COMMENTARIES

Hoya Saxa: An Interview with Dean Stephen Ray Mitchell

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I recently sat down with Stephen Ray Mitchell, MD, MBA, MACP, FAAP, FACR, the Joseph Butenas Professor of Medical Education and Dean of medical education at Georgetown University School of Medicine. In October 2019, it was announced that Dr. Mitchell's tenure as Dean of medical education, which began in May 2002, would end on June 30, 2020. In addition to his numerous accomplishments and improvements to the School of Medicine, he is a beloved teacher, friend, and colleague to students, faculty, and staff alike. I was privileged enough to talk to him about his voyage to medicine, time as Dean, and plans for the future.

ON HIS EARLY LIFE AND JOURNEY TO MEDICINE AND GEORGETOWN

I was born in far southwest Virginia, about 10 miles outside of a wonderful little town in rural Appalachia called Gate City. If you are Georgetown fan, you may know that name because Mac McClung, our Georgetown basketball star, is also from Gate City. My mom should have been the physician in the family, but she didn't go to college. So, I think she really was determined that her 4 boys were going to do that. I almost went to Davidson to play football—I was a 170-lb linebacker—and at the 11th hour, I changed my mind and went to [the University of North Carolina]. I'm not sure why—maybe because Davidson wasn't coed at the time!

Medical role models for me, then, were not in the family, but in the physicians around Chapel Hill. It was the first time I met physicians who had done both internal medicine and pediatrics. I think I probably always wanted to do primary care, but also loved engaging with pediatrics, and these physicians were wonderful role models who took care of sick children and sick adults. I was hooked. I stayed at Chapel Hill for a Med-Peds residency.

The [US Air Force] brought me to DC, where I was hired by the Chief of Medicine Dr. Al Bricetti (Georgetown grad and rheumatologist). I trained in both adult and pediatric rheumatology, then went down to Georgetown for a rheumatology fellowship. I was eventually boarded in medicine, pediatrics, and adult and pediatric rheumatology. Around this time, interacting with medical students during my residency with the Air Force, I figured out that I loved to teach.

Eventually, in 1998, I came over to the Georgetown Medical School as Associate Dean for Clinical Education and helped run clerkships. Two years later, I was appointed by Dr. Sam Wiesel to senior Associate Dean of Academic Affairs. I was a little intimidated; the school needed work. I spent time fundraising and advocating for the students.

Another 2 years later, in 2002, Dr. John DeGoia (President of Georgetown University) changed my title to Dean of Medical Education. Somehow, one day you look back and suddenly realize you have made a lot of progress. The good news is, you find what you love to do, somebody says they'll pay you to do that, and you get to hang out with people who humble you!

ON HIS LOVE OF TEACHING

Forgive me if you've heard me use this analogy before: take a look at the Knowlan print.¹ We told Dr. Knowlan that we wanted to do a portrait and he said, "I don't want to do any of these posed things. I want a patient in there and I want students in there!"

If you look closely, Katie Burgess (now an obstetrician in upstate New York) is examining the abdomen, and this nervous patient is looking into Katie's eyes. Dr. Knowlan has his hand on Katie's hand, and he's looking into Katie's eyes. And what's he looking for? He's waiting for her eyebrows to go up: "Oh!" "Feel that?" "Yes!" So, I realized I was addicted to the eyebrows. More than anything, I just like sitting down and seeing a patient with students.

ON HIS INTERACTIONS WITH DR. HARVEY AND THE PRESERVATION OF HARVEY'S LEGACY

It was a treasure to me to get to know Dr. Proctor Harvey. He was a poor kid who grew up in Lynchburg, Southwest Virginia, so maybe that's why we spoke the same language. He eventually went to Duke for medical school; I don't hold that against him!

When I got to know him, he was older. He was mellow in his old age, but he was kind his whole life. You would walk in to see Dr. Harvey, and he would say, "Have you eaten? Come in, sit down!" He would go to the refrigerator and take out a sandwich or something. Likewise, with his patients, he would fluff the pillow, he would talk to them, and then he would listen to their heart.

When Dr. Harvey moved his \$2 million endowment to the school (from a chair in medicine), he said it was because they were not appointing people who taught. He wanted to be sure every student learned how to use a stethoscope and how to be a good clinician. In addition to creating the Proctor Harvey Center for Excellence in Clinical Teaching, which buys every student a Proctor Harvey stethoscope, part of ensuring Dr. Harvey's legacy was building the amphitheater. If you saw the old room, it looked like a Hitchcock movie or an

old basketball gym. I wanted to create an amphitheater with a balcony and an exam table in the middle like the Anatomical Theatre of Padua or the Ether Dome at Harvard.

For funding, we decided to sell 100 seats for the 100 best teachers in Georgetown's history. In the end, there were about 650 donors and Dr. Harvey's estate. We also wanted investment from MedStar. So, I invited Dr. Stephen Evans (chief medical officer of MedStar) and I said, "We can link all 8 of your hospitals to this room and do teaching." MedStar gave the last bit of support. Now there is a plaque that reads: "W. Proctor Harvey Teaching Amphitheater, Home of the Georgetown-MedStar Educational Institute."

ON GEORGETOWN'S PARTNERSHIP WITH MEDSTAR

Before MedStar, Georgetown was small; it was a 500-bed hospital that would play somewhere about half to three-quarters occupancy. But as managed care hit the area, you could not be small. Teaching hospitals, including Georgetown, were losing millions of dollars per year. Most of that was in the hospital, and some was the necessary investment to do research. The university has slowly gotten this concept; we would not be a Carnegie One research university if there were no biomedical research. Eighty seven percent of the research of the university is on our campus. But the university could also not keep losing that much money.

So, they looked for a local partner in Helix, now known as MedStar, which began in Baltimore with 5 Baltimore beltway hospitals, National Rehab, and Washington Hospital Center. We were their first academic partner and had 450 full-time faculty. They were a not-for-profit, values-based organization that had, at the time, one other Catholic hospital, Good Samaritan, that went through the church approval process. MedStar respected the fact that this would still be a Catholic hospital and agreed to respect the Catholic social directives.

Almost immediately, the hospital operated more proficiently and efficiently with motivated, good-quality care. One advantage was that if you negotiate with an integrated system that's 26% of the mid-Atlantic, the contracts get better immediately! But they also understood painful decisions. For example, when Dr. Joy Drass, an alumna, came to run the hospital, she made the tough, but financially smart, decision that Georgetown close its cardiac surgery department due to the much larger programs at Union Memorial and Washington Hospital Center. It was shortly after I came to the job. [It was on] the day the [Liaison Committee on Medical Education] came to review our school. I remember it on the news: "Hospital that does the first artificial valve closes cardiac surgery."² It was painful, but I do think it was the right decision.

The partnership has been lasting: Although perhaps not the biggest program, one of my favorites is requiring an individual scholarly project for each student (Dr. Joe Timpone has been a co-conspirator). We recently reached 10 years

with this program. When we started scratching for some money to give summer stipends, our partners at MedStar Health Research Institute matched us. Now we usually get just about everyone who applies funded either for a Dean or MedStar stipend (about 30% of the class). Someone once asked if I was trying to crest a research school; my response was that I want to create intellectually curious men and women.

Recently, the university signed a new 50-year agreement guaranteeing a new critical care tower—30 new ORs, new ER, new parking, 156 new critical care beds, and a helipad on top. So, I think that quality care is a priority with the Georgetown and MedStar partnership. It has delivered my now 26-year-old twins and taken care of them, my wife, and myself when we're sick. This has been home.

ON LEAVING THE POSITION OF DEAN OF MEDICAL EDUCATION

I've had the job I love to do, a wonderful job, for 20 years. Would this have been my timing to step away? It may not have been. When Don Knowlan heard the news, he called me. You may recall Dr. Knowlan was the [Washington] Redskins' physician for many years. He said, "Eh, you know what they say: Hey, Coach! You won the pennant, but you've been here 10 years so you still need to go!" That was Knowlan; he said it was okay. Nancy Harazduk, director of mind-body medicine, came to see how I was doing, and her advice was, "You have no idea what God has for you to do now." I also think of Dr. Harvey, who was always gracious and grateful, which I've tried to be.

I'll look at other jobs, but importantly, I'm staying here for now. Dr. Bruce Luxon, the chair of medicine, has been gracious enough to give me my old office when I was program director 25 years ago. I'll leave the light on and the door open across the way, on the fifth floor of PHC.

ON HIS FUTURE PLANS WITH GEORGETOWN

I'm not ready to retire, and I'm grateful to the University for the best 20-year job anybody could have. I mean, think about it! Where else could you be the headmaster at Hogwarts?

I think that what I'll try to do is take that Harvey Center where it should be. I want to serve my time delivering on my promise to Dr. Harvey. We need to be better at bedside teaching!

I'm spending time now with some dear friends up at Hopkins doing more of this. They're doing OSCE's (Objective Structured Clinical Examination) with real patients for residents with 2 faculty in the room. We're going to want to do that with residents, but more so with medical students. Another thing I want to make sure we're doing a better job of is the transition from undergraduate medical education to resident. But if God whacks me over the head with any opportunity, I'm open to it!

ON HIS SUCCESSOR

What do I want from the person who lives in this office? I really want somebody who loves the place, who says there's more work to do. Where should we be? I don't think we've ever stopped thinking about that. I know we just changed the curriculum, but we need to do more. The Journey's curriculum, we're in the third year, and now the first-year students are saying, "Well, this is pretty cool!" For the first group, the class of 2021, it was bumpy! Change is always bumpy, so I would want someone to love it here, someone who loves and who cares deeply for the students.

This is probably not the office that needs the Nobel Laureate researcher, but it does need the Golden Orchard kind of teacher who says, "What can we do to make your life better?" There are good people out there who would love this job. Here's my bias: Are there good people out there who are alumni? Who know the place and know the tradition?

ON IMPROVING MEDICAL EDUCATION

Over the last 3 years, we have seen student debt come down slowly, but it's still too expensive. Recently, as you can imagine, I had an inbox that was bulging with people saying, "Did you see this with [New York University] going tuition-free?" We've done a lot of work to increase the amount of endowed scholarships, and we've started to see the curve bend. But what would it cost to go tuition-free? I don't know.

Are we doing enough with technology in education? We could try partnering again with MedStar; SiTEL has an incredible simulation center. We have some little pilots in virtual reality that teach empathy. You can have Alzheimer's in a VR setting. You can have macular degeneration in a virtual setting.

What should we be doing to increase resilience? We've worked on mistreatment, but the truth is it's not just the mean residents beating up our poor students, but the poor residents are getting beat up too. And so again, having the commitment from the top of MedStar, it's much better, but it's got to go farther.

The treasure to me has been the relationships with you and with your classmates. It's just a treasure! And I think as long as people value those relationships and understand that, we will be great. Thank you to all the students who have made this a great journey. I want us to always make sure we're not resting on our laurels. I have more work to do here, but it's going to be fun.

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