

# RESUSCITATOR

WAYNE STATE UNIVERSITY  
SCHOOL OF MEDICINE  
DEPARTMENT OF EMERGENCY MEDICINE

VOLUME 2, ISSUE 1

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## SPECIAL POINTS OF INTEREST:

**Resident Retreat**  
July 21-22, 2010

**Critical Care Conference**  
Traverse City, Michigan  
August 29-Sep 1, 2010

**ACEP Scientific Assembly**  
Las Vegas, Nevada  
Sep 28-Oct 1, 2010

## LETTER FROM THE CHAIR

### Assessment of the Practice of Emergency Medicine

A few months ago, my Chair's letter to you included an analysis of the most pressing challenges and rewards that academic emergency physicians will encounter in the next decade. In this issue, I want to expand on one important area, Maintenance of Certification (MOC)®. In an era of increasing medical complexity and movement toward improved healthcare quality, MOC has been designed to address the desire for greater public accountability in the practice of medicine. MOC is a commitment to continuous improvement, leading to new opportunities for providing better care.

Since 1999, the American Board of Medical Specialties (ABMS) and the Accreditation Council for Graduate Medical Education (ACGME) have required that six core competencies for quality patient care be adopted by training programs and by ABMS member boards: patient care, medical knowledge, interpersonal and communication skills, professionalism, systems-based practice and practice-based learning and improvement. The ABMS guides the MOC process for its 24 Member Boards (including the American Board of Emergency Medicine) with a four-part process for continuous learning. Part I, Professional Standing, requires medical specialists to hold a valid, unrestricted medical license in at least one state or

jurisdiction in the United States, its territories or Canada. Part II, Lifelong Learning and Self-Assessment, requires participation in educational and self-assessment programs that meet specialty-specific standards. Part III, Cognitive Expertise, requires physicians to demonstrate, through formalized secure examination, that they have the fundamental, practice-related and practice environment-related knowledge to provide quality care in their specialty. Finally, in Part IV, Practice Performance Assessment, requires diplomates to evaluate and improve their clinical practice according to specialty-specific standards for patient care. They are asked to demonstrate that they can assess the quality of care they provide compared to peers and national benchmarks and then apply the best evidence or consensus recommendations to improve that care using follow-up assessments.

I have spent a great deal of time thinking about Part IV of MOC, Assessment of Practice Performance (APP). I was compelled to do so during my recent tenure as Chair of the ABMS Medical Toxicology Subboard when our team launched LLSA and developed an APP program for the subspecialty. I view APP as the most challenging step in MOC. It is specifically intended to address the competencies of patient care, interpersonal/communication skills, professionalism, and practice-based learning. These are competencies that cannot be



Suzanne R. White, MD, Chair

easily assessed by a written examination. Now, with a pretty clear understanding of the complexities involved at the subspecialty level, I have recently been contemplating what APP means for each individual faculty member.

APP for emergency medicine became effective January 1, 2010. It is required for any emergency physician who plans to remain clinically active. **It is now upon us.** In fact, some of our faculty will need to begin APP in 2010-2011, if they plan to take the ABEM ConCert (recertification) examination in 2013. The mandated steps for APP include studying one's own practice, comparing one's practice to national standards/peers, determining areas where change is needed, instituting a plan for change, and re-measuring practice improvement. Simple inclusion of individual faculty members in global databases such as PQRI, core measures, or trauma registries is not sufficient. The APP process must be completed twice during each MOC ten-year cycle.

(continued on page 4)

## RED SHOE DIARIES

It is a tremendous pleasure to publish this edition of the Resuscitator and to write this editorial after the scare and ordeal of a lifetime. On February 20<sup>th</sup>, as I was leaving Detroit Receiving after a moderately busy, but not particularly stressful shift, my life changed forever. I suffered a large hypertensive intraparenchymal hemorrhage! It is not my desire to go into great detail about the experience or to elicit sympathy from you, gentle readers. I'll save that for the movie! My purpose in writing this editorial is to remind us all how easy it is to ignore the symptoms of illness in ourselves and to live in blissful ignorance while we dutifully care for our patients.

It is a well known concept in the legal profession that "A man who acts as his own attorney has a fool for a client." How often, however, do we act as our own physician and what hubris leads us to believe that we can be any more objective or successful in doing so? The problem is that we simply can't be objective when looking at (or overlooking) our own symptoms and medical needs. In the course of our educational journey most of us develop a fairly generous sized ego. We are not arrogant or obnoxious, but we are used to being right almost all of the time—or behaving as if we are. Our grades tell us that we are in the top 1 or 2 percent of the country academically. We have chosen a specialty that is both physically and intellectually challenging. During the course of our residency training, as well as our experiences as junior staff, we learn to make time-dependent, complicated and

critical decisions daily—usually with limited data and quite often simultaneously on multiple patients. If this were not enough, we are expected to do so with a veneer of calm and confidence no matter what the situation! It is no wonder that we become a little cocky and buy into the idea that we are able to make judgments regarding our own health. "I run 5 miles a day, that pain is just from my rotator cuff that I must have hurt playing ball." "That tenesmus and hematochezia is just from hemorrhoids." "This headache is just another migraine." There is no way we would ignore these symptoms from a patient, yet in ourselves we often rationalize and minimize them. We tell ourselves that if these silly little symptoms were truly something important, WE would know. "Coronary symptoms are much more severe and I couldn't run through the pain." "This headache feels pretty much like migraines." "Really, it's just hemorrhoids."

Even more insidiously, if we have some minor complaint, we are surrounded by our friends and colleagues who are more than happy to do us the favor of writing a prescription for an antibiotic, allergy medication or performing some small procedure for us. Therefore, we never really feel the need to see a health care provider for a routine visit at all. Somehow we feel that the recommendations regarding well-patient visits don't apply to us, or we are too busy or too young.

I had a number of opportunities to have possibly averted my stroke.

Four years ago I was attending a school function for one of my children and realized that the father of one of my son's friends was an Internist who had trained at the DMC. He had been a chief resident when I was a medical student and satisfied one of my only criteria in selecting a doctor—he was smarter than me! (He was also an excellent doctor.) In the course of our conversation I confirmed that he was taking new patients, got his business card, and assured him that I would see him soon. The next time I saw him was after I was discharged from the Rehabilitation Institute of Michigan for follow up of my previously undiagnosed hypertension that precipitated my intracerebral bleed. On the rare occasions in which I had my blood pressure checked, such as insurance physicals, it was always a "little high", but not too bad. I never had any symptoms so I attributed it to too much caffeine or "white coat syndrome". Once again, if there were actually anything wrong with me I would surely know it.

Another example in which I should have learned that a physician cannot treat him or herself due to a lack of objectivity or perhaps rationalization was my experience with cervical radiculopathy last year. I didn't notice the 3/5 abduction weakness because my trapezius was compensating and I kept ignoring the intermittent numbness in my thumb, which I attributed to my watch being too tight. After my treatment I told several colleagues about my experience and how it showed that we can't be our



Philip A. Lewalski, MD  
Clinical Associate Professor  
Editor-in-Chief

**During the course of our residency training as well as our experiences as junior staff, we learn to make time-dependent, complicated and critical decisions daily...**

own physician due to a lack of objectivity in looking at our own symptoms. I even silently vowed to get a routine physical soon, but again I missed the opportunity.

Even as my stroke symptoms began, I found myself trying to rationalize them. As I bent over to put on my shoes I briefly got dizzy. "That was odd." As I was walking down the hall I nearly tripped on my right foot a couple of times. "That was weird, but it can't be anything serious." As I approached my car, I dropped my keys and my right arm was definitely feeling funny. Realization was beginning to set in and yet I still got into my truck

(continued on page 4)

## HELP FOR HAITIANS AT HOME

Renee McCabe-Nicker, RN, former exemplary DRH staff nurse and wife of 1996 DRH Residency graduate and WSUSOM alumnus Dave Nicker, provided care and assistance to victims of the Haiti earthquake in a unique manner.

Renee works at Tampa General Hospital (TGH) which is one of several trauma centers in Florida that has volunteered to treat Haitian victims. The first airplane delivered 9 patients and their families, all of which were burn and orthopedic victims. "The orthopedic injuries were quite extensive and will require multiple follow up procedures due to extensive soft tissue injury and flaps,"

relates Renee. TGH has subsequently received 4 more flights, each containing three or four more patients with even more complicated orthopedic injuries, often complicated by sepsis. The hospital is expecting more in the future with an organization in Miami coordinating services and making sure no single hospital is overwhelmed. In Tampa, local churches are providing assistance to the families of the patients. Fortunately, many of the TGH staff speak French-Creole so there has been no significant difficulties with language barriers. Renee adds, "It has been very smooth for us, lots of warning, and all the services working together

very well as a team." Dave Nicker is an Emergency Physician at Mease Countryside Hospital in nearby Pinellas County, and although they have been on "stand-by" for many nights, they have yet to receive any of the Haitian victims.

Efforts such as those by Renee McCabe-Nicker to help the victims of the Haitian Earthquake (obviously in conjunction with hundreds of other volunteers) demonstrates how far and wide the caring spirit of Wayne State and the Detroit Medical Center extends.

Philip A. Lewalski, MD  
Editor-in-Chief



Renee McCabe-Nicker, RN  
David Nicker, MD

## TRIP SITTERS

*Trip sitter (n.) – One who remains sober while others use drugs. The role of the trip sitter can vary from ensuring physical safety to guiding a person through their drug experience to a third party documentarian and historian*

### Package Insert

Loebcludolol is a new drug for the treatment of hypertension. Take 1 tablet once a week to lower your blood pressure. Time to onset is 1-2 months. Side effects may include high blood pressure, exacerbation of chronic pain, diabetes, headaches, caffeine withdrawal and bad hair. You should stop taking all other medications when taking this. Do not take on an empty stomach but food may decrease the effectiveness. In overdose it has been shown to make you feel spectacular. Changing

altitude while taking this medication has led to tympanic rupture and epistaxis. Patients can treat these themselves provided they are among the few who experience Knowitallism<sup>1</sup>. You will no longer be able to appreciate irony, metaphor, hyperbole, puns, or similes. Your enjoyment of poetry will go down substantially because of this and you will hate your sudden compulsion to correct punctuation. To this point, ee cummings must be avoided. You may get pulled over by Transportation Safety Administration officers more frequently but it will only be because bottles of this medication give you a +10 to charisma. 30% of Caucasian users may experience Sudden Funk Syndrome<sup>2</sup> which, as usual, should be treated with liberal

application of G. Love and Special Sauce. Use of Loebcludolol has been casually associated with Selective Spousal Deafness syndrome as well as the more severe, Spousal Nudity Oblivion<sup>3</sup>. A voucher coupon for couple's therapy is available at no cost to patients. Italians may have trouble with family members as Loebcludolol has been known to decrease the enjoyment of Stallone movies as well as to induce Coppolaphobia. Flowers may look different to you, but it's only because you can now see into the infrared and ultraviolet spectra. If this is a problem for you, report to the Large Hadron Collider at CERN for what we are loosely calling, "therapy".

**The first airplane delivered 9 patients and their families, all of which were burn and orthopedic victims.**

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**RED SHOE DIARIES**

(CONTINUED FROM PAGE 2)

and told myself, "This is NOT happening. I will sit here for five minutes, I will feel fine and I will go home."

My academic achievements and my professional behavior indicate that I, like all of my colleagues, am a fairly smart person, yet if one looks at my track record I look pretty foolish. Unfortunately, I know I'm not the only one. Don't let our

hectic schedule, our pride or our inability to be objective stand in the way of our health. As it turns out, things could have been much worse for me. I could have been on the expressway, or asleep in bed when my symptoms began instead of sitting outside of a stroke center and receiving immediate care. The Rehabilitation world has a much different time frame than the one we

are used to, but my therapists tell me that I am making excellent progress and cognitively everything seems to be normal (for me). Let my experience be a lesson to all of you! Take care of your health and get a primary care provider. I want to see all of you when I come back to work.

Philip A. Lewalski, MD  
Editor-in-Chief

**Don't let our  
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**LETTER FROM THE CHAIR**

(CONTINUED FROM PAGE 1)

While we all understand the importance of continuous personal growth and improvement, how reasonable is it to have over 100 emergency medicine faculty members develop unique practice improvement plans every few years? Is there a more meaningful approach to achieving APP, one that moves us forward together, one that achieves both economy of scale and scope? I believe that there is. As I stated in the prior newsletter, one of my personal goals is to develop a department-wide solution to successful APP.

Currently, I believe that the best solution for our department is to incorporate APP into an area that we have already identified as one with great potential for clinical improvement. Specifically, it would be logical to build on the robust bedside ultrasound training and credentialing processes that have been initiated under Dan Morrison's leadership. Bedside US certainly lends itself to a staged approach to learning

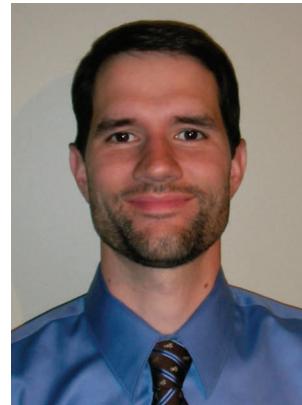
in ways that simply make this a great fit with APP. For those of us with graying hair, bedside US seemed to just magically "appear" one day in our EM practice. Now, our residents and even our medical students have mastered the technical ability to perform scans while many of us "professors" lag behind in our own technical skills. This is unfortunate since bedside US has such enormous potential to impact patient care and patient throughput in ways that are simply unparalleled. As a department, our biggest challenge in this arena has been our inability to develop a simple, efficient method for documenting our scans. I have come to realize that we cannot have a high quality program without appropriate documentation of our scans and without quality oversight.

While I am sad that Dan Morrison is moving on, I am extremely excited that a former alumnus, Leonard Bunting has been recruited as our new WSU Director of ED Ultrasound. Leonard has clearly hit the ground running

and has already made great strides toward finding innovative, simple solutions to documenting bedside scans in ways that will advance our care.

While we are all dedicated physicians and desire to continuously improve our practice, the constraints upon our clinical time seem to be simply overwhelming. As Chair, I believe that one of my most important roles is to provide you with educational opportunities that move us forward together in the patient care arena, that maintain our compliance with professional requirements, and that limit the intrusiveness of such activities upon you as an individual. I hope that you will share mine and Leonard's enthusiasm for building upon our excellence in bedside ED US. I look forward to hearing of your support and answering any questions that you might have.

Suzanne R. White, MD, Chair



Leonard Bunting, MD  
Director of Emergency Medicine UltraSound

## WELCOME EMERGENCY MEDICINE RESIDENTS CLASS OF 2013

**Detroit Receiving Hospital**

**Jeanise Butterfield**, Wayne State University

**Jeffrey Cloyd**, Saint George's University

**Ryan Doss**, Ross University

**Daniel Helzer**, Saint George's University

**Sarah Hyatt**, Ohio State University

**Deepa Japra**, Saba University

**Justin Kessler**, Wayne State University

**Cameron Kyle-Slidell**, Ben-Gurion University

**Deshon Moore**, Wayne State University

**Daniel Paling**, Saint George's University

**Sam Sadler**, Saint George's University

**Kevin Sprague**, Wayne State University

**John Wilburn**, Ross University

**Stefanie Wise**, Wayne State University

**Sinai Grace Hospital**

**Matthew Barrett**, Saint George's University

**Amit Bhambri**, Ross University

**Aaron Brody**, Hadassah University

**Suhas Channappa**, Bangalore College

**Adam Leisey**, Ross University

**Patrick Meloy**, Saint George's University

**Puja Patel**, Saint George's University

**Derek Schaller**, Wayne State University

**Katie Schroeder**, University of Arizona

**Jessica Taylor**, Ross University

**Jamey Walker**, Wayne State University

**David Zodda**, Ross University

**St. John Hospital/Medical Ctr**

**Rhett Brandenburg**, Wayne State University

**Branden Briggs**, Saint George's University

**Lindsay Chisholm**, Saint George's University

**James Kelly**, Wayne State University

**Chad Kovala**, Michigan State University

**Emmanuel Oke**, Saint George's University

**Lyle Patterson**, Saint George's University

**Pankaj Singhal**, Chicago Rosalind Franklin University

**Nastaran Talebiani-Solano**, Ross University

**Jared Zelinski**, Wayne State University

**William Beaumont Hospital**

**Tanja Andrzejewski**, Wayne State University

**Aaron Chen**, University of Illinois

**Leisa Deutsch**, University of North Carolina

**Sameer Draviam**, Northeastern Ohio University

**Evan Green**, University of Colorado

**Sopumya Jayasankar**, University of Illinois

**Stephen Joseph**, University of Toledo

**Robert Kim**, Loma Linda University

**Amy Kule**, Rush University

**Eugene Lee**, Rush University

**Stephanie Post**, Medical College of Wisconsin

**Navpaul Singh**, University of Illinois

**Jessica Triest**, Emory University

**Erica Walters**, Sackler School of Medicine

**TRIP SITTERS** (CONTINUED FROM PAGE 3)

We hope that you enjoy photosynthesis because you will become a human autotroph. You can expect either to travel without moving or become unstuck in time; it's really a coin toss as to which one you will get. Once you solve the paradox of time travel, please let us know so that we can never have invented this drug. Other complications to be aware of include the development of interrogatory hyposandwichemia and

gravidological emptoropathy. May lead to testiculomegally as well as poikilothermia but both of these conditions are transient and should resolve with cessation of the medication. Don't even think about stopping this medication, EVER. Trust us on that one. Loeb ludol may not be right for anyone. Ask your doctor if Loeb ludol is right for you.

Apologies to Steve Martin.

**1.** Simpson L. Skinner's Sense of Snow. 12(8). 2001.

**2.** Brailey J, Clinton G, Collins B. "Tear the Roof off the Sucker (Give Up the Funk)" Casablanca Records. 1975.

**3.** Roberts M, Vandermeer J. *The Thackery T. Lambshead Pocket Guide to Eccentric & Discredited Diseases*. New York: Bantam. 2005. Print

Keenan M. Bora, MD



Keenan M. Bora, MD  
Toxicology Fellow  
2008-2010

## VENTILATOR

**Doing Something By Doing Nothing**

He is going to die by the end of my shift, I think to myself as I examine Mr. Brenner. He was surrounded by his wife of 41 years, a daughter and a son. I knew Mr. Brenner was deathly ill when I saw that he had recently been discharged from the hospital after complications from metastatic prostate cancer. He was diagnosed nearly three years ago. He thought it was in remission, he said, but the cancer showed its ugly face again 6 months ago when Mr. Brenner started having lower back pain. He thought the pain was from years of lifting concrete bags as a construction worker, but discovered it was caused by the collapse of one of his vertebrae.

I peer at Mr. Brenner's vital signs. His heart rate is 125 beats per minute. He is sitting up in bed, his legs covered by a white hospital sheet. His hands grip the bed rails with the last of his strength. A hospital gown covers his chest. His eyes open and close slowly, like he hasn't slept in days. His skin is sweaty and blue, and a mask covers his mouth and nose, forcing oxygen into his lungs. Each breath is a struggle. I listen to his lungs and hear faint sounds of air entering the alveoli. I place my stethoscope on his heart hoping not to hear a friction rub. It sounds normal and I am relieved. I gently press on his distended abdomen attempting to localize an area of tenderness. My Brenner doesn't budge; I can tell he is focused on breathing. I glance at his family; they are silent, waiting for my response.

"Your husband is very sick," I say, directing my message to

Mr. Brenner's wife. "His cancer has spread throughout his body. His breathing is labored and he will not be able to keep it up much longer; eventually his muscles will fatigue and he won't be able to take a breath." "He is going to need a breathing tube," I explain. "This means we would have to sedate him and he will not be able to speak with you." I told her that I didn't think the breathing tube would ever be removed. I move closer and ask her if anyone ever talked to her about what she would like to do if he ever got to this point. "No," she replied. I was stunned, considering the advanced nature of Mr. Brenner's cancer. "Well," I said gently, "unfortunately, now is the time."

For the next 45 minutes, I discussed the options the Brenner family had. Some families choose to take a very aggressive route, I explained, the "do everything" choice. And some understand that the end has arrived and try to make their loved one as comfortable as possible and be at his or her bedside in the final moments. I tried to be unbiased. I felt the most important thing was to be truthful. I've had this conversation before, but not often enough to make it routine. I am by no means an expert at end-of life care.

The family asks me how long he has to live. I tell them he is very sick and will likely die within a few hours if he is not intubated. "And if he is intubated?" they ask. "Well, I cannot say for sure," I said, "but I don't think he'll ever be able to breathe without the tube." As they think about their choices I start to question myself. Am I doing the right thing? Should I just go ahead and start treating Mr. Brenner aggressively:

intubation, central line, antibiotics, pressors. It is the easy thing to do. Who am I to sway a family into not medically treating their loved one? Am I hastening the death of this man? Have I done something wrong?

After about ten minutes, the Brenners tell me that they do not want any further intervention. They simply want to be at his side, to hold his hand, and tell him they love him. "Please make him comfortable."

It is at this point that I realized I was doing the right thing. Explaining all of the options and scenarios to the Brenner family took time and patience. It is always challenging to tell a family that their loved one is going to die. It is the last thing they want to hear. But being able to talk about it in this situation is crucial. Allowing them to make an informed and comfortable decision greatly improves their last moments together.

Mr. Brenner was admitted to a private room on one of the medical floors in the hospital. His wife, son, and daughter, each grasping an arm rail, wheeled his stretcher through the hallway of the ED towards the elevator. This would be his final journey.

As emergency physicians, we are trained to always intervene, to try and stop death in its tracks. We spend years studying the pathophysiology of disease, perfecting the art of the history and physical exam, and the precise interpretation of laboratory tests. We practice the technical skills needed for life-saving procedures – placing large IV's into veins, tubes into the trachea, and even "cracking" a chest to hold a patients heart in our

hands to give compressions. But I've learned that sometimes we have to let death take its course. This can be the most difficult lesson. We are not being weak or doing the wrong thing; rather we recognize that sometimes the best treatment is to do something by doing nothing.

Adam J. Rosh, MD

As they think  
about their  
choices I start to  
question myself.  
Am I doing the  
right thing?



Adam J. Rosh, MD  
Assistant Professor

## FORMER RESIDENT VOLUNTEERS IN HAITI

I was in Haiti with "Friends of Fort Liberte", a non-profit West Virginia based organization that has been serving the Northeast Haitian town of Ft. Liberte for thirty years. This year, in addition to serving the town of 30,000 people, at least a thousand counted refugees and many more uncounted victims flooded the medical clinic we staffed. Our team consisted of seven physicians, six nurses, two pharmacists, a medical student and fourteen other helpers. Four healthcare workers were from OSU.

Haiti is transitioning from the acute phase to post disaster phase. This time period is riddled with medical problems resulting from displaced populations, poor living conditions, overcrowding, infectious disease epidemics and nutritional deficiencies. The clinic we set up saw a people devastated by just these things. In particularly dire straits were the orphans, often younger than six months, who were suffering from nutritional deficiencies due to a lack of breast milk. In a country where baby formula is scarce and expensive, infants left at the local for-profit hospital were being fed plantains and free water. Vomiting and diarrhea racked their tiny malnourished bodies and well-meaning caretakers brought in their relatives in distress. Diagnosing the babies' hyponatremia was

easy. Providing an alternative source of nutrition was the difficult part.

These babies and others soon became part of our makeshift hospital. Although the clinic was not set up with the intention of having inpatients, we soon collected an entire ward of patients that arrived daily at our doors at 7am and left only to sleep at night. Lack of space meant that these patients often lay on the floor or on boxes with IV's hanging from nails on the wall. One such patient was Gary, a lovely fifteen-year-old refugee of the earthquake whose brother could tell us only that Gary's bullous, desquamating rash and fever had started five days ago in Port au Prince. Involvement of his eyes and oral mucosa had made it impossible for Gary to even sip water and his tiny veins had collapsed. Unable to find an IV site, I decided to use our one central line kit. ("Do you really think you'll be started CVC's?" my FP friend had joked as I packed the kit.) My hand shook a little as I sterilized as much as possible on the creaky table Gary lay on, praying that obliteration of landmarks by the rash and the length of time it had been since I did this on a pediatric patient wouldn't interfere with the line being successful. Miraculously, it went in on the first try and we used it to pour fluids, antibiotics, steroids and antivirals into Gary for the next eight days.

With those medicines and plenty of loving wound care from our nurses, Gary slowly improved. Although not completely well by the time we left, he went from being unable to sip water, to eating three bites of pizza before we left!

Tiny success stories such as this one kept us going through those long days and gave us hope. However, the reality is, two thirds of the economy and one third of the county's population was destroyed when Port au Prince fell. For every victim killed, there is an orphan baby left behind, a family who was supported by a loved one in Port au Prince who is now gone, a business that imported goods from the capital city that is now closed, or a student whose university no longer stands. The ripples of the earthquake are far reaching and the infrastructure of a country on the brink of hurricane season is now gone. The support of OSU and hundreds of other international organizations has been invaluable to Haiti. However, long term, sustainable solutions are needed and as the media's light dies out, the fight for survival has just begun.

Ayesha Khan, MD  
Assistant Clinical Professor  
Department of Emergency Medicine  
Ohio State University  
Wayne State University  
Class of 2008



Ayesha Khan, MD



Our team consisted of seven physicians, six nurses, two pharmacists, a medical student and fourteen other helpers. Four healthcare workers were from OSU.

## CONGRATULATIONS

Jackie and Dan Taylor on the birth of their son, Daniel Jack, born on January 24th.  
Jessica Normile and David Michaelis on the birth of their son, Evan Walter

Michaelis, born on March 15th.  
Lisa and Ryan Phillips on the birth of their daughter, Molly Elizabeth on April 14th.

Jennifer Newby and Leonard Bunting on the birth of their son, Oliver Virden on May 18th.  
Anya and Dan Morrison on the birth of their daughter, Alana May on May 22nd.

Erin and Jeff Janowicz on the birth of their daughter, Kate Riley on July 7th.  
Danielle McGuire and Adam Rosh on the birth of their son, Rhys on July 7th.

## NEW ATTENDING PHYSICIANS

We would like to welcome the following physicians to the Wayne State University Department of Emergency Medicine. We look forward to working with you.

Ciara Barclay-Buchanan, MD will be working at S-G, HUH, and DSH.

Leonard Bunting, MD will be the new Director of Emergency Medicine Ultrasound. Leonard will be providing oversight for the

WSU EM resident ultrasound education and attending credentialing processes.

Paul Chrobak, DO will be working at HUH and DSH.

Zenzile Johnson, MD is working at HUH.

Varsha Mendiratta, MD will be working at S-G, HUH and DSH.

Katie Murinas, MD will be working at S-G, HUH and DSH.

Claire Pearson, MD will be working at DRH, HUH and DSH.

Marjan Siadat, MD will be working at DRH, HUH and DSH.

H. Bindu Vanapalli, MD will begin a Palliative Care Fellowship and will be working at S-G, CHM and DSH.

Brandon Warwick, MD and Jeffrey Bargeon, DO began a two year Toxicology Fellowship.

Congratulations on your decision to join this remarkable team!

## LEGENDS COME HOME

On May 6th, the WSUSOM, Department of Emergency Medicine was pleased to present a series of lectures by four truly legendary figures of our specialty. Drs. Ronald Krome, Brooks Bock, Blaine White and Judith Tintinalli represent the cornerstone of Emergency Medicine and were responsible not only for Wayne State's development into a full academic department, but also for the evolution of Emergency Medicine as a respected player in the halls of academia internationally. The contributions of these four pioneers in the fields of education, research, administration and the improvement of patient care cannot be overstated.

Dr. Krome led the presenters and reminded us from where we have come and how onerous the journey has at times been. (For those who desire more detail about our Department's origins, Ron

Krome wrote an intriguing book entitled 'The Floater's Log' which explores those early days.)

Dr. Bock spoke about the development of Emergency Medicine on the local and national stage, which is always fascinating when the speaker has been instrumental in effecting that change. Although Brooks Bock had retired to Colorado, it was not surprising to learn that he is again active in medicine.

Dr. White's lecture reminded us all why we became physicians in the first place. Those of us who had trained with Blaine White got a little scared when the metabolic pathway slides appeared and we prepared ourselves to feel pretty dumb, but he quickly drove home the crux of his lecture by quoting Dr. Krome. "When in doubt, examine the patient."

Dr. Tintinalli's lecture on the

past, present and future of Emergency Medicine training and practice left the listener excited for the future. Her enthusiasm for medical education was evident by her joy at returning to full time clinical practice after her tenure as chair.

Perhaps the best part of the conference was the question and answer session where each speaker's personality could really shine. It was truly humbling to listen to each lecturer and realize what each has accomplished. Emergency Medicine as we know it today was shaped by these individuals. I count myself very fortunate to have trained under three of these legends.

The contributions of these four pioneers in the fields of education, research, administration and the improvement of patient cannot be overstated.



Philip A. Lewalski, MD  
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"WE ARE COMMITTED TO BEING THE LEADERS..."

KUDOS

Rosemarie Fernandez, MD received the 2010 EM Patient Safety Award Fellowship which comes with a \$75,000 grant.

Robert Welch, MD is co-director of the clinical research coordination center for the WSU CTSA and the clinical translational science project. He has also been promoted to full professor.

Sarkis Kouyoumjian, MD received the 2010 WSUSOM Medicine Staff Award which is presented annually to an outstanding clinical instructor elected by the senior class.

Melissa Barton, MD and Frank McGeorge, MD were featured in the April/May 2010 ACEP Newsmaker regarding their work in Haiti. We are proud of our faculty members who provide disaster assistance, including our DMAT members Robert Dunne, MD, Marc Rosenthal, DO, Howard Klausner, MD and Phyllis Vallee, MD

The following individuals will be recognized for their WSU Years of Service: 10 Years, Gretchen Brownlow, Willie Johnson and Helena Yago; 20 Years: Gloria Daniel, Brian O'Neil, MD and Robert Wahl, MD.

Robert Zalenski, MD, Sinai-Grace Hospital and Seasons Hospital and Palliative Care of Michigan unveiled the State of Michigan's first inpatient hospital care unit in April 2010.

After a decade of service as Division Chief and Medical Director, CHM Emergency Medicine, Stephen Knazik, DO has decided to resume his role as a fulltime ED clinician. Steve has been-and remains-an extraordinary leader.

On April 1, 2010 Children's Hospital of Michigan appointed Prashant Mahajan, MD as Division Chief and Suresh Srinivasan, MD as Medical Director of Emergency Medicine.

Marson Ma, Jr., MD received the 2010 EMRAM Teacher of the Year award.