



# The Beeson Beat

## You Don't Have to Go Home, but You Can't Stay Here

Anne Mainardi

**Mr. C really had no reason to be in the hospital,** but he also did not want to go home. As a 68-year-old veteran admitted to the West Haven VA with lower extremity edema, he was relatively healthy, aside from being morbidly obese, and had been living with his sister prior to admission. His legs improved with a few days of diuresis, and the medical team decided he was ready for discharge. His sister, however, did not welcome him back to her house. No other family member opened his or her door to him, he did not want to live alone, and he was not a candidate for short-term rehab. Although relatively young, his goal was to move to a nursing home, yet he did not have any long-term nursing needs. The team was faced with a discharge dilemma and the VA social work team took on the job.

Tina Birdsall and Tara Hanniford are the acute care medicine social workers at the WHVA. Mr. C was not the first patient whose stay at the hospital outlasted his medical needs. Tina reports that patients try to stay in the hospital indefinitely for a variety of reasons. She describes one patient who wanted to live on 4W or T3W, so every time he was discharged he would re-present and be admitted again. This cycle continued until he passed away on 4W.



*Discharged— photo by Yihan Yang*

An obstacle often faced by Tina and Tara is the role that payment plays in disposition planning. While the VA provides many benefits, unfortunately it cannot cover all forms of inpatient and outpatient care and rehabilitation. One of the jobs of the social workers is to help patients apply for Title 19, a state entitlement for health care that covers transportation, home services, and extended care. While almost everyone is eligible eventually, there can be a long delay in approval, particularly if complex finances are involved and a patient's assets are used to determine eligibility. In Mr. C's case, the family refused to allow the patient to apply for Title 19 because he owned a property in Florida that they wanted to keep in the family.

Sometimes a person does not have decision making capacity and the social workers assist in securing a conservator appointed by the probate court to ensure that an adult's basic needs are met, including management of finances and health care decisions. Tina once undertook this process for a man in his nineties who was dropped off at the ED by his girlfriend, who absconded with his wallet and car to Florida. She had a criminal record in Florida for elderly exploitation and fraud. The patient was in the hospital for one hundred days while awaiting conservatorship. Eventually he lived out his dream of returning to Las Vegas.

When patients refuse to leave, Tina has to enlist the higher-up administration. Patients who overstay their welcome are told they are considered to be trespassing and may have to be escorted out by police. The goal, however, is always to provide a disposition plan that is safe and agreeable for the patient and his or her family. In the case of Mr. C, although he did not meet criteria for VA long-term care payment, a loophole was found that allowed him to move to a nursing home. This magical maneuver was just another day at the office for the social workers of the West Haven VA. **B**

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## All Necessary Precautions

Austin Robinson

**My favorite game on rounds** is guessing how much those yellow contact gowns cost.

People love offering ideas—I’ve heard figures ranging from a few cents to several dollars each. But, when it comes down to it, nobody really seems to know for sure. So, with a little help from my friends in Mountain View, CA, I found a more specific answer. A paper gown costs around \$0.85. When you include gloves and staff time, the price increases to about \$35 per patient, per day.<sup>1</sup>

That discussion raises questions about other costs of contact precautions (CP). A recent Chief-on-Call E-mail included a study estimating that IM interns spend 25% less time in the rooms of their CP patients.<sup>2</sup> There may be other problems, too: CP patients have higher rates of falls and pressure ulcer formation; they are also much more likely to develop symptoms of depression or anxiety while hospitalized. There is even some suggestion that satisfaction scores may be lower (but don’t tell the nurse managers on Fitkin). The benefits of CP, however, can be variable. There is broad consensus about CP for active *C. Diff* or an open wound infected with drug-resistant organisms, but things get trickier when you consider VRE or MRSA colonization. In the earliest RCT, CP yielded no improvement in limiting acquisition of resistant organisms as compared to simply wearing gloves.<sup>3</sup> In a more recent, ICU-based study, CP netted a mild drop in MRSA colonization, but it did not affect VRE acquisition or adverse events.<sup>4</sup>

These underwhelming results have led some to question the conventional wisdom of universal CP. Decision makers at UCLA Medical Center, for example, opted for a “less dogmatic” approach. This past July the hospital discontinued CP for all VRE- and MRSA-colonized patients. Emphasis was placed instead on syndromic isolation (e.g. CP for open, draining wounds) and measures with more established benefit, like daily chlorhexidine baths. Similar approaches have been adopted by other institutions, including VCU medical center and Toronto General Hospital.

So far, the results of this policy change have been encouraging. Dan Uslan, an ID attending and associate director of UCLA’s infection prevention program, notes that since the policy change, there have been “no outbreaks of MRSA or VRE, improvement in patient and provider morale, decreased waste and cost savings of hundreds of thousands of dollars due to decreased gown usage.”

Whether tailored CP policies make it to YNHH remains to be seen, but with these results, I may have to find a new way to pass the time on rounds soon. **B**

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## Radiology and Medicine: Creating a Bridge

Vastal Patel

### The challenge of deciphering mysteries behind

white and shades of gray brought me to radiology. To my surprise, reading images was only one part of the job. Radiologists must do three things: ensure the correct study was ordered, interpret the images, and communicate findings to the covering provider. Delays at any of these stages are frustrating for both clinicians and radiologists—I know this from firsthand experience, having done my medicine internship and now my radiology residency here at Yale. I remember being an intern on the floors, awaiting imaging results to guide treatment. When studies were delayed, it created extra work for me and delayed patient care. As a radiology resident, I experience the same level of frustration when a study is delayed. It creates a backlog of cases, adversely affecting my workflow and resulting in a delay in care for multiple patients. Clinicians and radiologists have the same goal—excellent and timely patient care. Why don't we work together to achieve this?

Before any imaging is done, radiologists must ensure the correct study was ordered. This process is called 'protocoling' the study. It may seem surprising that a radiologist has the power to change or cancel a study—after all, they have not seen or examined the patient! This is why the clinician's impression and diagnostic question is so critical—it helps the radiologist determine whether the requested study can provide this information. Unfortunately, very little history and clinical information is provided when a study is ordered. Important details such as pregnancy, kidney function, and allergies (including type of reaction) are frequently omitted. This causes delays, as the radiologist has to contact the ordering provider to learn these particulars. There is no downtime in the reading room, so calling a covering provider causes a delay that affects all subsequent workflow. Cases pile up, and care for multiple patients is affected.

Contacting providers for protocoling is a significant issue. Ordering clinicians often leave the 'contact information' section blank, or the number provided is inaccurate because the covering clinician has changed. Tracking down the current provider through EPIC is extremely time-consuming.

Communicating critical findings to covering residents is a significant issue. Our current system is color-coded to allow radiologists to communicate how life-threatening the imaging findings are. When the radiologist has to spend time figuring out whom the provider is and how to reach them, reporting of critical results is either delayed or sent to an off-shift provider.

Resolution of these problems will require lasting IT solutions. Until then:

1. Always provide a one- or two-liner history and pose a clinical question.
2. Give information on pertinent allergies, pregnancy status, and kidney function in the one-liner.
3. Provide the most active contact information at the time of placing the order. With the change of shift, be aware that the clinician who placed the order may be contacted instead of the active clinician. Consider providing the team Spectralink or pager number instead of a personal number.

Making these changes may help the radiologist's workflow and ameliorate some of the delays associated with image interpretation and result reporting. I hope this article will encourage more communication between medicine and radiology providers. I believe that by voicing our frustrations, we can find solutions and ultimately create a happier workplace and deliver better patient care. **B**

## Spandrels and Surrogates: Things that Exist, Things that Don't, and What Truly Matters

Geoffrey Connors

**Recently, an intern's question** at MICU morning report prompted a discussion not about medicine, but about the complexity of our human selves. Pursuing that existential path was not our intention. The pulmonary fellow was explaining oxygen carrying capacity and the physics behind the delivery of oxygen to tissues. The ensuing question was not about cooperative binding or how oxygen transits the alveolar-capillary interface. It was simply, "Why"? Why does the process occur as it does, with all its complexities and limitations? I responded with something scientific but inadequate, leading to a follow-up that was the same. "Why?" I realized that this was not a "why, explain it to me" question, but a "why is the body designed like this" question.

Neither my fellow nor I could proffer a reasonable theory of human design. Not convincingly and not in one hour. But we started talking about why anything is the way it is. And that led us to spandrels. And from spandrels it was a short leap to surrogates, a meandering on partial understanding, and why it matters to our patients.

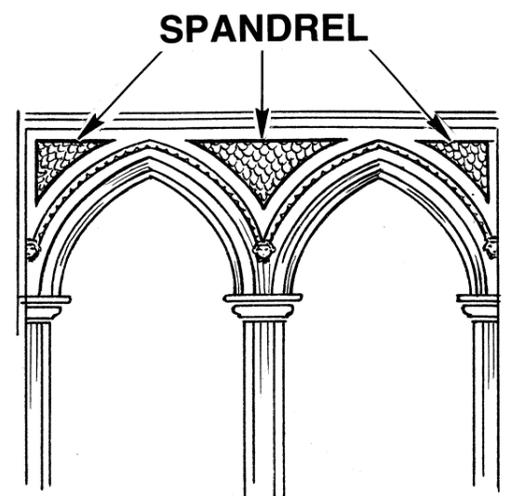
Originally, a spandrel was an architectural term meaning the area created when a dome was placed atop a set of arches (see drawing). In more general terms it is any thing that exists not by design but as the product of two other intentioned objects (the arches and the dome). In biology, we would say a spandrel is a phenotypic byproduct, not something upon which adaptive selection was acting. A simple example for physicians would be the axillary fossa, or, colloquially, the armpit. One could argue that there isn't really an armpit—just an arm and the thorax to which it attaches. But another person could say, "Of course there is an armpit. I can see it. It has function, even if it wasn't designed for that purpose." This debate has raged for centuries, with input from the philosopher Spinoza to the paleobiologist Steven J. Gould. Both camps have a point; but, without the other, each is lacking in its ability to fully explain the world.

Spandrels, as they relate to the care of patients, can be hard to identify. The patient who presents crying in clinic can be labeled simply as "stressed." But are the tears a spandrel?

Should we actually be seeing the intersection of abuse and poverty, or of sickness and job loss? The required intervention for each is very different. What about the patient who habitually arrives late to appointments? Is he oblivious to your time and effort, or is there something deeper?

Broadly defined, a surrogate is any concept or thing that stands in for another, more complex, concept or thing. We use surrogates because they are easy to measure, quantify, and understand. Cholesterol and BMI are surrogates for cardiovascular health. In our discussion, we were using mixed venous oxygen saturation to represent a shock state. Patients use surrogates as well. When they want to eat well, with limited time and money, they do not perform calorimetry or adopt a wholly vegan, 1,800 kcal diet – this is much too complex. They buy the packaged food labeled "25% less sodium" or "low fat." In this case, the surrogate for healthy eating is *relatively healthy* eating.

In truth, to refer to the outward signs of stress as a spandrel could seem dismissive—not handing a distressed person a tissue is uncaring, even if not the ultimate fix. And referring to a reasonable test as a surrogate may be diminutive and unhelpful, especially if it is the best information we have. This is not to say that we should become lost in the nihilism of the unknowable. But I've found that thinking about spandrels and surrogates reminds me that not all I see with my eyes, target with my labs, or read on the back of packaged foods supplies me with the complete story. Discerning the whole truth or appreciating the whole person often requires asking, "Why?" **B**



## From Tragedy, a Trial: iCOMPARE to Improve Care

Benjamin Cherry

### On a cold March night in 1984, a young woman

lay feverish and agitated on a gurney in New York Hospital. Exhausted and inexperienced, the intern responsible for her care failed to diagnose an evolving serotonin syndrome and prescribed Demerol to ease her agitation. The young woman developed marked hyperthermia, suffered a cardiac arrest, and ultimately died. The inhuman demands on an over-worked and under-supervised intern were cast as the culprits in the now infamous case of Libby Zion.

Much of the public awareness of Libby's death—and the push to reform graduate medical education—resulted from efforts by her father Sidney, formerly Assistant U.S. Attorney and a legal reporter for the *New York Times*. Mr. Zion leveraged his professional and media connections to call for shorter duty hours and enhanced oversight for resident physicians. The New York Department of Health and the American Council on Graduate Medical Education (ACGME) separately—and some say hastily—began to restrict the hours trainees could work. The debate over the merit of these policies has ensued ever since.

Last month, Yale's traditional Internal Medicine Program Director Mark Siegel announced that Yale had been randomized to the intervention arm of a multi-center, randomized trial comparing the current duty hour regimen (distinguished by its sixteen-hour maximum continuous work period) against a more flexible approach. Dubbed iCOMPARE, this study represents the first time in the thirty years since the Zion case that a well-powered, academic study has been applied to resident duty hour regulation.

Investigators at the University of Pennsylvania, Johns Hopkins University, and Harvard University lead the iCOMPARE study. They have enrolled residency programs from approximately 200 eligible institutions, stratified on the basis of residency program size and patient population. The intervention arm of the study

allows programs to design residents' schedules in any fashion that adheres to three conditions: 1) no more than 80 hours per week, 2) one day off in seven, and 3) call no more often than one in three nights; all averaged over a four-week period. Outcome data will be derived from Medicare claims, ACGME and program director surveys, in-training examination (ITE) scores, and trial-specific beginning and end of year surveys. All programs assigned to the intervention arm may choose which of their services to include and will receive duty hour waivers for the 2015-2016 academic year.

Dr. Siegel and the associate program directors have worked with the residency's Executive Council to identify the rotations that will utilize the investigational duty hours. Preliminary plans are to modify intern schedules on services that already have overnight call for residents, specifically VA floors, the Fitkin service, and the Yale MICU. The intended start date for the new duty hours is at the start of the 2015-2016 academic year this June.

Dr. Siegel emphasized that the benefits of iCOMPARE for the residency's newest physician trainees extend beyond simply determining which duty hours schedule works best. "The iCOMPARE trial will allow us to evaluate the best way of teaching interns, and to better study the intern experience." An informal survey of interns and residents revealed enthusiasm for Yale's participation in the trial, with some articulating a sense that this type of study was overdue. PGY-2 Stephanie McCarty said she thought that the study was a good idea and added, "I'm surprised that it wasn't done earlier." It is surprising that a profession of scholars would take so long to adopt an evidence-based approach to duty hour reform. The genuine tragedy and polarized debate behind the Libby Zion case created an environment where changes had to be made before randomized trial data could be collected. With sound information about clinical outcomes and trainee experience, iCOMPARE represents a new opportunity to improve the training of resident physicians at Yale and across the nation. ■

## Image Challenge: A Case of Severe Foot Pain

Joshua Bilsborrow



### A patient presents with complaints of left foot

pain and fevers/chills for the past 24 hours.

Left lower extremity radiograph was obtained. What is the diagnosis?

*Answer on page 9*

## Animals and Their Parts as Medicine

Karl Langberg

**Healers from the dawn of time to today have used** things found in nature for their healing properties. Remedies that we continue to use are animals and parts of animals.

Leeches and maggots were some of the first animals co-opted by physicians. Leeches, used as early as 800 BCE, were applied for diverse purposes, including phlebotomy, anticoagulation, and anesthesia. In Ancient Greece, Galen used these squirming annelids to chill out fiery “sanguine” personalities. Outcomes data are not available. Leeches are now used in post-surgical care to help drain blood from skin flaps with inadequate venous drainage. Maggots also were used since forever to clean wounds with necrotic tissue. They earned their claim to fame in wartime: soldiers in the Napoleonic Wars and the American Civil War were noted to suffer from sepsis less frequently when their wounds had maggots in them.

The use of animal parts in medicine entered a new era in 1922 when Banting and Best isolated insulin from dog, calf, and ox pancreases for use in people. Juvenile diabetes had been a universally fatal disease until this advance; since then, a whole mess of animal juices have found their way into the pharmaceutical industry, and into our patient’s veins. Heparin and calcitonin are two notable examples. Pharmaceutical heparin has been extracted from turkeys, whales, dromedary camels, mice, lobsters, mussels, clams, shrimp, mangrove crabs, and sand dollars. Calcitonin, on the other hand, is extracted from salmon, which is totally weird.

In the 1980s and 1990s genetic engineering made it possible for yeast and other microorganisms to make most of the agents previously extracted from animals. This may mean a decrease in the number of medications made from animal products, but don’t count the chickens before they hatch. Both leeches and maggots were FDA-approved in 2004. **B**

## Death with Dignity since Oregon

Armand Russo

*The barber talked to me of the newest ways to grow hair on bald death.*

-William Carlos Williams, from *Spring and All*, 1923

### We have been quietly assisting with death

for some time now [1,2]. Until 1997, when Oregon passed the Death with Dignity Act (DWD), the practice of prescribing lethal sedation was little reported by physicians. It took until 1998 for physicians to report in a national survey that sixteen percent of them had written a lethal prescription [1]. Now after Oregon, data on end-of-life practices have become more robustly reported. With the passage of legislation in Washington State in 2008 and pending laws in Hawaii, Pennsylvania, and Vermont, we may know more still.

The law, among other important constraints, requires informed consent based on understanding of the medical diagnosis, prognosis, risks of the lethal medication, the result of the medication (death), and the alternatives (palliative care, hospice, and pain management) [3]. In 2013, the Seattle Cancer Alliance, which serves Washington, Wyoming, Alaska, Montana, and Idaho in conjunction with the University of Washington's Fred Hutchinson Comprehensive Cancer Center (CCC), became the first institutional expression of DWD. Since its inception, forty people have had lethal doses of barbiturates or other sedatives dispensed through the CCC, and twenty-four people have died after using the lethal amount.

There are unexpected and conflicting outcomes from DWD, experience in the Netherlands, and the first institutional form of DWD at Hutchinson. First, the good outcomes. In contrast to many predictions, hospice referrals have remained stable in Oregon [4]. Physicians who have either referred patients for lethal doses of medications or who have prescribed the medications themselves report their absolute hospice

referral is no different than from before the law was passed. This suggests that even with the possibility of DWD, we have not lost faith in hospice to provide comfort for the dying. In addition, Dutch physicians, for instance, are more likely to discuss physician-assisted death now that it is legal, while before they feared reprisal or legal action for any participation [5]. Only forthright discussion can provide insight. This is happening in this country as well. I'm glad for that. Hospice stands to benefit.

Now for the bad: Roughly fifty percent of people who died with sedatives at the Hutchinson CCC were not enrolled in hospice at the time medication was prescribed [3]. Why not? Among the people who have died in Oregon and Washington with sedatives, almost eighty-five percent were enrolled in hospice, yet *still* sought a quicker death [3]. So DWD is being used for people who have not entered hospice, or for whom hospice has not fulfilled its palliative goals. We can do better ensuring hospice needs are met. This is the wormhole DWD opens.

DWD does not appear to have eroded the principles of hospice, as evidenced by stable referral rates, and it has actually been positive for truth-telling among physicians. However, the issue is far from settled. We are mostly moving on unsteady ethical and legal ground here. Why jump to an ultimate conclusion, when a proximal choice still requires refinement? Based on all the complexity involved here, Quill and others advocate neutrality, a careful consideration of all facets of the issue [6]. Please don't take too long to make up your mind; the question is too important and it will be answered without you. ■

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## Artists and Their Maladies: Goya

Max Stahl

### Francisco Jose de Goya y Lucientes was only

thirty-seven years old when a severe disease overcame him. This illness almost killed him, then mysteriously subsided, leaving him deaf for the rest of his life.

Goya's work today is categorized in two distinct periods: the period prior to his illness, filled with joy and light, and the period after his illness, characterized by darkness and depictions of the brutality of man, emblemized by scenes from the Peninsular War. Some argue that his isolation made him a closer observer of gesture, physical expression, and emotions. Certainly, in this period defined by demons and ghosts, he created many of his most famous pieces, including *The Third of May* and *The Witches' Flight*.

What were the exact symptoms of this mysterious disease? Fainting spells, temporary paralysis, delirium, hallucinations, severe abdominal cramps, partial blindness, and deafness. What would be the differential for these symptoms? We must consider not only the host and syndrome, but also the time period and social circumstances of his life.

Syphilis first comes to mind: Goya was known to have lived a stormy lifestyle in his youth in the 1760s, a time when syphilis is reported to have infected about ten percent of the European population. His wife Josefa had about twenty miscarriages; the famous painting *Saturn Devouring His Son* may have been inspired by the painter's guilt for infecting his wife.

Others consider his symptoms iatrogenic in nature, due to encephalopathy resulting from treatment with mercury, the most common syphilis treatment of the era. Lead poisoning has also been proposed, given that lead was in the paint as well as the wine and was known to have affected earlier artists like Caravaggio and Beethoven. One other highly possible entity on the differential is viral encephalitis. While an arbovirus was implausible, given that his illness developed in late December, mumps could explain all his symptoms, including abdominal cramps due to mumps-induced pancreatitis.



Although this midlife illness resolved, Goya again became acutely ill in his seventies. Fortunately, he found a compassionate doctor, Dr. Arrieta, whom he immortalized in a very moving portrait, one whose colors are more delicate and lighter than in other works of this period. It shows Goya in a fragile state, too weak to hold himself up and grabbing on to a sheet like he is clinging on to life itself. The inscription below the painting says: "Goya, in gratitude to his friend Arrieta: for the compassion and care with which he saved his life during the acute and dangerous illness he suffered towards the end of the year 1819 in his seventy-third year." He painted it in 1820 and lived until 1828, when the extraordinary painter died at the extraordinary age of eighty-two. <sup>15</sup>

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### Image Challenge continued...

**Answer:** Necrotizing Fasciitis

This lateral-view radiograph of the left foot and ankle demonstrates dissecting gas collections (linear lucencies in radio-dense soft tissue) along both superficial and deep fascial planes around the calcaneus. It also shows extensive arterial calcifications (linear radio-dense deposits in a vascular distribution). In the absence of recent trauma or surgery, gas tracking along fascial planes is virtually pathognomonic for necrotizing fasciitis. The patient was a 72-year-old gentleman with a past medical history significant for peripheral arterial disease, chronic lower extremity wounds, and diabetes mellitus. He was started on broad-spectrum antibiotics with vancomycin, piperacillin-tazobactam, and clindamycin and went for emergent tissue debridement with podiatry within hours of admission. He did well in the post-operative period and was eventually discharged back to his rehabilitation facility.

Necrotizing fasciitis is a rare, rapidly progressive infection of the skin and deeper subcutaneous tissues, with spread along the fascial planes of muscles, nerves, and blood vessels. The causative organisms are usually polymicrobial (55-75% of cases); mono-microbial cases are caused by bacteria such as Group A *Streptococcus* (*S. pyogenes* most commonly), *Staphylococcus aureus*, *Vibrio vulnificus*, *Clostridium perfringens*, *Bacteroides fragilis*, and/or *Aeromonas hydrophila*. Risk factors include immunocompromised conditions, including diabetes, chronic alcoholism, renal failure, peripheral arterial disease, and cancer. There is usually some minor/major trauma to the overlying skin as a precipitant for the infection.

Patients usually complain of pain out of proportion to the appearance of the involved skin. During early stages, it can be difficult to differentiate from cellulitis. Crepitus may be palpable (only 37% of cases), though subcutaneous air may only be evidenced on radiography (57% of cases). As the infection progresses, the involved skin can develop bluish-purple discolorations and/or hemorrhagic bullae. Patients usually present with signs and symptoms of sepsis, including fever, leukocytosis, tachycardia, and/or hypotension. Treatment consists of broad-spectrum antibiotics and surgical debridement. **B**

## Records

### Throughout the course of our collective experience

we have seen some remarkable physiology. Here are some extreme values that our residents have witnessed, in patients who have since benefited from our dedicated care. New values are noted with an asterisk.

| Highest:       |  |
|----------------|--|
| A1c            | 18—Albert Do (DM2)   |
| Ammonia*       | 336—Alex Norcott (cirrhosis)   |
| Anion Gap*     | 45—Matt Griffin (DKA)  |
| BNP            | 41,000—Alex Perelman (CHF)   |
| CK*            | >38,030— Ali Romegialli (rhabdomyolysis)   |
| CRP*           | 373—Shoshana Streiter (Necrotizing MRSA PNA)   |
| Glucose        | 1440—Albert Do (DM2)   |
| INR            | >29.99—Elana Shpall (Coumadin, abx, poor PO intake)                                  |
| Insulin Dose   | 225 units NPH BID—Adam Phillips (DM2)  |
| Lactic Acid    | 26—Steph McCarty   |
| Tele Pause     | 10 seconds—Krishna Sury (heart block)  |
| Troponin       | 104.5—Jen Ouellet (STEMI)  |
| TSH*           | 308—Cecilia Davis (hypothyroidism)   |
| WBC count      | 239,000—Steph McCarty (CML blast crisis)   |
| Lowest:        |  |
| BUN*           | 2—Dan Cleary (malnutrition)  |
| Hemoglobin     | 2.2—Aaron Soufer & Elana Shpall (Fe deficiency anemia from bleeding esophageal mass) |
| Platelet Count | <1,000—Beth Heuzey (ITP)   |
| Prealbumin     | 4—Ali Romegialli (malignancy)  |
| Potassium      | <1.5—Dan Savage (Hypokalemic Periodic Paralysis)                                     |

### Image Challenge Further Reading:

Hasham, Saïdy et al. *Necrotising Fasciitis*. British Medical Journal. 2005 330; 830-833.

Kotrappa, K.S., Bansal R.S., and Amin N.M. *Necrotizing Fasciitis*. American Family Physician. 53 (5): 1691-1697.

## Finding Inspiration

Amanda Freed

**The recent New York Times article** revealing a case of sexual harassment at Yale demonstrated an egregious example. As a woman, I hope I am never the victim of such an act. And, to be honest, I don't think I will be. I think those cases are few and far between. To me, the most striking thing about the article was its overall lack of women. The only woman portrayed is the victim. Her boss, the perpetrator, is male. Her boss's boss, Dean Alpern, is male. His boss, President of the university, Dr. Salovey, is also male. Women in academic medicine are, unfortunately, rare. According to a recent article in the *Journal of Academic Medicine*, "As of 2010, only 13 percent of the deans of medical schools were women—lower than the number of deans of law schools (20 percent women) and even presidents of universities (23 percent). Interestingly, only hospitals (12 percent of hospital CEOs are female) have as few women at the helm."

According to a recent article on the AAMC Web-site, "The higher up the professorial and leadership ladder one goes at a medical school or teaching hospital, the fewer women one sees. While women compose 35 percent of all faculty, they are concentrated in junior teaching positions. Women account for 42 percent of assistant professors, 31 percent of associate professors, 19 percent of full professors, 21 percent of division or sector chiefs, 13 percent of department chairs, and 13 percent of deans." Here at Yale, only 4 residency programs have female program directors: pediatrics, ob/gyn, ophthalmology and pathology.

At this point in my career, things are easy. I don't have to negotiate my contract, and I know that I'm being paid exactly the same amount as my male colleagues. Given the statistics, though, the future is bleak. The numbers tell me I will probably never rise to be a program director, department chair or dean of a medical school. I hope that I will have the fortitude and the support of an institution to rise to a leadership role. I hope that years from now, if there is another sexual harassment case, the dean of the medical school and the president of the university will be female. **B**

### References:

Lewin, Tamar. "Yale Medical School Removes Doctor After Sexual Harassment Finding." *New York Times* 14 Nov 2014: A15.



### Art Corner:

*A new feature where residents highlight their favorite pieces of art in the hospital*

Ben Howell

#### **If at all possible, I make the trip from the West**

Pavilion to the North Pavilion via the second floor, because doing so passes my favorite piece of art in the hospital. Covering the entire wall of the second floor balcony of the North Pavilion is a wall drawing/mural by Sol LeWitt, a Hartford native and one of the most important American artists of the last century. I love it because it's easy to overlook, but once you know it is there it is hard to ignore and lightens the walk from West to South Pavilion. Drawn by assistants from simple instructions, LeWitt's wall drawings manage to start from a point of conceptual rigor to create an immersive, playful, beautiful experience.

On loan from the Yale Art Gallery and installed after his death in 2007, the drawing also reminds me of all the opportunities to see great art in and around New Haven, including other LeWitt pieces. The Yale Art Gallery has significant LeWitt holdings, several currently on view at the gallery on Chapel Street, a local day-off destination I highly recommend. There is also a retrospective of his wall drawings at the Mass MoCA two hours north of New Haven in North Adams, Massachusetts. Not to be outdone, the Dia:Beacon, in Beacon, New York, a hour and a half drive to the west, has several LeWitt wall drawings and sculptures among their impressive collection of late 20th century minimalist and conceptual art. **B**

## Intern Spotlight

Yihan Yang



**Meena Elanchenny** – Traditional

*Hometown:* West Chester, Pennsylvania

*Undergrad:* Swarthmore College

*Med School:* University of Rochester School of Medicine and Dentistry

*Interesting Facts:*

- Meena’s parents were born in rural Sri Lanka in the late 1940s and immigrated to Canada and then the U.S as part of the Tamil diaspora. Her mother is one of eleven and her father is one of six, so she has twenty-five first cousins located on four continents.
- She was deathly afraid of ladybugs as a child—and to some extent still is!
- A Philly sports fan at heart, Meena’s guilty pleasure is watching ESPN’s SportsCenter on her days off.



**Hao Feng** – Prelim, Dermatology

*Hometown:* Santa Maria, California

*Undergrad:* University of California, Berkeley

*Medical School:* Yale University School of Medicine

*Interesting Facts:*

- Often known as “Fruit Monster,” Hao can eat fruit like no other.
- He loves country music and participated in bull riding at the Durham Fair.
- Hao chaired the ACP Council of Student Members and was a voting member on the ACP Board of Regents.



**Mike Kaplan** – Primary Care

*Hometown:* Rockville Centre, NY

*Undergrad:* Skidmore College

*Medical School:* Sackler School of Medicine

*Interesting Facts:*

- Mike was once a fisherman in Holland. AKA—his fiancé found a costume photo shoot in Amsterdam, and it was the best.
- He played triangle at Carnegie Hall and had to rent a tux for the gig.
- Mike is preoccupied with the physiologic generation of consciousness, stating, “Though the problem has been trivialized to the dark dungeons of philosophy, I’m (foolishly) convinced that insights from medicine could help explain how blobs of biological cranial meat can, and do, create subjective experience.”
- BONUS! Mike recently got engaged to his girlfriend, Sarah. Please congratulate him if you see him in the halls of the hospital!

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B