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Dr. Forsyth is the Onsite Medical Director of Radiology at Washington Adventist Hospital (WAH), a 252-bed acute-care facility located in Takoma Park, Maryland just outside of Washington, D.C. He specializes in Interventional Radiology and Nuclear Medicine, and he is board certified by the American Board of Radiology. Dr. Forsyth joined Radisphere to work at Adventist in 2011.

Why did you choose radiology?

With the merger of computers and medicine in the late 70s and early 80s, I saw radiology as the "next big thing" during medical school. Radiology started to hit on all cylinders with the first CT scanner prototypes built by EMI, the company that had signed the Beatles. The original images from these machines were little dots on a piece of paper that had a number. We had one of the first scanners in Denver, where I did my radiology residency. The patient placed their head into a balloon-type apparatus, and the images came out on Polaroid film arranged in a 64 x 64 matrix.

It was an exciting time to be there because the industry was transforming. It was intriguing to see the potential radiology held as a diagnostic tool, and there was strong demand to find better ways to determine and assess the internal workings of patients.

Why the focus on Interventional Radiology (IR)?

In 1977, a German-born physician Andreas Gruentzig did the first balloon angioplasty procedure on a coronary artery in Zurich, and I quickly became captivated by IR. Dr. Gruentzig was doing fascinating work *treating* disorders – not just *diagnosing* them. Until then, surgery was the only option for patients. Then we began using non-surgical procedures.

As these new IR procedures developed, surgeons started coming to us. It started with diagnostic interventions; we put catheters inside of arteries and then injected contrast to determine whether an artery was ruptured or narrowed or had cancer. After that, the therapeutic side of the equation began to develop. Once we were inside an artery, we could do things such as stopping bleeds, so I started doing embolizations as a resident using gel foam. I also did one of the first angioplasties in Dallas after Dr. Gruentzig developed the technology.

Do you have a favorite part of radiology?

My favorite part is the diversity of it all. The fact that I am in a hospital of this size and can read a CT one minute and a mammogram the next, and then do an arteriogram or a simple biopsy or an abscess drain all in one day is just great.

We had a case recently where a woman was bleeding to death – she had an artery leaking in her duodenum. It was a fascinating case that I presented to the medical staff – we embolized her in 30 minutes and she went home a couple hours later. That was pretty satisfying.

When it comes to IR, another interesting aspect is the consultative role I find myself in more and more with referring physicians. They ask for things based on what they think are appropriate. In the initial stages, they want to know if you can do what you say you can do—is your complication rate low and your success rate high. This approach enables me to build rapport and patient volumes.

Once I develop a relationship with them, it becomes easier for us to jump from the question to the solution more effectively. Once they find out what I can do, it has just grown. I am doing bone biopsies for the oncologists, breast biopsies, and I recently did a 4-vessel arteriogram for the neurologists, which helps them diagnose disorders like aneurisms or vasculitis. We also started doing kyphohplasty to help patients with collapsed vertebrae. These kinds of procedures are more fun than video games.

Why did you choose to join Radisphere, working onsite at WAH?

Joining Radisphere was the tallest ladder that I could find to climb. It was a great opportunity for me to blaze a new trail. I wanted to go somewhere where I can make something happen and surprise people.

Furthermore, Radisphere's radiology delivery model is superior. Its effective use of technology allows the model to work. Having an onsite "boots-on-the-ground" radiologist supported by a large group of remote subspecialists available to diagnose unusual problems within their expertise is a model that I had never seen before. Again, as early in my career, I have a good sense of when to get in "on the ground floor" of an excellent opportunity, and I think Radisphere is at the forefront of a new standard in radiology that will directly benefit patients, the hospitals we serve, and the greater healthcare system.

The model also provides me with the support I need so I can continually surprise people with the IR work we can do at WAH. I feel quite fortunate to be here doing what I am doing. I do unusual, interesting stuff every day. It is quite a blessing. Nurses who transfer into radiology are amazed to see what we do down in radiology. They come here and walk around for weeks with their eyes wide open. It's quite enlightening for them to see what's going on here in the basement.

What is your greatest professional accomplishment?

In 1993, Johnson & Johnson chose a group of 100 physicians to be the first in the country to introduce stents, and I was one of those physicians chosen. That was a wonderful moment – to be recognized as an innovator and to pioneer the use of a promising technology. It was like getting a "good housekeeping seal of approval" from the leading medical company. My mother was quite proud.

What do you want referring physicians to know about you?

That it is all about *their* patients. I want them to know they can count on me and that I am available. I never say no. And I will partner with them and take a leadership role.

The working relationship I have with the surgeons at WAH is vitally important to me. I try to be "Ed McMahon" to our surgeons. It many instances, it is their show, and I want to support them by working hand-in-glove and taking a problem-solving approach.

One example is dealing with GI bleeders. Rather than a surgeon doing exploratory surgery to find the bleed, it can be better for the patient to go with IR. They may not know where a patient is bleeding and we can embolize the bleed, which can be a permanent fix vs. having major exploratory – and invasive – surgery. It is a standard of care issue, and the surgeons want us involved if that is the most appropriate course of action for the patient. Radiology gets all of the "brisk bleeders" because we can localize and embolize them. And if a surgeon needs to get involved, we can provide a better roadmap for them prior to operating on the patient.

How do you see radiology developing in the next 5 years?

I think we are at the end of the golden age of development but more can be done in terms of service. There has been an explosion of toys, technologies and cures, and we now have to do more to help patients non-invasively. We need to focus on implementing new developments and making them work in the new patient-centered environment.

What would you want patients to know about you and radiology?

I care about them, I can help them, and it is unlikely that I am going to make it worse – do no harm. I want to keep my complication rate at less than 1%. I think you need to have those kinds of numbers to be successful at this kind of hospital. I want to help patients avoid operations (if feasible), feel better, and go home as soon as possible.

What is your most memorable/favorite moment as a radiologist?

I had a patient in Georgia with life-threatening issues that I was fortunately able to fix with IR. What I did not know at the time was that her father was a pretty well-known firefighter in New York and had just written a book about 9/11. Out of the blue, he came to my office and brought a signed copy of his book. He told me that he had dedicated the book to me because I saved the life of his daughter. It was an emotional moment for both of us.

That encapsulates why I do what I do: I want my patients to feel better and go home tomorrow to be with their families.