NEW ALUMNI

Graduating Residents, Class of 2019 (left to right): Bess Storch, Richard White, Brent Dibble, Erin Muckey, Hassan Mohamed, Luis Villegas, Joseph Levin, Sindhya Rajeev, Daniel McFarland, Phil DiSalvo, Howard Choi, Lauren Hart, Leah McDonald, Michael Gorynski
WELCOME NEW ALUMNI

HOW ARE YOU GOING TO...

ONGRATULATIONS! This year marks the 25th anniversary of our first class of graduating residents—the Class of 1994—from the NYU-Bellevue Emergency Medicine Residency. In a specialty that is still emerging from its adolescence, it’s an incredible accomplishment for our residency to have turned out class after class of outstanding physicians. The 25th graduating Class of 2019 are carrying on a tradition started 29 years ago when the first group of residents arrived at Bellevue. They will bring the same values, principles, and commitment to patient care wherever they practice emergency medicine.

If you look across our world of emergency medicine, you will see our alumni in many leadership positions, from chairing departments to leading training programs to spearheading cutting-edge research. But these individuals and the vast majority of our graduates will be recognized as a generation of physicians who have provided compassionate, humanistic, and clinically excellent care to their patients regardless of circumstance.

At this time of looking back, it’s just as important to look forward. Our nation continues to face a number of healthcare crises: too few covered, increasing costs, and a lack of focus on prevention and preparation. Burnout and frustration are endemic. As emergency physicians, we face every single one of these challenges daily. We see the gaping holes and papered-over

1. Darren Sutton-Ramsey (Res. 19) (pictured on left) was not at group photoshoot due to unforeseen circumstances. He arrived later and celebrated with his classmates, friends and family. Pictured on the right is Darren’s twin Dr. Desmond Sutton-Ramsey.
2. Simulation (SIM) Fellows (left to right) Brian Lin and Julia Paris, Safety and Quality Improvement (QSPI) fellow Matthew McCarty (right).
3. Pediatric Emergency Medicine (PEM) fellows Shweta Iyer (left) and Guillermo Di Angulo.
Your training at Bellevue prepared you exactly for this struggle. As a graduate of our program, you are an emergency physician imparted with the heart and brains of Bellevue and NYU Langone Health. As the nation revisits the means by which we deliver healthcare, you have a perspective to add to this debate that few others possess. Be it through political advocacy, dinner-table conversation, or patient education, you have the power to enlighten your colleagues, friends, family, and patients. Your effort and training within this residency have made you an expert clinician, consultant, advocate, and leader. Therein lies your power that few possess, and even fewer wield with the benevolence necessary to make the world a better place.

You were asked on your first day—for some of you, 29 years ago—a simple question: how are you going to change the world? As we embark upon the next 29 years of training residents here at NYU-Bellevue, we hope you continue to ask yourself that question throughout your career. We hope that you and generations of your fellow alumni answer that call.

Congratulations to the class of 1994, and to each and every class thereafter that carries forth our question to make the world a better place!

JEREMY BRANZETTI, MD
Program Director

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4. Emergency Medicine Physician Assistant (EMPA) fellows Carolyn Cabrey (left) and Kara Lacoste. 5. Medical Toxicology (Med Tox) fellows (left to right) Elie Harmouche, Madeline Renny and Jonathan Di Oiano. 6. Ultrasound (EUS) fellow Di Coneybeare (left) and Kristin Carmody, Vice Chair of Academic Affairs and Education Innovation.
Welcome to the second issue of EMalumni.

Congratulations to our newest graduates and to the inclusion of more than 800 new alumni from Project Healthcare to our community. To the Class of 1994, you inspire us as we continue the tradition you so bravely began.

Each alumni story tells us that early exposure to patients in the emergency department enhances their education. These interactions help students understand patient needs and improve their ability to recognize social determinants long before immersing themselves into the rigorous training of becoming emergency physicians. Their first experiences build resilience, humanism, and compassion—the foundation for transforming themselves into great young professionals. It begins here.

The concept of Morning Report, even at “Forty,” offers an open forum for learning. Led by our residents, fellows, faculty, and consultants, this forum consistently makes teaching and learning the cornerstone of our mission. Trainees become exceptional faculty, leaders, and academicians in our department and throughout the world.

I hope you will find joy in their stories as we follow their experiences and evolution to maturity. I am proud of the accomplishments of our Project Healthcare alumni, medical students, residents, fellows, and physician assistants. Many of them remain at NYU-Bellevue or return to us as excellent young research associates, educators, researchers, and emergency physicians. This issue contains numerous examples that emphasize the educational trajectory of our staff at every level. I believe you will be as impressed as I am when you read their stories.

ROBERT J. FEMIA, MD, MBA
CHAIR

“Their first experiences build resilience, humanism, and compassion.”
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NYU-Bellevue EMalumni Magazine Winter 2019
The alumni magazine of the Ronald O. Perelman Department of Emergency Medicine, NYU Langone Health

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On the Cover
The use of numerous bold colors on faceless forms reflects the diversity, inclusiveness, vulnerability, and courage of outstanding healthcare professionals. The unifier is that white coat, symbolic of shared goals and dedication to caring for others and becoming changemakers in their communities.

SHARE YOUR STORIES
We welcome your suggestions for articles, letters to the editor for publication and any milestones you wish to share.

Write to us: emalumni@nyulangone.org
Dear Alumni and Friends,

Welcome to the second issue of EMalumni magazine.

To celebrate our 25th graduating class, we are honoring the legacy of our pioneers, the class of 1994. We are proud of their legacy and their courage to overcome the barriers they faced during those early days of our residency program. The class of 2019 continued that rich tradition of compassionate patient care, resilience, devotion to service, and exceptional skills they too will pass on to future graduates.

We are featuring Katie Nerlino, an alum of Project Healthcare, in this issue for her investigative ability and enthusiasm. Her research work over the summer made our alumni family even more substantial—she found hundreds of missing Project Healthcare alumni whom we now welcome into the fold!

You will read about many of your peers who have followed diverse career paths that reflect the NYU-Bellevue values and worldview. Wherever our alumni find themselves, they continue to address challenging medical and social issues where they live and practice. Each story is inspiring.

We appreciate your congratulatory notes and comments. You have improved this issue. Let’s continue to make future issues even better. Your letters to the editor, questions, comments, and suggestions on stories will give us more clarity, as we share your interests and accomplishments.

Joan Demas
joan.demas@nyulangone.org
Congratulations Class of 2019! You are the proud members of the Silver Anniversary (25th) Graduating Class of the NYU-Bellevue Emergency Medicine Residency.

It is my absolute pleasure to provide a historical view of the early years, having been a member of the second class and the most senior resident from the program still roaming the First Avenue Superblock. It is quite remarkable to think back to when Emergency Medicine (EM) was in its infancy at Bellevue, adopted as a division under the Department of Surgery, and constantly battling for acceptance and respect as a legitimate specialty within the house of medicine.

It is incredible to have witnessed first-hand the growth in stature, esteem, and importance that EM has enjoyed within NYU Langone Health, Bellevue Hospital (Health and Hospitals), the Manhattan Veterans Administration, and the country in general.

At the inception of the residency program, despite numerous hurdles and obstacles, the mission was simple: be an exceptional academic training program to create ethical, professional, compassionate, and clinically outstanding physicians who would become national and world leaders in clinical care, education, and research. What was the draw to our special program? It was the opportunity to serve and the opportunity to learn. The common thread of our hundreds of alumni for over 25 years can be summed up by two famous quotes. Gandhi said, “The best way to find yourself is to lose yourself in the service of others,” and Einstein quipped,
“Education is not the learning of facts, but the training of the mind to think.” Everyone who has been part of the Bellevue family can attest to these goals and values.

As many of you know, the path was not always straight and certainly not smooth. In the early years, many of the current collaborative interdepartmental relationships we take for granted today were more like daily battles for existence, not just acceptance. Some may remember the altercations in the trauma slot (sometimes physical), the lack of paralytics in the emergency department (ED), pleading with radiology to perform a study, or begging to get patients admitted. Maybe you remember rotating on the cardiovascular surgery, neurosurgery, and general surgery services—rotations that no longer exist. Every procedure was a conflict; now we are often asked—and even expected—to do most procedures. It is because of the commitment and dedication to patient care and the tenacious work ethic of EM residents, who were continually scrutinized, that the current residents no longer have to fight some of those battles.

Within a decade (2003), the Dean recognized our numerous and stellar accomplishments in education, research, and clinical care, as well as our contributions to the medical school, and created an independent Department of Emergency Medicine within the NYU Medical Center—a full partner at the table of the School of Medicine and the hospital centers. Under the constant leadership and guidance of L.G., the program continued to excel and thrive as a nationally recognized program that competitively recruited like-minded students to further its academic and social missions.

Whenever a major event occurred in New York City, Bellevue was the beacon of light and hope with the ED and EM residents in the spotlight. For those who experienced the terrorist attacks of 9/11, the WTC bombing in ’93, the runaway van, the blizzards, the blackouts, Sandy, Anthrax, Ebola, H1N1 (to name a few), you know what it means to be part of history.

While broad and ambitious in scope, you represent the proof of the tremendous success in the formula that was devised to create the best EM physicians. With the extraordinary changes in medicine and EM over the past 25 years, the greatest constant within our beloved residency has been the resolute commitment to delivering outstanding care, 24/7/365, to all comers to the ED, especially society’s most underserved populations. These ideals and ethical principles are what has fueled so many of our graduates to become respected and admired leaders of hospitals, departments, residencies, fellowships, and corporations—passing along these values to the next generation of physicians and patients.

It has been a privilege and honor to be part of this outstanding department and residency for so many years (28 and counting), as part of its past, present, and future. We have accomplished so much in such a short period of time, and I couldn’t be prouder and happier about the incredible accomplishments that our alumni have achieved and small role I may have played. As I continue to see alumni at annual conferences and meetings, it is clear that NYU-Bellevue gets into your blood and creates bonds that can’t be severed. Trauma in the slot! Resuscitation room never seemed to take hold. Wishing you all the best and hoping to see you soon (maybe at the World Series at Yankee Stadium).

Jeff Manko became an Assistant Program Director after graduating in 1995 and after several positions in the Residency Program became Program Director from 2008 to 2017. He is now Director of GME Professional Development and Medical Director of GME/CME at NYSIM and continues to work as an attending physician in the emergency department at NYU Langone Health.

“It is incredible to have witnessed firsthand the growth in stature, esteem, and importance that Emergency Medicine has enjoyed.”

“The greatest constant within our beloved residency has been the resolute commitment to delivering outstanding care, 24/7/365.”
THE PIONEERS
STILL COURAGIOUS, ENTHUSIASTIC, AND COMMITTED
WHY NYU-BELLEVUE?

Erika Newton

Emergency medicine (EM) was a well-kept secret when I was in med school. Even my advisor thought the best training for EM was a residency in internal medicine! Fortunately, I’d gotten my hands on a book about the Bellevue Emergency Department and its extraordinary director, Lew Goldfrank, which was all the encouragement I needed. EM at Bellevue offered diversity, action, intensity, genuine need, and an unparalleled advocacy for the disadvantaged.

Paula Whiteman

In my first year of the NYU-Bellevue program, many of us had come outside the match. I had done a surgical internship; however, I realized that surgery was not for me. I had never considered EM as a medical student, but soon realized as a surgical intern how much I enjoyed my consults in the Emergency Department. I decided that EM was a better fit for me.

WHAT IS YOUR FONDEST MEMORY OF YOUR TIME AT NYU-BELLEVUE?

Erika Newton

A friend from out of town came to visit me while I was an intern. We were walking by the hospital (so I could show it off) when a man cried out to us from down the block. He looked to be homeless, but not very down and out. He was smiling and waving a set of keys excitedly. “Guess who just got his own place!” he said. “You really helped me out, doc. I thought you’d like to know.” My friend’s impressed reaction drove home what a rare privilege it is to be able to make such a difference for people.

Paula Whiteman

My fondest memory? Ha! I rotated through medicine as we all did. At the end of my medicine rotation in June, the residency director called me in to discuss my evaluation. He wanted to know what I had done . . . because the evaluation stated that I was the best resident all year! I knew what I had done.

The medicine attending had made the offhand comment that residents should be able to deliver all the key points of a presentation in two minutes. My co-interns proceeded to take 45 minutes to do their presentations. I turned to the attending and said, “Time me.” I don’t know if my presentation was more than two minutes, but it showed I had listened to his directions. Later, my supervising resident told me it was not appropriate to present a case so concisely while rotating through medicine. But being brief and to the point is the EM resident’s presentation style.

I also enjoyed meeting with Dr. Neal Lewin in the morning post-night call before my medicine rounds to discuss my cases. He would come in early to read the newspaper, but he was more than happy to discuss my admissions from the night before.

WHAT EXPERIENCE REMAINS WITH YOU TODAY?

Erika Newton

Too many to count, but one of them is definitely morning report—an unending litany of unique case presentations followed by invaluable commentary from the attendings and fellows (Lewis Goldfrank, Bob Hoffman, Susi Vassallo, Lewis Nelson, Neal Lewin, to name just a few). It always happened in an evocative setting, too: the dirty procedure room.

Another is the way my attendings managed the chaos, turning impossible challenges into tasks with practical solutions, all while getting patients to trust them and talk to them. Susi could be impressively calm, cool, and cheerfully matter-of-fact. A patient with a broken nose and twentieth on line? No problem: Susi numbed it up, reduced it, and

Paula Whiteman

Erika Newton

Paula Whiteman

Erika Newton
set it, all right there in the hall. I once informed her about a patient who told me he had passed out on the subway and traveled on it, unconscious, from one end to the other three times before waking up. “No, he didn’t,” she responded. She was right; he hadn’t.

Dr. Goldfrank’s compassionate and direct style with patients left an indelible impression on me. His questions always seemed to take the shortest possible path to solving problems, and patients trusted him implicitly.

**Paula Whiteman**

I once took care of the UN Ambassador from Northern Cyprus. I then received a glowing letter from him and was invited to a party at the UN, which I accepted. It was terribly exciting, I was also invited to go to Northern Cyprus, but I wasn’t able to go for various reasons.

**HOW HAS YOUR TRAINING AT BELLEVUE INFORMED YOUR PROFESSIONAL CAREER?**

**Erika Newton**

My main professional interest is in better aligning health care with patients’ needs—needs that Bellevue training sensitized me to. To this end, I pursued an MPH in 2012 and have become a proponent of shared decision making. In the clinical/teaching setting, I try to model the direct and nonjudgmental approach I learned at Bellevue. This approach is not only appreciated by patients, but it can make all the difference in how much relevant detail and context I walk away with and what management options make sense.

**Paula Whiteman**

I am very proud of my training at Bellevue. I published a paper during my residency with co-authors Dr. Goldfrank and Dr. Hoffman. It was very exciting to have my name connected to theirs. Dr. Goldfrank is the most compassionate physician I have ever met. I am truly honored to have trained under him. He taught us about treating every patient, regardless of socioeconomic status, with dignity and respect.

**WHAT ARE YOUR MOST PROUD ACCOMPLISHMENTS, PROFESSIONALLY AND PERSONALLY?**

**Erika Newton**

My professional history clearly bears the mark of my Bellevue experience. I’ve chaired my hospital ethics committee and currently serve on the university Institutional Review Board. I’ve delivered lectures, co-authored a chapter on conflict of interest, and helped end the practice of accepting industry-funded meals and gifts in my department. I teach and study the problem of overuse of care (over-testing and over-treatment), and the role of shared decision-making in reducing and better targeting patient needs. As a teacher, I strive to model respect for patients and be an effective listener. And, on Bob Hoffman’s example, I taught myself Spanish to be able to converse directly with more of my patients.

On the personal side, I’m the proud parent of a 17-year-old daughter who happens to be a remarkably talented singer-songwriter. And my intrepid husband and I once sailed a 35-foot sloop to New Zealand where I worked as an EM consultant for a year.

**Pauline Whiteman**

I am glad that I stayed at Bellevue to complete my pediatric emergency medicine (PEM ’97) fellowship. I am actively involved with the American Academy of Pediatrics, and I recently won my election to the position of District IX Vice Chairperson. This would have never happened without my PEM fellowship. Personally, I am very proud of my two young children—who are not so little anymore.

**WHAT ADVICE WOULD YOU GIVE TO YOUNG EMERGENCY MEDICINE RESIDENTS AND GRADUATES?**

**Erika Newton**

Be open to serendipity, take advantage of opportunities as they come up. Trying different things will help you find what you can be passionate about.

**Paula Whiteman**

If you are interested in doing a fellowship, then do it. Some people told me that my fellowship would not help my career. That was not correct. Aspire for a life’s career, not a job.

**ANY REGRETS?**

**Erika Newton**

I took a roundabout route back to academic medicine after graduating, and have at times second-guessed this decision. Graduating residents often yearn to practice their skills in a non-teaching setting before taking on a supervisory role, and this was true of me at the time. In hindsight, I believe new graduates make some of the best supervising attendings. Who better to relate to the residents’ perspective, after all? But at the same time, I can’t deny that my experiences have played useful roles in who I am professionally. There are an infinite number of routes to a satisfying career in emergency medicine. Flexibility about how one gets there may be more important than getting it right the first time.

**Paula Whiteman**

My regret? I took up ice skating late in life. Absolutely must have a non-medical outlet—preferably one that involves exercise. I work very hard at my ice skating and compete as an adult ice skater. I wish I had started earlier because skating brings me so much joy.
WHY NYU-BELLEVUE?

Richard Levitan
Dr. Goldfrank convinced me to be a pioneer in the new class at Bellevue. Although I looked at programs out of town, I also wanted to be in New York City for family reasons.

Jeffrey Levine
I chose Bellevue because it was a brand-new emergency medicine (EM) residency, because of its reputation as one of the premier public hospitals in the country, and because it’s in New York City.

WHAT IS YOUR FONDEST MEMORY OF YOUR TIME AT NYU-BELLEVUE?

Richard Levitan
I have several fond memories. I remember morning rounds with so many different faculty, toxicology fellows, and rotators. I remember ordering at the coffee shop: “Give me a blackjack! Bacon eggs on a rollie!” And that great feeling of walking into the busy corridors of the hospital in the morning.

Jeffrey Levine
I remember the struggles we had dealing with other departments—and the success we experienced was rewarding. I remember ordering a ‘cheeseburger deluxe’ platter from East Bay diner at around 2 am when I worked the night shifts.

WHAT EXPERIENCE REMAINS WITH YOU TODAY?

Richard Levitan
I am grateful for the teaching and mentorship of the faculty. There are many cases and experiences I will never forget—both good and bad. Incredible trauma saves—like after the 1993 World Trade Center bombing—a major fire on the 17th floor, guns being shot in the Emergency Department (ED), and homeless and sickle cell patients I saw almost every day and got to know. We had epic battles with the administration and other services, and we won most of them. I will never forget the kindness and support of folks during some difficult times in my residency.

Jeffrey Levine
I remember taking care of the trauma patients with our colleagues in surgery, EM, and nursing.

HOW HAS YOUR TRAINING AT BELLEVUE INFORMED YOUR PROFESSIONAL PATH?

Richard Levitan
Our department’s struggles within the institution—because ours was a new EM program, there was conflict over whether we could perform procedures on ED patients. We became primarily responsible for airway management in trauma cases, which led to my desire to improve my airway management skills. I ended up inventing the Airway Cam, which marked the beginning of 25 years of researching, imaging, and teaching airway management. This academic focus has become a huge part of my life, allowing me to travel all over the country and the world.

Jeffrey Levine
My training at Bellevue molded me and made it easy to work in other hospitals. The work at Bellevue was difficult but made subsequent practice relatively easy.

WHAT ARE YOUR MOST PROUD ACCOMPLISHMENTS, PERSONALLY AND PROFESSIONALLY?

Richard Levitan
I put a little booklet together and called it the Bellevue Book. It included phone numbers, other important information for the residents, menus from local restaurants—that sort of thing. I sold them and used...
the proceeds to help upgrade some of our equipment in the ED, as well as to solicit additional funds from the Committee of Interns and Residents.

I am proud to have contributed to a handful of innovations in airway management that are now standard the world over—ear-to-sternal notch positioning, ramped positioning in the morbidly obese, NO DESAT (nasal oxygenation during efforts to secure a tube), bimanual laryngoscopy, POGO (percentage of glottis opening) scoring for grading laryngeal view with imaging devices, the “laryngeal handshake” for identifying surgical airway anatomy, and others.

Jeffrey Levine
I am proud to have been an EM attending since 1994 working in New York City with a family with three kids, outside interests, decent health, financial stability, and general wellness.

WHAT ADVICE WOULD YOU GIVE TO YOUNG EMERGENCY MEDICINE RESIDENTS AND GRADUATES?
Richard Levitan
During my last year at Bellevue, I wrote out my 5/10/25 year goals, as well as my own obituary. It made me consider what I wanted to aim for in my life, both professionally and personally. I have been very fortunate to have accomplished almost everything on my list.

It took me almost two decades before I really “understood the game” of being an EM doctor. Nobody told me that, in addition to the possibility of being shot at, caring day in day out for folks who are dying can be the most stressful job in the world. Take a piece of paper and divide it in half with a line. Write on one side the list of things in your job you don’t control as an EM doctor. It will be a very, very long list—who comes in/out, who you work with, bed congestion, charting systems, stocking, consultants, and four million other things. On the other side, list the things you can control. It will be a much shorter list. I now try to put all my energies into the things I do control—and it has made me a happier and better EM doctor.

Jeffrey Levine
My advice comes from my high school band director: Work hard, party hard. Have outside interests. In my case, exercise worked. I ran some marathons in the 1990s. Now I go to the gym, bike, run, and do household chores.

ANY REGRETS?
Richard Levitan
I wish I didn’t sell the apartment I had in Kip’s Bay Towers; however, I now live on 63 acres in rural New Hampshire, in the mountains, and I can only visit NYC for a few days before feeling overwhelmed.

Jeffrey Levine
I don’t really have any regrets.

“There are an infinite number of routes to a satisfying career in emergency medicine. Flexibility about how one gets there may be more important than getting it right the first time.”
UNCOVERING THE WHEREABOUTS AND PASSIONATE PURSUITS OF PROJECT HEALTHCARE ALUMNI

By Katie Nerlin (PHC 16, 17)
I was overjoyed and overcome with gratitude at the chance to understand the breadth of Project Healthcare, a program that has been—for me, for many before me, and, surely, for many to come—one of the most transformative, enlightening, and inspiring experiences a person could have in his or her lifetime.

Dr. Goldfrank asked me to locate as many alumni from Project Healthcare as possible, dating back to the program’s founding year in 1981. The program initially selected between 4 and 15 students per year during its first five years, but quickly grew to an average of 50 students annually over the past 33 years. That makes 1,400 to 1,700 total Project Healthcare alumni.

Where are they now? What professions did they choose? What passions did they follow? All of this, and more, I set out to reveal.

The initial alumni database was primarily the work of previous alumni coordinators who had gathered information in 2009 and again in 2013 and 2014. These efforts were extremely successful, and I owe much of my success to them. I spent most of the first month on this project sorting through old emails, email address lists, and previously circulated newsletters to organize and integrate already-known information. A prior Project Healthcare Facebook Group turned out to be one of the most effective tools for tracking down and communicating with alumni.

Despite the significant work of previous coordinators, the alumni database was missing many names and years, including an entire decade (1984-1994). The hardcopy files, participant lists, and general documents from this pre-computer era had been lost in the offices at Bellevue and, unfortunately, were never found. Some of the names of the program’s earliest participants did not generate a single lead on Google; others generated a few leads, but it was impossible to find out if the individual is retired, is not on Facebook or LinkedIn, or shares a name with hundreds of other equally plausible professionals across the globe.

My first task was to develop a methodology to fill in the gaps from the years, when records weren’t maintained, with as many additional names as possible. I found the names of alumni by reviewing a) the work of previous alumni coordinators, b) hard-copy documents/address lists/projects in old Project Healthcare boxes, c) messages to Dr. Goldfrank over the years, d) alumni acquaintances from our spottiest years, who were asked if they could remember the names of any of their peers, and e) Facebook algorithms—if the Facebook group (which is currently “friends” with over 600 Project Healthcare alumni) had a “suggested friend” with whom our account shared anywhere from 7 to 30 mutual friends, I reached out to the individual to investigate.

Why this project? We would like to build a network with a formal pathway for communicating with alumni and create an alumni association that includes all of the program’s participants. We’re interested in learning where alumni are, what they have done, and what role Project Healthcare played in charting the course of their careers and life journeys.

I also asked early participants for names of coordinators or peers. Unsurprisingly, many didn’t remember specific names, but some were able to recall people they had engaged with. If alumni had been coordinators and/or if they were willing to help, I would send them...
After adding as many missing names as possible, I got an updated email address from each alumnus. I recorded professional information I found on the Internet, such as where the individual attended undergraduate and/or graduate school, a current occupation and place of work, and any professional interests and details. If this information were not readily available, I would inquire directly from alumni. I contacted alumni through the Project Healthcare Facebook account, the Project Healthcare email account (phcalumni@nyulangone.org), LinkedIn, and/or by phone. I called many professional offices and practices whose numbers were available on the Internet, if I could not reach the individual any other way.

I want to thank the alumni who took the time to help me throughout this endeavor. Many set aside the time to talk with me over email about everything they could remember, and this was because of the overwhelming gratitude they felt towards Dr. Goldfrank and the program. I was struck—but not totally surprised—by how many alumni expressed appreciation for the ways they believed they were changed or inspired by the program. I was not asking for such information (yet), although we hope to find out more on this going forward. Nonetheless, the feeling that I gathered among alumni as I made my way through the project was one of appreciation and excitement for a more formal alumni network.

The total number of Project Healthcare participants is estimated at 1,400, 77% of whom are known. Of these, 801 (74.2%) responded to the search request. The other 278 (25.7%) could not be located or did not respond to the search request. The Project Healthcare alumni network therefore consists of 801 alumni respondents. This review will discuss all those who participated prior to 2015, therefore limiting the discussion to those who have finalized career decisions. 92.1% of alumni whose professions are known went into numerous healthcare-related fields, whereas 7.9% went into other fields. 8.9% of alumni whose professions are known between the years of 1981 and 2014 went into emergency medicine (working as emergency department directors, attendings, residents, nurses, research coordinators, paramedics, EMTs, or physician assistants). 13.4% of alumni became NYU affiliates, returning to the NYU medical community formally at some point, either for medical school, a residency, a fellowship, or to work or teach full-time.

I had the privilege of speaking with many of the people from this special program’s past—connecting with them, witnessing their excitement, hearing what the program has meant to them, and, most profoundly, discovering what they have gone on to do with their lives. This project quickly became a breathtaking tribute to human ambition, conviction, and tenacity. I found Project Healthcare alumni to be exceptionally accomplished. I found them to be deeply involved in caring about others—driven, determined, and unlikely to become complacent in their dreams. I marveled at how many different degrees, opportunities, and additional training alumni sought beyond their primary line of work. For example, many alumni who went into healthcare also chose multiple residencies, fellowships, law degrees, business degrees, masters degrees, and PhDs.

In addition to their primary professions, many alumni pursue projects on their personal time. Projects include authoring a book educating youth about sexual assault on college campuses, founding a nonprofit that delivers cervical cancer prevention services to women low- to middle-income countries, leading nationally funded studies about workplace-related stressors in the emergency department, created a biotechnology startup that develops medical apps compatible with iPhones and iPads, serving with Doctors Without Borders in Africa during the Ebola crisis, founding EMT and Paramedic Training Centers, overseeing methods of curriculum development for teaching residents, and leading tuberculosis screening campaigns in remote communities.
islands near the Philippines with the Center for Disease Control.

Project Healthcare alumni live on Native American reservations to care for those in need, serve on the boards of directors for international non-governmental organizations, peer review journal articles across many specialties, and serve in the military as medics, surgeons, paratroopers, and many other capacities around the world. They have become teachers, professors, and clinical instructors, and somehow juggled such ambitious pursuits while also becoming mothers and fathers themselves.

Of the 7.9% of alumni who did not go into healthcare or medicine, the most popular field of choice is education, with careers ranging from law to firefighting to criminology to architecture. I marveled again at the various degrees, training, titles, accolades, auxiliary pursuits, and general indicators of passion and success. They showed the same commitment to their own desires and ambitions, which I began to understand as the defining trait among Project Healthcare alumni.

The accomplishments mentioned above are just the beginning of what my search uncovered. Every single alumnus has a story. We hope to spotlight our alumni and delve into these stories as we continue to build our network. In my work with this project, I even heard stories about what Project Healthcare participants have done for each other—braving residency together, becoming lifelong friends, and sharing important life events with one another. From a human-interest standpoint, there is a lot more to unpack here. We hope to reveal all of these stories.

I walk away from this project with a sense of optimism about the tenacity I witnessed. I cannot pretend to be able to speak for any of the alumni merely because I recorded their titles and degrees. I have no idea how they feel, what drives their ambitions, or why they chose to pursue what they did in their lives. But I would be remiss if I did not say that Project Healthcare alumni are a collective of ambitious people doing important things for our world. They seem to be making waves, creating change, and caring profoundly for others wherever they are.

I feel a sense of camaraderie and fellowship with participants of Project Healthcare, and I believe this is because one of the most uniting pursuits of all time is the pursuit of helping others. For the same reasons that people come together in crisis, people also come together through service, human connection, difficult experiences, humbling learning, proximity to suffering, eye-opening education, forms of self-discovery, motivation and inspiration, and through the experience of having the heart softened, enlightened, or just simply informed to the unique realities of our world—not unlike that which takes place during Project Healthcare.

Even though people who have gone through Project Healthcare are all exceptional human beings and although they have pursued diverse ambitions, there are stunning commonalities among so many of their stories, of which I barely scratched the surface. The many accomplishments of Project Healthcare’s alumni seem like a thread of shared humanity, a commitment to the common good, a genuine concern for mankind.

“The many accomplishments of Project Healthcare’s alumni seem like a thread of shared humanity, a commitment to the common good, a genuine concern for mankind.”

Katie recently finished a post-baccalaureate premedical program at Columbia University and began a new job researching Crohn’s Disease in the Division of Environmental Pediatrics at NYU Langone Health. She plans to apply to medical school in the spring of 2020 and looks forward to pursuing her interests in geriatrics, preventative medicine, public health, and compassionate patient care to a diverse population like that of New York City. Whatever she does, her most important goal is to bring the spirit of patient advocacy that she was first introduced to—and profoundly inspired by—in the extraordinary emergency room at Bellevue Hospital.

The alumni also reminded me that in our incredibly unfair and increasingly distressing world, there will always be conviction, gusto, work ethic, sacrifice, bravery, courage, and persistence. There will always be magnificent human beings, dreaming ambitiously, and striving forward fearlessly—soaring in their pursuits for others. There will always be social resilience wherever you look for it, should you find yourself needing to be reminded that it is there. There will always be individuals who dedicate their professional and personal existence to our collective good—people who train, study, and work hard to equip themselves with the skills and knowledge they will need. That one day they can help the next generation of human beings in need who they don’t know and haven’t met, but who they already care about deeply. In simple terms, there will always be people who are motivated beyond belief at the idea of helping each other. Nowhere is such motivation more apparent than among our alumni.
Every summer, I look forward to one of my favorite events in the Bellevue Emergency Department—the arrival of red-shirt-clad volunteers from universities across the country. I get excited because it means that for the next two months, the emergency department will run a little more smoothly. Patients will receive food, water, and blankets more quickly, get to their tests a little faster, and have a hand to hold when they need it most. For the volunteers, the two-month experience is challenging, rewarding, and formative.

In 2008, I had the privilege of working as a project healthcare volunteer. Before that summer, I knew little about Bellevue, apart from brief pop culture references, but I soon appreciated the institution’s energy, pace, and commitment to its patients. Going from my rural college campus to an urban county emergency department serving a diverse and primarily underserved population made for a different experience.

From day one, the Bellevue clinical staff made it a priority to integrate me and the other volunteers into the patient care teams. During one of my first shifts, Dr. Goldfrank had me spend time with an intoxicated, undomiciled woman who repeatedly tried to leave without being discharged. One day I changed a woman with dementia out of soiled clothing; another day, translating the risks and benefits of a CT scan into Spanish, I resorted to using body language to comfort a worried Mandarin-speaking patient. This unfiltered view into the front lines of patient care made me expand my comfort zone and taught me the challenges and rewards of serving vulnerable populations in a dynamic and fast-paced setting.

Returning to Bellevue as a visiting medical student and then as a resident felt like a homecoming. I was once again surrounded by peers and mentors who never hesitate to go above and beyond for their patients—whether it means working past their shifts to ensure excellent care or performing the less-glamorous tasks far beyond their job description. The desire to care for our diverse patients isn’t the only thing that keeps me working at Bellevue; as an attending physician it’s also the inspiration I gain from Bellevue’s devoted physicians, nurses, students, staff, and volunteers. While not all Project Healthcare volunteers will return to Bellevue, I hope they will continue to carry with them the calling to advocate for and serve those who need their help most.

By Alexandra Ortego
(PHC ’08, Res. ’18, EM Faculty)
I had just finished my junior year in college and was looking for a clinical experience to convince me that suffering through the basic science requirements was worthwhile. An alumna of my college told me about Project Healthcare (PHC) and I was intrigued. I went into the interview not knowing much about emergency medicine, Bellevue Hospital, or Dr. Goldfrank. He must have sensed how serious I was about emergency medicine and my passion for helping people. A journalism major going into Bellevue! It was intimidating.

My summer at Bellevue introduced me to emergency medicine, public health issues, disparities in care, and the impact that emergency physicians can have both on individual patients and on society. Needless to say, I was hooked. I was fortunate to be able to continue my PHC experience by serving as coordinator the following summer, which provided the inspiration I needed going into my gap time. It also exposed me to the administrative side of medicine—an important preview of things to come in my career.

I kept an open mind as I went through medical school rotations, but I was always excited to be sent to the Emergency Department (ED) to evaluate a patient. Whenever I walked through the ED doors, I felt a sense of comfort, despite the chaotic environment. The chance to care for the whole patient and not just a body system, as well as the wide variety of practice variations available to the emergency physician, made me realize that emergency medicine was the perfect fit. Once I made my decision, I knew I wanted to go back to Bellevue to learn from Dr. Goldfrank and the cast of attendings he had recruited. On Match Day, I realized I had come full circle and would be returning to Bellevue for my emergency medicine training.

Residency was a four-year return to PHC. I looked forward to seeing the arrival of the red coats every summer. The students’ enthusiasm was infectious and made integrating participants into the daily ED life easy. Watching other PHC alumni go through medical school and join the Bellevue EM residency family was particularly satisfying.

I’m currently practicing in Pittsburgh and serve as an associate residency director. The skills I learned in PHC are with me to this day. I enjoy translating for patients (even if I don’t have nearly as many opportunities to use American sign language or French here). I still actively seek out the college volunteers in the ED and spend a few minutes reviewing the events of the day with them. I am notorious for regaling my residents with stories of Bellevue. I can’t help but smile when one of them quotes my mishaps or comments on “the Bellevue way.” I encourage all of my residents to do a toxicology rotation at Bellevue to get a glimpse of the real thing up close.

I can honestly say that when I applied to PHC, I had no idea the program would ultimately shape my career and my views on healthcare. I am indebted to Dr. Goldfrank for taking a chance on this wide-eyed girl from New Hampshire.
Hippocrates envisioned a medical education system in which learners access educational resources regardless of financial means. Unfortunately, this concept was forgotten for millennia. Traditional medical education lived solely within the sanctioned halls of medicine, relying on large classroom lectures, textbooks, and medical conferences—all of which require considerable financial investments.

Fortunately, though, the advancement of medical education technologies has rapidly changed this paradigm. Learners are now able to guide their own education, and demand multimedia, multiformat platforms to access information. This revolution has motivated many educators to transition from pedagogical to andragogical forms of education, with increased focus on process.

With Free Open Access Medical Education (FOAM)—educational resources that are independent of platform and available to anyone—emergency medicine (EM) has been on the leading edge of asynchronous education. Hippocrates would be proud. Life in the Fastlane, a blog created by Australian emergency and intensive care physicians, is the model site for FOAM. With more than 11 million annual visits by 5.8 million unique users, the site is phenomenally influential, with a reach that far exceeds that of traditional education models, like lectures, small group workshops, and even journal publications. Over the last decade, FOAM has exploded with hundreds of blogs and podcasts available for use across a number of specialties, including EM, critical care, anesthesia, pediatrics, surgery, and more.

Despite its meteoric growth, however, EM FOAM focuses primarily on resuscitation, airway, and other critical care-related areas and is in need of more core content.

Recognizing this
need, we began working on the Core EM site in 2014. With the support of Drs. Jeff Manko, Lewis Goldfrank, and department administration, we were able to spend considerable time engaged in site, content, and team development. Dr. Michael Shamoon (Res. ‘18) built a uniquely designed platform that meets the needs of both our learners and our team. Simple in appearance but complex in function, the site provides easy access to blog posts, podcasts, and videos, on any type of device, from smartphones to desktop computers.

CoreEM.net launched in May 2015, with our first podcast touting our dedication to “core content for anyone, anywhere and just in time.” This podcast was instantly followed by blog posts and was the subject of several journal article reviews. Posts ranged from basic approaches to chest pain to life-threatening aortic dissections. Every week for three years, followers could expect a podcast (every Monday), a blog post (every Wednesday) and a journal review (every Thursday), as well as regular procedure videos. This resulted in the creation of an extensive library of education available to anyone with a Wi-Fi connection or data plan. Many videos were designed for use in the clinical setting, as well.

Each post receives rigorous peer review thanks to several faculty members who volunteer their time for the process. Core EM’s rigor and quality have been recognized multiple times by objective scoring systems used in FOAM curation by the Academic Life in Emergency Medicine (ALiEM) team. The site’s quality is reflected in the end-user numbers: 36,000 monthly visits, 1.25 million podcast downloads, and use in over 100 countries.

In addition to standard EM curriculum, Core EM also features a traditional blog enabling medical students, residents, and faculty to offer reflections from their clinical practice. The blog features excerpts from graduation addresses, as well as narratives from residents. Many of these posts highlight the art of medicine, contributing to the formation of well-rounded EM clinicians. The creation and maintenance of Core EM has been a Herculean effort made possible by the medical students, residents, and faculty who have contributed so much of their time.

I would like to thank a number of faculty for their critical contributions: Dr. Mike Mojica (PEM ‘93, PEM Faculty) for his expert takes on pediatric emergency medicine and critique of the literature; Drs. Rana Biary (Med Tox ’14) and Danny Lugassy (Med Tox ’10) for their incredible reviews of everything toxicologic; Dr. Marsia Vermeulen (EUS ‘13, EM Faculty) for her amazing ultrasound contributions; and Dr. Jenny Beck-Esmay (Res. ‘17) for her role as both resident and faculty member in creation of our podcast.

The number of contributing residents is too high for me to name everyone, but I would like to shine a spotlight on Dr. Michael Shamoon (Res. ‘18) for his guidance of the technical aspects of the project, Dr. Allan Guiney (Res. ‘18) for his support of the video content, and Dr. Sanjay Mohan (Res. ‘20) for bearing his soul in many blog posts.

I left NYU-Bellevue in 2018, and the Core EM project is now under the supervision of Drs. Brian Gilberti and Bree Tse (both EM Faculty). The site continues to deliver high-quality core content to EM clinicians globally—and it provides the outside world a glimpse into NYU-Bellevue’s amazing emergency department.

“... and to teach them this art—if they desire to learn it—without fee and covenant.”
–Hippocrates

“Simple in appearance but complex in function, the site provides easy access to blog posts, podcasts, and videos, on any type of device, from smartphones to desktop computers.”
MORNING REPORT AT FORTY

Mary Ann Howland, PharmD
and Neal A. Lewin, MD
“We have attendings who are skilled sonographers, knowledgeable intensivists, pediatricians and toxicologists. They all come and they educate us.”
–Dr. Neal Lewin

In 1979 Drs. Neal Lewin and Mary Ann Howland, brought together the few attendings, moonlighters, and surgery and medicine residents to discuss patients seen during their overnight shift in Bellevue’s emergency department. They all huddled together, many tired after their shift, to sit informally in any vacant room or the trauma slot to discuss patient complaints. They reviewed their approaches to the patient’s history, physical examination, and treatment and discussed strategies for prevention to demonstrate how an emergency physician and clinical pharmacist might think and practice. They were developing a system to enrich the specialties of emergency medicine, medical and clinical toxicology, and clinical pharmacy. They did the best they could through observation, experience, and questioning—without the use of technology—to teach one another on how to improve patient care. Years later, the spontaneity of such informal patient case reviews became Morning Report—a thoughtful discussion about solving complex medical diagnoses, brought to Bellevue by Lewis Goldfrank from the Bronx.

Four decades later, Morning Report remains a dynamic, informal teaching method. The process is the same as it was in the early days, but it is more technologically advanced. It’s a style of education that integrates the breadth and depth of emergency medicine and pharmacy in an informal, stress-free environment. Morning Report has become a rigorous intellectual session, presented by a fourth-year resident who utilizes a well-defined case, patient data, test results, and current research. Medical students, pharmacy students, residents, fellows, and faculty all sit together and appreciate that, regardless of their individual levels of knowledge and expertise, each one of them takes away valuable information from the discussion. The environment is respectful of the belief that there are no inappropriate questions; each question helps the learner appreciate how others think and facilitates improvement in their teaching style. Morning Report is an exceptionally creative, altruistic, humanistic education for all who participate.

“It is always the learning that keeps me motivated. Helping people learn and research new ideas. It’s really fun. I look forward to it.”
–Dr. Mary Ann Howland
VARIOUS PERSPECTIVES ON MORNING REPORT

ANNE LIN
PharmD Candidate 2020, St. John’s University

Morning Report is a great learning experience to see how emergency medicine physicians think through a case. As a pharmacy student, I primarily focus on the medications that are involved in the case; throughout pharmacy school, the cases that were given to us already had all the information that I needed to make a recommendation. After attending Morning Report, I have a sense of how physicians view a case as it unfolds, and this experience will help me become a better pharmacist. I will take everything I learned from Morning Report to use in future recommendations to physicians and other members of the patient care team.

MICHAEL DIAZ (Res. ’21)

Morning Report is one of the highlights of our program that makes NYU-Bellevue truly special. While not everyone may agree on every aspect of every case, this forum provides a safe place for learners to gain insight into different practice styles and different ways to approach a given problem. I hope Morning Report continues to be a part of this program forever, and continues to inspire the special people who have the honor of training at Bellevue.

EVANTHIA SIOZIOS
PharmD Candidate 2020, St. John’s University

Morning Report is not only about becoming more educated in the medical field, but it teaches me the value of the step-wise approach when solving a problem. Every patient is different and although the diagnosis and treatment may not be obvious at times, you have to look at each patient with an open-mind and step back to see the outcome. Morning Report has influenced my thinking and learning process by teaching me to not only look at the facts, but also the patient. It has taught me that in order to come up with a solution, you have to look at the many different causes. It relates to the pharmacy environment because when counseling patients, it is important to ask the patient many questions and get as much background information as possible in order to come up with the right answer.

LEE JOHNSON
Class of 2020, NYU Grossman School of Medicine

Morning Report is an opportunity to glimpse into the minds of the residents and experienced attendings to understand how they approach an array of problems. Rarely is everyone in the room in agreement. Hearing the debates that follow each case really illustrates the complexity of emergency medicine. It is an opportunity to learn from decades of experience at Bellevue and put current practices into perspective.
LEAH MCDONALD (Res. ‘19)

An exceptional aspect of Morning Report is that your experience changes each year of residency. During your intern year, you soak in each case and revel in “guessing the diagnosis.” In your second and third year, you are put into the hot chair more with questions from seniors and attendings and have time to demonstrate the knowledge you have been gathering throughout your residency. By your fourth year, you are challenged with turning a case that was meaningful to you and making it an exciting “story” for an audience. You force yourself to look deeply at your medical decision-making in what may have been a difficult case, and you have the opportunity to review the literature on complicated medical diagnoses. Every lecture teaches you something and shows you what it means to be a lifelong learner. Morning Report is a part of this residency that I will always remember.

EMILY TAUB (Med Tox ‘20)

I believe that Morning Report is one of the strongest parts of the emergency department’s educational mission. It is unique in that faculty are always present. It gives junior residents a space to learn and hear varying faculty opinions, and it gives senior residents a comfortable venue in which to learn teaching skills.

BRENNAN CHANG
Class of 2020, NYU Grossman School of Medicine

Emergency medicine is fast-paced and stimulating. Decisions are made with incomplete information. It’s part of why I was drawn to EM, but it isn’t the most conducive environment for learning. That’s the gap that Morning Report fills—it’s a time to refine one’s practice of medicine and gain new knowledge. It’s an opportunity to step back and really think through cases—to identify the good and the bad and come up with a game-plan that can be applied to a similar case in the future. It’s also an opportunity for generations of physicians to share their respective experiences and knowledge. The more experienced doctors have a wealth of knowledge, of course, but I’m always inspired by how the residents have strong opinions and aren’t afraid to defend their opinions with evidence.

BRIAN LIN (Res. ‘18, SIM ‘19)

It is a valuable, protected hour for resident education and an opportunity for senior residents to demonstrate their growth over the years. What I like most about Morning Report is how honest it is. No one has insider information, and it’s a frank discussion about real patients and presentations with some of the greatest minds in our field. Every point is valid, and it’s nice to not have any sense of hierarchy while in the room.
WHY DID YOU CHOOSE EMERGENCY MEDICINE AS A CAREER?
The joy of treating those who are at their most vulnerable cannot be measured. The look of relief in a patient’s eyes following an emergency intervention is precious—it is emotionally and spiritually satisfying to me.

HOW DID YOU LEARN ABOUT NYU-BELLEVUE? WHY NEW YORK CITY AND NYU-BELLEUE?
An online search! I wanted to join the best emergency medicine residency program available. The NYU-Bellevue program—with its strong reputation with world-renowned faculty—was number-one on my list.

WHAT GAVE YOU THE COURAGE TO LEAVE YOUR HOME, FAMILY, AND FRIENDS TO COME TO NEW YORK CITY?
I have traveled most of my life and continue to do so with my family. Leaving home for an extended period of time, however, was difficult. But I wanted to earn the credentials required for establishing a high-quality emergency medicine (EM) program in my home country Kuwait. This great honor was worth the risks and challenges that come with such long-term dedication. My training allowed me to return to Kuwait and pass on what I learned.

Following my residency, I wanted to enter a fellowship program that would allow me to help people in need around the world. When I completed my EM residency at NYU-Bellevue, I enrolled in another EM program and joined the international EMS/Disaster Medical Sciences Fellowship program at the University of California, Irvine Medical Center (UCIMC). I simultaneously completed the Executive Masters of Public Health and Global Health at the University of California Los Angeles (UCLA). My mentors both at UCIMC-UCLA were all supportive during and after the fellowship programs.

HOW DID YOU COPE WITH DIFFERENCES BETWEEN KUWAIT AND WESTERN CULTURES?
Coping and blending into life in New...
York City was not a concern. As a matter of fact, I chose New York City partly because of its diversity. I enjoyed the cultural differences and felt at home.

**WHAT WERE THE HIGHS AND LOWS OF LIVING IN NEW YORK CITY?**

Living in New York City is expensive! But the knowledge, experiences, and challenges that a multicultural city offers are priceless! Because I grew up in a hot climate, winters in New York were brutal. And during the summer, getting to the beach during off hours was difficult. I love to be near a beach.

**WHAT CONNECTIONS DO YOU MAINTAIN EVEN TODAY WITH YOUR PEERS AND TEACHERS? WHY?**

Apart from connecting through social media, I collaborate with several of my peers in workshops, training, and educational courses. I work on board reviews with Adam Rosh (Res. ’08) on RoshReview.com; wilderness medicine with the University of California, Irvine (UCI) team; marine EMS and urban search and rescue workshops and courses with Anh Nguyen (Res. ’10) and Nichole Bosson (Res. ’11); unified command system in disaster management with the UCI team; virtual Ohio board review courses for our residents; virtual emergency ultrasound training and education with the Sonosim program (SonoSim.com); and The Middle East and North African Toxicology Clinical Toxicology Conference 2019, here in Kuwait, with Dr. Lewis Goldfrank. I am also working with Anh and Nichole to introduce Augmented Reality (AR) solution into EM, EMS, and disaster medicine, and we plan to then introduce it to mass casualty incident triage and patient tracking. The list goes on, but this amazing journey with my peers and teachers is continually rewarding.

**HOW DID YOUR CLINICAL LEADERSHIP ROLES DEVELOP?**

The NYU-Bellevue EM residency program is all about developing and improving leadership skills through mentorship. Once I completed the fellowship program, I returned to Kuwait and collaborated with my colleagues to launch the Kuwait Board of Emergency Medicine through the Kuwait Institute for Medical Specialization (KIMS). KIMS is the local equivalent of the American Board of Medical Specialties and the American Board of Emergency Medicine in Kuwait. We are also engaging with international institutions to adopt the international accreditation and credentialing standards, evidence-based and best practices, as well as launching EM fellowship programs and exploring the feasibility of collaboration with international EM programs.

**HOW ELSE HAVE YOU CONTRIBUTED TO EMERGENCY MEDICINE IN KUWAIT?**

I have taught EM at the Kuwait University School of Medicine; served as a medical adviser to the Emergency Medical Services Department and Helicopter Emergency Medical Services; led project staff for the ER and emergency medical services Telehealth and its innovations; and introduced cutting-edge yet cost-effective technologies for training and education at the university.

**WHAT ARE YOUR PERSONAL ACCOMPLISHMENTS AND WHAT DOES IT MEAN FOR KUWAIT?**

I have a wonderful family and friends. I have the freedom to work on projects that are important. I do this in collaboration with my family, friends, and colleagues, who come from diverse healthcare communities. These diverse relationships give me wonderful opportunities for creativity, independence, and flexibility in shaping the future of healthcare in Kuwait.

I really enjoyed my time spent at both NYU-Bellevue and at UCIMC-UCLA, where I learned about multiculturalism in America. Many colleagues and friends asked me what I miss most about the United States. My answer is always the same: leadership and professionalism. I am happy that I can collaborate with supportive mentors and peers in the United States to advance EM and its subspecialties here in Kuwait, locally and regionally.
WE ARE IN A FOG.
As we re-enter our previous lives of emails, research, rounding, and laundry (lots of laundry), there is a disconnect. What previously seemed normal is now foreign.
We have just returned from a medical mission in Lebanon, where we provided care in the refugee camps of Beqaa Valley and Tripoli. The only people who seem to understand our disconnect from normalcy are our mission colleagues, who returned with us after a week treating Syrian refugees.
As we look through the pictures and read our daily journal entries, we reflect on our experience and its impact on us. Our team, under the auspices of the Syrian American Medical Society (SAMS), spent six days in Akkar, Lebanon, providing medical care to Syrian families. We saw a total of 1,219 patients, of whom 590 were children. We were a team of 13 physicians from different specialties and institutions, along with volunteers and interpreters. We all came together as strangers but left deeply connected—and deeply affected.
The ups and downs of one day in particular stood out to us.
We were deep into the week. We assembled at the usual 7:00 am, got into the van, and, apart from the two who were to man the local SAMS clinic, were divvied up into vans to make the hour-long drive to that day’s camp. When we arrived, we were directed to a courtyard about the size of a boxing ring. There was a cloth covering overhead, but all sides were open. We heard children giggling behind us as we unpacked our supplies. They gripped our hands, climbed on our backs, hugged our legs, and generally failed the marshmallow test (Google it) of waiting for the clinic to start.
We designated bouncers for crowd control, instituted a triage system with volunteers performing registration, and divided the square into four care teams, one in each corner. We set up our medical supplies in the middle, because if we put them too close to the edge, the examining gloves suspiciously disappeared.
And, thus, we began the clinic, working out bandage solutions to the problems they presented us. We saw children with growth failure from nutritional deprivation, poor speech development because of the cognitive impact of war, parasites from the water supply and skin infections from crowded conditions.
And yet when we finally made it through every single child in the camp,

“The gloves became balloons, and the kids used them as toys.”

(Left photo) The team enjoying the energy of Syrian children. (Top right photo) Syrian children thrilled to receive gifts of dental supplies. (Bottom right photo) Setup of medical supplies and equipment, arranged in the home of a gracious Syrian refugee.
the fun began with “Glove-fest.” We had given some leftover gloves to a few boys who had asked for them. Immediately, all the children swarmed up to us, asking for gloves. The gloves became balloons, and the kids used them as toys. The scene went from an organized medical team treating people with horrific conditions to the lovely chaos of a playground. Children shrieked with glee as they managed to convince doctors to give up their (least) used gloves. One team member had 10 children lined up in front of him, asking to be thrown in the air, while another had a girl climb on her back for a piggyback ride. Others were busy playing with happy children on the sidelines.

There was joy. Everywhere. Giggles, laughter, singing, games.

Meanwhile, my colleagues who had stayed behind at the SAMS clinic in Tripoli were having a different experience. One patient entered the clinic with a stack of papers. The interpreter-doctor team learned that the patient had recently been diagnosed with a terminal brain tumor. The father had come, not to learn more about the diagnosis or treatment, but to beg for help with affording palliative care for his child’s metastatic bone tumor pain. He was unable to pay for the analgesics necessary to treat pain, and felt helpless, as did our team members.

Emotions intensified when a second family came in with their eight-year-old who had a serious blood disorder requiring a bone marrow transplant, which they could not afford. They desperately asked if the American doctors could take their child with them abroad for treatment.

For anyone trained in a North American hospital, it’s very difficult to settle for anything less than what a patient needs. In this case, it was much less. We did what we could for these patients, but we could not deny our feelings of helplessness.

Throughout that day, at some point every team member had cried. Some on the bus, some in the hotel lobby, some in the car. In the evening, as we gathered at our concluding dinner, we learned heartbreaking news about one of the local SAMS mission leaders—and amazing man—who had driven us from point to point, ensured that we had water, and smiled every minute of the day. A few days prior, his home village had been bombed. His brother-in-law was killed and his family was lost somewhere in the desert between Syria and the Golan heights. Yet he continued to do his job, showing up on time and putting aside his own difficulties to take care of others. To take care of us.

We had come to the camps to offer up our skills and resources. The good we could do in a few days was a tiny fraction of what was necessary even for that week, let alone for the cumulative nine years since the Syrian war began.

However small our impact that week, it left a lasting impression. Both to the people we met, and to ourselves. For us, our proper shedding of tears, which would not have fallen in our comfortable professional cocoons here in North America, changed us for the better. We were lucky to share, briefly, in the joy and pride these refugees have in their beautiful, gleeful children. Their determination to create a better life for themselves, despite their current circumstances, is deeply humbling to us.

We have all been uncomfortably rocked to our core. In this, we have truly been blessed. Not all people are.

The Compassionate Care Mission Team includes NYU-Bellevue Drs. Shweta Iyer (PEM ‘19), Rana Biary (Med Tox ‘14), Laura Papadimitropoulos (PEM Faculty), Martin Pusic (former Director, Division of Learning Analytics).

To Volunteer: compassionatecaremission.com/who-we-are
“Everything you ever wanted is on the other side of fear.”
–George Addair

HOW DO YOU GET FROM HERE TO THERE? WHERE DO YOU SEE YOURSELF IN FIVE YEARS? TEN?

If you had told us that we would still be living in Tasmania eight years later, I don’t think we would have even stepped onto the plane. But an 18 month adventure? Sure, anyone can do that…. It isn’t often that a big leap sets our path in motion, but rather a series of small moments of bravery or seemingly manageable risk taking.

Like everyone else, living in the middle of Manhattan and training at NYU-Bellevue was our first choice. There were no second choices here. We met for the first time on a rainy night in the Pediatric emergency department. Those years provided us our first confrontation with mortality and what this path that we had chosen was going to look like. The memories collected over the years of neonatal airways and carrying four surgical pagers never leave you.

We are forever grateful for the patients that trusted us, the staff that hazed us and the mentors that guided us. But there is always more. The friendships and relationships that we developed during those years are still a bedrock—shared laughter and tears go a long way in creating bonds that stand the test of time. We were friends through much of residency, learning only in later years just how valuable those ties are and what they can sustain.

What we remember most from the aftermath of those years are the nights lying awake feeling overwhelmed—the mortgage, the shifts, the crush of patients, the push to move faster and to see more, coupled with the inevitability of missing something. There was the nagging guilt of not being at work when we were at home, and the guilt of not being at home when we were at work. It was never enough. Both of us never felt like enough. And beneath it all was a
sense that there had to be more—something bigger and better, or at least more fun.... We would lie in bed, those nights before sleep overtook us, and ask the same questions:

“WHAT ARE WE GOING TO DO?”
“ABOUT WHAT?”
“ABOUT EVERYTHING.”

So we packed up the kids—three at the time—and gave ourselves two months to travel across Hong Kong, Indonesia, and Australia. We arrived in Tassie with two suitcases and a boatload of hope and “what if.”

And somehow now, we’re still living at the far ends of the earth. We didn’t plan it. Does anyone plan something like this? Four children, a juggle of jobs, directing an emergency department and providing prehospital care on the helicopter? It brings to mind the adage, “How do you make God laugh? Make a plan.”

Of course, we do still harbor delusions of what five years from now looks like. Perhaps, instead we should try determining what fulfillment looks like. Perhaps being able to look back and feel giddy about all the choices you’ve made and lived to tell about, means you’re one step closer to fulfillment. Admittedly, a move to Tasmania is a bit drastic. It is certainly a long way from Brooklyn.

But if this job teaches you nothing else, it will teach that every day is a gift and that we are foolish if we take it for granted. How many times must we be reminded that no one ever inscribed on a headstone, “I wish I’d spent more time at the office.”

We can confidently say that we didn’t plan on being here, but that the adventure has been a beautiful one. One that we wouldn’t trade for anything. What kind of person will you be in five years? Hopefully one that has grown, one that has dared, and one that has given.

Thank you, Bellevue, for reminding us of what is important and for making us the people we are.
SO FAR, SO GOOD...
EMERGENCY MEDICINE, TOXICOLOGY, AND PHOTOGRAPHY

By Jason B. Hack
(Res. ’97, Med Tox ’99)
Suddenly, my mind takes me back in time to morning rounds in the old Bellevue emergency department (ED). Lewis Goldfrank—L.G.—walks in and scans the crowd from across the room. I see his eyes moving from face to face, and then locking on mine. And then it happens . . . the index finger comes up, points, and curls back on itself in a “come here” gesture. Is this good or bad? No chance for escape, no hope to run, no turning back—but I have faith that I will ultimately learn something from the experience, whatever happens.

I was raised across the street from the Brooklyn Museum and the Botanical Gardens in a family of educators. My parents retired after careers of teaching—my mother after 40 years of running a parent-cooperative Summerhill-based nursery school; my father, after 45 years as an educator and assistant principal in the public schools. Learning about new things was a family value. Summer breaks usually involved travel . . . which usually involved museums. I’ve been to museums about nature, science, art, lace, caves, pencils, cranberries, geology, salt, bog plants, glass, rivers, dams, television, mummies, and jewels.

My education outside the home was very New York—Brooklyn Friends Academy, Edward R. Murrow High School, and SUNY Binghamton. Because concept mastery—not testing—was always emphasized in my family, my grades on standardized tests have never been high. On my desk, the stack of medical school rejection letters got alarmingly tall before I finally received a letter from SUNY Downstate/Kings County Hospital—a terrific relief!

At Downstate, as I tried to decide on a residency and specialty that I could see myself doing for the next 50 years, I found my clinical rotations equally engaging and frustrating. Then I rotated in the Kings County Hospital ED and something clicked. I loved dealing with the immediacy of need, the variety of patients and backgrounds, the range of complaints, the hands-on approach of fixing things using simple tools. It was the caring for people whom others couldn’t or wouldn’t treat, the puzzle solving, the camaraderie and team spirit of the staff, and especially the seemingly endless array of things to learn. I worked with Dr. Lewis Kohl, whose calm modeling of “do anything and everything well” was an inspiration.

My next goal was clear: get into NYU-Bellevue.

I first walked through those historic metal garden gates of Bellevue in 1993. Moving down the path, I heard languages from all over the globe. I knew I had arrived somewhere special. My time at NYU-Bellevue broadened my horizons—every day I saw something new, heard something new, did something new, and, most important to me, learned something new!

I felt blessed to be surrounded by brilliant physicians committed to caring for anyone regardless of any social determinants, who treated everyone with kindness and respect. The world-class emergency medicine faculty at Bellevue provided a deep pool of mentors with exemplary characteristics—attitudes, approaches, and ability—that I could model and aspire to emulate as I developed my practice patterns. There are too many to name, but I will always be grateful to Drs. Wally Carter, Bob Hessler, Neal Lewin, Susi Vassallo, and Stephen Menlove.

“I loved dealing with the immediacy of need, the variety of patients and backgrounds, the range of complaints, the hands-on approach of fixing things using simple tools.”
Bellevue’s unique system of empowering the ED to admit any patient to any service established a sense of “doing the right thing,” despite occasional vehement resistance from admitting services. (Laboratory numbers don’t always provide the full picture of a patient’s need for care; cellulitis and a snowstorm don’t mix well for the undomiciled.) It also led to some quirky admission pathways at times. (“Refusal of bologna sandwich” was a clinching argument for a patient with abdominal pain.) And opening the “Back Pain Book” invited intense Talmudic-style debate with the admitting service up next in the rotation. (“Yes, you did get called yesterday about an admission, but since it did not occur and you are still up... No, intention to admit is not the same as getting an admission...”)

Residency was demanding, but I’m thankful for the skills I gained. I placed hundreds of IVs (antecubital, back of arm, shoulder, feet, finger), drew my own blood tests (learning which tube is for what test), and wrote specimen labels (if the blue plate machine wasn’t functioning) and sent them to the lab. I centrifuged capillary tubes in the trauma slot for hematocrit and gram stained specimens on slides. I learned to anticipate and collect into a basket (like Little Red Riding Hood) what I would need for testing, and to hang IV fluids after changing the line—a valuable skill for less back and forth. I untangled wires and attached patients to monitors, performed ECGs with the gel-spitting suction cup machine, and occasionally shot portable chest x-rays. I mastered stretcher inertia and entropy as I pushed patients to x-ray or CT scan and launched them into a Brownian orbit of the Satellite Observation Unit.

I was also taught to listen for harbingers of badness from any source. When you hear a patient say, “I feel like I’m going to die,” or their family members say, “Grandma’s color is off,” or Marion or Kim say, “Does someone want to begin CPR?”, or the housekeeper say, “I wouldn’t uncuff him if I were you,” or the transporter say, “Is she supposed to be making that noise?”—be humble and listen, these are gifts that will help you... get off your seat and pay attention!

A key repeated lesson was to ask open-ended questions and keep an open mind because assumptions based on patient appearance can be dangerous and misleading. Disheveled intoxicants found sleeping in the street might be UN attachés. A chatty patient with a “little pinching” in the chest may have ECG tombstones. Grandmothers can smoke crack, and protecting one’s genitals from trauma doesn’t rule out seizure. The lessons were many—don’t jump to conclusions, ask questions, look hard for clues to the real story.

As the end of residency drew near, I was unsure of my next step. My wife Allyson encouraged me to ask Dr. Goldfrank if I could stay on for two years as an attending, and I met with him to discuss it. It seemed like only a moment had passed, but the next thing I knew we were shaking hands. It hit me on the walk home that I had just said yes to his offer of becoming a Toxicology Fellow.

This unexpectedly pivotal moment changed my career and life. After completing the challenging two years at the New York City Poison and Control Center, learning from renowned fac-
An image from the NIPS exhibit that shows how much alcohol thrown out of cars goes unnoticed.
Rhode Island Department of Health and the Providence Fire Fighters to assess on-site cyanide bioaccumulation.

Through these diverse interests and activities, I’m not only working to improve aspects of medical care, but also to engage the general public on health-related matters—which has inspired me to explore alternative ways of disseminating my ideas. For instance, I developed an interest in photography as a way to visually weave together some of the most important aspects of my personal and professional life (toxicology, enlightenment, family, and nature) and to share it in an appealing, non-traditional way. My photography focuses mainly on beautiful and vibrant medicinal or poisonous flowers and other vegetation, and on overlooked items in our environment that can or should affect us. The photos are unstaged, taken at a close distance and intensely focused to allow the viewer to see the fleeting combination of natural light, breeze, color, and imperfections, and they minimize background and context.

I display many of my photos in frames found in junk piles and then refurbish to give them a second life. These flower photos tell the story of the medicines or toxins the plant provides. I find it amazing that the appearance and beauty of a plant has nothing to do with whether the plant is poisonous, curative, or benign—their silent secrets. My images are also designed to remind people of the powers of the natural world—that the sterile white pills we often take originated as beautiful, fragrant flowers and delicate plants growing in warm soil.

I donated a collection of my flower photos to the Women’s Health Inpatient Unit at Rhode Island Hospital and feel proud to see my work on permanent display in the halls of this brand-new institution. The physician assistant school at Bryant University also houses another medicinal flower photography collection.

I was honored to be asked to donate my Images in Impact series—a collection focusing on discarded alcohol bottles in the streets of Providence—to a multi-institutional (Rhode Island Department of Transportation, AAA, Rhode Island State Troopers, AAA, and others) initiative called The Ripple Effect. This initiative, designed to draw attention to the risks and consequence of alcohol-impaired driving, seeks to reduce alcohol-involved roadway deaths to zero.

Looking back, it all began with walking through a gate, performing novel tasks, being instilled with the confidence to challenge convention, and receiving encouragement to strive to learn and improve. I’m indebted to my family and my upbringing—and to Bellevue’s principles and culture, its staff, its patients, and its leadership for boiling everything down to a core question: Does this decision benefit the world?

“A manhole cover from the Street Jewels exhibit that brings attention to overlooked items around us. They are functional beauty.

“Moving down the path, I heard languages from all over the globe. I knew I had arrived someplace special.”

Online Art Gallery: ToxinRI.com
When I was halfway through my third year of Emergency Medicine (EM) residency at Bellevue, a new trauma surgeon told me that emergency physicians worked as co-fellows at Shock Trauma, and he thought it might be something I would enjoy. I liked the intensive care unit (ICU) and working with trauma patients, but I had not thought about what a career might look like after fellowship. At the time, I didn’t have anyone to help me with this decision, but it sounded like something cool to do. It turns out that it was.

Practicing two specialties certainly comes with challenges. Dividing my time between two departments with different pay structures, different expectations, and different schedule constraints have been the ongoing challenge of my career. Even though I am only 50% in each department, both seem to forget that I have another home. But despite the logistical challenges, the benefits far outweigh the drawbacks. I enjoy two work families. I’m part of an incredible national community of dual-trained EM critical care colleagues—a huge source of support and camaraderie. And my fellowship training in the emerging subspecialty of EM has paid off with valuable opportunities for academic productivity and leadership roles.

“Treating incredibly sick and challenging patients is personally rewarding.”

As I get older, I admit that the idea of decreasing my emergency department (ED) shifts and increasing my ICU shifts is getting more and more enticing. Trading off some ED work—which can be mentally and physically exhausting—for the regular hours of the ICU might be something I do in the future. Even though my ICU weeks are long (seven straight 11-hour days can be tough on my family), treating incredibly sick and challenging patients is personally rewarding. The ICU also affords me time to teach, research, speak to, and develop relationships with families, schedule meetings, catch up on email, and come home to my family with far more energy than I do after a day in the ED.

It’s been 13 years since I made my decision, and I continue to practice EM and surgical critical care equally. It’s hard to imagine giving them up. I consider myself an emergency physician first, but I joke that I still love it because I only have to do it 50% of the time. It’s the combination of both specialties, the opportunity to be an emergency physician and an intensivist, that makes me most grateful for my decision to do a critical care fellowship. I feel like I’m better at both jobs because of my experience in both places. It’s hard enough to find one job you love. I’m lucky enough to have two.
STARTING OUT
INTEGRATING EMERGENCY MEDICINE AND CRITICAL CARE

By Keegan Tupchong
(Res. ‘15)
Throughout residency, I felt myself gravitating toward the sickest patients in the emergency department (ED), no matter what side or team they were on. The rush of being involved in a resuscitation is what initially drew my interest in critical care. Over time, it became more about the complex physiology of critically ill patients and having additional data, such as labs, imaging, consultant input, and clinical course over time to make management decisions. Ultimately, continuity of care and getting to know patients and their families have been the greatest draw to being an intensivist. The most rewarding aspect of working in the intensive care unit (ICU) is sitting down next to a patient and his or her loved ones, getting to know them, and talking honestly and openly about the illness that affects all of them.

Serving as both an emergency physician (EP) and an intensivist requires a range of different skills, many of which overlap. One similarity between the two is the emphasis on finding and treating life-threatening conditions. Collaboration with other specialists and coordinating care across disciplines are also central to the job. However, since the ICU is a more controlled setting than many others, it often affords me the time to process how various disease states affect multiple organ systems simultaneously. My average day is spent doing morning rounds and consultations. When I am called to help take care of new patients—whether they’re from the ED, the operating room, the floor, or another hospital—important work has usually taken place already, which provides valuable data that helps me make informed decisions.

EPs bring a number of skills to the world of critical care that I think are sometimes understated. I received wonderful training at NYU-Bellevue, for which I will always be grateful. Taking care of the undifferentiated patient—the EP’s specialty—is a challenge. Having a broad differential, being able to commit to action when little information is available, and recognizing occult critical illness are incredibly important. I had a lot of inspiring mentors at NYU-Bellevue, who shaped how I think about clinical care, and I was very lucky to have had the opportunity to learn advanced skills in ultrasound, which impact my daily practice.

Recently, I received a call from an EP late at night about a patient presenting in undifferentiated shock and on the verge of death. Using bedside ultrasound, the EP quickly diagnosed a ruptured abdominal aortic aneurysm. He started massive transfusion, called in the surgeon, and got him to the operating room. The patient was incredibly sick, and I spent the entire night at his bedside, resuscitating him postoperatively. Several days later, he walked out of the hospital. While all critically ill patients ultimately have a team that cares for them, if it were not for this EP and the advancement of modern emergency medicine, the patient would have died.

I should add that my experience taking care of patients downstream from their initial presentations has allowed me to think differently about some of the time-sensitive interventions that impact patient outcomes. My paradigm of resuscitation, be it earlier transition to things like vasopressors, blood products, and mechanical circulatory support, has changed dramatically. In the ED, I now find myself anticipating what will be important in the next 12 to 24 hours, which affects my early management. Additionally, training in critical care has broadened my procedural skillset when I am in the ED. In this way, I think the presence of dually trained EPs/intensivists can help drive the advancement of care of the critically ill in the ED.

I am fortunate to practice both emergency medicine and critical care. The transition between both worlds sometimes requires a shift in mindset, which I find refreshing. When I am upstairs, at times, I miss the chaos and variety of the ED. But other times, I am glad to go into depth about a particular patient’s multi-system disease process and injuries, and get to know patients and their families. So far, this has been a very happy balance, as both sides complement each other.
SUPPORTIVE CARE AND EMPATHY
FUSING EMERGENCY MEDICINE AND PALLIATIVE CARE

By Susan Stone (Res. ’98)
As a young emergency physician in a large urban trauma center in Los Angeles—first in a safety net hospital, then in a community hospital—the absence of integration in the healthcare system was evident. The gaps that existed in patient care were everywhere. As I cared for patients and their families, I developed an interest in devising a strategy to close the gaps that existed and provide well-integrated healthcare. Several of us in emergency medicine got together to find the best ways to meet the needs of our patients. Our discussions led to the development of a subspecialty for emergency physicians—palliative care.

I wanted to become more skilled at treating and easing the pain of patients suffering from malignant pain, refractory shortness of breath, and other manifestations of serious illness. While the physical elements of illness are challenging, I realized that the psychosocial and spiritual issues were even more critical for patients and their families.

Fortunately, our team’s goals coincided with those of a new national movement to improve the care of underserved patients, and we began collaborating with others in primary care, internal medicine, palliative care, and hospice care.

Initially, many community members equated palliative care with hospice care. Hospice care is a service for persons with a life expectancy under one year and typically less than six months. Palliative care provides an extra layer of support in addition to other care that includes life-prolonging treatments. As a palliative-care specialist, I have been involved with solid organ transplantation, cancer-center patients undergoing both curative and palliative treatments, and patients in the intensive care unit who are at the end of life.

Homelessness, poverty, and lack of medical insurance are major obstacles to healing—and this is where palliative care comes in. One goal of palliative care is to provide expertise in pain and symptom management, to understand the goals of care and treatment preferences for patients and their families, and to ensure psychosocial and spiritual support for caregivers. Working in the community with patients in their homes is an additional layer of caring.

Providing a spectrum of care like this requires a transdisciplinary team of physicians, nurses, social workers, and chaplains. This model of transdisciplinary care is familiar to healthcare providers in emergency departments (EDs), where we work closely with nurses, social workers, prehospital workers, administrative staff, and case managers to ensure exceptional care.

When I started my training at NYU-Bellevue, I never imagined I would venture into palliative care. My background was in research and public health. Caring for diverse populations with complicated health issues and social isolation motivated me to make change happen. The time I spent in the public hospital system triggered a strong desire for health equity and providing top-quality care to all who enter our doors. Emergency physicians now have the opportunity to enhance their skills in providing important care to patients with advanced illness, and we now have access to subsequent fellowship training and educational programs.

Today, the healthcare industry faces more serious issues than ever. Undererved people who often lack healthcare directives strain the system, as does the increasing number of aging patients, many of whom spend weeks in hospitals on life support or frequently visit the ED. Including our aging population that lack healthcare directives and by integrating palliative care into the overall healthcare system, we will be better able to provide care that is consistent with patients’ needs and desires.

Our goal is consistent with the population health agenda of providing the right care for the right patient at the right time. This will require excellent communication throughout our systems, so we will be aware of every ED patient’s wishes and have the knowledge and tools to help them in meaningful ways. Our empathy increases patient satisfaction, as well as patients’ acceptance of treatment recommendations. It also improves the physician’s sense of satisfaction. To this end, it is imperative that student and resident curricula include training in communication, empathy, and listening.
$3.8 Million

Ryan McCormack was awarded a grant for $3.8 million that expands his research into substance use disorder in a National Institute on Drug Abuse (NIDA) multi-centered study, “Measuring Improvement in the Quality of Emergency Department-initiated Treatment for Opioid Use Disorder (OUD) Using Observation.”

He and his team are developing clinical protocols and implementation strategies to utilize “observation units” for initiating buprenorphine treatment and referral for emergency department patients with OUDs. The team will collect and evaluate data on quality measures and improvement initiatives to modify processes based on patient, provider, and stakeholder feedback. This significant grant follows Ryan’s recent award from the Emergency Medicine Foundation, “Rapid Induction of Buprenorphine in the Emergency Department.”

Ryan will continue to serve as lead investigator of two NIDA-funded projects through the Clinical Trials Network: Emergency Department Connection to Care with Buprenorphine for Opioid Use Disorder and Emergency Department-initiated Buprenorphine Validation Network Trial.

Ryan is dedicated to improving the standard of care for emergency department patients experiencing opioid use disorders.

Alumnus Appointed to the Veterans Administration

Curt Dill (Res. ’95), the former service chief of Emergency Medicine and deputy chief of staff at the Veterans Administration (VA) New York Harbor Health Care System, was appointed Chief Medical Officer of the New York/New Jersey Veterans Administration Health Care Network (VISN 2), effective August 25, 2019. In his new position, Curt leads the delivery of health care in New York, New Jersey, and Pennsylvania, to offer comprehensive inpatient and outpatient medical services.

Curt trained as a resident at NYU School of Medicine and Bellevue Hospital Center and, as a faculty member, created the affiliation between the NYU-Bellevue Emergency Department and the Veterans Affairs Medical Center. He analyzed the existing service and defined the efforts needed to create an exceptional standard of emergency care at the VA. His tenacity allowed him to establish the first VA-based training programs in emergency medicine and medical toxicology. He created, with his staff, the first emergency department-based “Women-only treatment area” for vulnerable veterans throughout the nation. His commitment to enhancing patient care led to his selection to the VHA Emergency Medicine Field Advisory Committee, the primary advisory body to the VA Undersecretary for Health in the Office of Patient Services.

Curt revolutionized the delivery of emergency medical services at the VA-New York Harbor Healthcare System. He transformed a complicated service into a model of emergency care delivery, making great strides locally while expanding his national role in healthcare. These accomplishments led to this new appointment.
Congratulations to the first EMPA graduates of 2019

This year, we celebrated the graduation of our first Emergency Medicine Physician Assistant (EMPA) Fellowship class. Our inaugural fellows, Carolyn Cabrey (pictured left) and Kara Lacoste, took on the task of pioneering the first postgraduate training program for PAs at NYU Langone, and did so with grace and tenacity. These fellows completed rigorous training in emergency medicine primarily under the leadership of the EMPA Fellowship Team, but also had the opportunity to maximize their learning opportunities through rotations in critical care, anesthesia, trauma, pediatric emergency medicine, orthopedics, ultrasonography, toxicology, and observation medicine. Both Carolyn and Kara accepted clinical positions in community hospitals after graduating, and are using their training to its fullest extent in providing optimal care for their patients and serving as leaders in their field. We are proud of their success!

Kelly Doran (Res. ’05, EM Faculty) received a grant for $2.3 million dollars for a multicenter study, “Randomized Controlled Trial of Relay—NYC’s Nonfatal Overdose Response Program,” awarded by the Centers for Disease Control and Prevention in partnership with the New York City Department of Health and Mental Hygiene (DOHMH). Jennifer McNeely, co-principal investigator and associate professor of public health and medicine, will collaborate with Kelly and the study team of researchers from NYU and the NYC DOHMH.

The team will evaluate the effectiveness of the DOHMH Relay program, an intervention that uses trained DOHMH staff (peer navigators), who have experienced substance use. The first intervention begins in the emergency department, where peer navigators provide overdose education, initiate motivational counseling, and provide referrals to patients who have had a nonfatal opioid overdose. Following discharge, support and linkages to services will be ongoing for 90 days.

The impact of Relay will be measured by assessing whether the program reduces the frequency of opioid-related adverse events after the intervention of peer navigators. The program’s effectiveness will be studied to determine the potential of peer navigation to reduce opioid overdose-related deaths among populations at highest risk. Kelly and Jennifer are committed to strengthening our public health services.
The Bellevue Association, under the leadership of Beth Farber, put on a grand affair to honor Dr. Lewis Goldfrank on October 2. The date—completely coincidental—marked Dr. Goldfrank’s fortieth year at Bellevue. A significant part of the proceeds from the fundraiser will support the Project Healthcare summer program, which Dr. Goldfrank started in 1981.

Held in the Rotunda of Bellevue Hospital, the gala rejuvenated a historical space at Bellevue, which is surrounded by murals painted from 1937–1941 during the Great Depression and restored by the same artist, David Margolis, in 1994. The glory of the Rotunda came to life and shone brightly.

The chatter of guests, many of whom had not seen one another in many years, was loud with excitement; hugging old friends came spontaneously. The guests came from all over the country to honor Dr. Goldfrank. He clearly touched some part of their souls along their journeys as students, residents, fellows, nurses, leaders, or volunteers.

Dr. Goldfrank believes in bettering the human condition and set out to make Bellevue a place where people would feel a sense of relief and comfort when they walked through its gates. The event was a fitting tribute to a humble physician who changed lives in ways that allowed many to go forth in the world and serve those in need.
1. Beth Farber (left) President of the Bellevue Association presents Dr. Goldfrank with a signed photo of the first ambulance while Robert I. Grossman, Dean, NYU Grossman School of Medicine and CEO, NYU Langone Health looks on.  
2. Kenneth Langone, Chairman of NYU Langone Board of Trustees congratulates Dr. Goldfrank. 
3. Pictured at left is guest speaker Maya Graves (PHC ‘17, ‘18, Class of 2023, NYU Grossman School of Medicine), Dr. Goldfrank and guest speaker Maria Raven (Res. ’05). 4. In attendance are members of the Goldfrank family (left to right) James Cariot, daughters Rebecca Goldfrank and Jennifer Goldfrank, Lewis Goldfrank and granddaughter Kay Goldfrank.  
5. Dr. Goldfrank celebrates with (left to right) Yves Duroseau (former Faculty), Eric Legome (Residency Director 2001—2007), Catherine Jamin (Vice Chair of Clinical Operations) and Robert Femia, (Chair, Emergency Medicine). 6. Guest speaker Mitchell Katz, President and Chief Executive Officer of NYC Health + Hospitals  
7. Guests included current and former faculty, alumni, friends and family. 8. (Pictured left to right) Vivian Zhang (PHC ’19), Antalya Jano (PHC ’17, ’18), Rachel Rothstein (Rothstein ’19, EM staff) and Anthony Ormota (Program Manager, Outreach and Volunteer programs). 

Photo Gallery
ANOTHER SUCCESSFUL EDUCATION DAY

Dr. Adina Kalet and Jeff Ridell, top scholars in their fields, were the keynote speakers at Education Day this year. Dr. Kalet, a leader in education innovation, scholarship, and research, discussed the factors that make mentoring relationships successful. Dr. Ridell, an award-winning physician, teacher, and researcher at the Keck School of Medicine at USC, explored the role of social media in medical education—trends, best practices, and current literature.

Resident workshops, which focused on how to provide both written and oral feedback to faculty and students, included interactive case-based sessions and didactics. Each keynote speaker led well-attended afternoon workshops for faculty, focusing on mentorship and the establishment of online identities as academic physicians. Poster presentations allowed attendees to interact with residents, fellows, and faculty to discuss current research.

The third annual Education Day on April 8, 2020, will continue the momentum. Look for details online at www.med.nyu.edu/emergency.
I wanted to use my sports medicine background to improve the curriculum for emergency medicine residents focusing on musculoskeletal care. Our goal is to highlight musculoskeletal conditions frequently encountered in the emergency department and provide relevant diagnostic and treatment recommendations. I hope this book will be helpful in the didactic and clinical realms.

Moira Davenport
(PHC ’93, ’94, Res. ’04)

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Moira Davenport
(PHC ’93, ’94, Res. ’04)

Adam Rosh
(Res. ’08)

The Rosh book series for the Physician Assistant National Certifying/Recertifying Exams are reviews of pathophysiology, diagnosis, laboratory, treatment, and more. These dynamic reviews make the learning process enjoyable and serve as an adjunct to your medical education. We hope the books in this series will help you organize your thoughts and provide supporting knowledge. Our purpose is to help you reach your goals.


Emergency Orthopedics Handbook, 1st ed. 2019
by Daniel Purcell (Editor), Sneha A. Chinai (Editor), Brandon R. Allen (Editor), Moira Davenport (Editor)
Laura Weber (Res. ‘21) and Paul Henry were married at Manhasset Bay Yacht Club in Port Washington, NY, on September 28, 2019. Laura met Paul during her first year at NYU Medical School. Paul is a real estate developer in Brooklyn. Many of Laura’s friends from NYU-Bellevue celebrated with the happy couple.

Lauren Hart (Res. ‘19) and Brian Lin (Res. ’18, SIM 19) were married on May 4, 2019, by officiant and friend Salil Bhandari (Res. ’13). Brian asked Lauren on their first date while working in Urgent Care! They were married in Brooklyn to include their NYU-Bellevue family. Brian is from Chicago and Lauren is from California. Brian is an attending at the Kaiser System and Lauren is completing a fellowship in EMS and Disaster Medicine at UCSF.
Anthony Orneta (EM Staff) and Barrett Hipes were married on November 2, 2019, at the Midtown Loft and Terrace in NYC surrounded by family and friends. Anthony (pictured right) is Program Manager Outreach and Volunteer Programs, Emergency Medicine, and Barrett is the Dean of Student Development at The Juilliard School. Anthony met Barrett in 2010 in NYC and were engaged in 2017. They celebrated their love by visiting their two favorite cities, Portland, Maine, and South Beach, Miami.

Audrey Bree Tse (EM Faculty) and Michael Tanzillo were married on August 10, 2019, in Half Moon Bay, California. They celebrated with family, friends and their beautiful eight-month-old baby, Parker.

Charles Farmer (Res. 20) proposed to Delores Sarfo Darko on June 29, 2019. To celebrate they enjoyed the Broadway musical The Lion King, a romantic dinner, and a musical performance by a Grammy-nominated saxophonist. They met at their alma mater Seton Hall University and seven years later are planning their wedding. Delores is an Assistant Director for Graduate Student Engagement at Rutgers University.
Ludim Gomez (EM Staff) and Anthony Castanon met in Florida where they attended high school. They have been a couple since 2007. They both wanted a destination wedding and tied the knot in Cancun, Mexico, with close friends and family. They are looking forward to a honeymoon in Japan. Their dream is to explore the world together.

Victoria Terentiev (Res. ’21) and Alex Leybov were married in Montauk, NY, on September 8, 2019. They met almost eight years ago in NYC while Victoria was studying for her MCATs. Alex is from New Jersey and works in financial services. They celebrated this joyous occasion with family and friends.
AVERY MAYA RENNY LESSLER
Madeline Renny (Med Tox ’19) and Adam Lesser are the proud parents of their beautiful baby girl, Avery Maya Renny Lessler, born on October 5, 2019.

DIEGO DISALVO
Phil and Ashley DiSalvo welcomed their pride and joy baby Diego DiSalvo, born October 15, 2019, and weighing in at 7 lb 5 oz. Happy to report mother and baby doing well! Phil is back to work after paternity leave.

MYLES LOUIS LALLEMAND
Teresa Spinelli Bowen (EM faculty) and Jeffrey Lallemand welcomed their bundle of joy baby Myles Louis Lallemand on July 3, 2019, at 6:22 am. Myles came early, at 35 weeks, weighing in at 5 lb 14 oz.

PARKER LIANG TANZILLO
Audrey Bree Tse (EM Faculty) and Michael Tanzillo welcomed their 6 lb 8 oz baby boy on December 4, 2018, at 4:02 pm. Parker was eager to get things started and decided to arrive a few weeks early.

YUNA WANG
Josh Wang (Med Tox ’20) and Jinjoo Yang welcomed their bundle of joy, beautiful baby Yuna Wang on July 4, 2019.
MARK YOUR CALENDARS

TOXICOLOGY
FOR THE
HEALTHCARE
PRACTITIONER

March 25-27, 2020

Leading the Didactic Lectures, Workshops, High-Fidelity Simulation Sessions, Clinical Case Conference are the accomplished faculty from Ronald O. Perelman Department of Emergency Medicine and the New York City Poison Control Center

New York City Poison Center
455 First Avenue, #123
New York, NY, 10016

All the information that you need will be at nyulmc.org/toxicologycme
This photo is of the pedestrian entrance to Bellevue Hospital Center bordering the 30th St. Men’s Shelter. The shelter, formerly known as the Bellevue Psychiatric Hospital or Bellevue, a nine story red brick structure, was built in 1931. In 1984 the city converted the Bellevue Psychiatric Hospital to an intake center and shelter for homeless men. In spite of a push to close the shelter in 2008, advocates for New York City’s homeless population held public protests because they believed that the city’s plan would reduce access to vulnerable homeless men. Today the shelter is the largest men’s shelter in New York City. This photo was probably taken by a very committed staff physician Dr. Sheila Herscovitch (now deceased) in 1988. Dr. Herscovitch a physician/photographer took many candid photos of the Bellevue Emergency “Room” at that time.
Welcome NYU-Bellevue EM Summer Fellowship alumni, 2019. Pictured (left to right) Marcus Mosley, CUNY School of Medicine, Stephen Bozier, Warren Alpert Medical School, Brown University, Philip Lin, NYU Grossman School of Medicine, Marisa Valenzuela, Keck School of Medicine of USC, Joe Babinski, NYU Grossman School of Medicine, Adrian DeLeon, University of Washington School of Medicine, Alexis Rodriguez, University of Illinois School of Medicine. Marcus, Stephen, Marisa, Adrian and Alexis were summer fellows in the EM Fellowship for Underrepresented Minorities in Medicine (URM), a five-week sponsored program for URM rising second-year medical students from around the country. Joe and Phillip were summer fellows in the EM Fundamentals Fellowship for rising second-year NYU medical students. All our summer fellows were immersed in learning the practice of emergency medicine through early exposure to the field of emergency medicine with the support of committed mentors, faculty and staff.