Honoring our frontline workers
Artist Janet André Block honors our frontline workers.

Bulletin
Awards 2020

A passion for food...
A love for food, a nonprofit and immigrant communities.

What if your town does not matter?

We for we, not me for me
Lessons learned from the Navajo Nation.

A journey to wilderness medicine
Finding a niche.

Learning secrets
Understanding our aging population.

A faculty tale
Michael Mojica tells his story.

A conversation with Corita Grudzen
Leading a research division.

Hearing from our QSPI graduates
Liliya Abrukin, Tona Rios-Alba and Matthew McCarty.

Emergency physicians in the arts
Art, poetry and comedy.

In Memoriam: Cleopas Milton Williams, Jr. MD (RES ’98), Brian Thomas Fletcher, MD (RES ’08) Lives well lived.

#HOPE!

Michael Mojica recounts his time at NYU-Bellevue from 1991 as a PEM fellow who later became director of our PEM fellowship program. He also shares his enthusiasm for teaching through his many PEM Guides, PEM CARS iBooks, and now PEM simulation case iBook.
It has been a remarkable year. We are at the crossroads of the pandemic, and vaccinations are allowing us to envision a better future.

We are inspired by the courage and compassion of all of our graduates, trainees, faculty, and staff. You defied a monstrous virus, unseen for more than one hundred years, and saved countless lives.

Our newest hires and trainees reflect our commitment to create a culture of diversity, equity and inclusion as we continue to innovate in education, excel in research, clinical care, and service to our communities. Working together to achieve these goals will not only improve patient outcomes, but ensure the well-being of all.

In this issue of the EMalumni magazine, you will read awe-inspiring stories of alumni who are advancing equity and social justice in their communities, leading in quality and safety, excelling in research and pediatric emergency medicine education, while exploring artistic abilities in creative and transformative ways. By telling your stories, you hold an exemplary role for our emerging young emergency physicians, trainees and leaders.

We have the potential to accomplish great things together. I am committed to further these efforts.

Sincerely,

Rob Femia, Chairman
HONORING OUR FRONTLINE ED WORKERS

When the pandemic struck, I had been bringing art to the hospital for almost 5 years, as I curated the Gallery for Art and Healing with Dr. Lewis Goldfrank and Joan Demas. So, as I was in isolation in my studio, I was aware and focused on what might be happening at the Bellevue Emergency Department. One day, I read about an artist from California, Michael Gittes, who made paintings for all the staff at Interfaith Medical Center in Brooklyn.

The next morning in my studio, I picked up a tiny 2”x2” canvas and thought, why not a painting for each of the staff at Bellevue ED? This project was not anything I actually analyzed or thought about. When inspiration hits, the best response is to create. Once I started, I couldn’t stop. The paintings are an expression of my deep appreciation to the staff of the Emergency Department.

My feeling is that what one creates doesn’t become art until it’s viewed by another human being. That experience, the response, gives the object its life. The staff will be giving life to these paintings.

The subjects of the paintings are the individual heroism of each staff person holding together to create a powerful response to our common tragedy. Each staff member and visiting staff will receive a painting in the next months. Later, a print of the assembled 2x2’s will hang in the Emergency Department.

Janet André Block
What one creates doesn’t become art until it’s viewed by another human being.”

Janet André Block is an artist based in Salisbury, CT. She has been adding life and beauty to the bare walls of our department since 2015. (Photo by Edward Rubin)

Left. Each 2” x 2” painting (more than four hundred) shown here photographed together as a quilt.
Dear Alumni and friends,

Welcome to our Fall edition, from a city like yours where we also lived through the ravages of the COVID-19 pandemic.

You gave of yourself then and now, surviving unimaginable suffering and death of not only your patients but loved ones. It is a testament to the compassion and fortitude of our emergency medicine family. You revealed your humanism. That generosity of spirit will carry you through the worst of times.

I dedicate this issue to all of you. You will read stories of gratitude, passion, service, innovation, creativity, selflessness, and hope with an overarching theme of compassion.

Janet André Block has touched our hearts. She has transformed our offices into places of beauty, calm, and healing through her paintings. Our own EM art exhibit! Janet was inspired to heal our spirit by gifting over four hundred 2"x2" paintings to each frontline person in the ED during the COVID-19 surge.

Class of 2021, you survived the fury of COVID-19 at its peak during a time of uncertainty with courage, integrity and exceptional humanism. We applaud you.

Warmest regards,

Joan Demas
Editor
2020
AWARDS
WE WANT TO PAVE THE WAY FOR OTHER WOMEN PHYSICIAN LEADERS TO INNOVATE IN PROJECTS THEY ARE PASSIONATE ABOUT.”
What does the award mean to you as women in emergency medicine?
This award means that our work to create a novel and sustainable program is valued and recognized. The idea occurred organically during the COVID-19 pandemic out of a strong desire to educate patients regarding their COVID-19 diagnosis, while also providing medical students with a meaningful clinical experience. We could not have done it without the strong support of our department leadership; operations, telemedicine, patient safety, medical education, clinical site chiefs and nursing leadership. As three women in Emergency Medicine we want to pave the way for other women physician leaders to innovate projects they are passionate about.

Why did you choose emergency medicine?
We love the excitement of the emergency department, the diverse disease processes that we are trained to treat and the ability to connect with patients from a variety of backgrounds.

What was the toughest hurdle you overcame in your careers?
I’m sure we can all agree that we never thought we would be fighting a global pandemic during our residency, let alone be in the epicenter with the world watching us. COVID-19 exposed the fragility of our healthcare system, disparities in healthcare, the need for resource allocation, as well as our mortality. It was and has been the most challenging aspect of our careers thus far, but the experience has made us better physicians and humans.

If you could change one thing about your training as emergency physicians, what would it be?
This pandemic has shown us that EM physicians are under a great deal of stress and are particularly susceptible to mental health issues given the intense environment in which we work. Small changes such as taking a short lunch break away from the clinical area can go a long way toward on-shift resiliency. Similarly, debriefing after an emotional patient encounter can serve as a team building exercise and foster a supportive environment. We should continue to instill on-shift wellness initiatives throughout our training and normalize being human in medicine.

What is the toughest challenge facing emergency physicians during COVID-19?
Battling the misinformation and politicization of a disease that we have seen affect our patients, their families and our colleagues so profoundly.

How do you stay enthusiastic?
Getting to work alongside our friends/co-residents and the excitement of never truly knowing what is about to come through the ED doors next.

Amber and Victoria graduated this year and remain at NYU Langone Health. Amber, an attending at NYU Langone Hospital-Winthrop and Victoria, attending and assistant chief of Emergency Medicine Telehealth at NYU Langone Health. Sana graduates in 2022, and is one of our chief residents this year.
In college, my advisor told me I would never get into medical school. My failures in undergrad were important as they forced me to examine what I wanted and what I would need to do to get there. It forced me to build resilience. It is a continuous challenge to build and maintain resilience particularly as we fight our way through a pandemic.

I wish I was mature enough when I trained, to learn everything I could from the wonderful mentors that surrounded me. As a resident, I didn’t realize how lucky I was to have Lewis Goldfrank, Neal Lewin, Maureen Gang, Jeff Manko, Bob Hoffman and Steve Menlove around to learn from.

We must maintain our mental health. In the best of times, emergency physicians do a poor job of caring for themselves. These are not the best of times. We need to find time to care for ourselves and our colleagues.

Medicine is a noble calling. We are fortunate to be able to do what we do. The challenge of caring for people with critical illness, the quest to learn something today that can help someone tomorrow and to pass on that knowledge keeps me moving forward.
It is an incredible honor to be named the inaugural SAEM Mid-career Investigator award. It means that I am on the right path and doing what I am passionate about seems to be working out OK.

Initially my affinity for the broad scope of EM, my desire to see many patients daily and my inclination for a procedure-oriented career drew me to look further into the specialty. Over time, my experiences with research, international medicine, administration and education all cemented my commitment to the exciting field of emergency medicine.

The K to R level funding transition is a notoriously difficult hurdle to accomplish, especially in the times of diminishing NIH budgets and increasing competitiveness for federal grant funding. Thankfully I was able to draw upon the wisdom and experiences of some tremendous mentors to get me across that particular finish line, such as Lynne Richardson, Yasmin Hurd, and David Vlahov. Good mentors are so important, not only because of the knowledge and skills we can learn, but also because mentoring provides personal support to facilitate success in one’s early career and beyond. Quality mentoring greatly enhances one’s chances for success.

Adopting the “pain is the 6th vital sign” during the era of my training has to be among the biggest mistakes we as a specialty have made and is the one thing I would change. Now it is up to us, as emergency physicians to be part of the solution to the opioid crisis.

I have ongoing concern that the COVID-19 pandemic will disproportionately affect populations with substance use disorders. There is an urgent need for us to examine COVID-19 risks and outcomes in patients with opioid use disorder (OUD), particularly among homeless and incarcerated individuals. Additional attention needs to be given to the risks of reduced services, such as medications for opioid use disorder (MOUD). Beyond these social risks, there are several plausible biological mechanisms for potentially worsened outcomes in patients with OUD who contract COVID-19.

I maintain my enthusiasm for my work by not sweating the small stuff, hanging out with enthusiastic people, eating well (thanks to my wife’s culinary talents), and constantly not allowing “perfect” to be the enemy of “good.”
My time at NYU-Bellevue was formative. While learning the practice of emergency medicine, I was simultaneously receiving a different kind of education from my attendings and co-residents working on the most challenging problems in our society. Under the guidance of Dr. Goldfrank, I had the courage to find my place not only as an emergency physician but also as an advocate for social justice.

In 2016, soon after graduating, I moved to the West Coast (Bay Area) to take a job as an emergency physician in Oakland, California. This was, the year that President Trump was elected, and years in which we saw xenophobic rhetoric take form into the horrific policy of child separation. We saw, images of children in cages, mothers deported, families left in limbo. I was not only personally outraged, but as a physician I saw how this was adversely affecting my patients.

There were horror stories about undocumented patients being intercepted on their way to the hospital or just after emergency surgery. The tension, anxiety and fear in the community was unmistakable. I saw a patient in his 50s brought in by Emergency Medical Services (EMS) in cardiac arrest who did not seek treatment because he was worried that the hospital...
Growing up as a second generation Indian American in the midwest, I have experienced my fair share of xenophobia and racism. That shared history makes me feel more connected to the communities that I serve. It pains me to see that fear has taken root in immigrant communities and forced families to make impossible choices. Does a mother take a sick child to the doctor and risk deportation or does she stay home? Does one go to work when there are immigration and customs enforcement raids ongoing or stay home? Does one sign up to get the COVID-19 vaccine or not because of fear of disclosing personal information?

These patient encounters stayed with me as I continued working in the emergency department. I started to feel the urge to do something more to address the root of the problem. I had also been struggling personally to find my place after leaving Bellevue, a place where no one is turned away and diversity is treasured. Then on
November 22, 2018, while watching the Trevor Noah special on Netflix “Son of Patricia,” I had an epiphany. Trevor in his usual comedic style talked about race, immigrant identity, and food. He offered a suggestion to his audience:

“I feel like there should be a rule in America, they should say, you can hate immigrants all you want, but if you do, you don’t get to eat their food. Yeah? That’s a fair exchange to me. You hate immigrants, no immigrant food. And when I say no immigrant food, I mean no immigrant food. Nothing. No Mexican food. No Caribbean food. No Dominican food. No Asian food. Nothing. Only potatoes. And I’m not even saying flavored potatoes. I’m saying plain potatoes. No spice. Because no immigrants, no spice. Don’t ever forget that. Both figuratively and literally, no spice.”

At that moment, the nonprofit No Immigrants, No Spice (NINS) was born. I resolved to give voice to the voiceless, by bringing the community together to celebrate our diversity through one common language, food! Having lived in New York City, I became a serious foodie. I love food - the taste, the process, the history, the ethnography, the ethnobotany, and the different food ways of “American” cuisine. So many of us love and enjoy the foods of immigrants and don’t even realize it.

NINS is a 501(c)3 nonprofit that shines a light on the contributions of immigrants to our social fabric - seeking to change hearts and minds. We work to flip a narrative in the media that vilifies and demoralizes immigrants, while simultaneously raising funds to defend the rights of people in migration and to educate and empower.

Our first campaign, #BBQwithoutborders, brought together six Bay area chefs not only to share their cuisine, but to discuss their journeys as immigrant chefs and explore their cultures.

"We are obligated as healthcare providers and conscientious citizens to combat xenophobia and systemic racism.”

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Attendees at the #bbqwithoutborders event.
immigrant health and was tasked to create a policy to expand “Safe Spaces” within our hospital campuses to protect all patients seeking healthcare. I was proud to be a voice at the table to successfully advocate for a written policy that has been disseminated throughout our regional network at Kaiser Permanente.

We are obligated as healthcare providers and conscientious citizens to combat xenophobia and systemic racism not just because it’s the right thing to do, but because it affects the health and wellbeing of us all. If COVID-19 has a silver lining, it should be that we are all mortal and our words and actions impact the most vulnerable people in our communities. I am invested in this work, heart and soul. It is my social mission.

Additional campaigns throughout this year have highlighted the plight and contributions of undocumented restaurant workers and immigrant farmers during COVID-19. It is outrageous that many of our essential workers who are undocumented cannot access the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). Through NINS we have been raising funds to keep undocumented folks housed, fed and safely sheltered in place during the pandemic.

During the 2020 election we ran an educational campaign on the history of voter suppression in LatinX, Asian American and Black communities. The campaign, called #eatvotelove was all about the foods, the history of voting rights and community organizing in these demographics. All funds raised from the campaign went to the organization When We All Vote.

Our newest campaign will elevate traditional postpartum wisdom as a form of postpartum justice for Black and Indigenous mothers. We will run an educational campaign in partnership with a group from UC Berkeley and raise funds for the delivery of nutritious meals from immigrant chefs to at risk postpartum women served by the East Oakland Roots Clinic.

Coming full circle, over the last year I conducted a speaker series on through dance, art and of course food. The Flamenco, Bhangra, Balinese and Street dancers were breathtaking. The art exhibit “Immigrants are Us” celebrated immigrants and their contributions to our communities in a myriad of ways, through their creativity, innovation, entrepreneurship, and hard work. #BBQwithoutBorders celebrated BBQ in the form of barbacoa tacos, Iranian sweet-sour chicken wings and Indonesian Ikan Bakar grilled seafood. The event attracted more than four hundred attendees and was featured on the San Francisco Chronicle. One hundred percent of profits ($12,000) went back into the community.

Vibha Gupta, MD, Executive Director and Founder of NINS, NYU-Bellevue alum, class of 2016.
PHOTOEXHIBIT AT #BBQWITHOUTBORDERS FROM “IMMIGRANTS ARE US”, A PROJECT BY PHOTOGRAPHER MARK TUSCHMAN WHICH COMBINES POWERFUL PORTRAITS WITH EQUALLY POWERFUL HISTORIES OF THE PARTICIPANTS.
"Flipping the narrative and shining a light on the contributions of immigrants."
The pandemic had become an X-ray that has exposed all of the fractures of a society.”

MANA KASONGO, MD
During the first weeks of the surge of COVID-19 in the emergency department, I coded a 60-something year old African American man who had COVID-19. It was in the middle of the night. He was an ICU hold. The nurse noted the patient’s heart rate was dropping, so she came to me. I was the only doctor in the hospital. By the time I got there, he was in asystole. We commenced CPR. We resuscitated him for a brief time. Then we lost his pulse again. We were not able to get him back. He died alone. When I asked about contacting his next of kin, I found out that he was the last of a family of three to die. His wife died a couple of days before him. The patient’s sister-in-law died two weeks before her. They all died alone.

I work at a 200-bed hospital in the heart of Southwest Georgia. As of 2019, the total population of the county where the hospital is located was about 22,000 people. It’s three and a half hours from Atlanta and Savannah, Georgia, Birmingham, Alabama, and Tallahassee, Florida. It’s breathtakingly beautiful, surrounded by pine trees, farmland, and hunting plantations. It’s in the heart of what is known as the Black Belt, the place where enslaved people were forced to pick cotton until the end of the Civil War.

Despite our violent history, our divisive politics, and our regions’ geographic isolation, as a Black woman who has lived in New York, Chicago, and Boston, Southwest Georgia is surprisingly progressive. I live in an integrated neighborhood. Half of the emergency physicians where I have worked have been Black or Latino, including the ED director. Black people here are relatively prosperous, and, dare I say, happy. Some of them even own property.

As I write this essay, COVID-19 has claimed more than 200,000 souls. Essentially, it’s as if the rural county where I work has died 10 times. The thought overwhelms me. It means that it’s not entirely impossible for entire rural populations to die without anyone noticing, to die as alone as the 60-year-old man and his family.

When COVID-19 first arrived in the US in January 2020, I had soothed myself with the thought that our geographical isolation would offer enough protection to at least give us enough time to prepare for the arrival of the virus. That did not happen. The virus arrived with such brutality in Southwest Georgia that we became national news. In April, the coroner of Dougherty County, Michael Fowler, made the cover of Time magazine. The photo showed him in the morgue, dressed in full personal protective equipment—gowned, double-gloved, face obscured by goggles and N95 mask. In the story, Fowler said the virus “started spreading at a couple of funerals. Those individuals who attended the funerals went back into their neighborhoods, homes, and churches, and more people were infected. It hit like a bomb.” Meanwhile, the hospital employees went through years of personal protective gear in six months. It was overwhelming. The doctors and nurses, along with techs and staff were dealing with a deluge of COVID-19 patients on a daily basis.

Before COVID-19 detonated, I had been in contact with some friends from New York who are emergency physicians. They told me what symptoms to look for, how to be prepared to surge your emergency department, and how to prepare for the emotional stress.
the pandemic would inflict. I took everything they said seriously, and did my best to fortify my staff and myself. When the virus did arrive, despite our best individual efforts, we were unprepared simply because a rural hospital cannot adequately prepare for a global pandemic without a strong and active public health infrastructure.

My first COVID-19 case happened in the middle of March. I was working the night shift by myself when a fifty-something year old African American woman, who worked as a nurse at the nearby marine base, arrived in the ED. The patient had fever that lasted for two days, so she was sleep deprived and dehydrated. She had only urinated twice in 24 hours, had no cough, fatigue, and body aches only when her fever spiked. Her oxygen saturation was 100 percent on room air. She had felt well enough to go to work that day but chose not to because of her fever. Not feeling any distress, she sat comfortably in the recliner. I took a thorough history: had she recently traveled to Asia, Seattle, New York, or Europe? No. Had anyone in her home been sick? No. She lived alone and had no visitors for nearly two weeks. All she did was go to and from work. Had she been in contact with anyone with the novel COVID-19? She said she didn’t think so. Then she remembered that three days before she had taken care of a veteran with COPD. He came into the office, coughing persistently. It was a dry hacking cough with a fever. “He looked terrible,” she said, “worse than normal.” Had either she or the patient worn a mask? Yes, but she couldn’t remember if she had kept her surgical mask on the whole time. He kept removing his mask because he coughed so badly he would vomit. Her workup was completely normal. Her labs and chest X-ray were normal, and at that time she had no fever because she had taken ibuprofen shortly before she came in. Her arterial blood gas was normal, her influenza and strep swabs were negative.

But, she had lost her sense of smell.
I recommended a COVID-19 swab. She agreed and I told her it would be several days before she got her result. In the meantime, I sent her home with an albuterol inhaler, azithromycin, vitamin C, and zinc sulfate, strict self-isolation orders, and gave her the Amazon link to get a portable pulse oximeter. If her oxygen level dropped lower than 92 percent, she was to come immediately back to the ED. Three days later the director of nursing told me that this patient was positive for COVID-19. We called her with the result. She was shaken by the news, but she felt well. The fever had subsided, and she was not in any respiratory distress. She felt she had gotten through the worst of it.

When I got back to work after having a few days off, our respiratory therapist told me the patient came back the day before and had to be admitted for bilateral pneumonia. They had intubated her overnight for worsening respiratory distress. She remained on the ventilator for over three weeks, with multiple attempts in between to wean her failing. Ultimately, she survived and was discharged after six weeks in the hospital.

Seeing my first COVID-19 patient worried me as it did my colleagues and friends in New York City. But unlike them, I had a deeper reason to worry outside of the coronavirus. Unlike New York City and places in Seattle that got hit really early and hard with this virus, I felt I was in a part of the country that, well, how can I say this delicately? No one cares about. I learned that painfully when the recession of 2008 hit the country and most bounced back as if nothing happened, certainly New York City and Seattle came back with a vengeance. Southwest Georgia, not so much. Too many companies to enumerate including Cooper Tire and Merck left town and many industries just closed and didn’t return.

I was further reminded of our insensitivity between 2017 and 2019 when this region was hit with tornadoes and hurricanes this region has never seen. In January of 2017, I was eight months pregnant. Right after New Year’s, an EF1 tornado and straight-line winds knocked down trees and powerlines, paralyzing the city. So many trees had fallen around our house that for the first and only time in my career, I couldn’t get to work. We had to temporarily relocate to a hotel room for two weeks since we didn’t have power. At least our house was still standing. Some of our neighbors weren’t so lucky. If that wasn’t bad enough, three weeks later a series of tornadoes swept across southern Georgia that made a bad situation worse. As a result of a bureaucratic snafu amongst local, state, and federal officials many people went weeks without power. In September of 2017, Hurricane Irma struck. In October of 2018, Hurricane Michael struck the Florida panhandle as a category five hurricane. By the time it reached Albany, 90 miles inland, three and a half hours from the Florida gulf coast, it was still a category three hurricane. That’s never happened before. Each of these extreme weather events caused extensive emotional and economic damage that only deepened the effects of the recession, increasing the all too real sense that Southwest Georgia could be forsaken if it meant preserving the economic well-being of those fortunate enough to live in big cities.

In addition, to the economic woes and extreme weather events Southwest Georgia was already dealing with a patient population that is sicker than their counterparts living in cities. According to the CDC, “people who live in rural areas, are more likely than urban residents to die prematurely from all of the five leading causes of death: heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke.” If you’re black and living below the poverty line, these disparities are compounded. Add to this, the fact that last flu season was the worst in a decade for children. It’s hard not to feel a sense of despair as we look forward to what may be a long winter ahead.

Yet even with my sense of pessimism, I could never have imagined such a
horrible bungling of the worst pandemic in 100 years. This is the most advanced and richest country in the world. We should be able to contain this virus? We can’t. We aren’t. We should certainly be able to mitigate this? No. We can’t. What are we doing? It appears several regions in the country are playing a game of whack a mole with the virus.

After my first patient, we saw a steady rise in COVID cases, usually people who worked in Albany, GA or had been around a family member in Albany. I expected this. I didn’t expect Florida to remain open for spring break, and provide a setting for a super spreader event. Suddenly, our small hospital had to handle an influx of people from out of state who were traveling up and down I-75. Then fast food workers started to arrive in the ED since all of these revelers were stopping at nearby local fast food restaurants to be fed while on their way home. Then I started seeing patients who work at the numerous meatpacking factories and farms coming in with COVID-19 symptoms. No matter what walk of life these patients came from, most of the people I intubated or placed in the ICU with the worst manifestations of COVID-19 are Black and Brown people. I realized very early on in this pandemic that the dire morbidity and mortality was disproportionately impacting Black and Brown communities. The pandemic had become an X-ray that exposed all of the fractures of a society that has relegated generations of Black and Brown people to the margins of society, resulting in limited access to healthcare, education and housing.

As with all issues related to race, the intersectionality of race and the coronavirus is multifactorial. First, a majority of minority people work essential jobs that don’t allow them to work from home. This includes meat packers, janitors, grocery store clerks, bus drivers, mailmen and women, medical assistants and certified nursing assistants especially in nursing homes, and healthcare workers, to name a few. Second, because of structural and systemic racism in the delivery of healthcare and allocation of healthcare dollars, minority people have baseline chronic medical problems that the coronavirus takes advantage of such as morbid obesity, diabetes, hypertension, kidney disease and lung disease. Third, because they are essential workers but generally low paid hourly wage earners, if they do not work, they do not get paid. Few get paid time off, so many of them continued to work despite either knowing or suspecting they had the coronavirus. And certainly, most of them did not receive hazard pay for working through a pandemic. Additionally, since 60 percent of all Black Americans live in the South, we could deduce that this virus was going to wreak havoc in southern, rural communities such as mine. And the numbers bear this out. As of this writing, Georgia has had 300,000 cases and about 6,500 deaths. Florida has had 699,000 cases and 14,021 deaths. Alabama 151,000 cases and 2,491 deaths.

At the beginning of April, the state of Georgia closed to make sure the state wouldn’t overwhelm hospitals with COVID-19 cases. It worked. Georgia began to reduce its transmission rate. Fewer people got sick. Then less than a month after closing the state, churches, gyms, bars, tattoo parlors, and hair and nail salons were allowed to open. Transmission rates hadn’t dropped for 14 consecutive days as the White House Coronavirus Taskforce recommended. The opening also coincided with new data that showed what I had already witnessed - Black and Brown communities were getting sick and dying while white communities remained comparatively less affected. Since the beginning of the pandemic, I understood that the virus didn’t discriminate. It was an equal opportunity destroyer. Now, I understood that public health policy can discriminate, and, for a region like Southwest Georgia, it may ultimately seal its fate.

Soon after the reopening, we were overwhelmed with cases. Our ICUs
filled with COVID-19 patients, suspected and confirmed. We held patients in the ED. Sometimes we had no choice but to go on diversion and not accept any ambulances from outside the county. It was a devastating but necessary decision for a critical access hospital such as ours. We had surged as much as we could. There was just no more space. COVID-19 patients stayed on ventilators for weeks, so ICU capacity remained a problem. After several staff members fell ill, we were required to wear PPE at all times with an N95 mask. We have 12-hour shifts which are really close to 14 hours. We went hours without drinking, eating, and feeling like we were suffocating under our masks.

One day, in the middle of my shift I called my husband in tears. It was a particularly bad day. COVID-19 and non-COVID-19 patients were coming into the ED fast and furiously. I had not had a second to take off my mask except for 30 minutes before my shift was over. I was angry that I was thirsty. My lips were actually stuck together. I told him I wasn’t sure I should even go home. I didn’t want to expose my family to this virus. I knew doctors who were staying in their garages, or in hotels because the risk of transmission felt too great. I know a friend who sent his young family away for months because of this virus. How could I go home? My husband was in the middle of calming me down, when the nurse bangs on my call door, and tells me yet another patient in respiratory distress was coming in. So, I had to cut him off, and attend to this patient.

It was a somber drive home that night. I was scared to go home. I thought about just renting out one of those extended stay hotels, but I have a three-year-old daughter and a seven-year-old son who already don’t see enough of their mom. I just knew that the psychological impact of them not seeing their mom, and knowing how deadly this virus was would only lead to more fear on their part. This question of whether or not to even go home has plagued me since the beginning of the pandemic. My husband signed up to be married to an emergency physician who had crazy and long hours, and a super stressful job. He did not sign up for possibly getting a deadly disease from me.

My job has become a nightmare of sadness, fear, and anger. Before the pandemic, I enjoyed my interactions with my patients. That doesn’t happen anymore. I don’t want to be a vector of disease for my patients or vice versa. So the conversations about where you come from, who your people are, and where you go to church don’t happen anymore. I don’t entertain anymore questions about where my name comes from or where my accent is from. I used to hug my well-known patients. Some of them are like old friends. There’s one patient I see so often I once told her that I saw her more than my own kids. These are the moments that make what I do worth it. It’s the smile you get or the high five you get from a child who feels better. That’s ended. The pandemic stole these moments from me. I don’t see those smiles. I do not shake hands anymore. Our interactions now seem distant, just from a public relations point of view, with the 6 feet of distance rule. My profession that I love, have sacrificed so much for, and took years to master, has changed seemingly overnight. Just that thought saddens me. Now, I find myself often thinking of planning an exit strategy out of the profession.

As the spring became summer, and now summer has turned to fall, and more states have reopened. The community has appeared to accept the pandemic as normal or think it has ended. Our pastors who used to
pray with us at the beginning of the pandemic stopped coming. Patients seemed shocked when staff greeted them with full protective gear. One patient seemed particularly offended with my PPE. She asked me why I was dressed like I was “going into space?” Did I think she had something? I said no. I didn’t necessarily think she “had anything,” but that Georgia COVID-19 cases had reached community spread, so we had to presume everyone had it. She seemed confused and added, “Oh, that’s still going. Coronavirus is still here?”

I am an immigrant. I know how uncertainty feels. I know what it is like to not know how the future will bear out. I know what fear is. I am from the Democratic Republic of Congo, Central Africa, called Zaire when I was born, a place that has been mired in civil war for too many years to count. I lived on the south side of Chicago in Hyde Park before it became gentrified and white and when we as school kids would be chased and terrorized by El Rukn gang members. I went to middle school in Liberia during the time of Samuel K. Doe, a dictator so brutal that

“What was instructive to me, through a recession, and several “once in a lifetime” extreme weather events was how rural America can be abandoned. Silently, quietly, and easily without much fanfare.”
when he was caught by rebel forces, he was tortured and killed. I went to high school in Massachusetts, easily the most racist state I've ever lived in, full stop. I volunteered in Haiti four days after the devastating earthquake of 2010 and experienced multiple aftershocks while I was there. I also traveled to Kenya with my husband after contentious elections and high levels of ethnic hostility. I say all of this to emphasize that I don’t scare easily, and I don’t get discouraged easily, and I will not be intimidated. But COVID-19 is bringing me to my knees and it is intimidating. It has changed how I view the future for myself in the field of medicine and the future of my children and America.

All of this defies reason. We are the United States, the most powerful and resourceful country in the world. I always thought that we can do anything. I was totally wrong. Instead of mobilizing the country to help Black and Latino people who were making up about 60 percent of all COVID-19 deaths, our president took to Twitter to exhort his base to “liberate” states that had shut down to protect themselves from a virulent pathogen that was killing its citizens. To add insult to injury, armed militias stormed state capitals demanding states reopen, ignoring mask mandates. Factory owners and politicians bow to quarterly earning reports and 24 hour news cycles that, no matter how much they report on COVID-19, cannot persuade enough politicians to help our grandparents who live in assisted living centers and our children who are back in school.

What was instructive to me, through a recession, and several “once in a lifetime” extreme weather events was how rural America can be abandoned. Silently, quietly, and easily without much fanfare. You are left to your own ingenuity. You’re left with all the risk, no matter how brutal the disaster or how merciless the novel zoonotic virus is. You. Are. On. Your. Own. When I think about what will happen to Southwest Georgia after this pandemic, it’s done through the prism of these experiences where good, hard working people would have no recourse against some entity that they never saw coming. This is not a trivial point. Just as we are seeing “once in a lifetime” wind, water and fire events happen every week, it’s not out of the question that we will have another “once in a lifetime” pandemic and, sooner than every hundred years. What happens to rural, Black and Brown communities everywhere who are skating by already on the thinnest of resources. What happens when we leave it all to chance? What happens when we as a society decide to substitute “luck” with public health policy? Are we all to be damned if we aren’t in New York, Chicago, LA or some place that “matters”? As of right now, I hesitate to answer because I need to believe we are better than who we have been since the pandemic started.

Note.
_Since this writing, over 600,000 people have died from COVID-19. While numbers are going down, and vaccines more available, the transmission rate is still very high in several states._
WE FOR WE, NOT ME FOR ME

BY TARA SOOD, MD (RES ’10)
My first Global Health patient experience was a 50-year-old woman with a past medical history of asthma who presented with several days of a dry cough and shortness of breath. Hearing wheezing on exam, I grabbed an albuterol Metered Dose Inhaler (MDI) from an old lunch box filled with a few medications and handed it to her explaining instructions for use. Surprisingly, she handed it back to me. Assuming her concern was regarding side effects, I explained that they were minor and that the benefit outweighed risk. She smiled at my misunderstanding of her intentions and responded, “I trust you, doc. I just don’t want to take it because you don’t have that many. Save it for someone who needs it more, like an elder.” In almost a decade as a physician, this was the first time I experienced a patient refuse medicine that they needed in order to save it for someone who might need it more. Over the ensuing weeks, I saw people habitually balance the needs of the community with their own. My first patient interaction wasn’t an anomaly, but the norm at Standing Rock Indian Reservation in North Dakota.

At its peak in 2016, almost 15,000 people gathered in Standing Rock to peacefully protest the construction of the Dakota Access Pipeline on tribal land. The police and private security forces hired by the oil conglomerate, Energy Transfer Partners, responded with firing tear gas, rubber bullets, and even water cannons at people in -20°C conditions. In response, indigenous tribes from around the world sent representatives to Standing Rock to stand in solidarity with the Sioux tribe. One of them, a Sami woman from Norway, came to me with abdominal pain that I suspected was appendicitis. A dozen people volunteered to drive her to the nearest ED, an hour and a half away. All of them chose to stay with her until she was discharged after surgery. In Standing Rock, I wasn’t caring for patients alone. People in the community were active and willing participants in patient care. They felt a responsibility to care for others. Routinely, patients I saw would stop by to drop off supplies they wanted to share, or to clean the space, or to shovel snow outside the medical yurt. Although most return visits were to bring me food daily, stemming from the elders’ deep concern about the perceived lack of “meat on my bones.”

Since Standing Rock, I have worked internationally over a dozen times. I view Standing Rock as my first global health experience because it was worlds apart from my conventional practice. However, I didn’t truly appreciate the effectiveness of community
For the first time in its history, Médecins San Frontières/Doctors Without Borders (MSF) deployed teams within the United States to the Navajo Nation.”
engaged care until recently, in the midst of this pandemic. COVID-19 struck the Navajo Nation early and viciously. Navajo Nation is a Native American territory that extends into the states of Utah, Arizona and New Mexico, covering over 27,000 square miles. It’s roughly the size of West Virginia and home to roughly 180,000 Navajo people (aka Diné). The first cases of COVID-19 were reported in mid-March 2020. By its peak, in May, Navajo Nation had the highest rate of COVID-19 cases per capita in the United States. Yes, higher than New York.

Several socio-economic factors accelerated the spread of COVID-19 through this community. As most Navajo people live in multi-generational households, in dwellings limited to one or two rooms, isolating or quarantining is an impossibility. Approximately 30-40 percent of Navajo people do not have running water, which makes frequent hand-washing a challenge. Nearly 60 percent live without access to the internet and 10 percent live without electricity, limiting the ability to disseminate educational information or public service announcements. Since there are only 13 grocery stores in an area the size of West Virginia, access to nutritious food is severely limited. COVID-19 underscored this pre-existing lack of basic needs and infrastructure.

I knew little about these deficiencies when I started volunteering in New Mexico at the Gallup Indian Medical Center (GIMC) emergency department located on the border of the Navajo reservation. The ED had only 13 beds, separated from each other with plastic sheets. Capacity was stretched with outdoor tents for stable patients. The acuity was high with only a handful of specialties available in-house. Throughout my time there, the hospital was full and all admissions required transfer to other cities. We alternated transfers between Albuquerque or Santa Fe, NM and Phoenix, AZ. If two members of a family became significantly ill with COVID-19, they generally ended up being admitted to hospitals in different cities, sometimes 480 miles apart. What’s worse, there was no efficient system in place to transport patients back to Gallup after their discharge. At times patients transferred to Albuquerque attempted to walk or hitch-hike 140 miles to return home, but ended up returning to our hospital with rhabdomyolysis, heat stroke, and renal failure.

Despite the hard-work and dedication of the staff who take great pride in serving the Navajo people, its healthcare system is chronically deficient. Indian Health Service (IHS) is the federally funded agency responsible for providing healthcare to Native Americans. In normal times, IHS is so underfunded it only spends one-sixth of what Medicare spends per patient. IHS facilities are understaffed by an estimated 25-40 percent. This chronic negligence is reflected by the almost four times higher rate of diabetes, double the rate of obesity, and a 5-year lower life expectancy than the general US population. During the pandemic, the negligence was more striking. When the Seattle Indian Health Board asked the Federal government for PPE and other supplies, they were mistakenly sent a box of body bags. The nations, separate from the state government, were excluded from funding in the first draft of the federal Coronavirus Air, Relief, and Economic Security (CARES) Act. This delay lead to additional challenges getting COVID-19 test kits, supplies and establishing isolation, quarantine, and contact tracing activities. IHS even received masks not approved for medical use! Given the lack of basic needs, infrastructure, and adequate healthcare, it’s no surprise that the Navajo Nation had the highest rate of infection per capita in the country. For the first time in its history, Doctors Without Borders/Médecins Sans Frontières (MSP) deployed teams within the United States to the Navajo Nation. Academic institutions such as Massachusetts General Hospital (MGH) and University of California, San Francisco (UCSF) also sent teams of
... the Navajo nation had a mask mandate with near 100 percent compliance. Navajo leaders acted swiftly with a shelter in place instituted three days after the first case.”

On my first day in Gallup, I experienced a snippet of the qualities that are the basis of the Navajo response to the pandemic. On my way to my first shift at GIMC, my car stalled. Before I could panic, strangers came to my aid and got my car functioning. Before I could make it to the nearest auto shop, my car stalled again and another group of strangers helped me get to the auto shop. Although her schedule was full, the mechanic agreed to repair my car the same day when I told her it was my first day in Gallup, and I didn’t know anyone in town who could help me. The owner of the shop drove me to my shift and picked me up after my shift. When I thanked him for his kindness, he responded “you are here for us, we are here to take care of you.”

In spite of all the challenges the Navajo people face, they successfully flattened the curve. In March, even with the politicization of mask wearing, the Navajo nation instituted a mask mandate with near 100 percent compliance. Navajo leaders acted swiftly with a shelter in place order three days after the first case. It was followed by a strict 57-hour weekend curfew which remained in effect until August when it was shortened to 32 hours. Although they have the strictest lockdown in the country, severely limiting mobility...
to obtain food and water, there were no protests against the orders. There has been widespread acceptance that people must tolerate inconvenience and loss for the community to survive this pandemic.

Adding to the prompt public health interventions of the Navajo leaders, there was mass grass-root mobilization. Local businesses house and feed people. When COVID-19 positive patients are discharged from the hospital and sent to designated motels to isolate, community organizations paid the bill, and provided a visiting doctor and food delivery. The Navajo youth grassroots programs delivered food, water, and cleaning supplies to elders on the Reservation so they can shelter in place.

The Navajo Nation have set up their own fundraising campaigns, to which the people of the Republic of Ireland famously made donations. In 1847, while the Choctaw people still suffered because of the Trail of Tears, they extended kindness to the Irish people suffering from the Great Potato Famine by donating $170, equivalent to $5,000 in today’s money. The Irish people reciprocated this kindness by donating almost $5 million to the Navajo COVID-19 Relief Fund. All these efforts successfully flattened the curve despite rising rates of infections in surrounding states. Warned by the experience of the Navajo Nation with COVID-19, other tribes across the United States instituted policies to protect their people before COVID-19 infections occurred in their communities.

I attended a lecture by Dr. Shaquita Bell, a Pediatrician at Seattle Children’s Hospital, when she spoke about the preventive measures Native American communities in Seattle had taken. One community organized for the young and healthy to do all shopping for the elderly. They mandated masks, set up screening check points for anyone entering the community, and routinely tested high risk individuals. By the time of Dr. Bell’s lecture in late July, the community had zero cases of COVID-19. Dr. Bell’s conclusions coincided perfectly with what I had witnessed in Standing Rock and the Navajo Nation: “My people have survived genocide and multiple pandemics. We will survive this one too. We have almost 100 percent compliance with masks, we take care of each other, and we protect our elders. Because in our culture, it’s we for we, not me for me.”

People of the Navajo Nation, have much to teach us. Despite all the deficiencies in infrastructure and health-care, the Navajo successfully flattened the curve because of immediate public health interventions, and community compliance, due to their shared values, summed up as “we for we.” It is worthwhile to learn from a people who live by values rooted in their culture for generations.

There are numerous ways to incorporate this value system into our personal lives, our practice, and our departments. Working in solidarity with the Navajo people is one way. Give of your time and skills by volunteering for humanitarian groups working with the Navajo Nation, such as Project Hope. Develop a program at your institution to facilitate volunteerism by physicians at IHS hospitals, like that of Brigham and Women’s Health Care Outreach Program. If you are invested in residency or fellowship training programs, arrange off-service rotations for residents and fellows on Indian Reservations. For those who want to contribute financially, Community Outreach and Patient Empowerment Program (copeprogram.org) is a Navajo run organization providing housing for quarantine and supplies. Since 30 percent of the Navajo people live without access to running water, consider supporting a Native organization such as Water Warriors United (collectivemedicine.net) or Navajo Water Project (navajowaterproject.org).

For anyone who wants to act in solidarity with Native Americans, there is no lack of opportunities. I was fortunate to be able to share my time and skills with the Navajo people and I left with valuable and long-lasting lessons to live by. The people of Standing Rock introduced it to me and the Navajo showed me how effective a community-based response can be in curbing a pandemic. I left Gallup believing the way for our country to stop losing thousands of lives to COVID-19, is to adopt and practice “we for we, not me for me.”

Tara in front of makeshift patient rooms created with plastic sheets at the GIMC ED.
Few people who end up in the field of wilderness medicine planned it that way. Many of us stumble across it by chance and stay.”

CARLO CANEPA, MD
What about wilderness medicine in Costa Rica? asked Dorothy.

“That sounds dumb,” I said bluntly. Like all of my best ideas, this one came from my then girlfriend and now wife. We were third year medical students planning our fourth-year electives. Jay Lemery (RES ’04) was putting on a two-week course in wilderness medicine in Costa Rica. We both had no idea what it was about, but we figured that two weeks in the jungle and on the beach would make for a great elective. Eight years later, wilderness medicine is an important part of my career. Few people who end up in the field of wilderness medicine planned it that way. Many of us stumble across it by chance and stay. It requires a willingness to go slightly against the grain and take a chance on something different. Through my own journey I hope to give some insight into this somewhat nebulous field and hopefully inspire the current residents.

I was born in Lima, Peru, and immigrated to the United States when I was 4 years old. My family fled a Maoist uprising called the Shining Path, which wreaked havoc on our lives through car bombings, power outages, and terrible inflation. We landed in New York City. I spent my elementary school years attending P.S. 116 and living in Stuyvesant town, just a few blocks from Bellevue and NYU hospitals. We were not an outdoorsy family in the traditional sense. We traveled and went to the beach, but my parents were not the type to choose to sleep outside in a tent and suffer. That was not part of our immigrant experience. I did not go on an actual hike until I was an undergraduate at Columbia University. It’s never too late to start.

The more I traveled, the more I fell in love with hiking, camping, and spending time outdoors. At the same time, I was figuring out that I wanted to become a physician. How could I blend the two? At first, I was inspired by Dr. Paul Farmer and the Partners in Health model. I researched malaria prevention and treatment while studying abroad in Madagascar. I volunteered at an HIV/AIDS clinic in Rwanda, distributing food during a summer break in college. During medical school at Cornell University, I spent a summer in Zwedru, Liberia, with current NYU EM resident Peter Luckow (RES ’23), conducting research on the effect of community health workers on HIV and Tuberculosis outcomes. By the time I finished medical school, I was somewhat burned out on global health and had a hard time imagining a career that could give me all of the things I was looking for – doing good in the world, and enjoying the process.

It was at this time that we went on our elective to Costa Rica – thanks to my wife’s foresight. It was a new and liberating experience. Although we were in the jungle and on the beach, it was no picnic! We took classes in the saturated humidity, ran a lot of simulations in the field, improvised splints and casts and litters, and learned about disease processes we had not come across during our medical training. The most exciting part was learning leadership skills while leading a team during multi-person casualty scenarios in a...
low resource setting. It was the first time as a medical student that I felt like I had some autonomy in a high-stress environment and thoroughly enjoyed the process. It was an eye-opening experience that boosted my confidence and made me excited to learn more. I returned home from that experience intent on incorporating wilderness medicine into my career.

During residency, there isn’t a lot of time to take electives and pursue one’s interests, especially if you’re focused on another equally interesting field like ultrasonography. Our residency had excellent mentors and opportunities for ultrasonography and fewer opportunities to pursue wilderness medicine. It was not a topic that came up often and even less so as a serious academic pursuit. I spent most of my elective time conducting ultrasound research, teaching ultrasonography, and going to national conferences to compete in “Sono Games.” I spent most of my vacations hiking, camping, and climbing. After residency, I even completed an ultrasonography fellowship at the Mount Sinai and Elmhurst Hospitals. But in my mind, I always knew that wilderness medicine was going to be a part of my career. I had too much fun during that elective to let it slip away.

I completed my wilderness medicine fellowship at the Massachusetts General Hospital (MGH) / Harvard Medical School in 2018. The year-long program included working in the MGH ED as an attending physician for half of the year and spending the other half pursuing a variety of trainings and experiences in the field. There is no one way to practice wilderness medicine. Everyone picks one aspect and focuses most of their time in that area. For example, one might focus on high altitude physiology, expedition medicine, or dive medicine. Others might focus on a specific sport like ultramarathons, mountaineering, or white-water kayaking. Or you can become a medical director for a national park, a non-governmental organization, or an expedition outfitter. The possibilities are truly endless. There is no one path. This fellowship gives you a year (or more) to hone your skills, network with others in the field, be exposed to the various opportunities, and decide on your career and the life you wish to create for yourself. One could pursue the same training and opportunities without a fellowship, but I imagine it would take at least several years to end up at the same place. The benefit of a wilderness fellowship is that it condenses the timeline.

During my fellowship year, my coursework included taking a mountaineering course on Mount Rainier in Washington State, being part of a medical team on a weeklong ultramarathon in the Utah and Arizona deserts, and taking an avalanche safety course on Mount Washington. I became an Advanced Wilderness Life Support (AWLS) instructor and led a 3-day course in Boston for local physicians, residents, PAs, NPs, and medical students. I was the first author for a publication on the use of ultrasound in austere environments and contributed wilderness medicine cases to a case files textbook. I also participated as a volunteer for the annual MedWAR wilderness medicine competition for residents at ACEP. It was a busy, but fun year.

The highlight was spending three months volunteering with the Himalayan Rescue Association (HRA) of Nepal in the Everest region. I was stationed at a high-altitude clinic in the small town of Pheriche (14,341 feet or 4,371 meters), which is on the route to Everest Base Camp where mountaineers attempt to summit the tallest mountain on Earth. For three months I lived out of a sleeping bag, without running water, a week’s walk from the nearest road, and surrounded by the stunning beauty of the Himalayas. Along with two other British physicians and three Nepali staff, we took care of approximately 500 patients and gave free daily high-altitude talks to hundreds more. We saw patients with wide ranging illnesses including high-altitude cerebral edema (HACE), high-altitude pulmonary edema.
Carlo performs a lung ultrasound as part of a high altitude physiology research study.
Carlo demonstrates how to use a Gamov bag to simulate descent for patients who are ill with high altitude illnesses (HAPE), acute mountain sickness (AMS), snow blindness, frostbite, acetazolamide-induced myopia, respiratory and gastrointestinal infections, and pregnancy. We made night calls to surrounding villages to meet patients who were carried on stretchers by porters across rocky terrain. The majority of our patients (around two thirds) were Nepali guides, porters, cooks, and tea hut staff. We charged foreign tourists a premium to be seen and treated in order to subsidize the cost of the local patients. I also conducted an ultrasound research project screening for asymptomatic pulmonary edema in trekkers as they ascended to Everest Base Camp. I, along with 4 research assistants—including two NYU-Bellevue EM alumni Julia Paris (RES ’18, US ’19) and Michael Shamoon (RES ’18)—scanned over 200 participants across altitudes ranging from 8,000 to 17,000 feet, inside tea houses and guest lodges.

What does one do after completing a wilderness medicine fellowship? My wife and I decided to spend a year living on an island in the western Pacific called Saipan, which is part of the Northern Mariana Islands, a commonwealth of the United States (Western Pacific Ocean). We both felt that after a dozen years of training in New York and Boston and each completing two fellowships that we needed a change of pace. We worked at the only hospital on the island, Commonwealth Healthcare Corporation. She was the only psychiatrist on the island, covering inpatient, outpatient, adult, child, and consult services. I was one of five emergency physicians. It was an opportunity to learn about marine envenomation, dive physiology, drownings, and other tropical diseases. But we also had the opportunity to serve a desperately underserved population of Pacific islanders including Chamorros, Carolinians, Yapese, Chuuk, and Micronesians. There was no MRI machine, very few consult services, and limited available interventions. Many patients had to be evacuated to other islands like Guam and Hawaii and to other countries like South Korea and

Carlo closes a scalp laceration in the middle of the night using a headlamp during a multi-day ultramarathon in the American southwest.
the Philippines for definitive care. Our son, Theodore, was also born on the island of Saipan. It was an amazing opportunity that blended emergency medicine and wilderness medicine.

After a year, we decided to return slightly closer to home. We moved to Anchorage, Alaska. I currently work as an EM staff physician at the Alaska Native Medical Center, a 173-bed level 2 trauma center that is part of the Indian Health Service. I primarily treat the members of over 200 tribes that make up the Alaska Native Tribal Health Consortium. We see over 60,000 ED visits each year. We have a large urban homeless population that we serve. We also take phone calls from over 180 villages around Alaska that are not connected to the road system, from the north slope to the far reaches of the Aleutian chain. We provide telemedicine guidance to community health aides in the villages while making decisions about helicopter and fixed wing medical evacuations to Anchorage, all while managing the ED. We treat bear attacks, seal bites, botulism, frostbite, snow machine and all-terrain vehicle (ATV) related trauma, as well as alcohol and drug dependence, domestic violence, and penetrating trauma.

I truly love my job because it combines service to a greatly underserved community while incorporating wilderness medicine into my daily routine. And I get to live in the great state of Alaska. In the future I do plan to return to academia, but for now, I’ll continue to cross country ski, fat bike, pack-raft, mountain bike, ice climb, pick berries, dodge bears, moose and lynx, fish for halibut and salmon, mountaineer, ice climb, and run on snow and ice.

“There was no MRI machine, very few consult services, and limited available interventions. Many patients had to be evacuated to other islands....”
My maternal grandmother and grandfather were my first link to Bellevue and the notion that geriatric meant interesting.”

MICHAEL STERN, MD
I have always thought older people were intriguing. Even from a young age, their words were passports to journeys I had yet to undergo. I found their aging faces and bodies fascinating. They spoke of experience, hardship, and triumph. A permanent limp was the result of singular time and place and context, a scar had a story, a lined face was the roadmap of a long-lived life. As a kid, I felt they knew secrets that I didn’t even know existed. As I have grown, older people still seem to me to hold the keys that unlock wisdom.

I was reminded last year of why I love emergency medicine as a specialty and, in particular, geriatric emergency medicine as my academic interest. While working weekends, holidays, and late into the night has never been my favorite part of practicing emergency medicine, feeling like I am part of the team prepared to take care of anyone at anytime with any issue has remained an ongoing privilege. It still feels as if we, emergency medicine providers, represent the ultimate safety net for our community – the initial guards of the frontline. So while sleeping in and having a leisurely Sunday breakfast with my family is always preferable, I continue to get deep satisfaction from being in the emergency department (ED) on a Sunday morning with my work family, ready for anyone who walks or rolls in. That ethos was central to my time at NYU-Bellevue during residency. I, like so many others, stand on the shoulders of giants like Dr. Goldfrank and the outstanding faculty that made up the Bellevue guard.

At 8:02am, in walked a 97 year-old woman wearing a terrific hat. She had a lower leg cellulitis that developed after sustaining an abrasion from a fall a few days ago. She was the definition of “younger than her stated age” and plucky, to say the least. I asked her what caused her fall. She stated matter-of-factly that she tripped because she was engrossed in a conversation with a younger friend in his 60s. They were on the same walking tour through Central Park to explore the extraordinary trees. I was impressed and immediately felt admiration for her. As I asked her about her medical history, I noticed she had tissues tucked underneath the sleeve of one of the arms of her shirt - exactly like my grandmother used to do.

“I have no medical history, if you mean conditions,” she said with a little sauce in her voice.

“Do you take any medications on a daily basis?” thinking that another angle of information gathering would yield results, as it often did.

“I take a multivitamin and a baby aspirin, but that’s only because my doctor says I should. I disagree, but I humor him,” she said with a wry smile.

“Do you still work?” I asked, fully expecting the answer to be Yes!

I was hooked and wanted to know more about this fantastic woman. She
replied that she was a book editor and stopped working in her 80s so that she could spend more time doing other things.

“When was the last time you were in the hospital?” I ask, realizing that I was talking to someone who was the epitome of the actuarial paradox. The longer you live, the longer you are going to live. She had no medical problems and was much more likely to live to 105 years old than my children or even future grandchildren. If she had advanced heart disease, COPD, diabetes, or cancer, it would have likely ended her life already. She was unfettered by disease. Her genes and lifestyle certainly played central roles. How fortunate was she! I thought it might be something to have time to talk with her over a meal, to hear her life story. But that wasn’t in the cards.

“Sit down young man,” as she patted the end of her stretcher. I obliged. When a 97 year-old woman asks you to do something, you do it. “The last time I was in the hospital, this hospital, was over 65 years ago for the birth of my third child. And I don’t intend to stay now. I think I need antibiotics, and I will be on my way.” “Yes, ma’am.” I said, with a big smile. She smiled too. I discharged her with a prescription for antibiotics and instructions for follow up. I won’t soon forget her.

As is often the case, family has influenced my story. My grandmother, my grandfather, and my father have all played key roles in my journey to medicine, emergency medicine training at NYU-Bellevue, and my ultimate focus on geriatric emergency medicine.

When I decided to switch gears from being an artist to becoming a medical student at the age of 33, my motivation was personal. I had grown up admiring my dad, a psychiatrist, and respecting that he deeply loved his work. But it was a vivid memory when I was thirteen of traveling to the ED with my father while he was having a massive heart attack that kept coming back to me. Seeing medicine in action in the ED in those pivotal moments while the doctors and nurses saved my father was profound. The immeasurable impact that they had on his life stayed with my siblings and me. But I had also never forgotten the fear, powerlessness, and ignorance I felt, and I never wanted to feel the same in the face of another crisis, especially since I was expecting my first child.

The tipping point occurred in my art studio in Soho. While looking at one of my abstract paintings - I had been working for years on the theme of natural rhythms - I realized I had been painting, in essence, variations on my father’s electrocardiogram rhythm on the monitor that I was glued to on that singular winter night long ago.

My father did his internship training at Bellevue and loved to regale me with stories about the ED and the “Psych Ward.” He always said it was one of the most thrilling and fulfilling periods of his life. But my maternal grandmother and grandfather were my first link to Bellevue and the notion that geriatric meant interesting. They were in their 60s and 70s, respectively, when I can recall my first memories of them.

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My maternal grandmother, Gladys Finlayson, was born in 1911 in New York City. Donna, as I called her, was raised from the age of five by her own grandmother, Miranda Peachie, the widower of an Episcopalian minister. As a young woman of 18, Gladys began her training as a nurse at Bellevue Hospital. Her favorite ward was Q4, a large room with expansive windows and a breathtaking view overlooking the East River. This was where all the indigent men were placed. She felt it represented the beautiful essence of Bellevue, and she loved it. She recalled the sharp looking nurses’ uniforms — pressed white cotton with collars, pleats, and hats — that she wore, feeling grownup and important for the first time in her life. During a night shift, she was carrying a tray of glass test tubes filled with blood when she spotted a tall, handsome doctor rounding the corner down the hallway. He was speaking with a southern drawl.

“When was the last time you were in the hospital?” I ask, realizing that I was talking to someone who was the epitome of the actuarial paradox.”
She instantly dropped the tray and the test tubes crashed to the ground, shattering around her. "It was instant love!" she wistfully recounted to me when I was young.

My grandfather, Kyle Hill, was born in 1898 in Heidenheimer, Texas. He was chief resident in pediatrics at Bellevue. He had grown up “dirt poor” as he later told me. To help out his family, as a child he picked cotton before he went to school. He fled Texas as a teenager and “rode the rails”, living on trains all over the south. After settling in New Orleans and having several successful years as a professional gambler, filling his time with his fair share of liquor, music, and romance, (his vagabond life, as Donna described it), he transformed himself into a medical student at Tulane University and ultimately became a beloved pediatrician on Long Island. He had a home office next to their living room and always accepted homemade apple pies and fresh eggs as payment for his medical care if the parents couldn’t afford to pay him. A seemingly 180-degree turn from his former life, this chapter lasted over 40 years. He cared for several generations of kids throughout his long career. I remember he had a drawl, smoked like a chimney, had a double-barrel shotgun hidden beneath the stairs, loved word-play and the creative side of language, and helped my grandmother raise yellow roses in their garden. He practiced medicine until he was nearly 70 years old.

My grandmother was always up for an adventure. Donna wore yellow tennis sneakers in the snow and learned how to ride a bicycle in her 40s. She enjoyed cold beer in a glass in the afternoons on special occasions, whispered “Horrors” when she was appalled or felt the impulse to curse, and never said an unkind word about anyone ever. She wore a mink coat, drank mint juleps at the Kentucky Derby with my grandfather, and preferred silence over gossip or boastful pride. Donna kept rubber bands around her wrists (“They are handy!”) and tissue tucked in her sleeves, like the 97 year-old patient I described at the beginning of this piece. In her pocket book, she kept birthday candles because “you never know when you may need to celebrate!” Years after my grandfather died, she moved to California in her early 70s and drove the sun-drenched highways around Pasadena in her yellow Ford well into her 80s. When I visited her out there during college, she told me how she had studied hard for her California Nursing Recertification Exam. She had recently passed and now was volunteering as a nurse. She read the New York Times from cover to cover in her nursing home into her nineties, and she always smelled like roses when I hugged her. She suffered a fall that required a hip replacement but bounced back, despite the predictions. In her last year, she had senile dementia that caused her memory to slip away from her on most days (although she would have moments of razor clarity almost until the end). She couldn’t remember all of our names so she gracefully referred to her grandchildren and great grandchildren as “my kittens.” She came as close to dying of “old age” as is humanly possible. I admired that. To me, it exemplified her fortitude and grace, and was divinely fitting for her. She died in her sleep at the age of 96 with no significant medical problems except, perhaps, for a pathologic love of oxtail soup and chocolate, which she ate, at times, back to back.

I bring my grandparents back to life now to make a point. In their later years, they were not simply geriatric patients with senile dementia and COPD. They were people who led interesting lives, full of character and color, idiosyncrasies and peccadillos, joys and triumphs and tragedies. They had stories. Remembering this is the key to appreciating older patients. It is what continues to intrigue me about meeting them and feeling honored to take care of them in the ED. Despite the often times complex nature of their presentations, the management challenges that exist around their treatment and disposition, and the time that older patients require to work-up
as the ED continues to swirl around you, they are worth it. Older patients continue to teach me about medicine and life.

In medical school, I deliberately started each rotation with the mindset that I might just choose this area for my specialty, even if I knew that it wasn’t true. As a distinct strategy, I would try to fake myself out, believing that I would learn more about every rotation this way. But I knew deep down that emergency medicine was for me. I loved so many of its aspects — the societal safety net as the front porch/door to the rest of the hospital; the energy and hum; the variety of patients and pathology; the acuity; the procedural components; the camaraderie among ED staff; the stories of the patients who present during a bad moment or, sometimes, on the worst day of their lives; and the chance to do good and occasionally save a life.

It was Dr. Lewis Goldfrank who specifically inspired me to come to NYU-Bellevue to train in emergency medicine. His philosophy of emergency medicine and the role emergency physicians play in society, often caring for those most vulnerable and medically underserved, was what drew me to train there. I reveled in learning the craft of EM by some of the world’s most talented emergency physicians and teachers. Caring for the diversity of patients in every domain — socioeconomic, ethnic, racial, cultural, sexual orientation, and age — was thrilling and humbling. It was a true theatre for humanity; sometimes circus-like, and often dramatic, unexpected, and poignant. I was particularly fond of the homeless population who became familiar faces that I warmed to quickly. I believe the entire team of providers in the ED saw them as I did: diamonds in the exceptional rough! We were Goldfrank’s disciples, after all. But I was particularly drawn to older patients because I experienced them as vessels of life experience. It is as if they were books, sometimes dusty and age-worn, with many chapters to delve into. I found them fascinating.

My fellowship training in Geriatric Emergency Medicine (GEM) was the brainchild of Dr. Neal Flomenbaum, a leader in emergency medicine for decades and a visionary in his ability to see the need for this specialty training. He created a first-of-its-kind GEM fellowship at New York Presbyterian/Weill Cornell with an interdisciplinary focus that combines comprehensive clinical, research, and educational experience. My GEM fellowship training has allowed me to develop an understanding of the complexities and specific needs of the increasingly large geriatric population. I have gained a different skill set and particular strategies to best care for them in the ED, often enabling them to return home to resume their independent lives, and sometimes providing specific comfort in their final moments. With the tremendous support of Rahul Sharma, a fellow classmate and friend during EM residency, and now the Chairman of Emergency Medicine at NYP/Weill Cornell, I have the continued opportunity to teach what I have learned to the next generation of emergency physicians, as well as contribute to a growing body of research focused on older emergency patients. I find my work extremely satisfying.

This is not the forum for statistics or pedantries. There are lots of articles, texts, and on-line resources to learn about the stats of the “silver tsunami” of geriatric patients that began hitting the shores of our EDs in 2011 (as the baby boomers started to come of age and cross the threshold of sixty-five), or about the multi-factorial geriatric syndromes and the core geriatric emergency medicine competencies. The saying that “geriatric patients are not just older adults,” the clever corollary to the adage that “pediatric patients are not just small adults,” is true. It encapsulates the uniqueness of this group, as well as the need to learn how better to care for them. The strength and vulnerability of our older patients are characteristics they share with the medically underserved patients who originally drew me to NYU-Bellevue’s EM residency pro-

My grandfather, Kyle Hill.
gram. And like them, caring for the elderly is both rewarding and challenging, in equal measure.

In sitting down to write this piece, much has changed in medicine and, specifically, in emergency medicine, since I started this medical journey nearly 25 years ago. And those changes are more pointedly significant at this current, scary moment in time. As advancements in healthcare-related technology, education, and pharmacotherapy have increased, people are living longer, better, and with more comorbidities than ever before. But the impact of COVID-19 on the elderly is stark. Age is an independent risk factor for a more severe disease course and worse outcome. This is a direct result of normal physiologic changes associated with aging that affect every organ system, including the immune response. Certain comorbidities are independent risk factors as well, and most on the COVID-19 list exist with higher prevalence in the elderly. As well, the devastating losses that have occurred in the congregate setting of nursing homes and long-term care facilities are staggering. The mortality rates for the elderly are shockingly high. During the height of the pandemic in the early spring, discussions were beginning to take place nationally about the rationing of resources. Geriatricians, emergency physicians and medical ethicists were quick to respond that age alone should not be a criterion for withholding care. We still have much to learn about caring for all patients with COVID-19. The elderly certainly deserve our focused attention.

The elderly population in our country has suffered from the unfortunate phenomenon of ageism for a long time. In my opinion, there are many reasons for this: the dissolution of the multi-generational family, the loss of a sense of community as urban living has prevailed, the American spirit of rugged individualism born from youthful adventure, westward expansion, capitalism’s philosophy of a person’s worth to society as measured by the job they do and how much income they generate, the blooming of nursing homes as the first and only option when infirmity sets in, and a lack of appreciation for the value of the currency of wisdom gained from life experience. As a result, older people have been relegated to the edges of our society. It is alarming and unconscionable.

The future of healthy aging is contingent on many things, on both micro and macro levels. Continued progress in healthcare literacy and lifestyle choices, technology and pharmacotherapy, access and preventative care, as well as education and research within the medical community, is of paramount importance. Emergency physicians must lead the charge, as we have often done in the past. Improved GEM education and training, geriatric specific clinical protocols and guidelines, environmental/physical modifications to our EDs, and dedicated research will help. But if we take note of our older patients’ humanity, their stories, their complexities, their gifts, we will truly be able to care for our elders in the manner they so richly deserve.

July 1st 1991 was my first entrance to Bellevue as a newly minted pediatric emergency medicine fellow. I had just done all of the things that they tell you not to do at the same time, but seem to go hand in hand with a career in medicine. I had gotten married, moved and changed jobs in the preceding two weeks. This was an interesting time to be at Bellevue. My start coincided with the start of the EM residency with such illustrious emergency medicine interns as Jeff Manko and Pediatric interns as Dennis Heon to work with. That makes me feel old. I had a lot more hair and a slimmer waistline back then (I could say the same for both of them).

I was not exactly sure what a PEM fellow was supposed to do or exactly what the field of emergency medicine entailed. Only one of my medical school classmates had become an EM resident. Sometime during my second year of my pediatric residency, I found an announcement in the back of a journal for Pediatric EM fellowships program that I didn’t know existed until then. The pediatric emergency room (yes, it was only a room and not a department then), was chaos personified. Supervision was at a minimum and you learned on your own or not at all. Somehow, I came to think that this chaotic, challenging environment was a perfect mix for my need for order and calm. No one tried to talk me out of it. It wasn’t until much later that I realized that creating calm and order out of chaos was the part that I enjoyed. Without challenge, there is no reward (that is not a Yoda quote).

My fellowship started with a bang (literally). My first shift was with Dr. Michael Tunik on July 4th at a time before Rudy Giuliani had convinced the population of New York City that blowing parts of themselves off with illegal fireworks was not a good idea. It was also a time of peak gun violence in the city. You were guaranteed at least one or two stab or gunshot wounds every Friday and Saturday night and this was when we only saw patients less than 18-years old.

The two years of fellowship flew by, and before I knew it I was a new faculty member and a year later the Pediatric Emergency Medicine (PEM) fellowship director. Knowing what I know now, I was significantly overconfident of my skill set at the beginning. Over time you develop a finer appreciation for the multitude of things you don’t know. I often wish I could go
back in time to talk to my younger self. I would tell him to be humble. Medicine has a way of humbling you if you are not. I would also tell him to start doing yoga before our body falls apart, buy Apple stock when it was four dollars and kill the guy who invented the tie. I’m pretty confident that my younger self would not have listened to a word I said.

I would like to tell you that my career was perfectly planned and I hit every goal on my timeline but that would be a complete lie. I never had a plan. I still don’t. Many of the skills that I’ve developed came from my inability to convince others to teach the fellows the things they were supposed to learn. I developed my skill set adding critical appraisal, statistics, research design, teaching the teacher and simulation to my tool box. I drew the line at ultrasound and quality improvement. I was older and crankier then, and had learned how to say no.

Flash forward to the present time. On October 1st, 2019, I officially stepped down as fellowship director after 25 years at the helm (insert Star Trek reference here). It wasn’t an easy decision. For the longest time, I thought I would be happy to retire as a fellowship director. I loved being a fellowship director. I loved my fellowship family. To this day I think of my fellows as my grown-up children that I didn’t have to pay college tuition for. I am just as proud of their accomplishments as I am of my daughter Lia’s. Unfortunately, the ACGME has sucked all of the fun out of being a fellowship director and I got tired of filling in check boxes that don’t mean anything. I now get to teach the fellows without the annoying administrative part.

If the early part of my career was focused on content and curriculum development, I am now in the dissemination phase. I’ve published a critical appraisal curriculum on MedEd Portal (I’ve called it M*E*S*S for the Making EBM Simple Series because no one told me that I couldn’t). The PEM Guides and PEM CARS iBooks are a time sink, but help to maintain my evidence and knowledge base. This April I published a PEM Simulation Case iBook.

Feel free to reach out, I’d love to hear from you (michael.mojica@nyulangone.org).

“Volunteer to do the things that you like before someone volunteers you to do the things that you don’t. Me.”
What does being named one of the leaders in funding nationwide mean to you and the research division?

It is an incredible accomplishment that has been a true team effort. Our faculty, administrative team, and research staff have all contributed in a myriad of ways to achieving this huge milestone that ultimately reflects our commitment towards improving the health of our patients and communities. Stephen Wall was the first faculty member to obtain an R01 grant in our department. From there, Kelly Doran, David Lee, and Ryan McCormack all went on to receive K awards and successfully navigated the “K-cliff” to transition to R-level funding. Our success would not have been possible without the help of our division administrator, Ada Rubin, our grants manager, Senem Suzek, or the research coordinators and data associates who translated each project “dream” into a reality. Support from the department chairs (Dr. Goldfrank then Dr. Femia), true collaboration with the clinical operations leadership, and financial support from central research administration were also critical. That being said, sustaining our success and grant funding will be our next and greatest challenge! We have been able to add many key new team members in finance (Daniela Sanchez) and administration (Denisha Brandford, Noah Klein) who are crucial to running research smoothly! And, of course, thank you to our research staff, data analysts, and project managers without whom none of this would have been possible! I imagine some may end up as emergency providers and researchers themselves.

What was the toughest hurdle you overcame in your career?

I think rejection is the hardest part of research, and shouldn’t be underestimated as a barrier to longevity. It is challenging for researchers to work for months on a grant proposal only to have reviewers reject it, often without the correct expertise or a thorough review. The constant rejection can make you really question your ability and ideas; but, in the end, I truly believe it makes success all the sweeter!

What does it mean, as a woman in emergency medicine, to be named the Assistant Dean of Clinical Sciences?

It has been wonderful to bring all I have learned in emergency medicine to bear in this new role. It cannot be overstated how much I use my ability to triage, problem solve, and multitask in this new leadership position. I believe emergency providers are especially suited for roles in large, complex health systems because of these carefully honed skills. As far as being a woman in a leadership position, I am acutely aware that I am standing on the shoulders of the women who have come before me. While I have had both male and female mentors along the way, it is the female role models that have made me feel that obtaining this type of position is actually achievable.

What are the greatest challenges encountered by researchers during COVID-19?

For many clinician-investigators, it has been challenging to balance our desire to help in the clinical are-
While I have had both male and female mentors along the way, it is the female role models that have made me feel that obtaining this type of position is actually achievable.

What advice would you give to young researchers?
Research is a marathon, not a sprint. Research is all about the long game; it is quite laborious and the fruit doesn’t grow until many years later. You have to have real passion for a topic, a patient population, or a specific methodology to persist when no one else seems to think your ideas are worth pursuing. It is, in my opinion, a remarkably rewarding career but has a lot of highs and lows. It is not for everyone.
CARING FOR SYSTEMS THAT CARE FOR OUR PATIENTS

BY LILIYA ABRUKIN, MD (RES ’16, QSPI ’17)
I vividly remember the start of my Quality, Safety, and Practice Innovation (QSPI) fellowship. I was scheduled to meet with Silas Smith, (RES '06, MED TOX '08) director of the division of QSPI, for our first formal didactics session and was working my way through hundreds of pages of National Health Services documents from the UK, wondering what I had gotten myself into. Choosing to pursue a safety fellowship was easy; over the course of residency I realized that my interest in what goes wrong with patients naturally extended into understanding what goes wrong with patient care systems. And while this fellowship was certainly far more challenging than the decision to pursue it, the year flew by, and I came out on the other side with a wealth of theoretical and practical patient safety knowledge, a Masters in Public Health, and the confidence to start my new role at New York Presbyterian/Columbia University Irving Medical Center, as the associate director of quality improvement and patient safety for the emergency department.

Much of my day-to-day work involves reviewing cases of near-misses or patient harm. The safety fellowship provided me with the tools and experience to do this work in a structured and objective manner that looks to address systems’ issues rather than assign blame. Having learned about a variety of theoretical frameworks and approaches to patient safety has provided me with the core knowledge and flexibility to customize my approach depending on the issue.

Equally important was the experience of leading and participating in a variety of committees and projects such as rapid improvement events. Learning to lead and work effectively with interdisciplinary teams is a critical skill required to translate patient safety issues into effective countermeasures. Analyzing data, understanding how to measure impact, and critically assessing research were all key components of fellowship training.

This practical experience as a fellow was further augmented by the formal MPH coursework that included research methodology, health economics, statistics, management, and program evaluation. Being able to test and apply the concepts covered in my coursework to my fellowship and bring back fellowship experiences to the classroom was invaluable in developing the skills required to lead teams and work towards meaningful impact in patient safety and quality.

During fellowship, I had the opportunity to teach and present on patient safety topics to a full spectrum of learners from medical students rotating through the ED to grand rounds at another institution. Teaching patient safety concepts in a variety of venues during fellowship not only helped solidify my own knowledge, but gave me the opportunity to integrate patient safety into bedside clinical teaching.

Now with a few years of experience under my belt, I fully appreciate how profoundly that fellowship year shaped my current practice. The Kenneth & JoAnn G. Wellner Patient Safety and Quality Fellowship provided the foundation for success in my current administrative position, influenced my role as an educator, and left me with a more nuanced understanding of my own individual clinical practice. Whether caring for an individual patient or thinking about patient populations as a whole, every encounter is framed in the context of the system, and improving care for all patients.

Note: On January 1, 2021 Liliya was promoted to director of quality and patient safety at Columbia University Medical Center for the emergency department. Congratulations!
My Journey to Patient Safety

BY TONATIUH (TONA) RIOS-ALBA, MD (QSPI '15)
My journey to being the first ever Quality, Safety, and Practice Innovation (QSPI) fellow at NYU-Bellevue began during my last year of residency. I was as yet undecided about what I wanted to do after finishing residency. I enjoyed many things within emergency medicine and my interests were wide including administration, education, and ultrasound. I considered doing fellowships in each of these subspecialties but none of them alone fit exactly what I wanted to do. The one thing I was sure about was that I wanted to find a niche that would provide me the opportunity to practice academic medicine but more importantly, give me the freedom to combine all my interests while providing a clear path to advance my career. In a way, this uncertainty about my career is what opened the path towards the safety fellowship. I was not convinced by any of the other subspecialties on their own and had decided to simply apply for an attending job. It wasn’t until late in the fall when I received an email from my residency director outlining a new fellowship at NYU-Bellevue. To be honest, I did not know very much about what patient safety entailed, but the fact that it was a growing field within emergency medicine was definitely something that attracted me to this subspecialty.

I was intrigued enough by the prospect of the fellowship that I decided to apply and was very excited to be offered an interview soon afterwards. I was unsure what to expect of my visit, this being a brand new fellowship in a field that I was not too familiar with as yet. However, any doubt I may have had about the fellowship quickly disappeared upon arriving and learning about the position. It all started with Silas Smith (RES ’06, MED TOX ‘08), director of the division of Quality, Safety, and Practice Innovation, making me feel right at home, and explaining his vision for the fellowship. He made it clear he had certain broad goals in mind, but that he wanted to incorporate all my interests into the training and shape it into the fellowship I had envisioned. After learning that this new subspecialty had the potential to incorporate my interest in quality improvement, academics, and operations, it seemed as if it had been created just for me! At that point I was convinced it was the perfect fit.

Once at NYU-Bellevue, I was happy to learn that all my expectations about the fellowship not only came true, but were exceeded. I of course learned plenty about the history of patient safety in medicine, the process of quality improvement, ED operations and ED management. I was surprised at how much exposure I got to other fields including simulation, residency education, medical school education, faculty development, ultrasound QI, observational medicine, amongst many others. Through the fellowship, I also participated in many multidisciplinary projects and worked with leadership from other departments such as trauma surgery, OB/GYN, internal medicine, and hospital administration. Last but not least of all, the exposure to leadership across the hospital and the connections that I was able to make with those leaders were an invaluable part of the training that prepared me well to become a leader myself later in my career.

Upon finishing the fellowship, I moved to Cleveland, OH, to be with my wife, where she was completing her residency in anesthesiology. I was very excited to get a job at the reputable Cleveland Clinic. It was there that I fully understood the true value of this fellowship. Less than a year after getting there, I applied for and attained the position of associate quality improvement officer for the entire Institute of Emergency Medicine for the Cleveland Clinic, which then encompassed 13 different emergency departments. This was a highly coveted position that I was able to secure over other more experienced physicians, thanks in no small part to having completed the quality, safety and practice innovation fellowship. Once having taken on the new role, it became very apparent to me that the training I received was invaluable and allowed me to succeed. The most difficult part of this role was trying to incorporate the needs of the different disciplines I dealt with on a daily basis, whether it was ED leadership, hospital operations, hospital administrators, or department chairs, all of whom may have different viewpoints on any given subject. I understand the importance of always holding patient safety as the number one goal - in the end everyone can always agree that ensuring patient safety is our most important role and from there the tasks become less daunting.

Reminiscing about my time as a fellow brings back many pleasant memories of the people I got to know at NYU-Bellevue. I will be forever grateful to Silas Smith for allowing me the opportunity to train under his tutelage at such a great institution. I would encourage any emergency physician looking to advance their career in the area of patient safety and quality to consider joining the NYU-Bellevue family and pursuing this fellowship. It will not only prepare you to transform your practice but will provide you with an unforgettable experience you will cherish for the rest of your career.

“Ensuring patient safety is our most important role and from there the tasks become less daunting.”
As an emergency physician, I have the privilege of interacting with people daily. These personal interactions are the primary reason I went into medicine. The diversity of these interactions in the emergency department (ED) is the reason I chose emergency medicine as my specialty. I have always sought to have a broader impact, to move beyond individual patients to improving the delivery of healthcare in the ED and beyond. The Kenneth & JoAnn G. Wellner Fellowship in Emergency Department Safety and Quality uniquely positioned me to lead quality improvement and patient safety initiatives. Working with Silas Smith, (RES ’06, MED TOX ’08) director of the division of Quality, Safety, and Practice Innovation, provided me with a fundamental toolkit I use both in my administrative role as the director of Quality Assurance at Weill Cornell and in my clinical work in the ED.

By emphasizing human factors and systems theory, the didactic program of the fellowship has shifted my approach to problem solving. When approaching medical errors, it is easy to focus on human error and blame the front-line provider. Why wasn’t the resident more careful when performing the procedure? Why didn’t the ED doctor think of an epidural abscess when treating that patient with back pain? This fellowship gave me a new perspective on the complexity of these events. By analyzing the web of factors that influence any one bad outcome, systems solutions often present themselves. By moving away from blaming individuals and looking for ways to fix the systems in which our ED colleagues operate, I am better able to develop solutions that have broad impact and hopefully prevent similar errors from occurring in the future.

Silas’ approach to patient safety is meticulously driven by data. Using data to identify a problem, analyzing where potential fixes exist, and proving that your solution is working, were fundamental elements of the fellowship. The rapid iterative cycles that we employed when approaching
problems during my fellowship at NYU-Bellevue served me well in my new role at Weill Cornell, particularly during the COVID-19 pandemic. Faced with the prospect of an overwhelming surge in patient volume, we had only a few days to create a home discharge program for moderate risk hypoxic COVID-19 patients presenting to the ED who otherwise would likely have been admitted to the hospital. The importance of attention to detail, rapid tests of change, and use of data allowed me to help spearhead creation of a telehealth follow up program to ensure that our discharge program provided high quality care and was as safe as possible given the circumstances we faced. The rapid redeployment of non-ED physicians into this telehealth followup role presented quality assurance challenges that could only be solved through strict adherence to data driven processes and outcomes. These were all measures ingrained in me during my fellowship. Data continues to drive my quality assurance work both in defining the problem, testing the effectiveness of any proposed solution, and assuring that any gains are maintained over time.

In addition to the robust didactic program, Silas ensured that the fellowship has broad experiences in relationship and team building. By encouraging me to become involved in projects beyond the ED across the enterprise, he emphasized the importance of early involvement of all stakeholders. One of the major projects during my fellowship was the creation of a spinal emergency protocol to streamline and standardize the approach to patients presenting to the ED with concern for spinal cord compression. This involved relationship building with multiple other services including radiology, neurosurgery, and neurology. This hands-on approach to consensus building during my fellowship laid the groundwork for all the interactions I now have with my colleagues both within and outside the ED. These lessons have been critical in my work to establish a robust ED followup program at Weill Cornell. Involving nursing, advanced practice provider, lab, radiology, and telehealth leadership at the start of the process and seeking their input with each step of the rollout has helped to ensure a smooth rollout of this program.

The Kenneth & JoAnn G. Wellner Fellowship in Emergency Department Safety and Quality has opened doors and has helped to define the course of my career in EM. This invaluable experience with Silas’ mentorship influences everything I do to protect patient safety and advance quality healthcare.
WELLNESS
A portrait of “DAMILOLA” by Michelle Romeo

Black Lives Matter
Black Lives Matter
Black Lives Matter
Black Lives Matter
Oluwatimola Idowu (Damilola), MD, is one of our socially responsible emergency medicine residents graduating in 2022.

On May 28, 2020, after the death of George Floyd and the outrage of Christian Cooper’s encounter in Central Park, Damilola emailed all faculty, residents, and staff. She titled the email “Reflecting on recent events and the loss of black lives.” This email started a conversation about systemic racism and racial disparities in public health.

Damilola, brought to the forefront the need to “call out racism in America as a public health issue.” She challenged her coworkers to acknowledge that “we do not practice medicine in a vacuum.”

The portrait of Damilola was done on the day our residency, hospital, and community came together to mourn the black lives lost for incomprehensible reasons. Residents, faculty and staff gathered to pledge to make tomorrow better while supporting each other in the moment on that day. I was inspired by Damilola, a fellow female physician who is underrepresented in medicine and all who advocate for social justice.

“DAMILOLA”

MICHELLE’S ART

Art was something I fell into, I realized I had a decent hand at it when I was younger. I wish I could say I do it all of the time, but with the realities of medical school and residency, it falls by the wayside. I hope to continue working on my art, not only for others but for myself. Every time I pick up a paintbrush or pencil I relax in a different way and remind myself I should be dedicating more time to the hobbies that help me balance.

Michelle Romeo, MD is a chief resident, class of 2021.

We do not practice medicine in a vacuum.”
A PLEA TO MY FATHER

KAMINI DOOBAY, MD (RES ‘21)
Is it a disease? I used to ask.

How can a man be ruled by a flask?

Falling into an abyss and falling so fast, Into this horrid spell that life itself cast.

Started with a drink or two - no different from the rest,
You worked for it all and felt so blessed.

I don’t even know when you lost control - When it conquered your mind, body and soul.

That luring bottle - so full of deceit,
I curse that dreadful day you chose to meet.

Now, I look into your eyes and feel such shame, With guilt and pain but no one to blame.

You’re dancing with misery with each sip, Ruining your days, you keep boarding its ship.

Powerful and canny - it will throw you out to sea, With nothing at all, not a chance to plea.

Take a look in the mirror, you’re falling apart,
Shedding tears and breaking heart after heart.

Its wretched claws holds on so tight, Taking away hope and outing the light.

But, this is a cycle we can together end, Whatever is broken can surely mend.

Take my hand and let us pull through, We want you back and want the real you.

This deep emptiness - a hole in my heart,
I want a happy father and want a fresh start.

A PLEA TO MY FATHER

Alumni
When Darien and I first started our comedy show *Doctors Without Boundaries* the goal was to create something that made people laugh while educating them about stigmatized topics in healthcare. Now, our only goal is to become so famous that we get sued by *Doctors Without Borders®* for trademark infringement.

The show structure is simple. We start off with workplace insults that we have accumulated over the past month. Here is one such example:

When I asked an inebriated patient where he was headed during his third attempt to elope, he responded with "To visit your mother." When I inquired about the nature of his visit he stated, "I'm going to wish her a happy Thanksgiving."

It was February.

Getting insulted, berated, and threatened frequently at work is taxing. Being able to use some of
The goal was to create something that made people laugh while educating them about stigmatized topics in healthcare.”
commentary as material at an upcoming show does not make it worthwhile, but it can soften the blow when the amusingly confused racist is telling me to go back to “…whichever country it is that your parents come from.”

Performances include material that touches on a medical topic that fits the theme of the month, which has included STDs, mental health disorders, and drug addiction. Comedy is difficult, and making people laugh when discussing a suicide attempt or a decade long addiction to methamphetamine takes an incredible amount of talent. We are fortunate to live in a city with many of the best comedians in the world. The comics we’ve booked have been up to the task of sharing a unique perspective on illness while simultaneously crushing it onstage.

Finding some semblance of joy in topics that cause discomfort, both as patients and physicians, can hopefully lead to increased awareness and dialogue about these issues. Whether or not we are able to accomplish this through a comedy show remains to be seen, but we’re finding the pursuit to be worthwhile.

Darien and I met during my NYU-Bellevue sub-internship, and we continued to work together on many Team 2 shifts throughout my intern year. While Darien was contributing regularly to SiriusXM Doctor Radio and creating MedEd content across his social media platforms, I remained steadfast in my pursuit of bombing at open mics. Fitting comedy into an intern schedule was not easy, and sometimes involved going to spots post call. One particular Lower East Side venue, Caveat, was working to fuse comedy and education in their shows and they were supportive when I pitched the idea of Doctors Without Boundaries. They suggested getting a co-host and Darien immediately came to mind. Darien, with no background in comedy, was able to scrape by on his intelligence, beauty, and charisma. Also, he is frustratingly hilarious.

COVID-19 has obviously dominated our lives. Healthcare workers in New York City were publicly praised and inundated with free beauty products. In short, we all finally knew what it felt like to be @doctor.darien a certified influencer.

On the night of March 10th, 2020 an attending came by after stabilizing their first COVID-19 patient. In lieu of their traditional electrocardiogram quizzing session, we reviewed the epidemiological data coming out of Italy. They were peaking. Based on their estimates, NYC was days to weeks from being in a similar position. After that shift, Darien and I tried to figure out how we could simultaneously promote social distancing and responsibly host a live medical comedy show in a crowded NYC basement mid-pandemic. We could not. Fortunately, our producer Kate Downey and the team at Caveat were able to quickly pivot, and we became one of the first shows in the city to transition to streaming online live from the venue without an audience.

I developed COVID-19 symptoms on Friday, March 13 at the end of a string of Team 1 overnight shifts. For NYU-Bellevue emergency medicine alumni, the scariest part of that sentence was likely “Team 1 overnight.” After sign out my back ached more than usual, and the scratch in the back of my throat had turned into a cough. That evening my low-grade temperature surpassed the 100.6 benchmark for work excusable illness, and for the first time I activated sick call (sorry Janelle (RES ’21)).

We pivoted again, and avoided even a small gathering of performers by glitching our way through a Zoom show. At the beginning of our show, Darien said “If COVID is a marathon, then Andrés tripped over the starting line.” At the time, I took solace in the thought that my antibodies were running laps around Darien’s superior immune system. Eight months later
Finding some semblance of joy in topics that cause discomfort, both as patients and physicians, can hopefully lead to increased awareness and dialogue about these issues.”

my antibodies are gone and Darien still hasn’t sneezed in over a year.

This past year was difficult, and it looks like we will continue to face new and existing challenges. Despite these, we are grateful to be working as emergency physicians and for the opportunities we’ve been afforded through our friendship, show, and NYU-Bellevue training. This past year alone, Darien signed with ABC News as a medical correspondent, moved to LA, began modeling for FIGS®, received gifts from Beyoncé, and has gained tens of thousands of followers on social media. And I became a third year resident.
OBITUARIES
WE CELEBRATE YOUR LIFE
CLEOPAS MILTON WILLIAMS, JR, MD
1963 – 2020
Cleopas “Cleo” Milton Williams, Jr. MD, died on July 3, 2020 in Melbourne, Florida.

Dr. Cleopas Williams Jr. graduated from the Howard University School of Medicine, one of the country’s most prestigious historically black universities in Washington, DC. In 1994, he came to New York to continue his training with us at NYU-Bellevue emergency medicine residency program. Being a physician underrepresented in medicine, he sought to train at a public hospital and was committed to caring for underserved populations.

"Cleo was simply one of the most wonderful human beings that I ever had the privilege of knowing," said Dr. Wally Carter, director of our residency program at that time. He spoke highly of Cleo’s clinical skills and fondly remembers his zest for life as a young resident.

Cleo was a devoted, highly involved, enthusiastic resident who always was available to lend a helping hand. His high energy was infectious and his devotion to his patients admirable.

“His smile was contagious and he was always available for a good laugh," said his co-resident Dr. Jeff Manko. Cleo was a “gentle giant” whose physical presence was big and welcoming. Dr. Susan Stone, his friend and co-resident is saddened as she “prized his friendship.”

Cleo’s life was one of service. His devotion to his patients and his friendships along the way will be remembered. He was humble, kind and compassionate.

We extend our sympathy to his loved ones.
BRIAN THOMAS FLEHER, MD
1974 – 2021
Brian Thomas Fletcher, MD, died on April 5, 2021 in Los Angeles, California.

Is with sadness that we announce the passing of Dr. Brian T. Fletcher a friend and colleague to many of us. In 1996, Brian, a Phi Beta Kappa, graduated Magna Cum Laude from Northwestern University, Evanston, Illinois and subsequently moved to Chicago to pursue a career in medicine at the University of Chicago, Pritzker School of Medicine, Chicago, Illinois. In 2004 Brian came to New York. His compassion, love for medicine, and a sense of social responsibility led him to train at NYU-Bellevue as an emergency physician.

After graduating, Brian eventually made Los Angeles, CA his home, where he was known not only as a brilliant and caring emergency physician, but as an intellectual who was called on frequently by several organizations and media to share his vast knowledge and experiences as an emergency physician.

Jeffrey Manko, his emergency medicine residency director and friend, remembers Brian as a free spirit who embraced life. He was a friend to everyone and was always willing to lend a shoulder or ear to comfort others. He had a way of making everyone feel special and exuded warmth and caring to his patients and colleagues. Brian provided thoughtful and compassionate care to his patients and was a strong advocate for underserved populations.

Brian was “a glowing presence and radiant spirit who was the brightest light in the room,” and will be remembered fondly by his NYU-Bellevue emergency medicine family.

Our deepest sympathies go out to Brian’s parents, siblings, and loved ones.
“I walked in to get my vaccine today and felt the most hope I’ve had since late March. #Hope that there’s a light at the end of the tunnel. I’m so grateful to the scientists who have worked so hard to bring that sentiment to so many. #getvaccinated!”

Leland Chan, MD (RES ’24)
12/2020