizing robotic-assisted surgery since 2005, and was one of the first medical

centers in the region to perform robotic-assisted surgery. Swedish-affiliated surgeons have performed more than 3,000 procedures using the da Vinci Surgical System. Various Swedish-affiliated surgeons have used the robotic-assisted surgical system to perform minimally invasive cancer surgeries including prostate, kidney, colorectal, uterine, cervical, ovarian and lung, and to assist in complex gynecologic reconstruction, non-cancer colorectal and bariatric surgeries.

Robotic-assisted surgery is a growing trend around the world due to quicker recoveries, shortened hospital stays, less pain and scarring, and the potential for better clinical outcomes. One of the benefits of the Swedish Robotic Surgery program is the experience

of its medical staff – experience shared with surgeons at conferences in Seattle, as well as at locations across the country and around the world. The Robotic Surgery program at Swedish is also among the first in the region to create a robotic-assisted training program for fellows.

The new robotic-assisted surgical system features a dual-console set-up, which allows for greater collaboration among surgeons and enhanced training capabilities for the program. It consists of an ergonomic surgeon's console, a patient-side cart with four interactive robotic arms, a high-performance 3D HD vision system. It also includes patented EndoWrist instruments that can turn 540 degrees, allowing for much finer movements than in conventional surgery. The da Vinci System is designed to seamlessly translate the surgeon's hand movements into more precise movements of the EndoWrist instruments to ‘virtually’ put the surgeon's hands inside the patient. A special 3D HD, dual-lens endoscope provides a highly magnified view of the surgical site inside the patient, allowing surgeons to see the surgical site up to 12-times more closely than human vision allows. 

## A Hybrid OR Suite for Complex Cardiovascular Interventions

*Kaj Johansen, M.D., Vascular Surgery*

As the distinction blurs between what “open” surgeons and catheter-based interventionalists do, it becomes increasingly feasible to carry out concurrent (or even simultaneous) surgical and endovascular reconstructions for

complex cardiovascular problems.

Sometimes, such tandem interventions are helpful, or even obligatory. Consider the following scenarios.

- An 80-year-old woman with a thoracoabdominal aneurysm

involving the visceral and renal arteries

- A 56-year-old man with intractable cardiac arrhythmias needing both transcatheter ablation and a Maze procedure  
*(continued on A5)*

## Hybrid OR Suite

(continued from A4)

- A 76-year-old man with unstable angina and proximal CAD stenosis, as well as critical aortic valvular stenosis
- A 68-year-old man with a pseudoaneurysm following dissection of the internal carotid at the skull base and a “difficult” aortic access
- An 86-year-old man with a leaking abdominal aortic aneurysm


What do these patients have in common? Each of these potentially (or actually) critically ill patients has a series of complex arterial problems, some of which can be managed by endovascular means and others which are best (or only) managed by an open surgical approach.

### Enter the hybrid OR suite

For a certain percentage of such patients a simultaneous open and endovascular approach makes sense, either from a safety or a logistic perspective. The new hybrid suite is being designed for a patient population with disease complexity and severity increasingly seen at the Swedish Heart & Vascular Institute (SHVI).

In broadest design it combines the relevant elements of the contemporary cardiovascular surgical operating room with those of the modern interventional radiology suite or catheterization lab – piped in anesthetic gases, vacuum and air lines, built-in fluoroscopy and image intensifiers, and mobile patient tables.

While both open and endovascular interventions will continue to be performed at most Swedish campuses, we will increasingly perform tertiary- and quaternary-level cardiovascular procedures at Swedish/Cherry Hill, where all cardiac surgical, and the overwhelming majority of cardiologic and peripheral arterial interventions, are performed.

SHVI's new hybrid OR will symbolize the convergence of novel cardiovascular diagnostic and treatment modalities that have exploded onto the scene during the last 15 years. 

## Swedish Issaquah Meets its Neighbors

In July more than 22,000 neighbors joined Swedish/Issaquah to celebrate the opening of its new medical office building. Helped by the likes of Blitz, the Seattle Seahawks mascot,




Swedish showcased the medical practices and services that are now available for residents on Seattle's Eastside.



Rajnish Mishra, M.D., David Patterson, M.D., John Brandabur, M.D., and Kristie Johnson, R.N., from Swedish Gastroenterology were among the many physicians, nurses and staff who were available to answer

questions and offer tours of their new clinics.

For more information about the practices and services available at Swedish/Issaquah, go to [www.swedish.org/Issaquah](http://www.swedish.org/Issaquah). 

## Liver Center Gets New Medical Director

The August arrival of **Anne M. Larson, M.D.**, and her appointment as medical director of The Liver Center at Swedish Medical Center, is testament to the commitment Swedish



has made to expanding access to care for patients with liver disease. In her new role, Dr. Larson will oversee The Swedish Liver Center, a program that promotes customized treatment plans that may include liver disease management, medical and surgical options, the use of state-of-the-art technologies, and liver transplantation.

Dr. Larson comes to Swedish

from the University of Texas Southwestern in Dallas, Texas, where she was the medical director of the Liver Transplantation Program and Clinical Hepatology. She received her medical degree with

honors and completed her internal medicine residency at the University of Washington School of Medicine in Seattle. She did her gastroenterology fellowship training at the University of California San Diego, and her transplant hepatology fellowship at the University of Washington. She is board certified in internal medicine, gastroenterology and transplant hepatology.

Dr. Larson is a nationally recognized researcher and lecturer, has numerous peer-reviewed publications, and is recognized as a leader in the field of hepatology.

“We are thrilled to be joined by Dr. Larson,” said **Marquis Hart, M.D.**, director of the Swedish Transplant Program, “and we look forward to her clinical expertise, guidance and leadership at The Swedish Liver Center.”

The Liver Center at Swedish offers a comprehensive approach to managing liver disease. Given the expertise of its team members and broad scope of *(continued on A7)*

## Eric J. Lehr, M.D., Ph.D., Joins Cardiac Surgery Practice

**Eric J. Lehr, M.D., Ph.D.**, has joined the Swedish Cardiac Surgery practice as the director of Cardiac Surgery Research and Education. Lehr comes to Swedish Medical Group from the University of Maryland School of Medicine, where he was an instructor of robotic cardiac surgery and advanced coronary interventions in the Division of Cardiac Surgery.

Lehr received his medical degree from the University of Calgary and his doctoral degree in experimental surgery from the University of Alberta in Edmonton, Canada. He also completed his cardiac surgery residency at the University of Alberta, a fellowship in minimally

invasive and robotic mitral valve surgery at East Carolina University in Greenville, N.C., and a fellowship in robotic coronary surgery and coronary interventions at the University of Maryland School of Medicine. Lehr is a fellow of the Royal College of Surgeons of Canada.

His clinical experience includes totally endoscopic multivessel coronary artery bypass grafting, mitral valve repair, maze procedure for atrial fibrillation and other cardiac robotic procedures. To date, Lehr has secured more than \$550,000 in research funding. His work has received international recognition with more than 130 publications and presentations. ∞




*Glenn Barnhart, M.D., executive director of Cardiac Surgery Services at the SHVI (on left), looks on as Eric Lehr, M.D., Ph.D., signs his Swedish Medical Group employment contract during a summer site visit of a fully operational hybrid OR. The visit was designed to enhance the planning and implementation of the new SHVI hybrid OR.*

## Liver Center

(continued from A6)

treatments and services, Swedish is able to personalize each patient's treatment. The Liver Center offers the most advanced technologies and newest strategies in the treatment of disease, from hepatitis to end-stage liver disease to liver cancer, to extend life and enhance quality of life.

"I am excited and honored to be a part of The Swedish Liver Center," said Dr. Larson, "and we look forward to providing a full range of services to the patient with liver disease."

Dr. Larson's leadership at the Liver Center elevates the care available to patients at Swedish to an unparalleled level. 

## CME Course Listing

### September – November 2011

Physicians from across the region and around the world come to Swedish Medical Center's Continuing Medical Education (CME) courses to learn about new research and innovative treatment techniques.

For times and locations, go to [www.swedish.org/cme](http://www.swedish.org/cme) or call 206-386-2755.

#### Physician Well-being 2011

– Friday, Sept. 9

#### Seventh John L. Locke, Jr., Preventive Cardiology Symposium

– Friday, Sept. 16

#### An Intensive Update in Neurology

– Thursday and Friday, Sept. 22-23

#### 15th Annual Pain Management Symposium: Taming the Pain

– Friday, Sept. 30

#### Orthopedics Symposium for the Primary-Care Physician

– Friday, Oct. 7

#### 9th Annual PsychoOncology Symposium – After the Diagnosis: Reactions and Consequences

– Friday, Oct. 21

#### Ninth Annual West Coast Colorectal Cancer Symposium: A Case-Based Approach

– Friday, Oct. 28

#### Third Annual Anticoagulation Symposium

– Friday, Nov. 4

#### Diabetes Management Update 2011

– Friday, Nov. 11

#### 25th Annual Roland D. Pinkham, M.D., Basic Science Lectureship

– Friday, Nov. 18

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## Swedish Medical Center

Founded in 1910, Swedish Medical Center is the largest, most comprehensive, nonprofit health-care provider in the Seattle area. Swedish comprises multiple medical facility campuses throughout the Greater Puget Sound Area, Swedish Visiting Nurse Services and Swedish Physicians – a network of primary-care clinics. In addition to general medical and surgical care, Swedish also is a regional referral center for cardiac care, maternal-fetal medicine, neurological care, oncology, orthopedics, pediatrics and transplantation. For more information, visit [www.swedish.org](http://www.swedish.org) or call 800-SWEDISH (800-793-3437).

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Seattle, WA 98107-3985  
206-782-2700

#### Cherry Hill

500 17th Ave.  
Seattle, WA 98122-5711  
206-320-2000

#### Edmonds

21601 76th Ave. W.  
Edmonds, WA 98026  
425-640-4000

#### First Hill

747 Broadway  
Seattle, WA 98122-4307  
206-386-6000

#### Issaquah

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Issaquah, WA 98029  
425-313-4000

#### Lake Sammamish

2005 N.W. Sammamish Rd.  
Issaquah, WA 98027-5364  
425-394-0600

#### Lakeside

6520 226th Pl. S.E.  
Issaquah, WA 98027  
425-427-8450

#### Mill Creek

13020 Meridian Ave. S.  
Everett, WA 98208  
425-357-3900

#### Redmond

18100 N.E. Union Hill Road  
Redmond, WA 98052  
425-498-2200

#### Swedish Visiting Nurse Services

6100 219th St. S.W., Ste. 400  
Mountlake Terrace, WA 98043  
425-778-2400

#### Swedish Physician Division

600 University St., Ste. 1200  
Seattle, WA 98101-1169  
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## Physician Opportunities

Are you a physician who would like to join a team-oriented, patient-focused practice?

Contact Mike Waters  
Swedish Physician Recruiter  
206-320-5962 (office)  
206-327-2790 (cell)  
[mike.waters@swedish.org](mailto:mike.waters@swedish.org)