



# RESUSCITATOR

WAYNE STATE UNIVERSITY  
SCHOOL OF MEDICINE  
DEPARTMENT OF EMERGENCY MEDICINE

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## SPECIAL POINTS OF INTEREST:

**Emergency Medicine Grand Rounds, Every Thursday, Detroit Receiving & Sinai-Grace Hospitals**

**ACEP Scientific Assembly  
October 14-17, 2013**

**DRH/SGH Combined Journal Club  
December 10, 2013  
(Location TBD)**

**DMC Emergency Department Holiday Party,  
December 20, 2013  
MotorCity Casino**

## LETTER FROM THE CHAIR

*New direction inspired by an old sage.*

I am honored to become the third Chair for the Department of Emergency Medicine at WSU-SOM. I attribute my success to the tremendous fortune of being able to stand on the shoulders of giants like Drs. Ronald Krome, Blaine White and Brooks Bock. Although I never agreed with any of them 100%, except for maybe Ron, I now understand each of them better. With the passing of Dr. Krome, Emergency Medicine has lost one of its founding fathers and true visionaries.

For those who did not have the honor of knowing Ron, he was a treasure. Ron was a visionary who truly changed the face of medicine. Ron was a straight to the point, colorfully accented orator and a shrewd negotiator who had a quick wit and when needed a sharp tongue. This was not the person you wished to debate either at the bedside or in conference, although I truly enjoyed the sport. He would defend his people to the hilt. He told me once, "You can say anything you want.....as long as you are right" and "Don't let anyone get to your people directly, make them go through you." Ron was willing to take chances and would buck the system, for all the right reasons. I never told Ron how much he influenced me, but I think he knew, because it was obvious how much I enjoyed his company. After his CABG he handed me a box of Cuban

cigars and told me, "With these cigars, you roll the windows up." Ron had more one-liners than Henny Youngman, in fact I just quoted him the other day stating, "I do not mean this to be demeaning, but I want you to take care of the patient."

***I would like to dedicate my Chairmanship to his spirit, willing to take calculated risks, putting our people first and bucking the system for all the right reasons.***

Ron in particular was able to build much with little. In my chairmanship I will be tasked with the same—with a scheduled cut in funding National Institutes of Health by \$5.4 billion (18.6%) for fiscal year 2014, which is in addition to another \$1.7 billion cut due to sequestration. This would equate into a \$15.3 million cut to research funding at Wayne State University School of Medicine. Furthermore, the WSU-SOM received a \$6 million haircut last year, a \$4 million buzz cut this year, and an expected shave of \$3 million next year. Ouch! You know, there was a time we did research with little to no money. It was dedication, sweat, partnerships and innovation that drove much of my early research. I remember going with Blaine to Meijer to purchase a baking pan, a peg board, a furnace filter and a bathroom mat to make a gel dryer. Pure genius...inspired by fiscal constraints. We are going to need this kind of innovation



Brian J. O'Neil, MD  
Edward S. Thomas Endowed  
Professor & Chair

to make it in today's environment. I am confident that we have the innovation, creativity, and work ethic to be successful.

I am humbled by your unanimous vote to make me your permanent chair and I will strive to make this excellent department even better. I will, as my compass, first do the right thing, take calculated risks, put our people first and buck the system for all the right reasons.

## RED SHOE DIARIES

When I get older, losing my hair  
Many years from now

Will you still be sending me a  
valentine?

Birthday greetings, bottle of  
wine?

As I looked upon the old  
photograph that Dr. Chris  
Heberer forwarded to me, I  
both thanked him and cursed  
him.



[Picture 1] I was thankful  
that he provided me with an  
idea for my editorial article. I  
cursed him, however,  
because he reminded me  
that no matter how old I may  
think I look, I am no longer  
that 20-something stud  
muffin that I still imagine  
myself to be. [Picture 2]



After I got over the initial  
shock and depression and  
after I began to realize that I  
don't **really** look that much  
different after all (no, really!),  
I began to contemplate how  
we—at least we men—view

ourselves. I also began to  
realize that despite loss or  
graying of hair, wrinkles, and  
100 pounds of fat (AND  
MUSCLE!) there are still  
inherent traits that we retain.  
These traits, I believe, are  
why 50 or 60 year old men  
still visualize themselves as  
they looked 30 years earlier—  
despite what their eyes may  
be seeing in the mirror  
(cataracts and macular  
degeneration not  
withstanding).

Men, I believe, age a little  
differently than women—at  
least until the metro-sexual  
era came into being. Sure  
many men may “tweak” their  
hair with either color  
enhancement or thickness  
enhancement (or both), but  
this is not done to ‘improve’  
how we look, but to realign  
the mirror’s image with how  
we **know** we truly look.

(“There must be something  
wrong with this mirror!” “I  
don’t look like that.”) This  
“mirror image dysmorphia” is  
a Y chromosome inherited  
trait and present in >95% of  
men. Look at your fathers,  
sons and brothers. I have  
watched my 17 year old son  
innumerable times as he  
walks down the hallway in  
our house toward a large  
mirror in our foyer. (There is  
always that one special  
mirror in a man’s house that  
he uses to confirm that all is  
right with the world—and his  
reflection.) Even though my  
son is an athlete and in  
excellent condition, his eyes  
go to the mirror and the  
shoulders go back and *the  
stomach draws in*. “There,  
now the **mirror** has it right.  
**This is how I always look.**”  
The problem is, the older we  
get, the more defective the  
mirror becomes. “*What is  
wrong with this stupid  
mirror?*” I believe it has to do  
with glass being a very  
viscous liquid and over 70-80

years mirrors inexorably get  
thicker at the bottle and the  
images sort of ‘sag’.

The theory that came to mind  
as I studied Chris Heberer’s  
photo [Picture 1] is that no  
matter how old we may  
become, certain innate  
mannerisms still remain and  
since we still ‘act’ the same,  
in our limited male brains, we  
must still ‘look’ the same.  
(How else can one explain  
the rich, fat ancient  
billionaire with his trophy  
wife? If he really saw himself  
as rest of the world did, how  
could he face the world with  
a provocatively clad version  
of a granddaughter on his  
arm? Maybe there is another  
male gene that gets  
expressed when a man  
becomes extremely wealthy.  
With my children’s parochial  
school and university bills, I  
don’t have to worry about  
that gene turning on, so I’ll  
leave that research to  
someone rich!)

Getting back to photo 1,  
there is no difficulty in  
picking out Rob Welch. The  
mannerisms are all still the  
same even 30 years later.  
The flannel, the khakis, the  
stance against the wall are  
all still seen today. Sure the  
hair and beard were a little  
darker, but I’m sure in Rob’s  
‘magic mirror’ these are  
barely noticeable.

Scott Freeman is also easily  
recognizable in photo 1. The  
way he is sitting and the red  
suspenders continue into the  
21<sup>st</sup> century. His famous  
smile that can either mean  
“Everything is fine and I really  
like you” or at the same time  
“If you even breathe wrong  
your world will end” is still  
frightening medical students,  
residents and junior faculty to  
this day! I’m not quite sure  
how to factor in the pony tail.

There must have been a



Philip A. Lewalski, M.D.  
Assistant Professor  
Editor-in-Chief



[Picture 3] plasmid that escaped  
from Jonathan Sullivan’s lab.  
Sully had very long hair for  
decades and this genetic mutation  
must be a slowly expressed gene  
that finally infected Freeman and  
me after knowing Sully for  
approximately 15 years. Luckily,  
Sullivan’s lab developed a cure  
and Sully, Freeman and I all cut  
our pony tails a few years ago.  
Scott and I have discussed my  
male aging theory and he sees its  
validity. He has often said that he  
still feels 18. Again, that magic  
mirror allows us to see past any  
imperfections in the reflection (the  
mirror’s fault) and see the same  
smile and mannerisms that have  
been present since our youth.

I must admit, the man in the  
middle of photo 1 took me a  
minute or two to identify, but then  
it came to me. The icy stare with  
just a hint of an impish  
(leprechaun?) grin, mixed with the  
head cocked to one side and the  
overall intensity that radiates from  
this image could be no one other  
than Padraic Sweeney. The fact

(continued on page 3)

## RED SHOE DIARIES ... (CONTINUED FROM PAGE 2)

that he is wearing a tie when others are casual cements the deal! (The early eighties must have been a wild and crazy time in our department because when I first met him in 1987, Pat Sweeny already had 'salt and pepper' hair.) I was going to ask Pat if he agreed with my theory or if he still feels he looks the same as this picture, but the more I looked at his intense, burning gaze, the more afraid I became. I'll just assume he does.



Picture 4 offers more support to my theory. Despite a 'few pounds of muscle' added, I of course look the same. Brian O'Neil must carry the same Irish gene as Sweeny that codes for the intense stare and boyish grin. The Irish must also have a gene for great hair as well! The man in the middle is not Dennis the Menace by the way. He is the father of our toxicology program, Jim Cisek and he hasn't aged either.



Picture 5 is mainly supportive of my theory. The fact that Binesh Patel hasn't changed

at all in 12 years was at first troubling. The answer is in the hair (or lack thereof). The smooth, shiny shaved head look makes age identification difficult. Is he gray? Is he balding? Who knows? Despite a 'few more pounds of muscle' added, I of course look the same. (There is no more fat, just 'loose muscle'.) The 'Cruz stance' is undeniable and hasn't changed since I met him in 1989. Alvan truly hasn't aged at all. (I was a little confused by the big smile, but then I realized that it was 2001 and he was looking forward to eight years of a conservative White House!) I'm sure when Cruz gazes into his magic mirror he sees the same man he did 20+ years ago. The Hedge smile and posture cannot be denied and despite some more 'muscle', he is the same as well. (Luckily for Matt, he has more of the 'firm muscle' and less of the 'loose muscle' than I.) Unfortunately, he must have been recently infected with the latent "Sully long hair plasmid". It is okay Matt, as I'm sure your magic mirror is telling you, your hair is looking good and if you ever change your mind, Sully has the cure! (Either that, or he is getting ready to star in an episode of Duck Dynasty!)

Interestingly, the male trait of seeing ourselves and our friends as looking the same over decades (at least in our minds) is not retrospective. In other words, the 'clock doesn't stop' as it were, until we meet that person. For example, Dr. Schwartz, I am sure, still identifies himself as a young (hair covered??) man, but in my mind he looks the same as when I met him in 1993. I have no ability to see him as a younger man. Odder still, when I first met him, I thought, "Jeez, what an old-timer." (That 'old man' was 5 years younger than

I am now! Ouch, I hate these forced reality checks!) In my mind's eye now, I picture him as a fine 'early' middle-aged man and unchanged in 20 years—just like the rest of us.

Thank you, Dr. Heberer for sending me the photograph that sent me on a bizarre tangent and thank all of you for reading my light hearted treatise on the minds of men. We truly picture ourselves as looking the same as we did at our 'physical peak' and because most men still have the same mannerisms, tastes in clothes and behave like they did in their teens or twenties, there is nothing to break the illusion—except irrefutable visual evidence. Heberer's and my photos can be dangerous therefore, as one should 'never challenge a fixed delusion', so trips down memory lane should be made sparingly. Excessive reality checks can be expensive as that is where little red sports cars, plastic surgery and trophy wives originate!

I do believe that women's minds behave differently than men's (thank God) when it comes to how we envision ourselves through the years, but I cannot hope to understand a women's mind—and I do not dare to try. If one of my female colleagues would like to enlighten me, I welcome an article that explains how they picture themselves as they age. Now if you will excuse me as I suck in my gut, square my shoulders and adjust the hair on the crown of my head, I am about to pass a mirror which will confirm the **fact** that I am still the same 26 year/old awesome specimen that I was, am and always will be...

The early  
eighties must  
have been a wild  
and crazy time  
in our  
department ...

*Give me your answer, fill in  
a form*

*Mine for evermore*

*Will you still need me*

*Will you still feed me*

*When I'm sixty-four?*

[Lennon & McCartney]

Philip A. Lewalski, M.D.  
Editor-in-Chief

## WELCOME EMERGENCY MEDICINE RESIDENTS CLASS OF 2016

**Detroit Receiving Hospital**

**Kevin Belen**, Eastern Virginia Medical School

**Nile Chang**, Case Western Reserve University School of Medicine

**Hannah Ferencick**, Michigan State University College of Human Medicine

**Lauren Holmquist**, Wayne State University School of Medicine

**Derek Kennedy**, Yale University School of Medicine

**Lyudmila Khait**, Michigan State University College of Human Medicine

**Justin Stimac**, Oregon Health & Science University School of Medicine

**Jessie Swan**, Wayne State University School of Medicine

**Sean Teshima-McCormick**, Ohio State University College of Medicine

**Jeffrey Van Laere**, Case Western Reserve University School of Medicine

**David Viau**, Wayne State University School of Medicine

**Henry White**, Northeast Ohio Medical University

**Megan Wolf**, Oregon Health & Science University School of Medicine

**Joseph Wollman**, University of Michigan Medical School

**Sinai Grace Hospital**

**Abdallah Ajani**, Boston University School of Medicine

**Tamara Augustine**, Ross University School of Medicine

**Andrew Berwick**, Wayne State University School of Medicine

**Luke Bisoski**, Wayne State University School of Medicine

**Natalie Eggleton**, Wayne State University School of Medicine

**Steven Irvin**, St. George's University School of Medicine

**Sharmin Kalam**, Wayne State University School of Medicine

**Usama Khalid**, Wayne State University School of Medicine

**Nicholas Morelli**, Wayne State University School of Medicine

**Sameed Shaikh**, Michigan State University College of Human Medicine

**Margeaux Snell**, University of Arizona College of Medicine

**Lindsay Taylor**, St. George's University School of Medicine

**St. John Hospital/Medical Ctr**

**Parag Amin**, Wright State Boonshoft Medical School

**Ashley Bowerman**, St. George's University School of Medicine

**Riley Jakob**, St. George's University School of Medicine

**Trevor Kuston**, Wayne State University School of Medicine

**Marson Ma, III**, Wayne State University School of Medicine

**Fei Lu Ye**, Rosalind Franklin University Chicago Medical School

**Veronica Miles**, Wayne State University School of Medicine

**Ashwin Sabbani**, Wayne State University School of Medicine

**Lindsay Richmond**, Wayne State University School of Medicine

**Andrea Patineau**, University of Minnesota Medical School

**Grant Nelson**, Wayne State University School of Medicine

**Mohamed Moussa**, Wayne State University School of Medicine

## CONGRATULATIONS EMERGENCY MEDICINE CLASS OF 2013

**Detroit Receiving Hospital**

**Jeanise Butterfield, MD**,  
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Srvs, Detroit Receiving,  
Michigan  
**Jeff Cloyd, MD**  
University of Tennessee  
Medical Center, Tennessee  
**Ryan Doss, MD**  
Locum Tenens—Vista,  
Georgia (then New Zealand)  
**Daniel Helzer, MD**  
Medical Center Emergency  
Srvs, Detroit Receiving,  
Michigan  
**Sarah Hyatt, MD**  
Tucson Medical Center,  
Arizona  
**Deepa Japra, MD**  
Staten Island Hospital, New  
York  
**Justin Kessler, MD**  
Medical Center Emergency  
Srvs, Detroit Receiving,  
Michigan  
**Cameron Kyle-Sidell, MD**  
Maimonides Medical Center,  
New York  
**Deshon Moore, MD**  
Advocate South Suburban  
Hospital, Illinois  
**Daniel Paling, MD**  
Emergency Medicine  
Specialists St. John Hospital/  
Med Ctr, Michigan  
**Sam Sadler, MD**  
Locum Tenens, Indiana  
**Kevin Sprague, II, MD**  
Bridgeport Hospital,  
Connecticut  
**John Wilburn, MD**  
Medical Center Emergency  
Srvs, Detroit Receiving,  
Michigan  
**Stephanie Wise, MD**  
Medical Center Emergency  
Srvs, Detroit Receiving,  
Michigan

**Sinai Grace Hospital**

**Amit Bhambri, MD**  
Advocate Health System,  
Illinois  
**Aaron Brody, MD**  
Medical Center Emergency  
Srvs, Sinai-Grace, Michigan  
**Suhas Channappa, MD**  
Marshfield Clinic, Wisconsin  
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Emergency Medical  
Associates, Florida  
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TeamHealth Florida  
**Patrick Meloy, MD**  
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**Puja Patel, MD**  
Medical Center Emergency  
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EmMed, Michigan  
**Katie Schroeder, MD**  
Presence Medical Group,  
Illinois  
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Physicians North Carolina  
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Hackensack Medical Center  
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Specialists St. John  
Providence Hospital, Michigan  
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Providence Hospital, Michigan  
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Emergency Medicine  
Specialists St. John  
Providence Hospital, Michigan  
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Sinai Hospital of Baltimore,  
Maryland  
**Lyle Patterson, MD**  
Halifax Medical Center,  
Florida  
**Lindsay Showers, MD**  
War Memorial Hospital,  
Michigan  
**Pankaj Singhal, MD**  
QuestCare, Texas  
**Nastaran Solano, MD**  
QuestCare, Texas  
**Jared Zelinski, MD**  
Infinity Healthcare, Wisconsin



Emergency Medicine Residents  
Detroit Receiving Hospital  
Class of 2013



Emergency Medicine Residents  
Sinai-Grace Hospital  
Class of 2013



Emergency Medicine Residents  
St. John Hospital & Medical Center  
Class of 2013

## TRIP SITTERS

**THE DOSE MAKES THE POISON**

These words have echoed through my training and my life in general, although I didn't always use those terms. More commonly this expression can refer to the balance we need to strike as clinicians in terms of the risk-benefit ratio we need to address when treating our patients.

Life is pain.

Pain is the fifth vital sign.

Now we need to find the balance.

I would like to use this opportunity to discuss opiate use and hopefully get you to think about your practice and your prescribing patterns. This is an opinion piece and not even expert opinion at that, so grade the evidence as you see fit. As always I would encourage you to seek and read the literature yourself, as your interpretation of the data may be different from my own.

Some background information that is telling of our society. The opiate equivalent of acetaminophen/hydrocodone 500/5mg tablets that are dispensed each year is enough for every man, woman and child in the country to take two tablets every six hours for two weeks. Hydrocodone in combination with acetaminophen is the number one prescribed medication in the country and has been since the mid-1990s—greater than simvastatin, metformin and lisinopril. Patients in the United States consume in excess of 70% of the world's opiates while representing

only about 8% of the world's population. Drug related fatalities currently exceed the number of fatalities related to motor vehicle collisions. What is worse is this overdose epidemic is by our own hand. According to the CDC there were greater than 11,000 prescription opioid overdose deaths—greater than heroin and cocaine combined. We may have a problem. Now that we have admitted that we may have a problem, we can work at correcting the problem. How did this come to be? We have been taught that single opioid prescriptions would not cause addiction. While this was the standard teaching, where did it come from? A retrospective chart review had 60 out of 11,000 exhibiting addictive behaviors, not a great methodology. As a side note, the vast majority of these patients were on low dose opiates, largely codeine and propoxyphene, relatively weak analgesics. These drugs are not even in the same league as the dosing regimens that are currently presenting to our emergency departments. This was followed by a consensus statement from the American Academy of Pain Medicine and the American Pain Society which helped physicians as a group feel comfortable with opioids for chronic and acute pain. When it comes to the evidence to back these statements, there was not much in the way of data at the time to either support or refute their claims other than opiates are effective for treating pain. The JCAHO initiative on pain management pushed our prescribing of opioids onward from that point, again, they will lower pain scales. This may have worked if patients had good continuity of care. Unfortunately that is not our

reality. Our patients frequently lack health insurance and are unable to see a primary care physician. Management of pain, particularly chronic pain is complicated. We certainly don't have large amounts of time to spend, and that primary care provider who is getting pressure from the insurance providers to see more patients and spend less time with them, also is not in a good position to give patient appropriate consulting regarding management of their pain. Additionally, that primary care physician's livelihood depends on his patient satisfaction scores and the pharmaceutical industry is telling him the answer for the patient's pain and his satisfaction score problem is just a little pill. While we can look back and say, "What did they think would happen?", I would hope these policy and prescribing changes were done for the right reasons, although the cynical part of me would like to point out that the consensus statement and the initiative on pain management did come about shortly after Oxycontin was introduced and during an era where spending by the pharmaceutical industry towards physicians was largely unregulated.

Pain is debilitating. Pain is what our patient's are coming to us for help in alleviating, heal the sick...right? These are admirable things and opioids are certainly very effective at treating pain, but what are our goals and what are we trying to accomplish? Should we be trying to achieve a pain score of zero or is decreasing the pain scale by two or three adequate? Are those two or three points enough to give improved function for your patient so they can go about their day to day activities?

(continued on page 10)



Matthew W. Hedge, M.D.  
Assistant Professor

**I would like to use this opportunity to discuss opiate use and hopefully get you to think about your practice and your prescribing patterns.**

## CHIEF CHATTER

### THE THINGS THAT MATTER...

If you've ever worked with Dr. Scott Freeman, you know he's full of classic quotes. One of my favorites is, "We have a great job, don't we?" I agree, we have a sweet job, but have you ever thought about the impact we have? Just yesterday, I sat down with a husband and wife to explain the stroke we had just found on CT, likely the explanation for his loss of vision. Just hours later, the conversation was with another family. Only this time, it was to tell him that his wife of 42 years had just died. Our job puts us in a position to be present for people in their times of great hurt and affords us the chance to make a difference.

You know what's embarrassing, though? Just a few minutes before we had this conversation about the stroke, I was thinking about how I hadn't eaten lunch

yet. Just after my conversation with the husband of 42 years, I caught myself complaining about how slow my voice-recognition program was working. Talk about a loss of perspective! I mean, if I actually noticed these kinds of conversations twice in one day, how many times do I miss them? I'd be willing to bet I am not the only one who spends more time considering my own pesky inconveniences than the pain that I come into contact with routinely.

Maybe we need a shift in our thinking. Consider what we do every day at work. We reduce broken bones, stick 18 gauge IV's in neck veins and check prostates (!). Sometimes our exams or interventions hurt. The news we share to families can be painful in a very different way. It's easy to become numb to what we see, but it is important to keep our

perspective. By this time in our training, we have seen and dealt with so many sticky or sad situations that no one is better prepared to sit down with the people we care for, to look them in the eye, and to tell them news that can be devastating. We do this day in and day out, and though it might be routine to us, it isn't to them.

Now that I think about it, DRAGON dictation isn't so bad, and I'm not going to die if I don't eat right now.

### DRH Chief Resident s

Jeff Cloyd, M.D.  
Deshon Moore, M.D.  
John Wilburn, M.D.  
Stephanie Wise, M.D.



## A PURPLE CRAYON

There are innumerable small moments to call to praise, to call to pause between the gurneys, hustle of EKG machines, volley of nurse between supply room and bedside medical students, residents, interns, various species that pull up the chart while patients moan forth their stories again, the facts checked against the body--s The phone that never stops its conversation the admitting doctors, outside consultants to parlay their problems into an OR and the families who call-- This shop keeps running its

medications its analgesic, antimicrobial, anti whatever patients flow, and at some point there is a hush, a lull when the cleaning crew gets a chance to disinfect, sterilize. And it lasts just enough time, before anything has a chance to dry an ambulance, five minutes before my shift ends, an hour clock that gets to wait to watch, who said time doesn't stand still while a patients is hefted out of the hands of paramedics into the hospital's and like Harold, I crawl with my bald white tumuli towards the ceiling or behind the machines, on

the wall to find a space to draw a door with my purple crayon to the moment when I walk out of those sliding doors greeted by the cars some backing out of the parking lot the pedestrian light turns white to walk.

Shradha Shah, MD  
San Francisco, California  
November 2012  
Class of 2008

...“We have a great job, don't we?” I agree, we have a sweet job, but have you ever thought about the impact we have?

## THE “NEW” CHIEF CHATTER CLASS OF 2014

**“My PCP is [Insert ED Doc’s name]”**

Welcome to another year of living the dream. You are an emergency department doctor, an adrenaline junkie, an “I hope this trauma code is a good one” personality. You live for the chance to get the history first, to throw the chest tube in, for the moment-to-moment life saving decisions based on little to no information, and ultimately, for the war stories.

The ambulance sirens fire you up, even when you aren’t working. When the alert goes off for a code in your ED, your ears perk up, your senses are heightened, and you are ready for it. Is it mine? You can’t wait for it. You thrive on it. You need to be the first in line to see it. The busy night in the ED when everyone is sick suddenly clicks you into a higher gear.

Over the course of your career, you will come to admire the battle-hardened attending physician who rarely seems shaken up by even the scariest of cases in resuscitation. The “sphincter tightening” rapidly expanding hematoma in the neck becomes commonplace and the difficult airway is not an obstacle, but an opportunity to “get the great tube” and live to tell the tale. You eventually marvel at the faculty who can

quote the literature, who know blow-by-blow the most current research developments (and are often on the cusp of developing them), but still live by their clinical gestalt, history, and physical exam techniques...all of which you hope to acquire and refine one day. You secretly gaze in admiration at your favorites. “I’ll be like them one day...”, you quietly say to yourself.

As ED residents, we are here to learn, absorb, and mold our own practice in the likeness of those attendings who most influence us, and with whom we identify. You take from each attending what you hope for in yourself. We did not necessarily choose this profession to manage the mundane, the chronic pain, the ear infection, or the STD check. But we see it—a lot of it.

All too often, our patients here in Detroit do not have a primary care physician. The answer to “Who is your PCP?” occasionally is “Huh?”, “I don’t have one”, “I don’t know”, or even a familiar ED attending’s name. In many cities, they rely on us, the emergency doctor, to answer what may appear to the medical professional to be some of the most basic of health questions, questions that should be addressed by their PCP.

“This isn’t an emergency, sir”. “Why didn’t you follow up like we told you the last time?” Have you heard this in your department? Have you thought or said these things? How do we, as the skydiver, balance the reality of our patient population’s need for the parachute-packer, with the rush of experiencing the free fall that we all live for?

The answer is to keep, or rediscover, your empathy.

Many of the patients in underserved populations such as ours simply do not have access—access to medicines, to medical care, to basic medical knowledge, to the ways to seek a PCP, to the means to seek care. Cultural norms and perceptions that YOU may have are not necessarily that of your patients. You will, we guarantee, at one point or another, feel the need to roll your eyes at the “flu like symptoms” patient.

The goals for your year should be to be patient. Be compassionate. And realize that you are the authority. The one they come to for answers. Try to learn as much as you can, absorb as much as you can, so that you KNOW the answers for them. The 21 year old with chest pain has no one

else to go to, and may have no better example to learn from. This is their emergency, or their perception of an emergency. If they are short with you, it may be because they have no other options. This ED is their safety net. Try to keep your perspective and compassion through your training and your career. Live for the thrill ride, but also be able to temper that ride with providing the ordinary miracles that are disguised as the every-day. You may not ever see a tangible result to know that your extra two minutes of counseling has reached someone, but you will rest easier knowing that you’ve tried. Recognize that you are living the dream, and many would love to be in your shoes.

**DRH Chief Resident s**

Francesca Civitarese, D.O.  
Vit Kraushaar, M.D.  
Kristi Maso, M.D.  
Tim Scott, M.D.

**When the alert goes off for a code in your ED, your ears perk up, your senses are heightened, and you are ready for it.**

**CONGRATULATIONS!**

Ciara (Barclay) and Steve Buchanan are the proud parents of a baby boy, Calder Jackson, born on December 9<sup>th</sup>.

ReneeMary Alexan and James Paxton are the proud parents of a baby girl, Genevieve Bree, born on January 21<sup>st</sup>.

Catherine and Brian Reed are the proud parents of a baby girl, Lydia Miriam, born on March 22<sup>nd</sup>.

Mandy and Marcus Moore are the proud parents of a baby boy, Asher Robert, born on April 22<sup>nd</sup>.

Amy and Duane Robinson are the proud parents of a baby girl, Gabriella Rose, born on June 22<sup>nd</sup>.

**BACK TO BASICS**

The basic science research laboratory in the Wayne State University Department of Emergency Medicine has a long-standing research focus initiated well over 30 years ago by Blaine White, MD. The overarching goal is to understand and develop therapies for cerebral ischemia. Throughout the years, this research group has trained leaders in the field of Emergency Medicine, including our current chair at DMC/ Wayne State, Brian O'Neil and the chair of Emergency Medicine at the University of Michigan, Robert Neumar.

The basic science research lab has changed dramatically throughout the years, but the scientific focus has remained the same; to understand the neurologic damage caused by ischemia and improve the neurologic outcomes of patients who suffer a stroke or are resuscitated from cardiac arrest. Our current research group of Thomas Sanderson, PhD, Rita Kumar, PhD, and Anthony Lagina, MD are continuing this exciting research with a diversified approach. Each member of the research team has developed their own independent, yet highly integrated research program. Dr. Sanderson's research is focused on understanding the mechanisms of cellular damage caused by cerebral ischemia and the development of a novel therapeutic intervention that was designed and tested in our lab. Dr. Kumar focuses on fundamental investigations into neuronal damage using molecular interrogation of isolated neurons. Dr. Lagina investigates the underpinnings of hypothermic neuro-protection for cardiac arrest victims and

tests adjunct therapies to augment hypothermia. All these projects are separate, yet highly intertwined, providing the investigators ample collaborative opportunities.

An immense strength of a basic science research lab in a clinical department is the opportunity to translate basic science discoveries from the bench to the bedside. A specific example of this is provided by a research project currently being conducted by the Sanderson lab. Reperfusion is critical to limit damage after brain ischemia but also causes significant damage by generating reactive oxygen species early during reperfusion. Therapeutic hypothermia has emerged as the primary intervention for minimizing cerebral damage; however, it is initiated in a delayed manner, thus missing a critical window for therapeutic intervention. The Sanderson lab has recently developed a novel therapeutic strategy capable of attenuating the early reperfusion-induced 'burst' of reactive oxygen species. This approach is non-invasive and based on the photoreceptive properties of cytochrome c oxidase for infrared light (IRL). This technology utilizes specific IRL wavelengths to control cytochrome c oxidase in the brain, thereby controlling mitochondrial activity. By modulating mitochondrial activity during early reperfusion, IRL effectively inhibits mitochondrial reactive oxygen species and was profoundly neuro-protective in small animal models of brain ischemia. This novel technology seeks to improve

on post-ischemic cerebral therapy serving as a simple, non-invasive treatment for early reperfusion, potentially augmenting therapeutic hypothermia. Based on our studies, IRL is a neuro-protective treatment that does not have any recorded side effects and therefore may be easily introduced in a clinical setting for patient treatment. We are currently designing pre-clinical, large-animal studies to gain the necessary information for design of clinical trials.

This therapeutic development is just one of many studies currently being conducted by the investigators of the basic science research group. The research team also takes the time to train Emergency Medicine residents and medical students in basic science research. Opportunities to learn and actively participate in a basic science research project are always available for enthusiastic students wishing to augment their clinical training. A key goal of our research program is to expand the scientific knowledge of the future leaders of Emergency Medicine. Any students or residents looking for research opportunities can forward their information to Dr. Sanderson at [tsanders@med.wayne.edu](mailto:tsanders@med.wayne.edu).

Thomas Sanderson, Ph.D.  
Assistant Professor,  
Basic Sciences

**The basic science research lab has changed dramatically throughout the years, but the scientific focus has remained the same...**

## TRIP SITTERS... (CONTINUED FROM PAGE 6)

I would like to touch on the risks and benefits of this class of medications. I know you know this already... respiratory depression, loss of protective reflexes and addiction... easy, right? Ok, a little more complicated than that, first question I would like to put to you is what is an acceptable risk to your patient for potential benefit? Is an 8-10 fold increase in mortality acceptable to alleviate this patient's pain? Why is that acceptable when a two fold increase in myocardial infarction, not fatalities, was intolerable with rofecoxib (Vioxx)?

Next, am I really helping this patient? As most physicians, I find the physiology of the human body fascinating. The body knows where it wants to be and it will make changes to get there no matter what you do—homeostasis. When you meddle, the body will respond so that pharmacologic treatment of their condition will provoke a change. Down-regulation of the opiate system, decreased expression of opioid receptors, decreased release of endogenous opioids, up-regulation of nociceptive transmission—this is referred to as “opiate induced hyperalgesia syndrome”. How fast does this syndrome happen? There is no real great evidence to give you firm numbers, but probably faster than you would like. The anesthesia literature, suggests this is a very rapid process, with the use of intra-operative opioids increasing post-operative use of patient-controlled analgesia. In a trial studying patients chronically taking methadone, they had a lower threshold to painful stimuli than control patients with cold water immersion even while the serum concentrations of Methadone were within normal therapeutic

concentrations. How long does this syndrome last?

Good question.

Unfortunately, again there are no good answers. Rats will take three-five days to come back to baseline pain tolerance, how to translate that to humans, no idea.

What about the question of addiction? While our initial assumption that patients are unlikely to become addicted as a result of therapeutic use of opioids is clearly incorrect, how frequently this happens is not clear. Couple of side points—addiction versus dependence. Addiction represents a maladaptive pattern of behavior involving craving and persistent use without heed to consequences of continued use. Dependence would be better described as a homeostatic process in response to the drug with the development of tolerance with use and withdrawal symptoms upon the removal of the drug, but without the maladaptive behaviors such as craving and misuse. Once a patient is an addict why do they keep using? To get high of course, isn't it? Not really, many addicts may start out abusing prescription opioids in a recreational fashion but once the addiction has taken hold many of these patients are using just to obtain a “normal” or “functional” status. There is no high. There is no fun. Their life revolves around obtaining the drug so they don't feel bad. Addiction is neither good nor bad but a disease and needs to be treated with compassion and definite treatment goals. As an emergency physician your goal should be identification, followed by a brief intervention to assess if your patient is ready to recognize their problem and referral to

treatment. Well, the first part you should definitely do and in an ideal world they would make it to a rehabilitation program.

Now you need to look at your practice pattern. There are some things you need to do to become part of the solution. If you don't have access to your state's automated prescription database, get it. When you do find a patient that has a suspicious pattern of multiple providers, several recent prescriptions, you should not think, “Look I caught a drug abuser”, but as someone who you can potentially help with their disease—which is not chronic pain. It is addiction. “Does this patient really require an opiate?”, should be your next question and if you decide to give that patient a NSAID and their reply is they have been taking them by the handful, is that someone who can follow directions and take a drug as prescribed? Americans have been taught the customer is always right. I think it is time we as physicians need to take more of a parental role with our patients. I remember an oath somewhere about prescribing for the good of my patient and not giving poison even if asked; there was also something in there about not doing harm. This is not always easy and the patients may not always like our practice but this is our contract and pact. You chose the path, now walk it. Unfortunately, I don't remember anything about patient satisfaction scores in that oath....I should have paid more attention.

Matthew W. Hedge, M.D.  
Assistant Professor

**The body knows where it wants to be and it will make changes to get there no matter what you do—homeostasis.**

## 2013 RESIDENT, TEACHING, SERVICE AND HUMANITARIAN AWARDS

### RESIDENT AWARDS

**Resident of the Year—**  
Deshon Moore, MD

**Medical Student Resident Teaching Award—**  
Jeanise Butterfield, MD and  
Jeff Cloyd, MD

**Norman Rosenberg, DO Award—** Jeff Cloyd, MD

**Resident Humanitarian Award—** Deepa Japra, MD

**Scholarly Achievement Awards—**

**1<sup>st</sup> Year—**Sean Michael, MD

**2<sup>nd</sup> Year—**Craig Sharkey

**3<sup>rd</sup> Year—**Cameron Kyle-Sidell, MD

### TEACHING AWARDS

**Distinguished Teacher of the Year Award—**  
Robert Wahl, MD

**Voluntary Teacher of the Year Award—**  
Jeffrey Janowicz, MD

**Lawrence R.Schwartz, MD Faculty Teacher of the Year Award—**  
Trifun Dimitrijeviski, MD

### FACULTY SERVICE AWARDS

**10 YEAR—**  
Sarkis Kouyoumjian, MD, Phillip Levy, MD, Alice Dea, MD, Patricia Wilkerson-Uddyback, MD, Marc-Anthony Velilla, MD, Claudia Whitaker, MD, and Marc Rosenthal, PhD, MD.

**15 YEAR—**  
Cynthia Lepak-Hitch, MD, William Lusk, DO, Regina Noack, MD, and Kamal Nangia, MD.

**20 YEAR—**  
Suzanne White, MD.

**MUNUSWAMY DAYANANDAN, MD HUMANITARIAN AWARD—**  
Kerin Jones, MD and  
Carolyn Sabbagh

## A CALL FOR YOUR HELP

We at the *Resuscitator* would like your input. We would love to hear from both our faculty and our graduates scattered throughout the country. If any of you have any gripes, concerns or comments, please submit them to me or

Sandie Garling for publication in the “Ventilator” column. If you have any funny stories or anecdotes, we will try to include them in the “Doctor Aware” column. For the creative among you, please feel free to send me any

artistic pursuits you would like to share. Finally, to our core faculty and researchers, please send me information about your on-going or future projects.

Philip A. Lewalski, M.D.  
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[plewalski254@comcast.net](mailto:plewalski254@comcast.net)  
[sgarling@med.wayne.edu](mailto:sgarling@med.wayne.edu)

## NEW ATTENDING PHYSICIAN AND PHYSICIAN ASSISTANTS

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

Aaron Brody, MD-SGH  
Colby Brown, PAC-SGH  
Jeanise Butterfield, MD-DRH  
John Gallien, MD-DRH  
Daniel Helzer, MD-DRH  
Justin Kessler, MD-DRH  
Andrew King, MD-SGH

Barbara Morris-MCES Admin.  
Puja Patel, MD-SGH  
Daniel Salinsky, MD-SGH  
Phawanjit Sekhon, DO-HUH  
John Wilburn, MD-DRH  
Stephanie Wise, MD-DRH  
Kristy Smith, MD-HUH

## AUNT MINNIE PASSES THE SPIT TEST...

Those who attended the Bedside Teaching and Integrating Technology into Education Conference on April 25<sup>th</sup> understand the title's reference to bedside teaching techniques. The conference, organized by Dr. Gloria Kuhn and hosted by the Department of Emergency Medicine at the WSU SOM, featured two national experts in Emergency Medicine education from outside our department—Dr. Diane M. Birnbaumer from the University of California, Los Angeles, Harbor-UCLA and Dr. Mary Jo Wagner from Central Michigan University in Mount Pleasant Michigan. In addition, our own Drs. Adam Rosh and Shereaf Walid provided information and perspective on integrating technology into teaching.

The educational experience was both informative and interactive as the attendees were split into groups to identify and then solve some of the myriad difficulties inherent in providing bedside instruction to residents and students in emergency departments that demand increasing amounts of our attention and time. We were also taught better ways of providing feedback and evaluations on the fly and the difference between the two.

Dr. Birnbaumer provided interesting lessons and

examples of the different ways that adults learn and strategies to provide the learner with information that is appropriate to their level of training in a rapid, efficient and useful manner. Some of the teaching tools had catchy acronyms like SNAPPS, RIME, and the popular SPIT test. Others had fun names like the AUNT MINNIE. The important lesson for the medical educator is that each of these (and other) techniques are very effective and can be done very quickly. The more education 'tools' that one has in their 'teaching toolbox', the more effectively one can educate at the bedside, despite the chaos and time demands of the ED.

The importance of timely and constructive feedback in the learning process was highlighted by Dr. Wagner as well as the future of the evaluation process in the computer age as it relates to residency review and certification. It was fascinating how subtle changes in language and style can turn well-intentioned feedback into a negative experience and vice versa.

Finally, Dr. Rosh provided insight into the pros and cons of integrating new technology into the teaching of residents and medical students. Dr. Walid brought a practical approach to technology, with

specifics on equipment, cost and troubleshooting.

This Bedside Teaching and Integrating Technology into Education Conference, deftly organized by our own medical education expert and legend, Dr. Gloria Kuhn (with significant assistance from Sandie Garling, Gloria Daniels and Shazzandra Doze) was extremely important to our daily practice and responsibilities. It is not just germane to the attendings, but also to our residents who provide a great deal of teaching to junior residents, rotators and medical students. The commitment to education by our faculty, residents and supported strongly by our administration is the reason that our department and the emergency medicine clerkship is rated the best in the country by graduating medical students. The conference gave us a few new tools to add to our toolbox.

Philip A. Lewalski, M.D.  
Editor-in-Chief

**Some of the teaching tools had catchy acronyms like SNAPPS, RIME, and the popular SPIT test.**

Website:  
[www.med.wayne.edu/em](http://www.med.wayne.edu/em)

# WAYNE STATE UNIVERSITY

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**“ W E A R E C O M M I T T E D T O B E I N G T H E L E A D E R S . . . ”**

### KUDOS

Congratulations to the following faculty members:

Brian O'Neil, M.D. for receiving the ACEP Outstanding Contribution in Research Award.

Rita Kumar, Ph.D. and Thomas Sanderson, Ph.D. on receiving a NIH Grant for \$1.7 million over five years.

Kerin Jones, M.D., Robert Sherwin, M.D. and Jonathon Sullivan, M.D. promotion to Associate Professor (Clinical Educator).

Ciara Barclay-Buchanan, M.D. has been appointed the Associate Program Director of the Sinai-Grace Residency.

Padraic Sweeny, M.D. has been appointed Co-Chair of the Physician Leadership Council at Detroit Receiving Hospital.

Trifun Dimitrijević, M.D., on receiving the Lawrence M. Weiner Award. This award honors outstanding contributions of non-alumni to the School of Medicine through the exceptional performance of their teaching, research and/or administrative duties.

Brian O'Neil, M.D. was elected Immediate Past President of the American Heart Association Emergency Care Science Subcommittee.

Sean Michael, M.D., Timothy Scott, M.D., Craig Sharkey, M.D. and John Wilburn, M.D. for winning EMRAM SIMWARS at the 2013 EMRAM Annual Meeting and Research Forum.

Sara Lolar, PA-C received the Dale Sillix Award of Excellence which is historically given in recognition of an outstanding intellectual contribution to the education of WSU Physician Assistant students.

Gloria Kuhn, D.O., Ph.D. for receiving the 2013 MCEP Lifetime Achievement Award.

Melissa Barton, M.D. for receiving the MCEP Ronald L. Krome Meritorious Service Award.