RESUSCITATOR

WAYNE STATE UNIVERSITY
SCHOOL OF MEDICINE
DEPARTMENT OF EMERGENCY MEDICINE

VOLUME 4, ISSUE 2

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SPECIAL POINTS OF INTEREST:

- **Emergency Medicine Grand Rounds, Every Thursday, Detroit Receiving & Sinai-Grace Hospitals**
- **DRH/SGH Combined Journal Club, December 11, 2012**
- **DMC Emergency Department Holiday Party, December 14, 2012, Attendance by ticket only**
- **EMIG Procedure Night, January 31, 2013**

LETTER FROM THE CHAIR

You are better than you think...

You know that physicians by nature spend more time on their failures than their successes—it is our nature as highly critical, motivated individuals. However, it is important on many levels that we take some time and reflect on what we have done as a department.

Education: *You have earned that swagger, moving like Jagger.*

Wayne State students consistently rate Emergency Medicine as the highest clinical rotation on the Graduate Questionnaire. The next best department is a distant second. Nationally, when compared to other medical schools, we are rated higher than all other academic departments on the questionnaire. This is a testament to the dedication of our medical school, coordinators, all of our clinical and academic faculty, our residents, nurses and ancillary staff. With all the pressures we face clinically, it is true dedication that drives us to spend that precious extra teaching moment with our medical students. The fact is most of you will never know just what kind of impact that has on the student's future direction and outlook. I am amazed by how very small things to us are magnified by their young wide eyes. I have had many come back to me later—most of whom I do not recall, and tell me, "Remember that time when you....., I will never forgot that and it has help lead me to where I am today." We have no true concept of the impact we have on these young impressionable students. We can change a life with what we perceive as so little. So, please continue to take that extra moment and touch a life, for life.

Clinical: *We're putting the band back together, man.*

We have not only trained most of the physicians practicing in southeast Michigan, but we have trained most of the physicians in Michigan! We have also trained many of the academic and administrative leaders, both locally and nationally. In my short time in the SIC world, I have had the opportunity to view the other EM departments in the Vanguard system and realize we are well ahead of the curve. Though, I believe we have the reputation of putting out clinically excellent physicians, we have also produced physicians with an academic spin. The 2012 graduating class is no exception, with five of our graduates going on to fellowship training. Our future is even brighter with new ideas, energy and innovation in our residency programs that are the envy of the nation. We are committed to establishing accredited clinical research, EMS and non-operative sports fellowships to supplement our outstanding toxicology, basic science and palliative care fellowships. We already have committed internal candidates for each of these fellowship positions. Fellowship training requires significant resources and I am proud to say that our department and our corporation are in lock step to make these a reality.

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Brian J. O'Neil, MD
Interim Chair

RED SHOE DIARIES

Get your motor runnin'
Head out on the highway
Lookin' for adventure
In whatever comes our way

On April 13, 2012, Michigan became the 31st state to allow an option for motorcyclists to forgo a helmet while riding. Riders 21 years or older with a valid motorcycle endorsement, completion of a motorcycle safety course OR two years experience, and the purchase of an extra $20,000 insurance coverage, are free to let the wind blow through their hair as they travel the highways and byways of our state. (Passengers 21 or older with the extra insurance rider are also permitted to ride helmet-free.) Our previous governor had vetoed two similar law changes, but Governor Snyder endorsed the law citing personal freedom and the potential for increased tourism. The increasingly Libertarian, anti-government meddling side of me supports the freedom of our citizens to make their own choices on matters that affect them—whether I agree with them or not. Another major side of me, however, is that of a physician, who has taken an oath to protect my patients' lives and health.

Michigan (and most other states) enacted helmet laws in 1967 in order to maintain federal funds for roads and other projects in a sort of 'carrot and stick' incentive policy. This requirement was eventually dropped years later and gradually the number or states that allow a no-helmet option has steadily increased. The interesting and germane question is how are injury and death rates affected when helmet laws are liberalized.

The supporters of the no-helmet option have several arguments and abundant studies to support their position. Most of the studies they quote are relatively old and some are rather obscure as well. They also argue that the increased injuries and deaths demonstrated in newer studies are secondary to the increased number of motorcyclists over the last few years and that actual 'rates' are dropping. Conversely, they assert that drops in fatality rates when helmet laws are enacted may be due to a decrease in riders (both residents and tourists). Previous studies that showed an increase in cervical spine injuries associated with helmet use are often quoted as well. It is also maintained that full face helmets increase the risk of accidents by decreasing a rider's peripheral vision and hearing acuity. I have also seen assertions that since the Department of Transportation (DOT) minimum requirement for a motorcycle helmet is to survive a six foot fall (13.43 mph) that under most driving situations, the rider would probably suffer a fatal injury whether or not they were wearing a helmet. Most helmets—particularly the full face type—significantly exceed the minimum DOT standards, but cost ($500-$700) which is another anti-helmet complaint. Perhaps the most compelling argument, however, is that helmets are a personal freedom issue and it is their right to decide if a helmet is right for them. They suggest that since there is data that helmets save lives in car crashes (definitely in auto racing) why are riders singled out to wear helmets and car drivers are not. It should be the operator's personal choice.

Anti-helmet groups, the Governor's Office, a slim majority of the Legislature and lobbyists for the bar and restaurant industry support the new helmet law as a way to boost tourism. They assert that a large number of motorcyclists from surrounding states avoid traveling in Michigan because they don't want to wear a helmet. The problem is that the data is not scientific and is mainly anecdotal. (I wonder how many riders, if asked, wouldn't come to Michigan because our roads are in such bad condition and therefore dangerous to motorcyclists.)

Motorcycles are inherently more dangerous than cars. A 2004 study by the National Highway Transportation Safety Agency (NHTSA) showed that per mile traveled, motorcycle collisions were 27 times more likely to result in death than car crashes. A 2012 CDC study (see below) demonstrated that motorcycles account for 3% of registered vehicles, less than 1% of total miles traveled and were responsible for 14% of vehicular deaths. Is there compelling data that one can mitigate those risks by wearing a helmet? The answer appears to be "yes" in a growing number of large studies.

In the same NHTSA study it was shown that the leading cause of death in motorcycle crashes is due to head injury. Not wearing a helmet leads to a 40% increased incidence of fatal head injury (and a 15% increase in non-fatal Traumatic Brain Injuries) (TBI). Between 1984 and 2002 helmet use is felt to have saved 13,774 lives and

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

Our previous governor had vetoed two similar law changes, but Governor Snyder endorsed the law citing personal freedom and the potential for increased tourism.

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

in Kentucky and Louisiana, the repeal of helmet laws led to a significant rise in the death rate per 10,000 riders. (Note: this is a per rider rate and not due to more riders as many anti-helmet groups assert.) A published study from the Southern Medical Journal demonstrated that in the seven years since Texas repealed mandatory helmet laws, the fatality rate per mile traveled increased by 25%. A subsequent report by the NHTSA in 2009 showed a threefold increase in TBI when helmets were not worn.

A 2011 study conducted at Johns Hopkins and published in *The Journal of Trauma and Acute Care Surgery* refuted previous studies regarding the use of helmets and subsequent cervical spine trauma. They found that helmet use led to a 22% decline in C-spine injuries.

A March 2012 study from the University of Michigan Transportation Institute found that the average cost per motorcycle crash increased by 48% with no helmets—$213,770 to $317,031).

A large study conducted by the CDC and released in June 2012 looked at over 14,000 motorcycle deaths (6,000 with no helmet) between 2008 and 2010. They found that in states with no helmet requirements, five times as many riders die and a cost of $500 is associated with every registered bike. They found no evidence that helmets decreased the vision or hearing ability of rider. They found that 88% of fatalities occurred in the thirty states (60%) that had no universal helmet laws. The study also demonstrated that $3 billion in 2010 alone would have been saved in medical costs and lost productivity with universal helmet use.

AAA spokesperson, Nancy Cain, as quoted in The Detroit News asserts, "The repeal of the motorcycle helmet law will result in at least 30 additional motorcycle fatalities every year, along with 127 more incapacitating injuries and $129 million in added economic costs to Michigan residents. This analysis...is based on the experience of other states where similar measures have been enacted."

It is troubling to me that Michigan's new law does not require the rider to carry any proof of the added insurance coverage. This will make enforcement very difficult. I am generally an optimist, but cynical enough to foresee insurance carriers denying payment for severe injuries to helmet-less motorcyclists who don't purchase the required coverage. The burden for these huge costs will fall upon the citizens of Michigan. (The cost of caring for a person with a significant TBI runs into the millions.) It is also disconcerting that 68% of the voters of our representative government did NOT want to change the law.

I am guessing that I didn't need to work too hard to convince or reaffirm most of your opinions to support universal helmet laws. I needed to go through this exercise to clarify my beliefs and those of my conservative brothers and sisters. At my core, I believe that people should be allowed to make their own choices and assume their own risks with little or no government interference. I deplore the so called 'nanny state'. Problems ensue, however, when someone else's 'personal choice' reaches into my wallet and the evidence seems to indicate that this will be the case with the new law. Also, driving is not a 'right' as defined by the Constitution. It is a 'privilege', and as such it is subject to rules and regulations for the common good and safety of all.

If any of you need further convincing, remember that we all took an oath as we graduated from medical school. An oath is defined as: 'a promise, calling upon something or someone that the oath maker considers sacred, usually God, as a witness to the binding nature of the promise.' There are various versions of the Hippocratic Oath. Whether it is the original, classical or modern version, the theme of *primum non nocere* runs through our oath. The commonly used 1964 version perhaps articulates it best and applies most directly to the helmet argument. "I will prevent disease whenever I can, for prevention is preferable to cure." This oath, my friends, is more sacred and more binding than one's political views.

Like a true nature child

We were born

Born to be wild

We can climb so high

I never want to die

(Steppenwolf)

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

It is troubling to me that Michigan's new law does not require the rider to carry any proof of the added insurance coverage.

WELCOME EMERGENCY MEDICINE RESIDENTS CLASS OF 2015

Detroit Receiving Hospital

Michael Antoniolli, University of Michigan, Rosalind Franklin

Heather Bowman, Wayne State University

Erin Ge, Loyola University

Brian Holowecky, Michigan State University

Daniel Hutchens, University of Michigan, Rosalind Franklin

Aditee Jodhani, University of Michigan, Rosalind Franklin

Eric Malone, Wayne State University

Maxwell Mayer, Wayne State University

Sarah Michael, Rocky Vista University

Sean Michael, University of Colorado

Eugene Rozen, St. George's University

Katherine Schulman, St. George's University

Laura Smylie, Wayne State University

Alexandra Weissman, St. George's University

Sinai Grace Hospital

Ryan Ehle, St. George's University

Shannon Graves, Ross University

Kristin Inger, Wayne State University

Tracy Kane, Ross University

Karyn Koller, St. George's University

Andrew Moonian, St. George's University

Katrina Godderz, St. George's University

Essi Harju, Philadelphia College of Osteopathic Medicine

Syed Jafri, Chicago College of Osteopathic Medicine

Joseph Khell, St. George's University

William Lunger, St. George's University

Yamen Nackoud, St. George's University

St. John Hospital/Medical Ctr

Vesta Anilus, University of Florida

Christopher Arnold, University of Oklahoma

Jacob Dickinson, American University of the Caribbean

Lindsey Goodell, Wayne State University

Ari Gotlib, Wayne State University

Darrius Guiden, University of Illinois

Kenneth Kuper, Wayne State University

Daniel LaLonde, Wayne State University

Timothy Newton, Touro University Osteopathic

Fahad Syed, Nova Southeastern Osteopathic

Amrita Vempati, Wayne State University

Rosie Voelker, Arizona Midwestern Osteopathic

NEW ATTENDING PHYSICIAN, PHYSICIAN ASSISTANTS&NURSE PRACTITIONER

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.

Ayse Avciolglu, MD-DRH
Sarah Albers, MD-DRH
Brandon Cheppa, MD-DRH
Katie Dobratz, MD-DRH
Mark Favot, MD-SGH
Dylan Foord, DO-HUH
Kristiana Kaufmann, MD-DRH
Marcus Moore, DO– SGH
Dawn-Dianne Scruggs, MD-SGH
Shereaf Walid, MD-DRH
Bret Weathers, MD-SGH
Amy Nefcy, MD-Toxicology Fellowship
Claire Jensen, MD-Palliative Care Fellowship
Nicole Reske, PA-C-DRH

OBSERVATION PHYSICIANS, PHYSICIAN ASSISTANTS and NURSE PRACTITIONERS
LeQuishia Alexander, MD
Mark Aronov, DO
Hadi Berry, MD
Kashif Chaudhry, MD
Catherine Guido, DO
Ramanjit Kaur, MD
Talal Khader, MD
Lilian Lai, MD
Fergus Peacock, MD
Amit Sagar, MD
Abhijit Saste, MD
Siama Siddiqui, MD
Curt Dalken, NP
Ronald Dalton, PA
Kamal Hachem, PA-C

CONGRATULATIONS EMERGENCY MEDICINE CLASS OF 2012

Detroit Receiving Hospital

Sarah Albers, MD, Medical Center Emergency Services, Detroit Receiving, Detroit, Michigan

Ayse Avcioglu, MD, Medical Center Emergency Services, Detroit Receiving, Detroit, Michigan

Brandon Cheppa, MD, Medical Center Emergency Services, Detroit Receiving, Detroit, Michigan

Bao Dang, MD, St. Vincent Health, Indianapolis, Indiana

Katie Dobratz, MD, Medical Center Emergency Services, Detroit Receiving, Detroit, Michigan

Claire Jensen, MD, Medical Center Emergency Services, Detroit Receiving, Palliative Care Fellowship, Detroit, Michigan

Brian Junnila, MD, Essentia Health, Duluth, Minnesota

Deborah Kim, MD, University of California Davis Health System, Sacramento, California

Detroit Receiving Hospital

Meenakshi Munshi, MD, Critical Care Fellowship, Cincinnati, Ohio

Aimee Nefcy, MD, Medical Center Emergency Services, Detroit Receiving, Toxicology Fellowship, Detroit, Michigan

Katherine Ohlendorf, MD, St. John Hospital and Medical Center, Detroit, Michigan

Daniel Seitz, MD, Chicago, Illinois

Matthew Steimle, MD, Pediatric EM & Ultrasound Fellowship, Augusta, Georgia

Shereaf Walid, MD, Medical Center Emergency Services, Detroit Receiving, Detroit, Michigan

Sinai Grace Hospital

Rebecca Byrd, MD, Georgia Emergency Associates, Savannah, Georgia

Michael Gerstein, MD, Kaiser Permanente, Walnut Creek, California

John Hicks, MD, Lawnwood Regional Medical Center, Fort Pierce, Florida

Monty Lybbert, MD, St. John Hospital and Medical Center, Detroit, Michigan

Romajit Multani, MD, St. John Hospital and Medical Center, Detroit, Michigan

Megan Oxley, MD, Easton Shore Emergency Medicine Physicians, Easton, Maryland

John Oteri, MD, Emergency Physicians Medical Group, Sacramento, California

Neema Patel, MD, Emergency Physicians Medical Group, Sacramento, California

Daniel Salinsky, MD, Covenant Health Corporation, Saginaw, Michigan

Michael Schwartzwald, MD, Kaiser Permanente, Fontana, California

Michael Tiqui, MD, Hospital of Central Connecticut, New Britain, Connecticut

Bret Weathers, MD, Medical Center Emergency Services, Sinai-Grace, Detroit, Michigan

St. John Hospital/Medical Ctr

Gary Baskin, MD, Franklin Medical Center, Winnsboro, Louisiana

Patrick Butcher, MD, Emergent Medical Associates, Los Angeles, California

Agata Dow, MD, St. John Providence, Macomb Hospital, Warren, Michigan

Maurice Lawton, MD, University of Minnesota

Trinh Le, MD, Emergency Medicine Specialists, PC

Adriian Maestas, MD, Wheeling Hospital, Wheeling, West Virginia

Neil Majmundar, MD, Unknown at this time

Steve Masson, MD, Questcare, Dallas, Texas

Daniel Park, MD, Emergency Medicine Physicians, Sacramento, California

Lori Schmerling, DO, Northsore Medical Center, Miami, Florida

Roy Solano, MD, Independent Emergency Physicians, Warren, Michigan

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.
Editor-in-Chief
plewalski254@comcast.net
sgarling@med.wayne.edu

TRIP SITTERS

Bombed at Receiving…

There are few things that keep my professional life more interesting than techno/house music and the remarkable ability of young adults to make bad choices at these venues. Recently, there was a performance at the Fillmore Theater by Bassnectar, not something that is currently in my iPod but I probably need to get some as they are good for business and it certainly makes my work life more interesting. I believe someone once said there is nothing worse than being an interesting case in the hospital.

I'm minding my own business when triage calls me and asks where they should triage the kid who took N-bomb and then had a seizure. Next was the question, "What is N-bomb?" My initial response was I didn't know and was it anything like the F-bomb.? While some people have more delicate sensibilities than others, I have never heard of the F-bomb causing seizures. The history that EMS had was some unknown person (one of those two dudes) was walking around the theater with a nasal spray and giving people shots up the nose. So let me get this straight, someone walked up to you and offers to spray an unknown substance up your nose and you say yes!!?? Like I said kids have a remarkable talent for making my work life interesting.

Well, when all else fails, look at the patient. (I know he's not my patient but it sounds interesting and well, I'm kinda nosey.) He's awake, talkative, pupils like dinner plates, and tachycardic. When I get back to my module there is someone yelling that they are going to die, never really a good sign, so I have a look. The same ambulance crew that was in resuscitation says, "Yeah, this is the other one we brought." Now that is peculiar. Similar to the other patient, although more agitated—again mydriasis, tachycardia, diaphoresis and now three beat clonus in the lower extremities. As the night and the show continued, another three or four patients made their way to the emergency department and subsequently into the hospital with similar signs and symptoms, and a few with visual hallucinations.

Congratulations, you are now part of your first toxicologic cluster. We will come back to the N-bomb but first we need to take care of the patient.

Drs. Google, Wiki and Erowid—while useful resources—are not going to take care of this patient, you are. The bulk of what you want to know about any drug overdose is with the patient. They will tell you what they took, if you listen. Our patients presented with an agitated delirium, tachycardia, diaphoresis, all of which says way too much catecholamines. Now looking for which particular flavor of catecholamine… Unfortunately, the catecholamines rarely travel alone and frequently patients will present with some combination of symptoms related to these similar neurotransmitters. There is definitely too much epinephrine and norepinephrine as evidenced by the agitation, tachycardia, diaphoresis. Then there is a strong serotonin presence here as well with the lower extremity clonus and hallucinations. The patients have signs consistent with an early serotonin syndrome.

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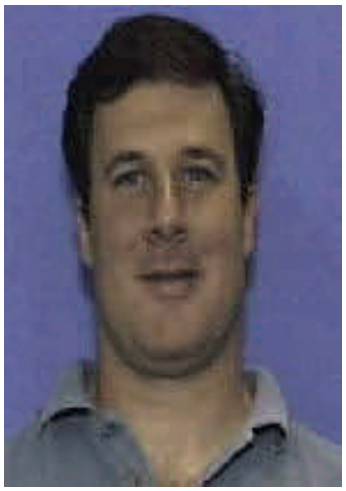

Matthew W. Hedge, M.D.
Assistant Professor

I believe someone once said there is nothing worse than being an interesting case in the hospital.

the orthopedist lives
inside my brain along the back molars
braced up against the deep recess of my jaw
near to the grinding mechanism
where big fish are broken first
that is where he gets his work.

Shradha P. Shah, M.D.
Class of 2008

UPCOMING ACLS SESSIONS

Volunteers/Faculty are needed. Please contact Shazzandra Doze at sdoze@med.wayne.edu

January 2013—8, 10, 15, 17, 24 & 25.

February 2013—5, 7, 12, 14, 19, 21,26 & 28

LETTER FROM THE CHAIR… (CONTINUED FROM PAGE 1)

Research: *Getting our MOJO back, (we never really lost it—just needed recharging).*

Our research, both clinical and basic science, is poised to vault back into the upper echelon of academic departments. We are currently 11th in federal funding and I truly expect us to be in the top ten by the end of 2013. We have systematically added resources to our department and are currently the GO TO department for clinical research throughout the DMC and Wayne State University. In the last six months we have secured an amazing database guru, a gifted and proficient regulatory and IRB maven and recently have retained the part-time services of Scott Millis, our PhD biostatistician, who is a productive, efficient innovator—who just gets it.

Departmental: *Lead, Follow or Get Out Of The Way.*

Having sat in the SIC seat now for a few months, I am constantly reminded of what a talented and effective leadership team we have in EM. Our department is consistently held out as the example of how to get things done. In nearly every initiative put forth by DMC/ Vanguard we are the first to engage and first to complete. We are blessed with bright dedicated medical directors and their competence is noted at the highest levels of DMC/ Vanguard. This expertise is shared freely within our department and is the reason EM is regularly placed into positions of authority with the DMC. We obviously are leading. I was recently reminded of the impact that a few knowledgeable people, with a laser focus on improving patient care, can have in creating evidence based protocols in a matter of hours that can change how we manage patients for the better. As we move forward in our new health care system, protocols such as these will be the norm. This initiative was spearheaded by EM and has the real possibility to go system-wide. I think this is the first of many from EM.

Our future is so bright we need to all get shades.

I think we all need to take a few moments, reflect on our accomplishments and what a top tier department we are all privileged to work in, then congratulate those around us…….Alright that's enough. Back to work.

Brian J. O'Neil, M.D.
Interim Chair

In nearly every initiative put forth by DMC/ Vanguard we are the first (Department) to engage and first to complete.

CONGRATULATIONS!

Rania and Bill Bahu are the proud parents of a baby girl, Nura, born on April 8th.

Allison and Martin Reznek are the proud parents of a baby boy, Oliver Axel, born on April 24th.

Varsha and Shyam Mendiratta are the proud parents of a baby girl, Sanjan, born on July 13th.

Amber and Matthew Steimle are the proud parents of a baby girl, Emma, born July 19th.

Heather and Daniel Helzer are the proud parents of a baby girl, Lily, born on July 23rd.

Claire Pearson and Mark Babisz are the proud parents of a baby girl, Jade Morgan, born on August 21st.

Dawn and Ryan Scruggs are the proud parents of a baby girl, Holly Fae, born on August 24th.

Sarah Albers and Mike McLaughlin are the proud parents of a baby girl, Sydney Anne, born on November 13th.

Melissa and Justin Kessler are the proud parents of a baby girl, Mirielle Colette, born on November 28th.

2012 SERVICE AWARDS

10 YEARS
Susan Corrion, MD, Prashant Mahajan, MD

15 YEARS
Nancy Walter, MD, Jonathon Sullivan, MD, Michael Falzon, MD, Roy Elrod, MD and Ann Marie Garritano, MD

20 YEARS
Philip Lewalski, MD, Helene Tigchelaar, MD, Alvan Cruz, MD and Robert Malinowski, MD

25 YEARS
Robert Welch, MD, Christopher Heberer, MD, and William Berk, MD

30 YEARS
Scott Freeman, MD

TEACHING AWARDS

DISTINGUISHED TEACHER OF THE YEAR—Kerin Jones, MD and Michelle Lall, MD

VOLUNTARY TEACHER OF THE YEAR—Jeffrey Janowicz, MD and Tolulope Sonuyi, MD

LAWRENCE R. SCHWARTZ FACULTY TEACHER OF THE YEAR– Ross Tabbey, MD

MEDICAL STUDENT FACULTY TEACHER OF THE YEAR AWARD-Ann Marie Garritano, MD

DAYANANDAN HUMANITARIAN AWARD—
Kenicia Adams, RN and Kathleen Pilchowski, MD

MARK BRAUTIGAN LEADERSHIP AWARD—`Ann Marie Garritano, MD

BITTERSWEET NEWS...

Bear Bryant (Alabama), John Wooden (UCLA), Duffy Daugherty (MSU), Bob Wahl (WSU)... What do these names have in common? On the surface, not much—except they all worked for universities. Is it that they all were involved in championship athletics? Well, Bob is a pretty competitive volleyball player, but no. What they all share is that they define an era in their fields. Well, an era lasting an entire generation has ended. On August 1st, Dr. Bob Wahl stepped down as residency director for the Department of Emergency Medicine at DRH, a position he has held for over 21 years. Dr. Wahl's tenure started at the beginning of my 3rd year of residency and remarkably, he looks the same as he did in 1991, despite 42 groups of six month evaluations and countless minor and major crises. (Although there is a broad range, the average tenure for an EM program director is about five years.)

Bob Wahl left his native Boston to attend Michigan State for his undergraduate studies. He graduated from WSU-SOM and completed his emergency medicine residency at DRH in 1987. Four short years later and after completing the ACEP/EMF Teaching Fellowship Program, he was asked by Dr. Brooks Bock to assume the role of residency director. Dr. Wahl excelled at his position as the residency grew from nine residents that graduated in 1992, to the current 14/year—including several years of combined EM/IM and EM/Pediatric programs. As the saying goes, "If you want something done, ask a busy person." Bob has been and continues to be involved in numerous hospital, university and national committees and is heavily involved with ABEM—now serving on the Board of Directors. He also has a number of original articles, presentations, and book contributions to his name. Whether it's giving lectures, teaching ACLS, BLS and ATLS, or simply countless hours of bedside teaching, Wahl has educated and influenced hundreds upon hundreds of physicians. Bob was promised that this article would not be overly sentimental or immodest—after all, he is not retiring or leaving the program—but a little praise can't be helped! Those of us who work with him or were trained by him know Dr. Wahl's commitment to his patients and to the residency program; as well as resident and medical school education. His dedication and hard work are evident in the eight Distinguished Teaching Awards our residents have given Bob, as well as the Michigan EMRA Teacher of the Year Award, ACEP National Teaching Award, and the Munuswamy Dayanandan Humanitarian Award he has received. *[O.K. Bob, I'm done now!]*

When asked about the good (and bad) changes in resident education he has observed over the last 21+ years, Bob sees many of the technologic advances as being very beneficial. "I like the use of high fidelity simulation as an educational medium. It's safe, reproducible, and provides a level playing field against which to evaluate resident performance," says Wahl. He also is pleased with the "education and training regarding clinical applications of emergency ultrasound to efficiently and safely manage patients." Bob feels that the "opportunity to incorporate asynchronous learning modalities to educate residents, instead of solely using the 'time honored' lectures and slide presentations, and the use of technology (video streaming) to record educational sessions and provide them for viewing at the learners' convenience" is a boon to graduate and undergraduate medical education.

On the negative side Bob adds, "I feel that the ACGME has expanded the overall program and specialty requirements for EM training programs to such a degree that increased time is required to document how programs meet the requirements and show outcome measures of improved resident performance. This seems to take away time from directly observing and assessing resident performance clinically in the ED." Regarding duty hour changes, he responds, "Although I believe that the concept is good, the reduced hours have negatively impacted residents' clinical experience (in my opinion); e.g., overnight call as EM-1 residents, opportunities for procedural experience, decision-making in significant clinical situations, and the necessity of being able to focus and concentrate when fatigued. We don't really seem to be preparing residents for the 'real world', as we all know that there are no duty hour regulations for practicing physicians (as there are for air traffic controllers, pilots, etc.)."

When asked what he has found most rewarding, Bob replies, "Clearly the many talented people that a program director has the honor and pleasure to work with are most rewarding, especially the support staff in the academic office, members of the residency

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Robert P. Wahl, M.D.
Assistant Professor

On August 1st, Dr. Bob Wahl stepped down as residency director for the Department of Emergency Medicine at DRH, a position he has held for over 21 years.

BITTERSWEET NEWS ...(CONTINUED FROM PAGE 8)

leadership team, departmental administration and support, and certainly not least, the residents—dedicated, intelligent, and accomplished individuals with innumerable talents directed toward educating and training young physicians to become the best emergency physicians possible. The residents, with their enthusiasm, motivation and dedication to their training, the desire to do the best for their patients, and the strong desire to not let their attending physicians down, are truly amazing young women and men to work with. Their success infuses immeasurable pride and satisfaction that makes the job of program director extremely fulfilling." The fact that Dr. Wahl feels the most difficult part of the job is the endless administrative responsibilities and how they conflict with personal and family pursuits should come as no surprise.

Bob is most proud of the residents' and the program's continuing success over the years and that he's had the honor and pleasure of being their program director. "I feel that as a program, we have been very responsive to residents' concerns, opinions and suggestions for improvement, and have been able to implement and provide superb clinical and educational opportunities for residents to experience and develop their knowledge, skills and abilities as emergency physicians," says Bob. However, if given another chance, Bob adds, "I realize that I could have become more actively involved with the Council of Residency Directors, and worked even harder to find solutions to the difficult task of training residents, rather than whining about new regulations and requirements handed down by the ACGME. I should have learned sooner to always maintain a positive outlook and focus on using the available resources to provide the best possible opportunities for clinical training and education."

Dr. Wahl is not yet ready to kick back in his easy chair (if he even has one) and will be active in academic emergency medicine both locally and nationally. "Within the department I will dedicate one day a week on average contributing to the residency program. I would like to directly observe residents' clinical performance, especially in resuscitation and with certain procedures to provide direct and timely feedback on performance in those areas. I will also help with resident recruitment and interviewing, and lend assistance to resident remediation. Nationally, I will be very involved with the American Board of Emergency Medicine as a Board Director. I will participate on several committees (Americans with Disabilities Act (ADA) Advisory Subcommittee of the Test Administration Committee Credentials Committee, Research Committee, Test Administration Committee, and Test Development Committee), and I will be a Co-Editor of the ConCert examination."

When asked about his family, the proud (and probably broke!) papa adds, "Our family is doing great. My eldest, Bobby, is in his second year at Wayne State's Medical School. He's not quite sure yet what field he will enter, but doesn't seem to think that it will be pediatrics. He spent a summer externship in our department at DRH and really enjoyed his experience. Christopher has started his first year at Michigan State University School of Osteopathic Medicine, and he is doing great. He lives in the same apartment building that I lived in back in 1979-80 as a senior undergrad at State! Christy is in her senior year at MSU and will be pursuing Speech and Language Pathology. She is currently working with a young child and a speech pathologist in East Lansing during her off time from school. She really enjoys the experience and is amazed to see the rate of improvement of the young girl. Michelle and I are really enjoying this new phase of our lives. I took a two week vacation in August, which was the longest vacation that I've had since graduating medical school and before starting residency. I can really get used to some idle time! Our two Shih-Tzu puppies keep us very busy; and Michelle still finds the time to bake her outstanding desserts."

Dr. Wahl is not yet ready to kick back in his easy chair (if he even has one) and will be active in academic emergency medicine both locally and nationally.

In closing, Bob would like to offer the following thoughts. "I want to thank everyone that has had a role in making my position as residency director over the past 21 years an invaluable and rewarding experience. I have built personal and professional relationships, and memories, that will last a lifetime. The program is in great hands with Adam Rosh, Kerin Jones, Eric Olsen and Scott Freeman at the helm and with Gloria Daniel as the world's greatest coordinator, and the accomplished faculty and staff at DRH to support them. Thank you for the years!"

Please join everyone in our department in thanking Dr. Wahl for his tireless service as residency director for a generation and wishing him success in his new endeavors.

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

ADAM ROSH APPOINTED NEW PROGRAM DIRECTOR

As I was nearing the end of my second year of residency, I had an interaction that has left a lasting impression. I completed my residency at NYU/Bellevue Hospital. It is a four year program in the heart of New York City. Just like Detroit Receiving, we cared for people from all walks of life. On this particular day, I saw my Chairman, Dr. Lewis Goldfrank, take a call at the communications desk. Shortly thereafter, Dr. Goldfrank approached me and a few of my colleagues individually and told us that there was a "VIP" patient coming in; someone he would like us to personally take care of. In New York City, "VIP" could mean Beyonce or Bill Clinton; Derek Jeter or Eli Manning. Each of us was silently exhilarated for having been selected to care for this "VIP", not knowing that we were all, in fact, chosen. I was just hoping not to make a mistake--especially with a "VIP".

When the ambulance arrived, however, the patient did not look like a celebrity or a pop star. Instead, she was a homeless woman found in the tunnels under Grand Central station. She was disheveled, malodorous, hypothermic, clearly septic, and was clutching a dead baby in her arms, placenta not yet delivered. We cared for her, cleaned her, and saved her. And we never forgot that day. Although she was homeless, Dr. Goldfrank expected us to treat her the same way we would treat a "VIP". Indeed, there should be no difference.

I always reflect back to this story when I get frustrated while working in the ED. It reminds me of our commitment and special role that we have to society and to each other as emergency physicians. We all have our reasons for why we chose emergency medicine as a career. The landscape in which we practice is filled with constant challenges and we are continually asked to do more with less. But one thing has not changed. Each morning we wake up and have a privilege that most people never experience in life. We get the opportunity to save someone's life, to teach better health practices, and to galvanize our residents and medical students to do things that inspire them and help them grow so that they can go on and prepare the next generation of emergency physicians.

As program director, I pledge to continue our excellent training program and look to stimulate our residents' professional growth, encourage them to be involved in emergency medicine on a local, regional, and national level, to develop sound clinical reasoning skills, practice evidence-based medicine, feel confident in an environment of academic rigor, and to prepare them for life after residency whether it is in academics, community medicine, as a director of an ED or even chair of a department.

For faculty, our responsibility is to guide our residents, to offer suggestions and make them feel as if they are acting totally independent even though they are not. Just remember, it is our residents who will be treating us and our children. Each one of us has an abundance of talent to share. I hope we continue to challenge the residents and most importantly, continue to challenge ourselves.

For the residents, I offer some advice as we begin this journey together. Always exhibit restless energy and seek out opportunities for intellectual and professional growth. Have an absolute commitment to render quality care in a compassionate setting and an absolute dedication and a sense of mission about your work. Treat every patient like a "VIP". Your responsibility, above all, is the health care of the patient. Our responsibility is to nudge you just enough to allow you to recognize and achieve the greatness that is inside each of you.

As each resident takes on new roles and responsibilities in their training, I will be too. Beginning August 1st, I will be the new residency director following in the footsteps of Dr. Bob Wahl. This will not be an easy task. As you know, Bob served this residency for over 21 years. For more than two decades, he has been an inspiration to hundreds of residents and young faculty, such as myself. He served as a clinical role model and mentor in the arena of career development. Despite all that he has achieved, Bob remains humble and approachable with a genuine willingness to listen to your needs and work with you until you achieve your goals. Simply put, there are few others like Bob and he will be leaving this program better than he found it. Indeed, this is all you can ask of a leader. I hope to adopt these same principles that made our residency program so successful under Bob's guidance.

As I assume the responsibilities of program director, I will join a group of passionate, caring, and dynamic individuals in Drs. Jones, Freeman, and Olsen, who have added more value than you can imagine in making the DRH program what it is today. They remain committed to resident education and will continue to serve the residency with infectious enthusiasm and selfless dedication. I also look forward to working with the residency's invaluable front office staff, who are truly the ones who keep this ship afloat, Gloria Daniel and Shazzandra Doze.

It's been 43 years since Drs. Krome, Bock, Jayne, and Tintinnali began laying the foundation of our residency. These four pioneers dedicated their lives to creating our department, our residency, and the specialty in which we practice today. Let us all aim to live up to their ideals, to continue their vision, and to strive for the same excellence that they practiced for over 40 years. One of Dr. Krome's favorite sayings is that…"he receives the greatest joy from seeing his students achieve successes greater than his." It is my hope that we follow in the footsteps of Dr. Krome and all of the other dedicated physicians that built our great department of emergency medicine here at Detroit Receiving.

Thank you again for the opportunity and trust in allowing me to serve you.

Adam Rosh, M.D.
Program Director
Department of Emergency Medicine
Wayne State University/
Detroit Receiving Hospital

Adam Rosh, MD
Assistant Professor

RETIREMENT!

My dear colleagues,

On July 1, 2011, I arrived at the Promised Land. Retirement, Hallelujah!! Emergency Medicine (EM) is a fairly new specialty. It is only recently that attrition has occurred among the older members of the profession through retirement and death. (I recommend the former over the latter.) Colleagues ask two questions. How did I manage to retire so young; and what do I do with my time? The short answer to the first question is that I am not so young. I retired last year at 62 years of age. The better answer is that I maximized retirement benefits. I only had two jobs in my 32 year career. I was at William Beaumont Hospital for 14 years followed by Medical Center Emergency Services and Wayne State University School of Medicine (WSUSOM) for 18 years. Both had great benefits. Additional financial advice is live within your means. You can only spend one dollar once. Keep your debt to a minimum.

I retired from clinical practice in December 2010, continuing as an educator for the next six months. What did I do when the great day came? At first, the pleasure of sleeping in and having nowhere to go every day was very enjoyable. I told my wife I was making up for 35 years of sleep deprivation. I hit the gym three to four times a week training with and being humiliated by middle-aged women who are in a lot better shape than I am. I want to stay healthy. I didn't want to retire only to drop dead shortly thereafter. Then there was the inevitable *honey-do list*. I had to attend to years of neglected house maintenance. Those of you who know me know that I didn't do any of the work myself. I had to find contractors to replace leaky windows, fix dowel rod leaks in the basement, improve drainage of a soggy area on the side of the house, etc., etc., etc.

Then there was the fun part of retirement – travel. I didn't have to schedule vacation time around professional obligations. My wife and I, in celebration of our 40th wedding anniversary, took a three week European vacation, starting in Barcelona, followed by a 12 day cruise around the Iberian Peninsula, followed by three days in London. I discovered on the cruise what the wealthy elderly do. They take great vacations.

I still had plenty of time so my next project was volunteering. I became a literacy coach through the Detroit Public Library. I work with a gentleman twice a week who is dedicated to improving his reading ability. This has gotten me to start reading again. I had forgotten how enjoyable it is to be immersed in a book. I have continued my career as a tour guide for Preservation Detroit, giving tours in Midtown Detroit and also participating in the annual Detroit Theater Tour.

I did miss something. The longer I was away the more I missed it. It was working with the medical students and the residents. My work with medical students and residents has always inspired me. What a privilege it has been to work with bright, hard-working, altruistic young people. WSUSOM has been a terrific place to work. Although retired, I am still able to work part-time. Therefore, I resumed teaching Physical Diagnosis the winter after I retired. I have also taught ACLS, BLS, helped Drs. Kouyoumjian with the EM OSCE and Kerin Jones with simulation. I call these teaching gigs.

I must confess that I miss the excitement of the ED. Patient care and bedside teaching have been rewarding and satisfying. As emergency physicians, we perform a heroic job. We are truly the medical safety net of society. We see people in the most acute phases of illness and injury. We must make clinical decisions quickly with a paucity of information in a glass house. Our outcomes are both exhilarating and devastating at times. Our specialty provides us with a lot of satisfaction and a lot of stress. We must be proud of our accomplishments while recognizing and developing ways to manage stress. Stress can be debilitating to us physically, mentally, and socially. I miss the excitement and the satisfaction of the clinical arena. I don't miss the stress.

So this is what I have been doing with my time. I teach; I tutor; I'm a tour guide; I come to Thursday EM Grand Rounds when I can to keep up my CME hours and my knowledge base. I sleep in when I can and I travel to see my kids in LA and Dallas. Sometimes I think I'm the busiest retired person I know.

Retirement is terrific! I heartily recommend it.

Larry Schwartz, M.D.

Lawrence R. Schwartz, MD
Assistant Professor

Colleagues ask two questions. How did I manage to retire so young; and what do I do with my time?

Lawrence Schwartz, MD
Assistant Professor
Sarkis Kouyoumjian, MD
Assistant Professor
Medical Student Coordinator

TRIP SITTERS... (CONTINUED FROM PAGE 6)

Some more GI symptoms and it would easily meet diagnostic criteria. Hallucinations, while a complicated and still not a well understood phenomenon, are usually present with drugs that have a high binding affinity for specific serotonin receptors. According to Aldous Huxley they will open 'Doors of Perception' while causing distortion to the processing of sensory input.

Now that we have identified the offending neurotransmitters, what do we do about it? Well when I was a kid, an eminent toxicologist once told me there are precious few toxicologic problems that can't be taken care of through suitable and liberal application of benzodiazepines, and 14 mg. of lorazepam later, she found a calm place. She required more than some of the others (I'm unsure if that was a dosing issue on the patient's part or mine) but I blame Dr. White.

First take care of the patient, one of those early axioms we hear over and over again. As a physician do I really care what they took? I would argue it doesn't really matter. Physiology has a relatively limited number of ways of doing things and when it finds one that is effective it tends to stick with that same pattern. Bringing us to pattern recognition and the infamous toxidrome, the patients all presented with some degree of a sympathomimetic toxidrome or serotonin syndrome. As a side note, some other considerations for your toxicologic differential diagnosis would include anticonvulsants, antihistamines, antimuscarinics, sedative-hypnotic withdrawal and substrate problems (carbon monoxide, cyanide, dinitrophenol, hypoglycemics, methemoglobinemia, salicylates), would be a good start, in addition to the medical etiologies that you need to keep your eye on. Clinically, there are features that will help differentiate a sympathomimetic toxidrome from a serotonin syndrome and for academic purposes it is interesting, but aggressive goal driven therapy will effectively treat both. Just treat the symptoms' is not as satisfying as many people like but there are symptoms that must be controlled and others that are not so important. Starting with the vital signs (they tell me they are important...almost vital) and temperature is an independent marker for mortality in animal models of sympathomimetic intoxication. Intoxications that presents with hyperthermia—that is your one and only warning shot. Get the temperature under control and do it fast or it is going to get very difficult for your patient. How to accomplish this goal, antipyretics? Buzzz...wrong answer. Hyperthermia in the intoxicated patient is typically mediated through a couple of mechanisms—excess generation of heat via increased muscle activity, increased substrate consumption in the mitochondria or problems with heat dissipation (usually related to an inability to sweat); not excessive 'prostdemons' (prostaglandins) that are going to moderate body temperature under normal and many pathologic processes, so the your usual antipyretics are not going to be useful. To get control we need to again have the patient tell us (there is that physical exam thing again). Is your patient pulling or shaking—sometimes you will see sustained tonic contracture as the etiology for the hyperthermia; or are there tacky mucus membranes and lack of axillary sweat. Now that you have established the 'why' the patient is hyperthermic, fix it. Increased muscle activity? I can smell the hammer coming down. What hammer!!?? Well the Benzo Hammer of course. I would consider your education/ indoctrination to emergency medicine incomplete if you didn't meet 'Da Hammer'. Pick the benzodiazepine flavor you like and pick what dose you feel is a universal safe starting dose and administer to the patient and then re-evaluate in an appropriate time interval. Depending on the onset and duration of action, re-evaluate the patient in10-20 minutes. If the patient is still doing what is pathologic, double the dose and repeat until the problem stops. During this dose escalation you may need to obtain a secure airway and hypotension will be the other limit to keep in mind. What I am advocating is early goal directed therapy—define your goals, control agitation and hyperthermia, define a time interval and then carry out the plan. Sometimes you can't control the hyperthermia with just sedatives, but if you reach the point where the patient's temperature is rising and you still have substantial involuntary muscle activity generating heat, you can take care of that problem too—paralytics—muscle activity will stop. Nondepolarizing drugs are preferable to depolarizing drugs as there will be some degree of rhabdomyolysis and possibly hyperkalemia. The problem with the use of paralytics is the possibility that you will lose the ability to monitor for seizures clinically and the patients will require continuous EEG monitoring at that point.

Seizures are the next complication of this clinical syndrome that will get you into trouble. Goal directed therapy—looks a lot like 'Da Benzo Hammer' is coming back around. As a class, the benzodiazepines are active at GABA receptors and will cause hyperpolarization of cells, decreasing the frequency of depolarization. When on the rare occasion that benzodiazepines fail me (occasionally even your best friend will let you down), step up the GABA ladder—barbiturates. While the benzodiazepines will increase duration of the chloride flux, a barbiturate will increase both frequency and duration of the chloride flux and it does not require intrinsic GABA to open the channel. The next rung up the ladder, propofol, will improve flux through the chloride channel on the post synaptic side and it will also increase GABA release from the presynaptic neuron. That will shut just about everything down, moving aggressively towards the goal.

Next you need to address the issues with the cardiovascular system. Again with the hyperadrenergic state, hypertension and tachycardia are the predominate features. You are looking at too many catecholamines, and the best way to solve this aspect of the problem is to shut the brain down. Remove the head of the beast and the monster dies. Here comes the hammer again.

(continued on page 13)

TRIP SITTERS… (CONTINUED FROM PAGE 12)

"When in a fight to the death, one wants to employ all one's weapons to the utmost. I must say that to die with one's sword still sheathed is most regrettable."

-Miyamoto Musashi "The Book of Five Rings"

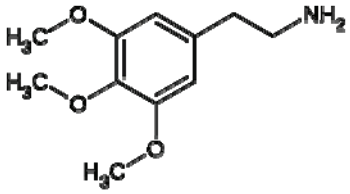
I know the book says there are some specific antidotes that can be used to treat serotonin syndrome. The specific antagonist that has been used is Cyproheptadine. This drug has antagonist properties at serotonin receptors. The initial therapeutic approach should start with a dose of 8-12 mg. followed by another 2 mg. every two hours until some degree of control is established. This is followed by 4-8 mg. every six hours for the first 24 hours at which point decreasing or withdrawing the drug could be considered. Drawbacks of this therapy include that it is only an oral therapy and it also has antagonistic properties at the muscarinic receptors as well—unfortunately this will inhibit heat dissipation—not ideal. Alternative therapies that have been reported include Olanzapine and Chlorpromethazine. Olanzapine has been successful in treating serotonin syndrome at a dose of 10 mg., although this therapy has not been rigorously studied. Chlorpromethazine has been recommended at a dose of 50 -100 mg. The benefit is that this therapy may be administered via the intramuscular route.

Risperidone has also been used in an animal to successfully treat serotonin syndrome. While the use of neuroleptics looks promising with respect to serotonin syndrome due to their antagonist properties at these receptors, there are some risks that go with these drugs as well, such as potassium channel blockade, letting the neurons relatively depolarize (smells like seizure), antimuscarinic effects again (heat is the issue) and peripheral alpha antagonism (possible hypotension).

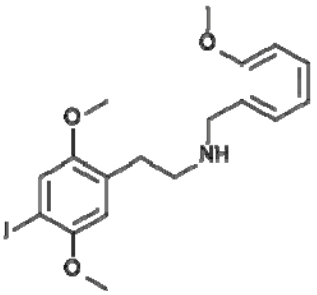
Returning to the N-bomb (well that is how we heard it) but like so much else with illicit or soon to be illicit drugs, misinformation is a constant problem. So, the reported compound is 2-(4-iodo-2,5-dimethoxyphenyl)-N-[(2-methoxyphenyl)methyl] ethanamine (quite a mouthful) or the abbreviated term 2,5 I N-BOMe. Now, pass that term to the kids and you get the N-Bomb. Looking at the chemical structure, yes, I'm really going there, over time you start to see similarities and these will lead you to predictions of activity related to structure. There are some vague similarities to the usual phenyl amines, but there are some interesting similarities to mescaline as well. That little piece of trivia will serve me well tonight. Good rigorous scientific work is limited at best so I'm stuck with a bunch of trip reports off of erowid.org, a couple of unconfirmed bad case reports and some in vitro animal data that is not even close to my patient—yes, I'm pretty much making it up as I go along. That is exactly why you should study your patients and learn everything they can teach you because you too will be confronted with a real time physiology experiment and the skills that you build during these times will be the skills that carry your patient through and if you learn what the last one taught you, you will be able to carry the next patient too.

Next my pitch for the poison center (much maligned and you never want to talk to my SPIs) but this is how the information gets into the right ears. That lovely N-BOMe that just sent all those people to the hospital from one venue is active at microgram dose ranges and milligram dosing is considered way too much. Do you trust the average teen to early '20 something' to successfully mix anything to a uniform microgram concentration? Something like this must be illegal, right? No, not so much. That is why these cases need to be reported. I know you are capable of treating a sympathomimetic intoxication and most serotonin syndromes, and you don't really need my help with 'Da Hammer' but if you would like to see more of these cases, please don't report them. As the law stands, the drug doesn't have enough structural similarity to fit the analog laws nor has the drug made enough waves for it to be independently scheduled (although the state is looking at this drug). To possibly schedule it they need to be able to demonstrate harm to the populace. If those cases or case clusters never make it to the lawmaker's ears, then N-BOMe will continue to be a research chemical with an interesting affinity for serotonin receptors that will be exploited by anyone with the knowledge and the will to take advantage of a dangerous situation. Your patient may have been lucky today but when that tenfold dose error comes down the track or when the trickle of patients becomes a flood of cases, how could this have been stopped? In reality it is not likely to be stopped. While many of the cathinones and synthetic cannabinoid receptor agonists have been scheduled in the last year, there is always something new coming—that is why understanding the physiology is so important. While you may not know what the next wave will bring, you will be able to make a reasonable attempt at correcting the derangement.

Questions or comments about this rant or for topics you would like to hear about in the future can be sent to mhedge@dmc.org



Mescaline



2-(4-iodo-2,5-dimethoxyphenyl)-N-[(2-methoxyphenyl)methyl]ethanamine

Matthew W. Hedge, M.D.
Assistant Professor

CHIEF CHATTER

The DRH Chief Resident Column

What a great start to the year it has been! July brought us a new crop of freshly graduated attendings who are eager to teach, and another great group of first year residents who are well-prepared for their journey through residency. The second year residents have adjusted to their new roles and are keeping things humming around Receiving's ED while the third years are maturing their personal practice through shifts in various places like the ARC, Huron Valley, and Harper EDs. Through it all, we have adjusted our goals of the academic curriculum and find ourselves already two months into the new year.

As this year's chiefs, one of our main goals was to make changes to our curriculum that would better reflect the learning styles of adults (particularly from our fast-paced, technology-heavy generation). We spent hours reading about learning and teaching theory, and had more than a few conversations with our own nationally-recognized expert on medical education – Dr. Gloria Kuhn. What was born was a Thursday morning conference with less emphasis on PowerPoint slide content and much more emphasis on group interaction and case-based discussion. To achieve this, lectures have been shortened from 60 minutes to 30, providing ample time for discussion. Senior residents send out a review article that provides a wide-based foundation for their lecture one week before, allowing presenters to jump right in to the conversation and skip some of the more 'core-content' – the information is still at hand, but the expectation is that it has been reviewed before coming to lecture. To make sure this new format works, each PGY-2 is coupled with a chief resident who reviews their slides and presentation early, making adjustments and recommendations along the way. What we have seen is a conference style that greatly increases participation, attendance, and learning (while reducing in-conference sleep!).

Another new feature of conference is the Difficult Case Series. Using a tough case, residents work through a differential diagnosis as the case develops and review the diagnosis and management of classic emergency presentations – all in rapid fire. The presenter's job is simply to guide the discussion while the teaching is done entirely by the audience. Our Clinical Skills Series continues with Dr. Berk's world-class EKG rounds, while this year Drs. Freeman and Wilburn have put together a similar series focused on arterial blood gas interpretation and Dr. Jones presents radiographic images that will improve anybody's skills!

Our conference has already welcomed a visit from Dr. Judd Hollander from the University of Pennsylvania, as well as a video conference with Dr. Mel Herbert from the University of Southern California. Many more visiting lecturers and Skype conferences are planned for the year including David Newman, Michael Winters, and Peter DeBlieux. It is going to be an exciting year!

Following the great changes made by Dr. Walid last year, we also continue to record each individual lecture and expect to have a central location where all of those videos can be watched online within a few short months.

More changes to the curriculum are on the way, and as always, we not only welcome input, but look for your recommendations to make our conferences world-class. Please join us Thursday morning, 7 am to 12 pm in Crockett B (most of the time). We look forward to having you there!

The Chiefs

Jeffrey Cloyd, MD
Deshon Moore, MD
John Wilburn, MD
Stefanie Wise, MD

"...and another great group of first year residents who are well-prepared for their journey through residency."

2012 RESIDENT AWARDS

Scholarly Achievement Awards
1st Year—Craig Sharkey, Megan Dougherty , Joe Peterson and Erin Brennan
2nd Year—Cameron Kyle-Sidell and Aaron Brody
3rd Year—Ayse Avcioglu and John Hicks

Medical Student Resident Teaching Awards
Katie Dobratz and Neema Patel
DRH Resident of the Year—Bao Dang
SGH Resident of the Year—Michael Gerstein

Norman Rosenberg, D.O. Award—Shereaf Walid
ARC Dayanandan Resident Award—Meenakshi Munshi

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"WE ARE COMMITTED TO BEING THE LEADERS.."

KUDOS

Congratulations to the following faculty members:

Gloria Kuhn, D.O., Ph.D., has been elected 2012 President of the Academy for Women in Academic Emergency Medicine.

Sarkis Kouyoumjian, M.D., on receiving the SOM Recent Alumni Award.

James Paxton, M.D., on receiving the Vidacare EMF Grant for $100,000, his first funded grant as a junior investigator.

Susan Smolinski, PharmD., on receiving the Michigan Department of Community Health (MDCH)-Health Policy Champion Award for the early identification of bath salts and getting MDCH involved essentially preventing an epidemic.

Brian O'Neil, M.D., has been appointed the DMC Specialist-In-Chief for Emergency Medicine.

Margarita Pena, M.D., received the Emergency Physician of the Year Award from the Michigan College of Emergency Physicians.

Anthonio Bonfiglio, M.D., received the Emergency Medicine Educator of the Year Award from the Michigan College of Emergency Physicians.

Robert Dunne, M.D., received the Ronald Krome Meritorious Service Award from the Michigan College of Emergency Physicians.

Sarkis Kouyoumjian, M.D., and Robert Sherwin, M.D., on receiving the 2012 Faculty Award for Emergency Medicine.

Prashant Mahajan, M.D., on receiving the 2012 Faculty Award for Pediatrics.

Trifun Dimitrijevski, M.D., on receiving the 2013 Recent Alumni Award. The Recent Alumni Award was established in 2003, and is presented to alumni who received a medical degree from WSUSOM within the last fifteen years and have demonstrated outstanding professional achievement, community contributions or service to WSUSOM.

Gloria Kuhn, D.O., PhD., has been selected as the inaugural recipient of the Wayne State University School of Medicine Women in Medicine and Science Leadership Award. This award recognizes faculty members who, by their leadership, have specifically promoted the advancement of women faculty members. Gloria's commitment to women faculty by fostering an environment of mentoring and networking, and providing advice and educational programs for career success and advancement forms the basis for her selection as the recipient of this award. Please join us in congratulating Dr. Kuhn.

AAMC 2012 Medical School Graduation Questionnaire—WSU SOM Emergency Medicine was rated 'excellent' by 78.6% of respondents (versus 51.9% nationally) and also surpasses all other specialties by far. Congratulations to Sarkis Kouyoumjian, M.D., Trifun Dimitrijevski, M.D., and all of the staff and faculty who help make our department so well liked by the students.