

PUBLIC & GLOBAL HEALTH

Expanding the Mission through Partnering

Winter 2013

It is a pleasure to introduce the 2013 edition of our Section of Public and Global Health newsletter, which describes the many exciting and effective programs that are making great contributions to local, national and global public health. A few highlights:

🌍 The Violence Intervention Advocacy Program, under the leadership of Dr. Thea James, celebrated its fifth anniversary in October 2012. The program has consistently delivered comprehensive care, services and advocacy to thousands of victims of violence and their families.

🌍 The BNI ART Institute led by Drs. Edward and Judith Bernstein continues to spread its influence and impact on both local and national levels. See page 3 for a feature about Project Assert's partnership with the city of Gloucester to combat opiate addiction and page 4 to read about SBIRT training in Puerto Rico.

🌍 The BMC Injury Prevention Center, led by Dr. Jonathan Howland, has a wide range of studies and programs aimed at decreasing violent injuries, older adult falls and airport injuries, as well as improving traffic safety and safe infant sleep.

🌍 This past year has been extremely productive for the section's Global Health initiatives. Dr. Hani Mowafi helped investigate human rights abuse in Qaddafi's Libya. Other section members played important roles in bringing health-care improvement to Ghana, Kenya and other countries, and numerous emergency medicine residents experienced life-changing elective experiences in underserved countries. This issue further describes the many important programs and initiatives of our Section of Public and Global Health. I hope you enjoy it.



Jonathan Olshaker, MD

Chief, Department of Emergency Medicine,
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Professor and Chairman, Emergency Medicine,
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DEFENDING CHILDHOOD TASK FORCE SUBMITS REPORT

Thea James, MD, Director of the Boston Medical Center Violence Intervention Advocacy Program and an Emergency Physician at Boston Medical Center is one of 13 leading experts appointed to the US Attorney General's Defending Childhood Task Force. The Agency identified and recommended

individuals knowledgeable about issues relating to children's exposure to violence in the United States, a domestic social problem now approaching epidemic levels. Members include practitioners, child and family advocates, academic experts and licensed clinicians selected after an extensive vetting process by the Department of Justice.

The Task Force presented its findings and policy and practice recommendations to the Attorney General in a final report, "Defending Childhood: Protect, Heal, Thrive," published and disseminated in late 2012 (see story on page 2).



Photo: Office of Justice Programs

L to R, Front row: Deanne Tilton Durfee, Chief Jim McDonnell, Dr. Steven Marans, Dr. Alicia Lieberman; Middle: Dr. Thea James, Gen. Tony Taguba, Attorney General Eric H. Holder, Jr., Dr. Sharon Cooper, and Sarah Deer; Back: L to R: Georgina Mendoza, Joe Torre, Robert Listenbee, Dr. Robert Macy

Our Mission: By utilizing the principles of epidemiology and public health, the Department of Emergency Medicine — Section of Public & Global Health — strives to promote and improve the health of the populations we serve. We are dedicated to excellence in emergency care through Research, Education, Advocacy, Clinical Competency and Humanitarianism (REACH).



A Shared and United Commitment to ANTI-Violence

United States Attorney General, Eric Holder launched the Defending Childhood initiative in September 2010 to address a national crisis: **the exposure of America's children to violence as victims and as witnesses.** In October 2011 AG Holder appointed a 13-member National Task Force which traveled the country to listen to practitioners, policymakers, academics, concerned citizens, and victims.

Its goal was to learn how violence and abuse affects our kids and our communities.

The AG's Task Force gathered in Washington, DC, to present the report just two days prior to the horrific events in Newtown, Conn. Children's exposure to violence, whether as victims or witnesses, is often associated with long-term physical, psychological and emotional harm. Children exposed to violence are also at a higher risk of engaging in criminal behavior later in life and becoming part of

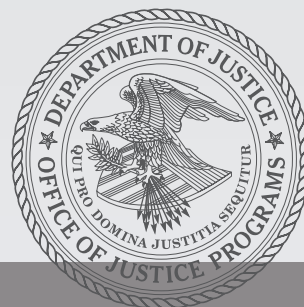
a cycle of violence. The final report will be used as a blueprint for actions we can take to prevent children's exposure to violence and mitigate its effects and will serve to strengthen our robust anti-youth violence work already underway.

Personal testimony was delivered by 65 people from 27 states and the District of Columbia. These included survivors of violence, young people, social service providers, medical personnel, researchers, practitioners, advocates, tribal and local officials, private foundation representatives and community residents. The public hearings were held in Baltimore, Albuquerque, Miami and Detroit and listening sessions took place in Anchorage, Oakland and Joint Base Lewis-McChord outside Tacoma, Wash. The cultural diversity of these seven sites allowed task force members to grasp the big picture of violence in the U.S. — revealing that violence is more than an urban problem — it is pervasive throughout our nation. They also found that in rural and tribal areas, the damage is often compounded by the difficulty of getting resources for victims.

To hear a message from Attorney General Eric H. Holder, Jr., and download a copy of the Task Force final report, and recommendations, visit: www.justice.gov/defendingchildhood.

“The best way to help children is to make sure that they feel safe ... and ensuring that they know that the violence they witnessed or experienced was not their fault.”

– Defending Childhood Initiative,
National Task Force



TASK FORCE ON CHILDREN EXPOSED TO VIOLENCE

WORKING TOWARD A COORDINATED NATIONAL RESPONSE: *When our children no longer have to bear the traumatic burden of violence exposure but are supported by an informed and committed citizenry and well-trained and trauma-informed providers and community members, they will have the opportunity contribute to the social capital, productivity, strength, and security of our country, which is still looked upon by other nations to lead the world. Every child we help recover from exposure to violence is an investment in our nation's future.*

Thea James, MD, Task Force Member and one of its 13 leading experts, is an associate professor of emergency medicine at Boston Medical Center and Boston University School of Medicine. She also is the director of the Boston Medical Center Violence Intervention Advocacy Program (VIAP). Dr. James is a founding member of the National Network of Hospital-Based Violence Intervention Programs (NNHVIP).



HEALTH ADVOCACY — Project ASSERT

CITY OF GLOUCESTER COMBATS OPIATE ADDICTION: ADOPTS PROJECT ASSERT

By Deric Topp, BNI ART Institute, Assistant Director

By Joan Whitney, M.Ed, LCSW, Healthy Gloucester Collaborative, Director

The city of Gloucester had a crisis on its hands. Its per capita opiate overdose death rate was twice that of nearby cities and towns. The city's health department substance abuse prevention coalition, the Healthy Gloucester Collaborative, recognized that the problem required a community approach. The coalition convened a multi-disciplinary team of first responders, health providers, hospital leaders, court forensic specialists and community-based agencies who identified the emergency department at Addison Gilbert Hospital as a key component in their strategic plan to better serve those in the community who are at high risk for injury, illness or death due to alcohol and drug use. They called on the BNI ART Institute at the BU School of Public Health and the BMC Emergency Department to help Addison Gilbert's ED adopt substance abuse screening, brief intervention and referral to treatment (SBIRT) as part of a city-wide health initiative to decrease opiate use and overdose. The BNI-ART Institute specializes in training health-care educators and providers to screen, intervene, and refer patients to treatment who engage in high risk or dependent alcohol or drug use and other preventable, unhealthy risk behaviors.

The ED SBIRT model employs a designated specialist called a health promotion advocate (HPA) to conduct universal screening of all patients, a brief intervention for those that screen positive for at risk use, and active referral to treatment for dependent users. The HPA navigates the treatment system with the patient, negotiating between the patient, hospital, treatment facility and insurance company. The program becomes a key link in a referral network of community organizations to provide even more resources beyond traditional substance use treatment to also include social, behavioral, financial and medical services.



“The BNI-ART Institute specializes in training health care educators and providers to screen, intervene, and refer patients to treatment who engage in high risk or dependent alcohol or drug use and other preventable, unhealthy risk behaviors.”

The hospital initially agreed to a 10-month pilot program funded by the Massachusetts Department of Public Health Bureau of Substance Abuse Services. The program quickly provided tangible successes that won over ED staff. Over the pilot period, at roughly 18 hours per week, the HPA screened 456 patients, of those 176 patients (38.6%) screened positive for risky or dependent alcohol or drug use, 149 of those received a brief intervention and 46 received referral to treatment for substance use. In addition, 99 patients received referrals to other resources such as primary care, social service agencies, shelters or financial services.

The pilot program was such a success at the Addison Gilbert Emergency Department that the hospital created a budget line for the part time HPA position. It also committed to a plan to sustain and expand the SBIRT program. The plan includes an additional part time HPA to conduct pediatric screening. Funding for three years from the Tower Foundation totaling \$183,000 and supplemental coalition funding will help fuel this expansion. The anticipated expansion will support a range of activities including expansion of the SBIRT training to other ED providers, integration with other departments in the hospital as well as coordination with other services in the community.

As a result of this process, a multi-disciplinary “High Risk Task Force” has been formed to increase coordination of care for other high-risk patient groups including the homeless and those deemed at risk to harm self or others. Even the hospital's pastoral care program adopted this program. The SBIRT model is currently being adapted to the medical teams of the Gloucester Family Health Center and a faith-based day drop-in facility, the Grace Center.



Providing SBIRT Training in the Caribbean

FROM THE BMC EMERGENCY DEPARTMENT TO UNIVERSIDAD CENTRAL DEL CARIBE IN PUERTO RICO

By: Brenda Rodríguez, MBA, Consultant for BNI-ART Institute and former BNI ART Institute Deputy Director 2006-2008, and Edward Bernstein MD, FACEP, Director of the BNI ART Institute at Boston University School of Public Health

The BNI ART Institute, which works in close collaboration with Boston Medical Center (BMC) recently traveled to Bayamon, Puerto Rico, to train members of the faculty and the president of the Universidad Central del Caribe (UCC), in Screening, Brief Intervention, Referral to Treatment (SBIRT). This training originated to meet SAMHSA's priority to incorporate behavioral health in primary care, and based on the goal of Universidad Central del Caribe president's Dr. José Ginel Rodríguez, to provide graduates of the medical school with the skills and knowledge to prevent and treat addiction to drugs and alcohol. Dr. José Ginel Rodríguez envisions adding SBIRT to the medical school curriculum. This training was sponsored by the Caribbean Basin & Hispanic Addiction Technology Transfer Center (CBHATTC) at Universidad Central del Caribe under the coordination of María del Mar García, who said "with this training we are filling a big education need in the field of primary medicine."

The training was lead by Dr. Edward Bernstein, MD, FACEP, Director of the BNI ART Institute at Boston University School of Public Health and Professor and Vice Chair for Academic Affairs, Department of Emergency Medicine at the Boston University School of Medicine. Other BNI ART Institute trainers who participated included, Caitlin K. Barthelmes, MPH, Nilsa Rodríguez, BSW, and Brenda Rodríguez, MBA, Consultant for BNI-ART Institute and former BNI ART Institute Deputy Director 2006-2008.

This three-day training, bilingual in English and Spanish, took place in April 2012 and included classroom instruction, practicum exercises, role plays, and on hand training in the emergency room (ER) of the Ramón Ruiz Arnau hospital, where trainees had the opportunity to interview patients and put into practice, in real time, what they learned in the classroom. The training benefited from an excellent training facility that included a simulation lab at the UCC Medical School. This technology allowed the group to view and critique the trainee's performance of screening and brief intervention in real time.

Another big asset the UCC has is its strong partnerships with treatment providers located at the Ramón Ruiz Arnau University Hospital and other nearby locations, which provide medical and psychological care

as well as spiritual counseling to adults that present with addiction to drugs and alcohol. Trainees were able to help patients who presented with substance abuse problems get the care they needed by referring them to these providers. They also were able to put in practice their brief negotiated interview skills with at risk patients for substance abuse and worked with them to establish realistic goals to practice healthy behaviors around substance use.

Currently, Dr. Bernstein continues to provide expert consultation to trainees as they implement next steps to ensure SBIRT is part of their medical curriculum and of everyday primary health care practice. According to Dr. Bernstein, UCC is leading the way in medical education by requiring their students to demonstrate their SBIRT skills. UCC continues to strengthen relations with the hospital's ER and the local treatment centers as partners and training sites to implement SBIRT in their medical curriculum.



Dr. Bernstein provides instruction to Dr. Jose Franceschini, Psychiatrist, Professor and Chairperson, UCC.





Violence Intervention Advocacy Program (VIAP) VIAP CELEBRATES FIVE YEARS

The Violence Intervention Advocacy Program (VIAP) celebrated its fifth year anniversary in October 2012. Programs from Boston Medical Center, Massachusetts General Hospital and Baystate Medical Center in Springfield, Mass. gathered at BMC to honor supporters, clients and the work done for violently injured patients across the Commonwealth. Former Massachusetts Department of Public Health Commissioner John Auerbach, who played an integral role in the program's genesis, opened the festivities. He spoke passionately about his belief that all clients receive comprehensive care, and that programs like VIAP need to be expanded and available for all victims and their families.

Along with the Department of Public Health, the Boston Public Health Commission and The Boston Foundation were recognized for their outstanding support of the VIAP Program. Other collaborative partners in attendance included Street Safe Boston, Youth Opportunities Unlimited, Youth Connect and Brigham and Women's Hospital. Advocates from each program spoke about what the program meant to them, their clients, and the communities they serve.



Former rivals Jermaine Foster and Norris Douglas celebrate a bond fostered through VIAP.

The most moving testimony came from two VIAP clients, who cited the services and support they received from VIAP as integral to their physical and emotional healing. They were from different neighborhoods with a history of not getting along. Historically, this could be a recipe for disaster in many other arenas, but through diligent work and support navigating interpersonal relationships, they have formed a friendship and bond that is based on truth, honesty, and hope for the future.

Since its inception in 2006, BMC VIAP has served 3,176 victims of violence, primarily consisting of gunshot and stabbing victims. By gender, VIAP served 2,811 males and 365 females.

Services provided by VIAP include crisis intervention, support and advocacy, safety planning, mental health and substance abuse services, and family support services. Clients also receive ongoing case management and connections to a diverse array of community resources such as access to medical insurance, primary care physicians, financial assistance (food stamps, victims compensation and SSDI), housing application assistance, legal support, education and job training programs, life skills training (financial literacy and effective communication), and recreational and wellness programs. A family support coordinator also offers services for victim's families. The coordinator has offered victim's families help with mental health navigation through school, legal and other

systems that are difficult to work in, especially in the face of the traumatic injury of family member.

The value of the VIAP is undeniable and evident in the numbers, but far more convincing are the stories we hear every day. Take the story of a mother who got fired from her job due to missing work so she could take care of her injured child. She has tears of gratitude for the caring professional from VIAP who brought her to the food bank, helped her apply for food stamps and benefits, and assisted her in relocating her apartment because she did not feel safe in her neighborhood. These mother's tears are the real testimony to the value of VIAP, providing hope and opportunities for families to move forward and lead healthy, productive lives.



Former Massachusetts Department of Public Health Commissioner John Auerbach and VIAP Program Manager Elizabeth Dugan, MSW, LICSW Manager, VIAP



Thea James, MD, Director VIAP



ED RESIDENTS TOUR THE COMMUNITY

By Ryan Sullivan, PGY 2



Photo: Anufo Baez

Eternal Presence, John Wilson's seven-foot tall sculpture celebrating human creativity and spirituality, outside the National Center for Afro-American Artists in Boston.

I had been ordering x-rays for over a month before I knew where Radiology was. Starting off as a new intern in the Emergency Department at BMC, I could simply click a button from my workstation and a patient would be whisked out the double doors of the department, and results would eventually pop up on my computer screen. Sometimes the process would take minutes. Other times it would take hours, with patients occasionally getting lost along the way. Only later would I leave the physical confines of the ED and make the short walk to the Radiology Department, finally seeing the spaces where images were taken and read, meeting the techs and radiologists that shot and interpreted our films, and then began to understand all the challenges inherent to the process.

In that first month as an intern I was involved in the care of more than 200 patients. And not unlike my experience with Radiology, those patients would come from the outside world through our double doors and into the safe confines of the Emergency Department. It was here that we would meet them, examine them and start to hear about their medical illness. They would often be alone, separated from the contexts of their families, of their environments, and of their daily lives.

And yet we know that these things matter. The CDC and WHO conclude that the social determinants of health – poverty, race, health literacy, culture, geography – contribute significantly to the overall health of a patient population. They affect how our patients understand their medical illness, how they respond to it, and ultimately the outcome they will face from it.

So on June 29th, 2012 the rising PGY 2 class stepped beyond the doors of the Emergency Department to learn more about the communities that we serve. Led by Dr. Ed Bernstein and members of the Project Assert staff, we participated in a community tour of the South End, Roxbury, and Dorchester neighborhoods of Boston. Project Assert has been an integral part of BMC and the surrounding community since its inception in 1994. In an effort to break the cycle of substance abuse and its deleterious effects on medical and psychiatric illness, Project Assert provides screening, targeted interventions, and treatment referrals for substance abuse and primary care within the Emergency Department setting. Its Health Promotion Advocates, many of whom come from these same neighborhoods, have years of experience providing services to residents of our surrounding communities.

So together with members of the Violence Intervention Advocacy Program, Social Work, and Case Management, our PGY 2 class went on a guided tour of our surrounding neighborhoods. Led by a community historian from Roxbury, we learned about the history of community development, immigration, social policy, and culture. It included a tour of the Museum of the National Center of Afro American Artists in Roxbury, a historic neighborhood institution dedicated to the promotion of cultural arts heritage. The day ended with lunch at a local Dominican restaurant where we had the opportunity to talk and share our impressions of the day.

Having the opportunity to see and learn about our patient's neighborhoods was a great experience by itself. Few of the members of our residency are from Boston, and even fewer had spent significant time in these communities. But just as memorable was the opportunity to spend time with the Project Assert staff. All of us had utilized their resources in the ED and referred patients to their services. And yet few of us had previously had the opportunity to spend time just sitting and talking with them, to hear about their wealth of experience, and about their stories of success. On a daily basis in the ED we see patients who are in need of their help. But we didn't hear enough about the success stories, about those patients who were winning their fight with substance abuse and addiction. In going around the room and individually sharing our reflections on the day, it was clear that the mission of Project Assert, and the mission of BMC as an underserved urban hospital, was a large part of what attracted us to our residency program in the first place.

One of the biggest challenges and greatest opportunities in Emergency Medicine is that all of society's problems will walk through our hospital doors. Even more so at a large, urban safety-net hospital like ours. But knowing where our patients come from, and the challenges they face, makes us a little better equipped to achieve our ultimate goal – to provide compassionate, quality care when they need us the most.



BUATP

Boston University Advocacy Training Program

EM FACULTY MENTOR MEDICAL STUDENTS IN USING THEIR WHITE COAT AS A LEVER IN SOCIETY

By Daniel Dworkis, PhD, MS IV

Eight years ago, a group of students at BUSM created a course to teach each other about the social issues affecting the health of their patients and the communities they were training to serve. Over time, this single course evolved into a full student-led, faculty-mentored curriculum called The Boston University Advocacy Training Program (BUATP), which trains medical students at BUSM to understand, identify and address hunger, homelessness and other social determinates of their patients' health and well-being. Along the way, multiple EM faculty including Thea James, Hani Mowafi, and James Feldman, have taught classes, spoken on advocacy panels and worked with students to understand the multiple ways in which physicians can and should leverage their clinical experience to change the social barriers their patients face. "At BUSM, we are taught early that neither suffering nor disease occur in a vacuum, and the BUATP helps us develop the tools we need not only to address the patient in front of us, but also to work on why they are sick in the first place," says BUATP co-founder and student director Dan Dworkis (MS-4). "This is especially evident in the emergency room, where understanding the context of where a patient is coming from and what he or she is facing can have an enormous influence on everything from diagnosis to disposition planning." Students self-select into the BUATP, which trains approximately 15% of each graduating class through a combination of didactic, skill-based, and service-learning training. So far, approximately 130 medical students have trained with the BUATP, approximately 70 of whom are now practicing physicians. Unique features of the BUATP include cross-disciplinary training with students from the BU School of Law, a project incubator combining mentorship and funding for summer research in medical advocacy for MS-1 students, and an action-focused mentorship program that trains medical students in team building and project execution. To learn more about the program, please contact buatp@bu.edu.

BMC INJURY PREVENTION CENTER UPDATES

The BMC Injury Prevention Center (IPC) begins its second year with a wide range of epidemiological and interventional trials, including violent injury, older adults falls, traffic safety, safe infant sleep and alcohol mixed with energy drinks. The following summarizes some recent activities.

The BMC IPC is participating in the Science Research Program, an advanced science activity at the Saint Francis Preparatory School in the Bronx. This program pairs high school students who are interested in a career in science with academic or corporate researchers. Luisa Alvarez, a junior at Saint Francis, proposed a research question on the effects of mixing caffeine and alcohol on hangover and sleep quality. Using data from Drs. Howland and Dr. Rohsenow's study on the acute effects of caffeinated alcohol, relative to alcohol alone, on a simulated driving task, the team determined that mixing caffeine with alcohol does not affect the incidence or severity of hangover or self-reported sleep quality. Their results were presented at an international conference in October 2012 and Ms. Alvarez will co-author a forthcoming paper.

The IPC is working with the Department of Public Health and the newly appointed Massachusetts Falls Commission to develop an inventory of community-based falls prevention programs.

Dr. James has completed a qualitative evaluation of the BMC Violence Intervention Advocacy Program (VIAP). Abstracts of results have been accepted for the upcoming meeting of the Society of Academic Emergency Medicine (SAEM).

Lisa Allee, LICSW, Drs. Burke and Howland and Nicole Krellenstein, RA have completed a study of the prevalence of Post Traumatic Stress

Syndrome (PTSS) (the precursor of PTSD) and trauma surgery patients. Their findings indicate that PTSS is significantly more prevalent among those injured intentionally than those suffering unintentional injuries. Although this cross-sectional study cannot determine whether PTSS is the cause or consequence of interpersonal violence, the finding suggests that trauma surgery patients should be screened for PTSS and referred for counseling/treatment if positive. A paper reporting study results has been submitted for publication.

At the request of MASSPORT, Drs. Howland and Dyer and Salma Bibi, MPH conducted a study of falls at Logan Airport. Results showed that in 2009-2010, a fall requiring emergency services response occurred every 2.3 days and that 37% of these were transported to area EDs. Almost half of these falls involved older adults falling on elevators. Investigators' recommendations for encouraging use of elevators, in lieu of escalators, have been implemented by MASSPORT, including new signage and audio reminders to take elevators if carrying bags. (See Howland et al. (2012) *Journal of Safety Research* 42:133-136)

BMC IPC investigators are working on an NIH grant proposing a randomized trial of a brief intervention to promote participation in community-based fall prevention programs among older adults who present at the ED with a fall related injury. The grant will be submitted in March 2013.



PATIENT PRIVACY IN THE ED

By Morsal Tahouni, MD

The emergency department is often a chaotic setting. Perhaps nowhere is this more true than in the trauma room where multiple providers work simultaneously to provide life-saving care. As the team attempts to stabilize often life-threatening injuries, patient privacy can sometimes be compromised. Unfortunately, this can have unforeseen consequences for the patient and the healthcare staff.

Outside observers, such as family members, public safety staff, non-emergency department personnel, and law enforcement personnel may have access to patients during times when the medical staff is focused on patient care. This can be unsettling for patients. They risk having more than their private medical information made known to other people. Personal property may be removed without the patients consent. Further, their role in possibly illicit or criminal activity – as victims or perpetrators – may also come to light. The patient may become upset by these intrusions into their privacy; and these emotions may further be magnified through the lens of critical illness.

One significant area of privacy concern is the presence of law enforcement personnel (LEP) during patient treatment. Due to the nature of emergency medicine, LEP often arrive contemporaneously with ED

patients, especially those that are victims of violence. Like emergency medicine, law enforcement investigation is time-sensitive and requires work to begin as soon as possible. While LEP presence serves a public safety need, it can also complicate patient privacy. Further, such violations can complicate emergent medical care if patients feel that the boundaries between their medical providers and law enforcement are not clearly defined.

In an attempt to clarify the roles of healthcare providers and LEP, the BMC Department of Emergency Medicine has worked with multiple departments to develop a policy regarding LEP presence in the ED that emphasizes patient privacy and focuses on the efficient and confidential provision of emergency care. The policy clearly delineates for providers when and where LEP contact is appropriate, and the importance of approaching the patient prior to contact to help ensure confidentiality. It further specifics how patient property should be handled, and when it can be transferred to LEP personnel.

Although this policy will help improve communication between hospital staff and LEP, the ultimate goal is to protect the patient. BMC has always had a commitment to excellent patient care and strong ties to its community. This policy helps reinforce that commitment while improving the ability of the health-care staff to perform its job.



“BMC Department of Emergency Medicine has worked with multiple departments to develop a policy ... that emphasizes patient privacy and focuses on the efficient and confidential provision of emergency care.”



International News

BMC EMERGENCY PHYSICIAN HELPS INVESTIGATE HUMAN RIGHTS ABUSES IN QADDAFI'S LIBYA

Reprinted from Physicians for Human Rights, *"32nd Brigade Massacre Evidence of war crimes and the need to ensure justice and accountability in Libya"*

This report was written by Richard Sollom, MA, MPH, Deputy Director at Physicians for Human Rights (PHR), and Hani Mowafi, MD, MPH, attending physician at the Boston Medical Center's Trauma and Emergency Department.



The death of Colonel Muammar Qaddafi following his capture by opposition forces near his hometown Sirte in October 2011 signaled the end of Libya's eight-month war. While Col. Qaddafi's death

prevented Libyans and the international community from holding him accountable for four decades of dictatorial rule marked by gross human rights violations, alleged war criminals from all sides of the recent conflict remain at large and must be brought to justice.

The rule of law must be the bedrock of a new and free Libya. As the interim government charts a new course for the country in a post-Qaddafi era, it must ensure that perpetrators are held accountable for atrocities (i.e., grave violations of human rights, including possible war crimes and crimes against humanity) that they committed or ordered. Individual accountability is the best guarantee for preventing future human rights violations and ending a cycle of violence.

Physicians for Human Rights (PHR) conducted an investigation into one such atrocity that occurred at a warehouse in Tripoli during the final days of Ramadan in late August 2011. Initial reports offered conflicting numbers and partial accounts of the events. Physicians for Human Rights sought to clarify what took place and identify who ordered and carried out the alleged torture, rape, and summary executions. To answer these questions, PHR investigators interviewed three eyewitness survivors of the massacre as well as one of the alleged perpetrators, conducted medical evaluations of two of the survivors documenting evidence of torture, and forensically documented the crime scene for evidentiary purposes, cited in part here in corroboration of the accounts of the interviewed witnesses.

The evidence PHR gathered elicits a pattern of crimes including murder, torture, rape, and unlawful confinement of civilians and combatants at a warehouse in Tripoli, which 32nd Brigade soldiers used as a makeshift detention facility. The collected testimonies place high-ranking military authorities at the warehouse crime scene, demonstrate their intent to carry out the massacre, and document their plans to conceal and destroy evidence of their crimes. The evidence of war crimes in this report provides a measure of truth and acknowledgment for victims and helps to build an important historical record; this report also provides recommendations for future investigations for international or national courts of law, for the purpose of securing justice and accountability for all Libyans.

The findings from this medico-legal investigation constitute the basis for this report, which for the first time provides a detailed and comprehensive account of the 32nd Brigade massacre on 23 August 2011. It also demonstrates the requisite level of forensic expertise that the new Libyan government needs to employ when investigating other crime scenes. The international community can best support the interim authorities in that endeavor by providing such expertise and building local capacity to conduct forensic investigations. This capability is critical as Libya currently faces alleged war crimes committed by all sides, which the interim government must thoroughly investigate and address.

This report concludes with detailed policy recommendations to Libyan authorities and the international community, which serve as a road map to investigate alleged crimes and thus ensure justice and the rule of law. Key policy recommendations include the critical importance of immediately securing all sites where alleged war crimes and other similar acts occurred so that evidence may be preserved for future prosecution and truth seeking efforts; allowing the International Criminal Court (ICC) to continue investigating crimes in Libya, including alleged acts by any party; dedicating human and financial resources to building domestic institutions that will address the crimes of the past and seek accountability for crimes according to international legal standards; developing a transparent and thorough vetting process to ensure that perpetrators of war crimes and other international crimes do not hold positions of power in the new government; ensuring that the International Committee of the Red Cross (ICRC) can access detainees in Libya and ensure their wellbeing; and supporting the professionalization of the police and the armed forces. (Full report at www.phr.org)





TRAINING EMERGENCY CARE PROVIDERS IN RURAL UGANDA

By Sushama Saijawani, MD, PGY 4

My perspective on global health has evolved with each international medical experience. My work in rural Uganda during February 2012 proved no exception. I travelled to Karoli Lwanga Hospital, a hospital that care for a population of over 300,000 in Nyakibale, a rural mountainous area of southwest Uganda. It is here that a Massachusetts-based organization called Global Emergency Care Collaborative (GECC) has set up a two-year curriculum to train



Ugandan nurses to be emergency care providers. These providers run a six-bed emergency room where they care for high acuity patients without ventilators, telemetry,

advanced imaging or even portable oxygen. Even running water and electricity can be unreliable in that part of the country. The hospital has three Ugandan doctors on staff. Due to a lack of any specialists, these physicians need to extend their scope of practice, from general medicine to pediatric surgery, from trauma surgery to obstetrics.

My purpose in travelling to Nyakibale was to conduct bedside teaching for the emergency care providers and also supervise didactics in the spirit of a 'teach the trainers' model of international medical education. The providers, who had already completed two years of training, were taking on responsibility for teaching the new students in an effort to create self-sustainability. Through lectures, bedside teaching and developing educational materials I helped train new providers in bedside ultrasound, plain film interpretation, common infections and antimicrobial therapy – as well as conducted workshops on common emergency procedures like drainage of abscesses and tube thoracostomy.

My goal was to impart knowledge of emergency care, but my work in Uganda proved to be a valuable personal and professional learning experience. I was forced to adjust my practice to the lack of diagnostic testing available and rely more heavily on the patient's history and physical exam for diagnosis. In Boston, I was accustomed to seeing "pathologies of excess" and now I had the chance to witness the pathology of malnutrition. It was intimidating and yet confidence-building to work in an environment, where one's training and personal skills are the only available resource.

One day, I was faced with a young woman suffering from AIDS who was in respiratory distress due to a large pleural effusion from tuberculosis. I knew the effusion had to be drained, but we lacked the proper equipment to conduct the procedure and post-procedure imaging to assess for complications. I also knew that if her respiratory distress became worse we had even fewer options to stabilize her. Combing through several boxes of dusty, antiquated equipment in hospital storage, we were able to put together a closed tube system to drain the effusion and save her life.

We were not always so successful, however. A 3-month-old child was brought to the hospital tachycardic and febrile, likely due to sepsis. As is the norm in Uganda, the child had been taken first to a local health post that was not fully equipped. By the time the child reached the emergency room at Nyakibale, her condition had worsened. With no monitoring available, the emergency staff was unaware when this baby became pulseless.

A few days later, a 12-year-old boy presented with four partially amputated fingers of his right hand. The injury was sustained when his older brother punished him by taking a 'ponga' or machete and mutilated him. Since a hand surgeon is not available at the hospital, the only option was to complete the amputation for appropriate wound healing. Without child protective services, the child returned to live alongside the sibling who had maimed him for life.

These experiences made me reflect on how different the outcome would have been for these patients had they only lived in the United States. Had they presented to our own hospital, the baby's life could have been saved and the young boy may not have had to lose the use of his hand and return to the care of a violent sibling. I recognized how much we take for granted, not only running water and electricity, but also the first-class medical care that is available to each of us at our doorstep. I realized the blessing that we don't need a dedicated pediatric malnutrition ward in our own community.

My global health experiences have made me aware of how small a fraction of the world's population lives with good health care and personal security. My trip to Uganda made me realize that this fraction is even smaller than I had previously imagined. I was glad for the opportunity to travel to Uganda with GECC and hope I was able to make a small difference in the on-going training of emergency care providers there.



On the Ground Floor:

WITNESSING THE LAUNCH OF EMERGENCY MEDICINE IN VIETNAM

By Jonathan Fleurat, MD PGY 3

Last spring I had the privilege of becoming the second BMC resident to rotate to the developing Emergency Medicine training program in Hue, Vietnam. I was based at Hue University Hospital and Central Hospital, a system that serves the city of over one million people. While my arrival was prior to the official launch of the formal training program, there was already an emergency department staffed with physicians and an active continuing training program. This program was designed in partnership between Hue University and the NGO, Good Samaritans. The establishment of the formal EM residency program will mark the culmination of eight years of collaboration between these groups, practicing physicians and the local government.

As a second year resident at Boston Medical Center, this rotation was my first opportunity to see EM practiced in a setting where the "culture of EM" was still new and the practice of emergency medicine was still being developed. I spent the majority of my time in Hue working with faculty and teaching residents on essential EM topics. In addition, I had the opportunity to teach EM ultrasound techniques and demonstrate their ability for more rapid assessment in the emergency room.

However, the most lasting memories I have from my time relate to what I witnessed in the day-to-day care of patients. I watched family members carry in patients, bring food, bathe patients, transport them to studies and care for them on the floors. While I understand that much of this was necessary in a resource limited setting and that it relieved the burden on an already overworked nursing and physician staff, I could not help but notice that in many ways patients appeared happier, families were more involved, and how this operation bridged the gap between compassion and medical care. While this is not something likely to occur in a US hospital, it highlighted the importance of keeping families involved in any system.

While I ventured to Vietnam with the goal of sharing valuable skills and knowledge I had gained as an EM resident at BMC, I found that my experience in Vietnam afforded me a rare opportunity to learn more intimately about the obstacles faced by a developing health-care system. I was exposed to tropical medicine, the challenges of working in a resource limited setting, and witnessed creation of the emergency medicine as a new specialty. While emergency medicine is experiencing its adolescence in the US, with our nation's first formal residency program established in 1970, emergency medicine in Vietnam is at its exciting conception.

Vietnam took its initial step towards creating a formal emergency medicine program by developing its knowledge base and educational foundation under the guidance of Dr. Carter Hill in 2004. Since that time, Hue has welcomed emergency medicine practitioners and educators from around the world to work with local EM providers to train students, doctors and nurses in emergency care. In exchange, each rotator has shared knowledge in the form of lectures, case discussions, and direct patient management.

Additionally, emergency physicians in Vietnam launched a formal Society of Emergency Medicine and in 2010 held their first scientific meeting that brought physicians from around the country as well as sixty other nations. During this conference, more than 200 Vietnamese physicians received continuing medical education on topics such as emergency medicine, pre-hospital care and disaster management. They have continued this tradition of medical education with annual conferences on emergency medicine and emergency nursing.

Recently, growing interest in emergency medicine has led to the formation of the first emergency medicine student interest group in Hue. Coordinating with the head of the EM interest group, students learn the basics of emergency medicine and a symptoms-based approach to patient assessment.

This winter marks the launch of the country's first official emergency medicine residency program, an event which signifies the culmination of eight years of dedication and hard work. I am grateful for the experience that I had in Hue and for the opportunity to see the growing interest and early formation of an emergency residency program. Although our domestic emergency medicine program is further developed and established, there are many lessons our system and physicians can learn from the Vietnamese system of care.



Photo: John Barker



Photo: Trần Đình Hiệp



Photo: Sándor Laza



Social Justice: Shaking Off Our Lassitude

CREATING A GLOBAL HEALTH SERVICE-LEARNING PROGRAM FOUNDED IN SOCIAL MEDICINE

By Francis X. Coughlin, BUSM IV

In February 2012, four Brown medical students and three Rhode Island Hospital internal medicine residents began a month-long service-learning program based in social medicine and global health in the city of Santiago, Dominican Republic. I had been selected by the program director to serve as the program coordinator in order to both provide a clinical experience in a resource-limited setting while at the same time help trainees understand the social, economic and political factors that create such settings and perpetuate social and health disparities. Significant time was spent delving into the complex systems of global economic structure, environmental degradation, and structural violence that can contribute to poor community health.

Following a service-learning model, the course was split into two focus areas — with clinical work each morning and a social medicine course in the afternoons. Our clinical time was spent in Hospital José María Cabral y Báez and Clínica Santa Lucía. The Cabral y Báez is a large teaching hospital that serves as a tertiary referral center for the entire northern third of the country. Elective participants rotated through the emergency department, intensive care unit, general medicine floors, as well as outpatient clinics. Participants joined in daily rounds and clinical



Group members and community health workers after our "Día de Salud."

discussions of disease processes rarely seen in the US, such as malaria, tuberculosis, dengue fever, leptospirosis, and organophosphate poisoning through patient-based presentations, done by rotating members of the elective team. In addition to the hospital, members rotated through Clínica Santa Lucía, a primary care clinic located in the impoverished barrio of Santiago. Here members observed the medical staff as well as accompanied health promoters on home visits. Finally, the team spent a few days in a rural area of the Dominican Republic assisting in teaching clinical and public health skills to a group of health promoters.

The social medicine course consisted of a lecture series, readings, films, field visits, and reflection sessions. It attempted to place the clinical experiences in a national and global context as well as begin to address the structural causes of poverty and poor health in the developing world. The course was divided into four main sections — an introduction to social medicine and the Dominican health care system; structural determinants of health and social disparities; different paradigms of global health intervention; and the role of social justice in health, specifically through a "right to health," as well as briefly researching health organizations engaged in social justice work.

Unfortunately, although we are on the front lines of suffering, most medical professionals are never exposed to such an anthropological approach to the problems that affect vulnerable populations. Without such knowledge, we lose sight of the context in which our medical services are needed. Just as we would not treat a fever without searching for an underlying cause, the course attempted to provide some of the tools to understand the causes that underlie our patients' suffering. While it may be impossible to teach trainees all there is to know about social medicine in only a month, the course provides members a toolkit and does the crucial job of instilling a strong sense of the physician as advocate. There have been some service-learning programs to connect social justice to medicine and other professions, such as the CommonWell program at BU, but they remain rare. My hope is that as global health electives become more and more ubiquitous in medical training, the question of justice is asked as we in the medical field strive towards a world with less disparities and more access for all.

Group members enjoy authentic Dominican food.





Megan Leo teaches medical officers point of care echo in Kenya.

INTERNATIONAL EMERGENCY ULTRASOUND EDUCATION

Megan Leo, MD, RDMS

Emergency bedside ultrasound has been rising on the list of high-yield interventions in global emergency care. The ability to rapidly diagnose emergent conditions like ectopic pregnancy, placenta previa, breach presentation, intra-abdominal solid organ injury and pneumothorax can lead to declines in preventable deaths and speed the transfer to definitive care in young otherwise healthy patients who are critically ill or injured.

The Boston Medical Center Emergency Department has several international ultrasound education projects with which residents can get involved. In 2012, our ultrasound section was involved as part of a consortium of institutions in an ultrasound education initiative in Kisumu, Kenya and in Kigali, Rwanda. The goal of both of these initiatives was to teach core bedside ultrasound skills to providers in district hospitals where ultrasound machines are available but adequate training to use these machines has lagged. The section is also working on establishing two new ultrasound education programs in Zambia and Namibia, as well as a resident-led research and training project in Vietnam.

The Kenya education initiative was funded by AIIT, a nonprofit organization who's goal is to use technology to improve health care in various African countries. The course was directed toward a broad base of providers, including medical officers (physicians), clinical officers (PAs), nurses and midwives. The course emphasized reduction in maternal and

Many of the trained providers came from extremely rural and under resourced clinical settings – including six Red Cross providers from the Dadaab refugee camp on the Somali border and twenty healthcare providers from various settings in the newly created country of South Sudan. Some providers can only reach their clinical site by traveling two days by boat up the Nile, making ultrasound a critical mode of imaging. The goal of this initiative is to improve the care for the critically ill and injured in these especially remote sections of Kenya, South Sudan and other vulnerable areas of Africa.

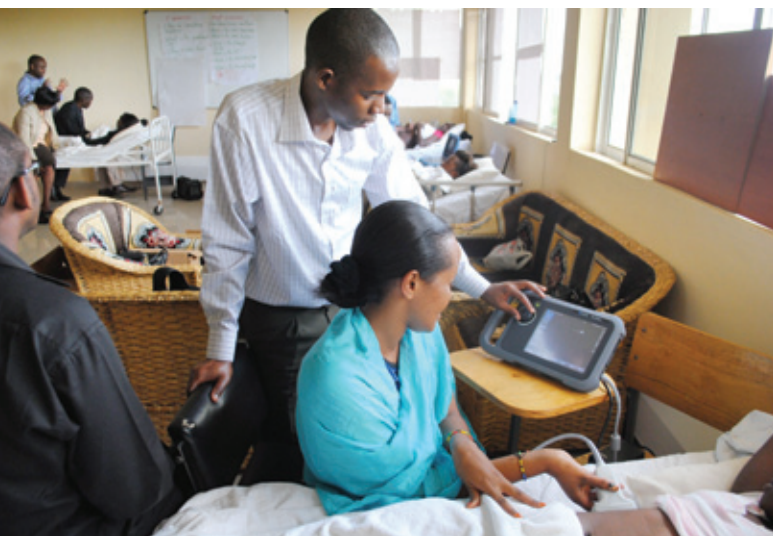


Graduating class of medical officers, nurses and midwives at the AIIT ultrasound course in Kisumu, Kenya.

The ultrasound education initiative in Rwanda was run by a nonprofit organization called PURE (Physician Ultrasound Rwanda Education). The goal was to establish a training program for Rwandan physicians as part of their annual continuing professional development (CPD) program. It is an eight-month curriculum, to conclude in May 2013, and aims to equip Rwandan physicians from district hospitals with the core applications of emergency ultrasound with the hopes of credentialing them under the same standards we credential our physicians under ACEP guidelines. The curriculum places a strong emphasis on follow up and continuing quality assurance with the 18 selected trainees. The training program began with a two-week, intensive course in bedside ultrasound, of which our ultrasound section played a large role by giving several lectures and providing daily hands-on training. After the initial course, approximately 20 ultrasound-trained North American physicians will be visiting the different district hospitals over the course of 8 months to provide ongoing educational support.

Currently our ultrasound section is working on the development of a partnership for ultrasound training and credentialing with the University Teaching Hospital in Lusaka, Zambia and with an independent non-profit organization called C2C (Containers to Clinics) in Namibia. Our international ultrasound curriculum will focus on an ongoing quality assurance with these groups to ensure high quality training and standards for accuracy.

We hope that our training programs in emergency ultrasound will allow providers from under-resourced clinics and district hospitals to identify high risk conditions earlier and reduce the time to definitive diagnosis and treatment in critical patients. Residents have the opportunity to be involved in the ultrasound training courses and the ongoing follow up with these partners in Zambia and Namibia.



Kenyan medical officers perform a hands-on review of point of care ultrasound.

fetal mortality through prenatal ultrasound screening for dangerous pathology such as placenta previa and breech positioning. There was also a focus on trauma and critical care ultrasound, with a special emphasis on using ultrasound to manage shock.



Partnering with Ghanaian Colleagues in Clinical and Education Projects

BRINGING HEALTHCARE TO RURAL COMMUNITIES IN GHANA

By Thea James, MD, Co-founder, UFGH

The UFGH Ghana project comprised a Stroke Prevention and Rehabilitation Curriculum. The team included a contingent of medical professionals — two neurologists from the University of Medicine and Dentistry, Newark, NJ — one an advanced practice stroke nurse and the other a physical therapist with a special interest in stroke.

The Stroke Team divided their time between Agona Swedru Government Hospital and a rural community in Dominase. The team partnered with hospital personnel, evaluated patients with stroke and other neurological disorders, treating hypertension, and counseling patients on stroke risk factors,

Photos (Top): UFGH Neurology Team broadcasts on-air stroke education, prevention and rehabilitation discussion; (Center): Early arrivals await the mobile clinic and images of patients being treated at the clinic; (Bottom): Rural trade school teaching wellness and healthy relationships



and teaching stroke deficit rehabilitation. The team conducted a series of five short lectures for hospital personnel and practitioners and an enthusiastically received rehabilitation workshop was held. The hospital has expressed interest in a formal training relationship and establishment of a stroke center. The stroke team presented on the regional radio station which then featured their program on the daily health segment broadcast for two consecutive weeks.



Social workers and artists followed up on two previous UFGH projects at a girls school in rural Ghana which recently became co-ed. This program was also featured on the regional radio station.

UFGH Emergency Medicine team physicians partnered with Ghanaian hospital personnel, working alongside them in the emergency department. The team also rotated personnel between the hospital and conducting rural mobile community clinics.



UFGH
Unified for Global Healing



Public & Global Health Section

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AWARDS AND RECOGNITION

Edward Bernstein, MD, MPH

Professor of Emergency Medicine and Professor of Social and Behavioral Sciences in the School of Public Health at Boston University

Jerome Klein Award for Physician Excellence

Dr. Bernstein received the 2012 Jerome Klein Award for Physician Excellence, being recognized as a physician who has demonstrably improved the lives of his/her patients and who has the following characteristics:

- High standards and expectations;
- Clinical and/or research excellence;
- Leadership with a positive attitude;
- Serves as an outstanding mentor and role model; and is
- Supportive of colleagues and other health-care providers.



Ed Bernstein receives congratulations from his fellow emergency physicians (l to r): Brendan Magauran, Thea James and Hani Mowafi.



James A. Feldman, MD, MPH, FACEP

Professor of Emergency Medicine at Boston University

Dr. Feldman received two prestigious awards in 2012:

Region IV Mark E. Weinstein MD Award

Dr. Feldman received this award for his outstanding dedication and commitment to the metropolitan Boston Emergency Medical Services region.

The Pinnacle Award

At the annual meeting of the Massachusetts College of Emergency Physicians (MACEP), Dr. Feldman received this prestigious career achievement award. "The Pinnacle" is a given by MACEP to a small number of individuals who have made significant local, regional and national contributions to MACEP and Emergency Medicine.



Thea James, MD

Associate Professor of Emergency Medicine, BUSM; Director, VIAP

Recognized as a Leading Health Care Professional

Dr. James was honored as outstanding physician by the Boston Business Journal for work in violence intervention that she and the VIAP team have conducted. Dr. James received the award at the Boston Business Journal's annual Champions in Health Care event August 23, 2012 at the Seaport Hotel, Boston.

Named Assistant Dean of Diversity and Multicultural Affairs

Dr. James has been appointed to the position of Assistant Dean in the BUSM, Office of Diversity and Multicultural Affairs. Throughout her 20 years of service at BMC and BUSM, Dr. James has lectured internationally and received numerous awards for her work in violence prevention, health care disparities, multiculturalism and health care delivery.

Honored by BMC President and CEO Kate Walsh at Celebration of Women in Healthcare

BMC President and CEO Kate Walsh served as the guest speaker at the Schwartz Center's 10th annual Celebration of Women in Healthcare. The event recognized the key role of women in advancing compassionate care in today's changing health-care environment. Walsh honored Pat Kimball, RN, Geriatric Home Care Program, and Thea James, MD, Director, VIAP and Emergency Medicine Physician. "These women personify the compassionate care that is the Schwartz Center's mission," said Walsh.



Laura Eliseo, MD
Emergency Medicine Physician

Emergency Medicine Residents' Association Certificate of Appreciation

Dr. Eliseo was honored by the Emergency Medicine Residents' Association with a Certificate of Appreciation for fostering medical students' interest in the field of emergency medicine. Eliseo's nomination was initiated by Boston University medical students.



Kristin Carmody, MD, RDMS, RDCS
Director of Emergency Ultrasound; Assistant Professor of Medicine, Boston University School of Medicine, Boston MA

Academy of Emergency Ultrasound Chair

Dr. Carmody has been elected Chair of the Academy of Emergency Ultrasound (AEUS). Carmody is a current board member of AEUS, an organization that brings together bedside clinician sonologists with the common goal of advancing patient care and safety by use of bedside ultrasound.

Society for Academic Emergency Medicine Trophy Awarded

The **BMC Emergency Medicine Residency Program** took home a trophy from the Society for Academic Emergency Medicine's 2012 annual meeting in Chicago. The team won the inaugural Sonogames, a national competition of ultrasound skills. Demonstrating their skills and knowledge of point-of-care ultrasound and all aspects of US competence in clinical practice were **Joe Pare, MD, Derek Wayman, MD, and Neil Hadfield, MD**. Forty residency programs competed in the event.



Left to Right, PGY 3 residents Neil Hadfield, Derek Wayman, Joe Pare; and Director of Emergency Ultrasound, Kristin Carmody, MD.



Boston EMS Receives Regional Honors

Innovation of the Year — Boston EMS Diabetic Refusal Follow-up Program

Diabetes is a growing health concern across the country. If not properly monitored, an individual can have hypoglycemic events when blood sugar is dangerously low. The Boston EMS Diabetic Refusal program provides a wellness check within a short window of a hypoglycemic incident. Patients meeting the case criteria receive a follow-up phone call by a Paramedic in an effort to ensure they have the resources to maintain their blood sugar in a safe range.



REDUCING OPIOID OVERDOSE DEATHS

BMC Leadership Collaborates with the Boston Public Health Commission

Edward Bernstein, MD, Director, Public & Global Health Section



A recent article in *Annals of Internal Medicine* reported that “Naloxone distribution to heroin users is likely to reduce overdose deaths and is cost-effective.” This is important news in the face of a national opioid overdose epidemic. 18,000 opioid

overdose deaths were reported in 2009 nationally, and in many states like Massachusetts opioid overdose deaths exceed motor vehicle fatalities. In 2011, Boston EMS reported transporting 421 patients to the BMC ED who had overdosed.

As of 2010, a total of 188 U.S. programs distributing naloxone reported that they trained 53,032 persons and recorded 10,171 reversals. From 2006-2012, the OEND programs in Massachusetts equipped over 17,000 people with naloxone take-home kits; these program participants have reported over 1,700 overdose rescues. Since September 2009 our BMC ED Project ASSERT has been part a national and statewide community response to educate opioid using patients and their families on the risks for opioid overdose and the use of rescue techniques to save lives. In December 2012, Project ASSERT’s Health Promotion Advocates had a banner month, distributing 23 Nasal Naloxone kits and educating 30 individuals. An effort is currently underway at BMC to reach as many emergency department patients as possible who present after an overdose to provide them with Opioid Overdose Education and Naloxone Distribution (OEND).

The BMC Adult and Pediatric ED was the first ED to provide OEND to its patients. A recent follow up study of a convenience sample of 51 patients receiving overdose education found, among those who received naloxone rescue kits that there were no adverse events from the program, no additional risk of opioid use, and no fewer 911 calls compared to those who got an overdose education session but no kit. Most importantly, four of these kits were used by trainees in successful overdose reversals.



These preliminary findings are important because of public concern that naloxone kit distribution to drug users might provide a ‘golden parachute’ (i.e. might make heroin users feel comfortable trying higher doses), and there was the possibility that the kit might also cause a false sense of confidence in being able to handle emergencies, resulting in fewer life-saving calls to 911.

MASSACHUSETTS IS A NATIONAL LEADER IN OPIOID OD PREVENTION

Dr. Alexander Walley, a member of Boston Medical Center’s Injury Prevention Center, recently published a landmark article in the *British Medical Journal* (BMJ): Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis.

“This study provides observational evidence that OEND is an effective public health intervention to address increasing mortality in the opioid overdose epidemic,” says Walley, “OEND implementation seemed to have a dose related impact, where the higher the cumulative rate of OEND implementation, the greater the reduction in death rates.

“Too many families have been impacted by the rise in opiate abuse and overdoses in Massachusetts.

As we continue to combat opiate abuse and provide resources for prevention and treatment services,

Narcan has proven to be a powerful tool in saving lives, so that opiate abusers can receive treatment and begin to recover from their addiction.”

— Lieutenant Governor Timothy Murray, Chair of the Interagency Council on Substance Abuse and Prevention.





BMC'S DEPARTMENT OF EMERGENCY MEDICINE WELCOMES NEW PERSONNEL

New Emergency Medicine Faculty



Cristopher Amanti, MD



**Kalpana Narayan Shankar,
MD, MSc, MSHP**



Jordan Spector, MD



Injury Prevention Center Welcomes Research Assistant

Nicole Krellenstein joins the Injury Prevention Center (IPC) as a Research Assistant.

Ms. Krellenstein has a B.A. in Experimental Psychology from Vanderbilt University and recently completed a pre-medical post-baccalaureate program at Tufts University. To prepare for a career in medicine as an advocate for preventive care, she joined the IPC to help develop and implement a research program aimed at identifying and evaluating injury prevention policies and interventions.

Perry Named Data and Research Manager for VIAP

In her new position as Data and Research Manager, **Ariana Perry** will advance the VIAP program's ability to analyze and synthesize data both internally and externally. Responsible for the development of data management protocols, she will also participate in all aspects of VIAP research, including IRB application to study completion.

Ms. Perry graduated Cum Laude from Skidmore where she studied Psychology and is a contributing author of the book "Treating Self-Injury: A Practical Guide."



Society for Academic Emergency Medicine

SAEM Annual Meeting 2013

MAY 16, 2013 — Atlanta, Georgia

Didactic Presentation:

*Building Blocks for Establishing
Hospital-based Violence*

Intervention Programs in (Your) Emergency Departments.

Presented by: Thea James, MD, Director, VIAP, Boston Medical Center, BUSM

Theodore Corbin, MD, MPP, Director, Healthy Hurt People, Drexel University, Philadelphia, PA

Rochelle Dicker, MD, Director, Wraparound Project, San Francisco General, UCSF





The Department of Emergency Medicine's Public and Global Health Section has many faculty members with advanced degrees and education in the field, including Masters in Public Health (MPH) and International EM Fellowship training.

Public & Global Health Committee, Department of Emergency Medicine

Jonathan Olshaker, MD, Chair, Section Editor

Edward Bernstein, MD, *Director, Public & Global Health Section*

Hani Mowafi, MD, MPH, *Director, Global Health Section*

Peter Moyer, MD, MPH, *Chair Emeritus BUSM*

James Feldman, MD, MPH

William Fernandez, MD, MPH

Thea James, MD

Megan Leo, MD

Judith Linden, MD

Ward Myers, MD, MPH

Elissa Schechter-Perkins, MD, MPH

Morsal Tahouni, MD

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For more information about BMC's Department of Emergency Medicine
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