Baharak “Baha” Moshiree, MD, MSCI, on a Clinical and Research Career in GI Motility

By Jill Gaidos, MD, FACP

Between scientific sessions, Dr. Moshiree and I took a few minutes to sit outside, enjoy some San Diego sunshine, and talk about her career in motility and functional bowel disorders with the sounds of the San Diego Padres game in the background.

**What led to your interest in caring for patients with GI dysmotility and functional bowel diseases and then studying these disorders in your research?**

**BM:** I was interested in motility and functional bowel diseases when I was a third-year medical student and started rounding with Dr. Nick Verne while at the University of Florida (UF). Once I started residency at Medical College of Virginia/Virginia Commonwealth University (MCV), though, I changed my mind for a short period and felt that pulmonology was a better career move. Then later again I changed my mind mostly as I felt I really wanted to take care of patients with chronic illnesses and in the clinic setting, and from my limited intensive care unit experience, that seemed to not be the case as an inpatient. I was excited when I got recruited back to UF for a GI fellowship with the same folks who had mentored me as a student. During my fellowship, I was on the National Institutes of Health (NIH) T32 grant, and that really helped solidify my interest in motility disorders, as I did a motility continuity clinic and had the opportunity to do physiologic testing in the laboratory, including rectal barostat studies and functional MRI testing in patients with irritable bowel syndrome for research purposes. I felt the physiologic testing was very helpful in diagnosing these patients. And, I got to see what great diagnosticians people who do motility are because they not only have to tease out symptoms but they also have to see, based on the physiologic studies, what is actually a motility disorder or what is a functional bowel disorder. And, there is a lot of psychiatry/psychology involved in taking care of these patients, which I really appreciated because you have to think of the patient’s quality of life, think of psychosocial factors, think of what is happening at home, other stressors, work, etc. You have to be somebody who is very detail-oriented, and I felt that really fit in with my personality. Also, there were not very many women in that field. I felt like this is something that is much more common in women—4:1 female to male ratio for most functional bowel diseases—so, I felt as a female, I may have more to contribute to the field.

**What additional training within the GI fellowship do you recommend to fellows who are interested in specializing in this area? Can you get this training in a three-year fellowship or do you need more focused training?**

**BM:** We do not have a fourth-year fellowship, like an inflammatory bowel disease (IBD) or advanced endoscopy fellowship, but through the American Neurogastroenterology and Motility Society (ANMS) and through The Rome Foundation there are both training programs and visiting professorships that fellows in their first three years can go to for rotations in these centers of excellence that will teach them motility testing and clinical care of patients with motility disorders. If they are lucky enough to have someone who has expertise in motility at their own institution, I think a time frame—about six months—where they are really in motility...
clinics, they see patients with functional bowel diseases, they spend time with the nurse who does the motility testing, they actually do the tests, they actually learn how to mark for reading of the tests, and they go to the ANMS meetings—they can become proficient. I think that is sufficient time. The ANMS has put in for training programs the number of required procedures—like anorectal motility, esophageal high-resolution manometry, impedance testing, etc.—associated with them. I have actually successfully trained four fellows who have gone on to have a practice in motility: two in private practice and two in academics—one who will start an academic position at the University of Pittsburgh this year and another who is in Seattle. Mike Kingsley, my fellow going to Pittsburgh, has done six months of formal clinical training with me since I am the only motility person at the University of Miami (UM). He did all of my clinics and is spending time in the lab. When I am away, he actually reads the studies and I get to test to see if he read them correctly. I am away, he actually reads the studies and is spending time in the lab. When I trained, I spent a year in the motility lab, but that was before the time of high-resolution manometry. I think with the previous testing, it was a little bit tougher to perform and read the tests, and we had antroduodenal manometry as well, which can be more complicated. One reason why a motility fellowship does not exist is because there are only a handful of academic programs that have more than one faculty member with expertise and time to train.

Do you see the number of people in motility going up? I feel like there are not a lot of gastroenterologists interested in motility, but not enough even in academic centers. So, if fellows are not exposed to that in fellowship, then that is not something that they are even going to know that they may be interested in.

BM: Since motility disorders and functional syndromes are the most common disorders seen by gastroenterologists, all fellows should be adequately trained for at least level I training. This is unfortunately still not possible in many programs. I think it is the opposite effect with advanced endoscopy. Advanced endoscopy has seen a huge rise in interested fellows because they like procedures and they like to scope. There are still a fair number of procedures in motility, depending on what you do. If you are an esophagologist, there are a bunch of procedures such as dilations, stent placement, Stretta for reflux, procedures to treat Barrett’s esophagus, etc. But I do not think they would see the more complex cases unless they are in a program that has somebody who specializes in motility as well. For our fellows, it usually takes them to the second year, by the mid-second year they start to realize either they want to do motility or they do not. But they have to be exposed. Otherwise, they can go to meetings, and they do not really get a sense of what the patient profile you are going to see in clinics maybe and may assume our patients are just complainers and have no pathology. It is once they do clinic that they get to see we really can impact their lives and reach a diagnosis that the patient will be satisfied with. But, in private practice, they are going to see a lot of patients with functional bowel disorders. Unfortunately, though, there are not enough of us who want this as an academic career, which is good job security.

Do you think this will eventually become a fourth-year fellowship?

BM: I think in the future, with the expansion of all the different areas, like esophagology, gastroparesis, the functional bowel disorders, and anorectal disorder treatments with sacral stimulators, there will be different pathways. I think eventually it will be. But at this time, we do not even have enough people to teach the young. If you do not have enough trainers, then you will not have trainees.

You got a Master of Science in clinical investigation while you were on junior faculty at UF. How did this progress your career? How did it help you?

BM: Well, it helped in two ways. One of the ways it helped me was that I did not have formal grant writing or statistical support prior to this, and all those things that I needed, and it was all provided during the masters course. We actually had to write grants, talk to a statistician, and take courses which trained us on research. The other part that was nice was I actually had time during those classroom months to write grants. Because, oftentimes for junior faculty nowadays it is very hard to get that protected time. With hospitals going more RVU-based, taking more of a clinical stance than an academic stance, unfortunately—which is happening
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supported by Drs. Phillip P. Toskes and James E. McGuigan—both prior Chairs of Medicine at UF and wonderful mentors. Still, I did not have anyone else in motility. I also lacked mentorship where I moved to—Miami—but my decision was solely based on wanting to be in Florida, close to where I wanted to be as far as location and proximity to family and friends. The other plus was having Dr. Maria T. Abreu as my boss, who is not only an international expert in IBD but also gave me continued protected research time. I have seen that as you build programs, especially ones in motility, you get busier and busier clinically, and this eats away at your research time. The decision was just to continue protected research time and be able to advance my own career.

In June 2015, you were presented with the Chester Cassel Endowed Chair in Gastroenterology. What does that mean overall, and what does that mean for your career?

BM: There is a change now from mentorship in many universities to sponsorship instead. And you can take sponsorship in different ways. Sponsorship could be money that you are given by donors, which are often patients’ family members. This happens to be a well-known gastroenterologist in Miami who was really well respected, Dr. Chester Cassel. This donation to UM was from his two daughters, who wanted to foster the career of a young faculty member interested in motility disorders. This endowment ideally helps with funding for research proposals, educational funds, if you want to sponsor one of your fellows to go to a meeting, coordinator salary, and other things that are so much harder since we are no longer permitted to directly use pharmaceutical money in universities. And, in places where you do not have the mentorship, you can actually use the money to travel to go learn about a new device or a new project, or meet with mentors away from your institution if need be.

Does this also provide additional salary support?

BM: Perhaps. That is what I have been told.

Does that cover your protected time?

BM: It covers my protected time and at the same time provides some educational funds and research money that I can use for grants.

So, it is a sum and then they tell you what you can use it for?

BM: The dean’s office tells me. Which portion is salary versus grants/funds seems to change yearly.

Depending on your productivity?

BM: Depending on the dean, the needs of the university, and the needs of the institution.

I read that you go on medical mission trips with medical students each year, including trips to Nicaragua, Peru, Dominican Republic and Haiti. How did you get involved with these trips?

BM: I teach the GI physiology modules for the medical students, the second-year class. It is a six-month period course for the MD/MPH and MD students. I got to know some of the medical students, and they needed a faculty sponsor that just goes with them to the trips and who can represent UM. They needed a sponsor to go with them. So, I volunteered, and we go with a group of 80 students.

80 students?

BM: Eighty medical students, yes. We set up camp in Managua, Nicaragua. We mainly get to see primary care type of patients, but there are some specialty physicians who come as well. We have ER physicians, trauma surgeons, dentists come. So we do prophylactic stuff, preventative check-ups, fluoride treatments, but mostly we do blood pressure checks and diabetes monitoring. We want to eventually set up flexible sigmoidoscopies and maybe upper
endoscopies without sedation—because they actually have a facility for that—so that is something we want to do in the future. It is a very good learning experience for the medical students and allows them to have hands-on training. They do that during their spring break. We have started to do research projects through it now. It is just a hassle going through the institutional review board approval in both countries can be very tough. But, we have looked at doing H. pylori testing for these patients, with the finger stick, the CLO testing, to test and treat those patients. The students find it more fun for them because they are doing a diagnostic test and are going to make a change based on the results.

**Do you do stool cards?**

**BM:** We do stool cards. Not FIT yet; FIT is too expensive. But we do hemoccult.

**It would be nice if you could follow that up and identify those with positive tests.**  

**BM:** Every three months a group from a different university from Florida goes to the same facility. So they do get this follow-up, and the same patients are supposed to come back. They have a system where they keep tabs on where the patients come from and their address, so they can follow up.

**What are some of the most memorable moments from one of these trips? Any particular patients that you remember?**

**BM:** The most memorable is seeing the patients that come in with atrial fibrillation and going over the risk factors and the EKG with the students, hearing murmurs, or the patients that are very ill and need to be taken to the hospital. The patients who come in with very visible tumors, such as some with neck tumors they admit they had not noticed before, are also memorable. Or when you see a medical student who is so compassionate and is trying their best for an hour and a half doing a full physical exam, but they miss the big picture and an obvious diagnosis. I think that is memorable because it is a good teaching experience for them. My dad came with me on one of the trips and that was really nice. He is a pediatrician and does primary care now in Jacksonville, FL. Not only is he an amazing physician but he is very old school, which is perfect for that setting. His manner of taking care of these patients and taking such a full history and doing a very thorough physical exam was so different than many of us who are trained in the age of such advanced technologies, EMR and algorithm-based diagnoses. And the latter approach does not work on these mission trips. Whereas we may feel a bit paralyzed in a third-world country without access to these technologies, he felt right at home and very confident in his care. Also memorable was seeing patients with psychiatric disorders that come in with depression, but really have nothing else wrong with them despite complaints of a host of pain syndromes.

**How do you make time for yourself?**

**BM:** So, that is the hard part, right. It is always a struggle between all the commitments that you have made, all the things that you have said “yes” to, the review articles, the papers that you have unsubmitted, editing, speaking engagements, teaching, etc. As I come to Digestive Disease Week, I meet some of these people that I know I have told, “Yes, that paper will be in next month,” and it is not yet done—I’m overwhelmed. But you really have to take time away from these duties nowadays. It is part of this mindfulness, stress reduction, that I think is really popular now, for valid reasons because we are in such a tech-happy world and everything is gadgets, interruptions are frequent, and we really need time to ourselves. So, I do it by exercising, that is how I get my stress out. That is the only thing I really take time out for and which I am protective of since I do not have kids or a spouse. I have tried to minimize the amount of people I socialize with because, unfortunately, I do not have time. You have to know what is important to you and not finish things if you cannot finish them on time, and as I get older time gets shorter and shorter. If it is something that is important to you from a social aspect, then do it. But you really cannot do everything. There is always something that is going to be late, disorganized or not done at all. You have to just cope and come to terms with realizing that is okay. As long as your patients are taken care of, these other important duties are going to have to wait. I am still trying to come to terms with the guilt of that latter reality. I try to help my fellows, especially the females with kids/family, etc., to stop apologizing for having family commitments get in the way of their work deadlines.

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