

## EDUCATOR SPOTLIGHT

### “WORLD’S SMARTEST DOCTOR”

An interview with  
Kathleen Delaney,  
MS, MD, FACP, FACEP, FACMT



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# HIGHLIGHTS

## 3 President's Comments

New Year, New SAEM

## 4 Educator Spotlight

"World's Smartest Doctor" Reflects on 40 Years in Medicine (33 in the ED)

## 7 Research Committee: News You Can Use

National Institute of Health Loan Repayment Program

## 8 Diversity and Inclusion

The Need for a Research Agenda Promoting Diversity and Inclusion

## 10 Ethics in Action

End of Life Care: When and How Should a Physician Intervene?

## 11 SGEM: Did You Know?

Are Men and Women Wired the Same For Acute Stress?

## 12 First Person

A Learner's Perspective on Intubation

## 16 Resident-Student Guide

Clinical Decision Tools for the Emergency Department Physician

## 18 Social Media in Academic EM

FOAMED for the Newbie

## 19 Briefs and Bullet Points

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# PRESIDENT'S COMMENTS



## Andra Blomkalns, MD

University of Texas Southwestern Medical Center at Dallas  
SAEM President 2016-2017

## New Year, New SAEM

The new year is traditionally a time for focusing on renewal, growth, and new beginnings. Thanks to your commitment to our specialty and your continued support of the society, this New Year begins with the launch of several new programs and initiatives that represent exciting milestones in the history of the Society for Academic Emergency Medicine:

### **A freshly branded, easier to navigate SAEM website**

Including optimized mobile platforms, single sign on, access to the latest journal articles from the home page, and content that is reorganized so it's easier to find! Visit [www.saem.org](http://www.saem.org) to see our new look!

### **Introducing AEM Education and Training (AEM E&T)**

After months of planning and preparation, SAEM's newest publication—[Academic Emergency Medicine Education and Training \(AEM E&T\)](#) publishes its first issue in January 2017. AEM E&T is dedicated to the publication of papers focused on the advancement of education and training in emergency medicine.

### **All SAEM Publications Are Now All Digital**

Starting with the January 2017 issues, [ALL SAEM publications](#) ([Academic Emergency Medicine](#), [AEM Education and Training](#), and [SAEM Pulse](#)) will be online-only. This change makes content more readily accessible and feature-rich, with reference linking, article sharing, embedded videos, expandable images, and more!

### **New and improved Academy websites**

Each [SAEM academy](#) now has a newly-branded, easier-to-navigate site to house online education, provide information, explain the benefits of membership, and market academy products, services, and events.

### **Upgraded, Highly-Searchable Directories**

SAEM's [Clerkship](#), [Fellowship](#), and [Residency directories](#) have been transformed into powerful, highly searchable

online databases with improved functionality and completely updated data.

### **Free Interest Groups**

SAEM members can now enjoy free, unlimited access any of its 25 [interest groups](#). Now you can explore as many subspecialties as you wish, at no extra cost.

### **Military Membership**

SAEM supports our men and women in uniform! [Military membership](#) is now available to any faculty member who works for the military full time. Please [contact SAEM](#) to have your membership category updated.

### **A State-of-the-Art Training and Collaboration Space**

SAEM's new meeting and classroom spaces can accommodate up to 20 for education and training events. Each conference room is equipped with large flat screen monitors, Apple TV, and built-in work stations. A well-equipped dining area has extra-sized white boards for lunchtime brainstorming and our comfortable living room is a place to congregate and collaborate. For our out-of-town guests, the new space is conveniently located close to both O'Hare International Airport and several reasonably-priced hotel options. If you are interested in scheduling an event or meeting, please contact [Alex Keenan](#).

### **EM Job Link**

If you are an employer or a job seeker, you'll want to check out our renamed and refreshed [EM Job Link](#)—the niche job source for the academic emergency medicine community. You'll find a clean, mobile-responsive user interface; better employer functionality; a streamlined pricing structure, and new marketing initiatives to give you job ad maximum exposure.

### **A New Look for Community Sites**

SAEM's online [community sites](#) have been refreshed and redesigned to align with

*"It's a New Year  
and New SAEM  
and we couldn't be  
more excited to  
share it with you!"*



*continued on page 7*

# EDUCATOR SPOTLIGHT

## “**WORLD’S SMARTEST DOCTOR**”

Reflects on 40 Years in  
Medicine (33 in the ED)



*"Kathy Delaney has been labeled for all of the years that I have been at UT Southwestern as the "W-S-D", which stands for "World's Smartest Doctor." Her astonishing intellectual command of Medicine is humbling to those of us who gain so much from her insight, her body of knowledge, and perhaps most importantly her sincere commitment to work to the betterment of the human condition. I count her as my teacher, a profound inspiration, and a dear friend." – Ray Fowler, MD*

*Sharon Atencio, chair of the SAEM Pulse Editorial Advisory Task Force talks with Kathleen Delaney, MS, MD, FACP, FACEP, FACMT. Dr. Delaney is one of the most widely published authors in medical literature, and during her 40-year career she has influenced emergency medicine on an international scale. She has announced her retirement as Chair Emeritus of the John Peter Smith emergency medicine residency. Dr. Delaney is regarded as one of the specialty's premier educators, and we are pleased to feature her in the first of what will be an ongoing series of educator interviews.*

## **SAEM Talks with Kathleen Delaney, MS, MD, FACP, FACEP, FACMT**

**Please tell us about your career from the beginning.**

I was a high school dropout. I completed my GED and then worked and traveled for two years; next I enrolled at UC Irvine, completed a bachelor's degree in biochemistry, worked and traveled for two more years, and accepted a graduate position in chemistry at UCLA. I earned a master's degree and enrolled in medical school at Columbia University. I thrived in medical school—I loved pathophysiology and clinical diagnosis, and back then there were no CT scanners to help. I was selected to Alpha Omega Alpha, and after graduation I completed an internal medicine residency at NYU Bellevue. I wanted to be a trauma surgeon, but my Public Health Service obligation precluded a surgical residency (unless I did prenatal exams in Brooklyn or Window Rock, Arizona, for two years first!).



"Kathy Delaney is a wonderful inspiration to me as well as countless other people. She is truly a master clinician who cares about her patients as if they are her family. She is always available to teach but is humble, being the first to say that she always has more to learn." —Kelly Klein, MD

Bellevue had plenty of emergencies and a chaotic emergency department that needed a lot of work. As a medicine resident, I spent a great deal of time there, was rarely supervised, and made a lot of mistakes. Around that time Dr. Lewis Goldfrank arrived to help bring order to the chaos. I signed on with him after my residency and never left the ED; I was able to complete my PHS service in that emergency department. My major interest was at first not education (except of myself) but helping to bring a higher quality of medical care to the indigent New York City patients who depended on us for care. We felt that the best way to do that would be to take charge of the ED and develop a residency training program to solidify our efforts. I spent ten years on the faculty working to grow that program— and by default, I became an educator.

In 1987 the same thing was happening in Dallas at Parkland Memorial Hospital under the leadership of Mike Krentz, who was supported by other community EM leaders such as Compton Broders, Jim Hayes, Leonard Riggs, and Dighton Packard. They wanted to have well-trained emergency physicians, and Parkland wanted supervised care in their ED. After a few years, the first initiative crumbled. I worked for EMCare as locum tenens and learned that my “academic” skills served well in the community setting. We revived the effort at Parkland, successfully this time; and over many years we developed the residency program. I served for a short time as the first program director, then acting chair, vice chair, medical director of the ED, and then Parkland Medical Staff President. Throughout all these roles and political machinations I remained committed to the provision of quality care and to the training of physicians who could provide it. I was the first full professor from the EM faculty at UTSW and retired in 2010 after 19 years. I then went to John Peter Smith Hospital as Academic Chair to help develop their residency program, which is now in full swing. I am boarded in medicine, toxicology, and emergency medicine.

### **Tell us about how you learned to be an educator. Did you have formal training?**

I have no formal training, although Lewis Goldfrank was a serious mentor. He modeled excellent bedside teaching. We both wanted to train good clinicians— and hopefully some who were interested in research and writing. We asked for a very high level of conscientiousness and commitment to clinical practice.

### **Do you have a teaching mission statement, and if so, what is it?**

Train compassionate doctors who listen to their patients (i.e. take a thorough history), keep an open mind, do a thorough exam, and test rationally.

### **Who are some of the teachers you've had in the past who have influenced how you train your students today?**

Bedside teachers such as Lewis Goldfrank, John Brust (a neurologist at Columbia and an excellent clinician), and Myles Behrens (a neuroophthalmologist at Columbia).

### **Do you believe that people have a dominant learning method (visual, auditory, or kinesthetic)? If so, how do you allow for this in your teaching?**

Clinical medicine requires visual, auditory and kinesthetic skills. I work with my residents to develop these if they don't have them.

### **How do you engage learners and keep them motivated?**

I do a lot of case-based teaching, challenging clinical thought processes.

### **How much value do you think lies in the physical exam? History?**

The history and physical, guided by knowledge of disease processes, are the most critical and basic clinical interactions with patients. It's very hard to make a challenging diagnosis with all the false positive and false negatives of laboratory and imaging studies without their guidance. The declining focus on clinical teaching and thought processes and the increasing reliance on imaging is very distressing to me. Whither the doctors?

### **Tell us about a specific training challenge you encountered (Language barrier? Lack of resources?) and how you dealt with it.**

Most of my training challenges are provided by individuals who are so anxious about missing something that common sense goes out the window, or so afraid to appear lacking that they do not recognize their limits and ask for help when it is needed. This is the physician who takes a very superficial chest pain history and admits everyone; who cannot accept that one can diagnose the cause of vertigo on history and physical and gets a (negative) CT in every case. I supervise these trainees more intensely than

# Words of Wisdom from 33 Years in the ED

## From Dr. Delaney's farewell note to her students

- "Keep reading, refreshing, learning from colleagues, following up with your patients."
- "The mastery that I did achieve was not a gift, not magical and not elusive, just a result of mindfulness of experience and effort and is achievable by all of you."
- "Be humble and flexible."
- "Remember to LISTEN to your patients, OBSERVE them carefully, THINK broadly, test RATIONALLY, and follow up to see if you were close to the mark."
- "Be a leader in your institutions—get on the committees, go to the social events; don't be just the bringer of bad news in the middle of the night."



"I owe a large portion of my career to Dr. Delaney. She's a wickedly smart woman, a generous mentor, a brilliant writer, and, overall, a force of nature." —Larissa Velez, MD

others. The tendency to cut corners is another problem that I am tough on: for example, skipping pelvic exams in women with dysuria or rectal exams in men with prostate symptoms.

### What behaviors do you try to model for your trainees?

Listening, thoughtfulness, compassion, clinical common sense.

### Malcolm Gladwell's book *Outliers* suggests that it takes 10,000 hours of deliberate practice to achieve mastery in any field. How long do you think it takes to become proficient in emergency medicine?

You can hardly know enough to practice expert EM. That said, I began to feel confidence after ten years. I do feel pretty expert now, although I still encounter cases that I've never seen. Humility is a big asset!

### How do you help your trainees learn to deal with mistakes?

It depends on the cause of the mistake and its consequence. It is a very terrible emotional blow to make a mistake that results in someone's death. I am very supportive—we've all come close. There have been two occasions when residents did something that I had specifically instructed them not to do and the patient died. That was hard on both of us. For mistakes due to sloppy practice, I help them improve their practice. For mistakes

due to lack of knowledge, I help them to direct their reading. For lack of skills, I help them understand that the skill will come with practice.

### What experiences in your life, outside of medicine, do you feel have made you a better educator?

Listening to the experiences that friends have had with the medical system. And travels to underserved countries.

### What advice would you give to a resident who would like to go into teaching?

Acquire expertise in a few areas of medicine—that means read all the primary literature in that area and know it. It brings a depth to your teaching. Oftentimes this leads to publications and research projects in those areas, which is how I directed my academic career.

### Tell us about a particularly satisfying moment you had while training a student.

I love to see the light go on. I was at the bedside with a resident seeing a woman with a third ED visit in three days due to "pain all over." She refused to open her eyes and look at the resident, and he was getting frustrated. The pain was lancinating, shooting down her arms and legs; further investigation revealed that she had no reflexes. Her closed eyes were due to ptosis. This was a Miller Fisher variant of Guillain-Barré syndrome with a predominant sensory component. She was intubated in the ICU for several months.

### What do you think is the future of emergency medicine education?

I'm a little worried about it. There is more and more focus on the finances of EM and less support for research and education of faculty. The focused review of symptoms that should contribute to a diagnosis has become a means of padding the bill. (Who cares if someone with an MI does not have dysuria?) There is an intrusion of scores and acronyms that substitute for clinical thinking.

### Do you think that some personality types are naturally better suited to emergency medicine? What qualities do you think are most important in a resident?

Emergency medicine requires a great deal of energy, a good nature (illness does not generally improve the personality of the ill), maturity, confidence, and humility when faced with the unknown.

### What are some unconventional methods you've successfully employed in your teaching?

I think my methods are pretty conventional: a heavily case-focused lecture approach, with lots of pathophysiology underlying the disease processes I talk about (this is how I think clinically). In the ED I supervise very closely. Some of the junior residents chafe at this and the seniors love it.

### How would you like to be remembered by the emergency medicine community?

As an excellent clinician and teacher of clinical medicine. My book and papers will soon be forgotten!

### What do you plan to do in your retirement? Do you think it will be a difficult transition?

I can't really give up medicine so easily. Lewis Goldfrank is setting up an Emergency Department in a teaching hospital in Ghana. I'm looking closely at that option! ▶

SAEM's visual identity and to ensure brand continuity and consistency.

#### **Abstract Submissions Made Easier**

Our new event management software, CadmiumCD, streamlines the abstract submission and review process for [SAEM17](#).

#### **Research Resources Are Now Online**

Everything a junior investigator needs to help with study design, implementation, evaluation and dissemination can be found at our [online research resources page](#).

#### **Announcing the Medical Education Portfolio Builder**

Online help with building an [education portfolio](#) to keep track of your teaching activities.

#### **Academic Emergency Medicine Gets an Upgraded Look**

What started with a new cover in 2016 has emerged into a complete makeover of [AEM journal](#) in 2017, with new page layouts, full color throughout, updated typography, and an overall more contemporary aesthetic that aligns with the SAEM brand.

#### **SAEM Newsletter Gets a New Name**

SAEM Newsletter is now [SAEM Pulse](#), to more adequately support the size, format, editorial positioning, purpose, and content of the publication.

#### **... And an Editorial Advisory Task Force**

The new SAEM Pulse Editorial Advisory Task Force will help guide the direction of the SAEM Pulse and provide insights, knowledge of topics, and suggestions of possible authors, articles, and interview subjects that are of relevance and importance to readers.

#### **The "I am SAEM" Campaign Kicks Off**

The "[I am SAEM](#)" campaign showcases the uniqueness, diversity and depth of SAEM members with a series of print ads, web content, social media posts, and video clips highlighting distinctive and noteworthy facets of SAEM members and how these activities help them relieve stress, and balance work and life.

#### **Down the Road in 2017...**

SAEM members can look forward to webinars and a searchable, online library featuring lots of new content to further career development and academic success of both educators and researchers in our field. Stay tuned!

It's a New Year and New SAEM and we couldn't be more excited to share it with you! To take advantage of all of these new features, please make sure your member profile is up-to-date. On behalf of everyone at the Society for Academic Emergency Medicine we thank you for your ongoing commitment to SAEM and wish you and yours a Happy New Year and the very best for 2017! ▶

## RESEARCH COMMITTEE: NEWS YOU CAN USE



### National Institute of Health Loan Repayment Program

By *Justin N Carlson, MD, MS*

For early-career investigators, there are several challenges to establishing a successful research career, including balancing the demands of clinical and research requirements while working to pay off medical school and undergraduate loans. In 2015, the median student loan debt was \$183,000 with 12% of graduates having over \$300,000 in student loans.<sup>1</sup> The financial pressures of such loans may

drive talented young clinician-scientists away from research and towards more lucrative careers, especially given the potential for delay in income incurred by training programs such as research fellowships.<sup>2</sup>

There are, however, programs that help to financially support talented, early career investigators by assisting with student loan debt; most notably, the [National Institutes of Health Loan Repayment Programs](#) (LRPs). These are a set of programs that are 'designed to recruit and retain highly qualified health professionals into biomedical or biobehavioral research careers.'<sup>3</sup> For those not employed directly by the NIH, there are five main areas of interest for the LRPs; Clinical Research, Pediatric Research, Health Disparities Research, Contraception and Infertility Research, and Clinical Research for Individuals from Disadvantaged Backgrounds.

The LRPs provide up to \$35,000 annually towards qualified educational debt, awarded in two-year periods. These awards do not provide direct salary support, financial support for the research, or indirect funds for the researcher's university or hospital. To apply, researchers do not need to have current or previous NIH funding, but do need to have a track record that indicates that they will be able to build and sustain a career in research. The annual deadline for applying is December 1. While the specifics are reported in detail on the [website](#) typically, the application consists of a six-page project summary, personal statement, biosketch, and letters of support from research faculty.

Emergency medicine is typically under-represented compared to other specialties, however those involved in acute care research receive funding at rates higher than many other specialties.<sup>4</sup> As the average time from residency graduation to independent NIH funding (e.g. R01) is roughly 10 years for emergency researchers, other programs designed for junior researcher are essential to bridge this gap.<sup>5</sup> The NIH LRP provides an excellent opportunity to help support early-career clinician-scientists through student loan debt relief as they build their careers. ▶

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*About the author: Dr. Carlson is the Director of Resident Research at Saint Vincent Hospital, vice chair of the Institutional Review Board for the Allegheny Health Network, and a current awardee of the NIH. He is also a member of the [SAEM Research Committee](#).*

# DIVERSITY AND INCLUSION

## The Need for a Research Agenda Promoting Diversity and Inclusion

By Dowin Boatright, MD, MBA

There were fewer black men in medical school in 2014 than there were in 1978.<sup>1</sup> Despite recommendations from multiple medical bodies (including the National Academy of Medicine and Association of American Medical Colleges) to increase the diversity of the physician workforce, Black, Hispanic, and Native American physicians remain underrepresented in medicine. As a specialty that treats an increasingly diverse population, emergency medicine (EM) has not been immune to these struggles pertaining to workforce diversity.

Since 2006, the proportion of underrepresented minorities (URMs) in EM training programs has stagnated at approximately 10 percent.<sup>2,3</sup> While many leaders in EM have recognized the need to increase the racial and ethnic diversity of the field, many training programs lack awareness or knowledge of strategies shown to make their programs more attractive to URMs. Consequently, there is a growing need for a research agenda focused on elucidating evidence-based guidelines and best practices designed to increase the recruitment and retention of URMs in EM.

In 2016, researchers published an innovation report in academic medicine describing the diversity recruitment efforts at the Denver Health Residency.<sup>4</sup> In this article, the study authors described a program with three principal strategies: 1) a scholarship based externship for fourth year URM medical students; 2) a funded second look event for exceptional URM residency applicants; and 3) increased involvement of URM faculty in the residency interview and recruitment process.

After the initial year of the intervention, the Denver Health program experienced nearly a three-fold increase in the number of interviews for URMs and matched an intern class comprising approximately 23% URMs compared to 5% in the prior year.<sup>4</sup> This work is promising. Moving forward, additional

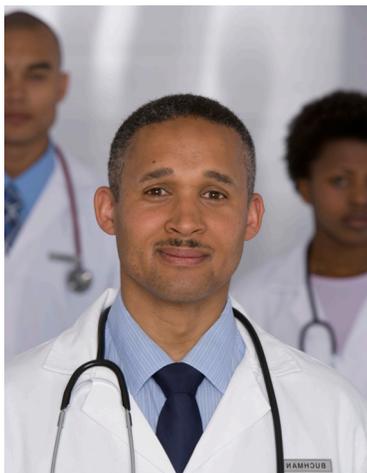
"Research addressing the experience of discrimination, both overt and implicit, among URM residents in EM is needed. Furthermore, curricular elements must be developed to educate EM residents and faculty on how to respond when instances of discrimination are experienced personally or witnessed."

research from Denver Health showing sustained levels of diversity could provide a model for other EM training programs looking to augment the diversity of their classes.

In addition to recruitment, additional research should focus on the training climate for all residents, with particular attention paid to the climate for URMs. Research at the level of undergraduate medical education has shown that URMs are more likely to experience instances of discrimination.<sup>5</sup> These experiences compounded over four years could lead to higher rates of depression and withdrawal from medical school for non-academic reasons among URMs when compared to their white counterparts. Research addressing the experience of discrimination, both overt and



*"Since 2006, the proportion of underrepresented minorities (URMs) in EM training programs has stagnated at approximately 10 percent."*



implicit, among URM residents in EM is needed. Furthermore, curricular elements must be developed to educate EM residents and faculty on how to respond when instances of discrimination are experienced personally or witnessed.

Finally, more data is needed concerning the retention of URMs in academic EM. It is estimated that only 10% of academic EM faculty members are URMs.<sup>6</sup> URM faculty members play an integral role for the recruitment of URM residents and medical students. Prior work by the author has shown that EM residency programs with high faculty diversity (defined by the proportion of URM faculty) are five times more likely to also have high levels of diversity among residents.<sup>7</sup> Residents choose to pursue a career in academics for a variety of reasons. Qualitative research exploring factors associated with URMs pursuing a career in academic medicine could prove valuable for the development of interventions to recruit a diverse workforce in EM.

Integral to improved diversity and inclusion will be a research agenda offering academic medical centers evidence-based best practices focusing on the recruitment of URM residents, assessing and improving the educational climate of EM training programs for URMs, and ultimately retaining URM residents as EM academic faculty. ▶

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*About the author: Dowin Boatright, MD, MBA, is a Fellow in the Robert Wood Johnson Foundation Clinical Scholars Program and clinical instructor in the Department of Emergency Medicine at Yale School of Medicine.*

# Academic EM and the AAMC: What you Should Know



**By Michael Brown, MD, MSc**

[The Association of American Medical Colleges \(AAMC\)](#) is a not-for-profit organization established in 1876 by 22 medical school deans. Today, the AAMC represents all LCME accredited medical schools in the US and Canada, approximately 400 major teaching hospital and health system members, and over 75 academic and scientific societies.

Headquartered in Washington DC, the association provides a unified voice to congress and legislative bodies on critical issues facing academic medicine such as the increasing burden of student loan debt, the need to increase diversity among our professional workforce, and the essential role NIH funding plays in advancing health. AAMC educational programs encourage exploration of cutting edge approaches to medical education and the development of skills essential for leading academic healthcare into the future.

The AAMC provides essential services to the medical education community, many of which are familiar (ie, MCAT, ERAS, and VSAS) and others that are likely new to SAEM members (e.g., Convey—an electronic conflict of interest reporting system). Staff at the AAMC work

closely with other organizations such as the NRMP to address critical issues such as the recent escalation in applicant volume that has overwhelmed program directors and burdened medical students with the costs associated with interview travel. The most recent AAMC meeting in November covered a broad range of topics relevant to emergency medicine, ranging from innovations in medical education research to health policy issues impacting academic medical centers. The annual meeting also provides a unique opportunity to network with representatives from many other medical specialties.



"Today, The Association of American Medical Colleges (AAMC) represents all LCME accredited medical schools in the US and Canada, approximately 400 major teaching hospital and health system members, and over 75 academic and scientific societies."

As an academic society, SAEM has representation in AAMC governance by appointing two members to serve a three-year term on the [Council of Faculty and Academic Societies \(CFAS\)](#): the CFAS chair and chair-elect to serve at the highest level of the AAMC with seats on the board of directors. The Association of Academic Chairs of EM (AACEM) and Council of Residency Directors (CORD) are also society members of the AAMC. Another pathway for SAEM members to engage with the AAMC is to seek nomination within your medical school as a CFAS representative.

*About the author: Michael Brown, MD, MSc, is professor and chair, Department of Emergency Medicine, at Michigan State University College of Human Medicine, He is also CFAS representative, AACEM.*

## End of Life Care: When and How Should a Physician Intervene?

By Gerald Maloney, DO

End of life care is an evolving field in emergency medicine. Our success at managing chronic diseases has resulted in an increase in the number of patients surviving longer with these illnesses. This has the subsequent effect of a greater number of patients presenting to the emergency department in the terminal stages of disease. When the patient is young and healthy, end of life care due to an unexpected terminal condition, or catastrophic injury, presents with a problem not usually associated with an older patient: Due to the age and health of the young patient, his or her wishes regarding end of life care has never been discussed; consequently families are utterly unprepared to make important end-of-life decisions regarding a young loved one.

### Ethical Considerations

In some cases, when faced with the imminent loss of a young loved one, family members may inherently know and agree that their child “would never want to be kept alive artificially if there is no hope for recovery,” but all too often family members disagree on end of life care, or simply are at a loss as to what to do. Parents might understandably have a difficult time letting go of a child who was only hours before in perfect health. It is at this point—when the decision of whether to provide aggressive medical care is indicated—that the physician needs to intervene and help the family determine what is in the best interests of the patient. When a patient’s preference cannot be clearly and easily determined, the physician must make a judgment as to what care would be beneficial and what would be futile.

Futile care is defined as care which is not expected to provide any meaningful benefit to the patient, either in clinical improvement or quality of life. It is a very individualized and situational concept. There are some general instances in which care may be considered a priori that is likely to be futile, and in general it is a concept that must be applied patient by patient. While futility can be used as justification for not providing further treatment, or for not initiating alternative treatment (e.g. resuscitation or chemotherapy), futility

is only one consideration in the complex decision to withdraw existing life support. It is rarely, if ever, the sole consideration. In addition, futility is a factor in care beyond the heroics of resuscitation (e.g., the use of vasopressors, diagnostic testing, and surgical care); its application is more far-reaching than end-of-life care.

Hospital ethics committees can assist in making a determination about futility, but ultimately that remains the purview of the treating physician(s). Most hospitals have policies that address the determination of futile care, especially when the patient is incapacitated and the decision makers are not making decisions that are in keeping with patient’s best interests.

Once a determination is reached that further care would be futile, and if the patient is incapacitated, the matter must be discussed with the patient’s decision makers (family, friends, guardian, etc.). If the patient is competent, then the discussion must occur with the patient. There are no legal or ethical imperatives forcing a physician to provide futile care simply because a patient (or surrogate) demands it. Whether in dealing with the patient directly, or with his or her family/decision makers, it is difficult to convey that due to medical futility you will not be providing certain types of care. Unfortunately, because of this difficulty, coupled with the fear of legal action, many physicians feel compelled to provide care to an insistent patient. While there are no guarantees that an angry patient or family member will not seek legal action, an empathetic, reasoned discussion is usually persuasive and does much to defuse a potentially confrontational situation. In the case of the patient in this scenario, the patient cannot make decisions, but a detailed explanation of his condition, as well as time allowed for the family to spend with him and come to an acceptance of his terminal prognosis, may help bring them around to the idea of withdrawing life support.

Regarding the statement by the trauma surgeon of “Don’t try too hard,” there is the reminder that care must be delivered



*THE CASE: It's the middle of a busy shift and a 25-year-old male patient is brought in by EMS with a transcranial gunshot wound.*

*He is tachycardic, hypertensive, and has a GCS of 3T without sedation. His family arrives, understandably distraught, and the ED and trauma attendings meet with them.*

*The nonsurvivable nature of the injury is discussed in detail, and both physicians recommend withdrawal of life support and plan to have the local organ donation agency talk with the family. The family declines to have life support withdrawn, preferring to let their son “die when it's his time and not hurry things.” The trauma service asks you and your attending to hold the patient in the ED and “not try too hard” to resuscitate him. You are unclear about the plan: Is the patient a full code?*

*If his wound is unsurvivable, why are we contemplating resuscitation? Can the family make this decision even if it is clinically obvious that aggressive care is futile?*



"In some cases, when faced with the imminent loss of a young loved one, family members may inherently know and agree that their child "would never want to be kept alive artificially if there was no hope for recovery," but all too often family members disagree on end of life care, or simply are at a loss as to what to do."

earnestly; that is to say, there should be no "slow codes." If the care is determined to be futile and resuscitation is not medically appropriate, that should be determined in advance if possible, and if the physician feels that he or she does not wish to override the wishes of the family/decision-makers in regards to withdrawing futile care, then the physician is obligated to provide resuscitation as he or she would to any other patient. As education in end of life care has grown more pervasive, "slow codes" are becoming much less common. Performing inadequate resuscitation as a way of avoiding a more difficult discussion about medical futility is not in the best interests of the patient nor is it professionally ethical.

**To sum:** In this ethics case, the family was allowed to spend time with the patient and had their pastor visit as well, after which they agreed to the withdrawal of life support, upon which the patient expired rapidly. The family members were grateful for the care provided and the opportunity to come to some degree of peace with the tragic injury before the patient passed away. ▀

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## SGEM: DID YOU KNOW?



### Are Men And Women Wired The Same For Acute Stress?

**By Jeannette Wolfe, MD**

Physiological stress is often triggered when an individual is exposed to something novel, unpredictable or uncontrollable—aka our last shift. A recent study by Seo et al., questions whether men and women respond similarly to this acute stress. Researchers used functional MRI scans to examine 55 men and 41 women who reported similar ratings of acute stress after they were exposed to a validated stress-inducing task. They found that under stress, men were more likely to light up areas of their brain associated with motor processing and action (caudate, midbrain, anterior cingulate gyrus and thalamus) while women utilized more areas associated with emotional experience, verbal expression, and visual processing (insula, the right temporal gyrus, and occipital lobe). Interestingly, they also found that men and women had opposite responses to stress in certain areas of the brain including the medial prefrontal cortex and inferior parietal lobe, areas intrinsically involved with executive functioning, such that stress dampened the signaling in men and amplified it in women. Ultimately their work suggests that our internal experience of acute stress is biologically sex dependent and this may have important implications for stress management as well as treatment of stress-induced anxiety disorders. For example, mindful meditation is known to tone down prefrontal firing and decrease rumination while cognitive behavioral therapy is associated with increased prefrontal firing and inhibiting potentially undesirable impulsive actions. While this research is still in its infancy, its impact on understanding sex-based differences in physiological stress response is an important first step to helping us better understand ourselves and our patients. ▀

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*SGEM "Did You Know" is a recurring SAEM "is a recurring SAEM Pulse submission designed to present concise facts that demonstrate how patient sex and gender effect emergency care. Submissions to this column are welcome. Please send contributions to coeditors Laruen Walter and Alyson J. McGregor at [sgem@lifespan.org](mailto:sgem@lifespan.org). SAEM Members who are interested in adding the Sex and Gender in Emergency Medicine Interest Group (SGEM IG) to their membership may do so by simply logging in to your profile and joining today. SAEM Members who are already part of the SGEM IG can find more information and resources by visiting the [SGEM IG Community Site](#).*



*"Intubation is the Holy Grail of procedures for most fledgling EM physicians."*

## A Learner's Perspective on Intubation

**By Sharon Atencio, MS-IV**

Do you remember your first intubation? Can you possibly even recall it more clearly than your first kiss, your wedding, or your medical school graduation? Intubation is the Holy Grail of procedures for most fledgling EM physicians. Let's be honest: It's sexy, it's exciting, and ultimately, it's a life-saving intervention we can accomplish with our own two hands, and isn't that part of why we were attracted to emergency medicine in the first place?

Learning how to intubate can be daunting. As a fourth year medical student, I've read up on the procedure, studied plenty of YouTube videos, and observed dozens happening in front of me—handled by interns through senior attendings, from relatively simple, low-stress tubes to multiple-attempt knuckle-clenchers performed on crashing patients, with an airway full of blood, cric tray open and ready. I've gone through the physical motions many times, my left forearm trembling from trying to apply enough force directly away from my body to coax open a mannequin's mouth and visualize those elusive, plastic vocal cords (Don't crank on it! Don't break the teeth!). I'll admit that I've always found intubation labs frustrating, because I've consistently struggled with physically manipulating the mannequin enough to complete the task. Yes, I'm a woman and I lack Popeye forearms, but I can knock out 20 burpees with a lot less angst than trying to cram that Mac blade into the right position on a dummy's airway. I've felt very discouraged at times, worried that I'd never get it right when it came time to intubate a real patient.

I did my first sub-internship at John Peter Smith Hospital in July, one of a handful of MS-IVs showing up alongside a new class of interns, all of us eager and ready to learn. Only a few days later, we were trained in airway management in a way that made a profound difference for many of us. JPS is one of a handful of residency programs that provides the Difficult Airway Course for first-year residents, and I was lucky enough to be invited to participate though I was only a rotating student.

Several big names are instantly

recognizable in airway management: Rich Levitan, Reuben Strayer, Ron Walls. The Difficult Airway Course is the Walls curriculum, which can be tailored to different audiences from EMS to various specialties including anesthesia and critical care. We participated in the Residency iteration, a one-day class attended by JPS interns in emergency medicine, family medicine, and surgery.

We showed up in scrubs, each of us ready to take a step forward in our airway skills regardless of our current expertise, mine being zero. Dr. Seth Krupp of Henry Ford Hospital led our opening talks, which emphasized the fundamentals and overall strategies of airway management. We walked through various algorithms, with the disclaimer that much like ACLS, the algorithms are not the end-all in management but rather a tool to guide your thinking and prompt you to the next step, rather than repeating interventions that haven't worked. This big-picture discussion improved my understanding of what to do, when, and why by a hundredfold. We walked through several scenarios (trauma, peds, head injury, shortness of breath with impending respiratory failure), discussing indications for placing an advanced airway, which medications would be most appropriate, and selection of a backup plan should initial attempts fail.

Happily for those of us who struggle to focus through a full day of lectures, this was the end of the traditional classroom format and the rest of the day was hands-on. We moved through various stations and activities intended to familiarize us with all the tools of the trade. I was given the chance to practice traditional direct laryngoscopy, and now with a high-quality mannequin, coaching from a great instructor, and enough time to make multiple attempts, I finally began to catch on. Muscle memory began to kick in. For the first time, I thought to myself I'm getting the hang of this.

We practiced with Macs and Millers and various sizes of blades and tubes; I personally gained a lot of insight from working on the sagittal model, in which you could see where the blade met the vallecula. Next



were the fancy toys of video laryngoscopy: the C-MAC for direct visualization and the Glidescope for indirect. Getting to practice with both of these back-to-back helped clarify the differences between them. Another concept I left with is that the humble bougie—that cheap-looking, awkward piece of plastic—will be my best friend someday. It's earned a permanent spot in the valuable real estate of my scrub pockets.

As the afternoon progressed, we broke into even smaller groups to participate in simulation cases, each with a mannequin and all the tools you might need. An attending ran each station, and we were presented with challenges that included an unanticipated failed airway and a trauma case involving a pregnant patient needing intubation. When it was my turn to be team leader, my scenario was run by an animated young woman who led us through a case with a baby unable to breathe. (I later learned that our attending was JPS's Program Director, Jo Anna Leuck, whom I hadn't yet met; I probably would have been a bit nervous if I'd known who she was!) Pros: I think I handled the scenario reasonably well and didn't long to figure out that the baby's airway was blocked by a foreign body. Cons: When I picked up the tonsil forceps to attempt to remove the foreign body, I held them upside down until a kind resident corrected me. Whoops. But this is why we practice!

Just when I was thinking that our day couldn't get any better, we moved to our final station: performing crics on pig tracheas. I'm not sure my non-medical friends completely understood my enthusiasm when I explained this facet of the course, but I know that you, my cohorts in emergency medicine, completely get it.

Speaking for myself as a novice, this day made a profound difference in my confidence level when approaching a challenging and potentially intimidating procedure. Getting to use all the different equipment multiple times was incredibly helpful. Perhaps most importantly, I left with a vastly improved high-level view of airway management and the logic required to select plans A, B, and C when preparing for each intubation.

I'm very grateful to the powers that be at JPS for allowing me to attend this course, as well as Dr. Krupp and the rest of the excellent attending physicians who educated us. Thank you—you've made a difference! ▶



*About the author: Sharon Atencio is a fourth year medical student at Rocky Vista University College of Osteopathic Medicine, Parker, CO. She is expected to receive her Doctor of Osteopathic Medicine in May 2017.*



# Clarifying the CLER: Clinical Learning Environment Review

By David K. Barnes, MD, FACEP

## The Old System

Historically, training programs and institutions were evaluated by in-person site visits. A “Letter of Notification” from the ACGME officially announced the visit, and included information such as program status, accreditation cycle length, and any previous citations. It was critical for a program and the sponsoring institution to correct any prior deficiencies and ensure that similar issues would not emerge at the next site visit. Preparation for site visits depended largely on creation of the Program Information Form (PIF) for programs and the Institutional Review Document (IRD) for sponsoring institutions, both generally taking about a year to complete. A five-year accreditation cycle and a site visit resulting in no citations were considered signs of success.

Assembling the PIF and IRD, both large documents, tested the organizational skills of program directors, house staff coordinators, and graduate medical education (GME) staff. It was critical to ensure the accuracy of both and to provide sufficient documentation to support the statements made in those documents. Missing paperwork or poor organization would spell certain disaster in the form of a citation.

The tone of the site visit was dependent on the site visitor, a field representative (program) or team of visitors (institution) from the ACGME. Their meeting with residents and fellows was critical to the success of the site visit. Most importantly, it was essential that trainees corroborated information listed in the PIF and IRD. Trainee feedback about the program and sponsoring institution was given privately to the site visitor(s) and via a confidential survey. A report to the program or institution addressing new, ongoing, or resolved citations, as well as news about accreditation status, followed a few months later.

## The New System

The ACGME introduced the Next Accreditation System (NAS) in 2012 with two major goals: decrease the accreditation burden on programs and sponsoring institutions, and link the accreditation process to educational outcomes. NAS is comprised of: Accreditation Data System; the Clinical Learning Environment Review (CLER); ACGME Resident, Fellow and Faculty Surveys; Case Log and Procedure Data; Program and Institutional Self-Study; and the Program and Institutional Site Visit.<sup>2</sup>

The CLER is one component of NAS and supplements the institutional site visit. CLER was designed to “encourage clinical sites to improve engagement of residents and fellow physicians and learning to provide safe, high-quality patient care.” The CLER framework is comprised of six focus areas: patient safety; healthcare quality (including healthcare disparities); care transitions; supervision; fatigue management, mitigation and duty hours; and professionalism. The focus areas—functionally, institutional core competencies—are subdivided into a series of pathways. Each pathway is further divided into key properties of the clinical learning environment, inclusive of the entire clinical training spectrum—from resident, to fellow, and faculty member. There are a total of 6 focus areas, 34 pathways, and 89 properties in the CLER program.<sup>3</sup>

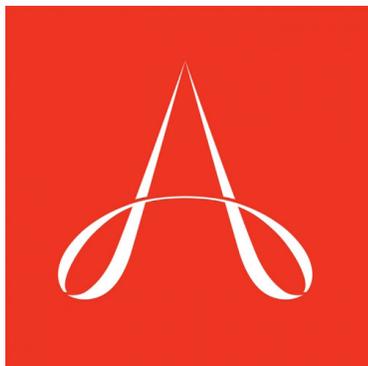
**Patient safety.** Trainees and faculty must recognize a patient safety event or near miss and have the knowledge and ability to report the event, preferably through a centralized reporting system. Programs and sponsoring institutions must be able to communicate important educational findings and implement improvement plans to minimize future patient safety events. Faculty members must also be competent to apply principles of patient safety, risk identification, and harm reduction in order to educate their trainees.

**Healthcare quality.** Residents and fellows must not only learn about quality improvement principles through didactic presentations, but also through experiential learning and integration into quality improvement programs. Trainees must be aware of institutional quality improvement priorities, possess the knowledge and skills to evaluate their own processes of patient care, and critically appraise their own patient outcomes. Healthcare quality competency also includes attention to healthcare disparities: trainees must learn how to recognize disparities in healthcare delivery and be respectful and cognizant of variability in healthcare belief systems in different cultures. The clinical learning environment is strategically poised to help trainees address healthcare disparities that exist in low-income populations and in communities of individuals from different backgrounds (e.g. gender, race, ethnicity, sexual orientation).

**Care transitions.** A safe and effective process of care transition, or patient handoff,

*The Accreditation Council for Graduate Medical Education (ACGME) was established in 1981 with the purpose of adding necessary oversight and structure to the training environment and decreasing the variability in the quality of graduate medical education programs.<sup>1</sup> In addition to residency and fellowship program accreditation, sponsoring institutions—also called clinical learning environments—are evaluated and accredited across a number of standards.*

*“Healthcare delivery in the 21st century is complex and largely interprofessional, and it is no longer sufficient for trainees to just show up and take care of patients.”*



is a vital component of quality healthcare. The clinical learning environment must work with residency and fellowship programs to standardize essential components of care transitions while remaining flexible to accommodate local practice variation (e.g. OR, medical surgical floor, dialysis unit). Effective handoff strategies are supervised and evaluated by faculty members, and include both written and verbal content, provider access to clinical information (i.e. electronic health record), and an opportunity to ask questions and clarify goals of care.

**Supervision.** Programs and clinical learning environments must ensure appropriate graduated supervision of trainees. However, the optimal supervision balance—avoidance of both over- and under-supervision—is an elusive target. Trainees who are over-supervised are more likely to enter practice unprepared, lacking confidence to practice alone. Alternatively, trainees who are inadequately supervised may jeopardize patient safety as they may lack competence to care for patients safely early in their training. Residency and fellowship programs must work closely with the sponsoring institution to optimize faculty supervision to ensure both patient safety and professional growth of its trainees.

**Fatigue management, fatigue mitigation, and duty hours.** The first iteration of standards for duty hours went into effect in 2004. The ideal shift length, duty period, and rest period is unknown. Recent evidence suggests that longer duty hours beyond the currently permissible maximum sixteen hours for PGY-1 trainees does not lead to worse patient care outcomes and may improve the educational experience. It is clear that residents and fellows who are fatigued risk committing medical errors and compromising patient safety. Moreover, trainees also jeopardize their own health and safety when they are too tired to get home safely or are chronically fatigued.

**Professionalism.** The final focus area addresses behavior unbecoming of physicians, staff and educators: actions that are disruptive or disrespectful, behavior that violates the trust of trainees and the reputation of the medical profession, and overt mistreatment and abuse of residents and fellows. Clinical learning environments should be safe places in which to learn. The sponsoring institution has the responsibility to educate its trainees about professional behavior expected from them and their peers, and also to ensure that its faculty and staff treat residents and fellows with the respect to which they are entitled.<sup>3-5</sup>

## What to Expect

CLER is a 2-day, in-person site visit by a team comprised of three ACGME field surveyors with expertise in GME and institutional review. CLER site visits are short-notice visits: the institution's Designated Institutional Official (DIO) is contacted at least 10 days in advance to ensure they and the CEO will be present for the opening and closing meetings. Institutions may provide five blackout dates in a four-month period. If a visit cannot be confirmed for another date within 24 hours of initial contact, the institution is allowed to pass up to three times without penalty. If the sponsoring institution fails to schedule and complete a CLER site visit within their window, it may be placed on administrative probation for no less than 24 months and no more than 36 months.

During a CLER visit, surveyors meet with five distinct groups from the clinical learning environment: residents and fellows, core faculty members, training program directors, nursing staff, and executive leadership, including the DIO, chief executive, medical and nursing officers, and patient safety and quality officers. The CLER team observes clinical operations and evaluates all aspects of the clinical learning environment such as care transitions, rounds, and patient care activities. The team meets with focus groups of residents and fellows, program directors, and core faculty, all identified by the sponsoring institution before the visit. Several aspects of the learning environment are explored—with particular attention to the six focus areas—using a series of questions and scenarios administered using an anonymous audience response system. Surveyors ask scripted and extemporaneous questions to get a feel for the culture and educational environment of the sponsoring institution.

Institutional leaders can expect the CLER visit to require a substantial investment of time and resources from staff, clinicians, and trainees. Similar to other accreditation agency surveys (e.g. The Joint Commission), staff must commit to being present for focus groups, huddles, tours, and all scheduled meetings with the site visitors.

## The CLER Report

Unlike the old structure, where citations could be found unexpectedly in the site visit report, the CLER team debriefs with the institution's senior leadership at the end of the review session. The CLER Evaluation Committee issues a formal report to the sponsoring institution several weeks after the visit summarizing their findings and offering formative recommendations to the institution. The CLER report does not

result in formal citations for programs or the institution. Rather, it serves only to promote institutional improvement and advocate for best practices across the focus areas.<sup>3</sup>

Healthcare delivery in the 21st century is complex and largely interprofessional, and it is no longer sufficient for trainees to just show up and take care of patients. The framework for the CLER report emphasizes the roles that all stakeholders—nurses, trainees, faculty, and executive leadership—play in the new model of healthcare education and delivery, one in which patient safety, patient-centeredness, and healthcare quality are paramount.

## Future Directions

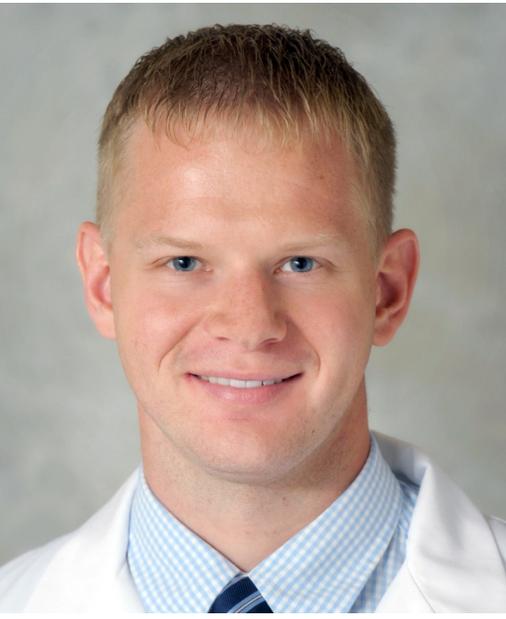
The ACGME recently released its first report of aggregated national CLER visit data that provides performance benchmarks for institutions and individual specialty training programs.<sup>6</sup> Ideally, sponsoring institutions will use this data to engage, educate, and support their training programs' residents and fellows in an optimal learning environment that addresses each of the six focus areas, emphasizing the competencies that will ensure a "well-performing, efficient, and cost-effective health care system."<sup>2</sup> While there is currently no punitive effect or formal citation resulting from a CLER visit, there remains the possibility that institutions may be sanctioned in the future for failing to meet expected standards.<sup>7</sup> ▶

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## Clinical Decision Tools for the Emergency Department Physician

By Zac Wilson, MD

Any physician who has spent time in the emergency department recognizes the challenge of quickly making decisive and informed clinical decisions regarding a multitude of patients about whom very little background is known. The lack of longitudinal relationships renders the job all the more challenging as we have no context in which to place their complaints. Even unintentionally, many of us fall victim to the trap of type 1 thinking in which we use subconscious stereotypes to guide decision-making. As we have seen time and again, this type of thinking leads to mistakes and misses. Unfortunately, mistakes and misses in the emergency department often have repercussions which can be dangerous or even fatal for our patients. Many emergency department physicians are aware of this trap and attempt to counteract it by becoming overly conservative in our clinical practice. We have been accused by our inpatient and consultant colleagues of over testing, over treating, and over admitting. I grudgingly admit there may be some truth to these claims. Overdoing, however, also poses dangers to our patients and places undue stress on the medical system. In the emergency department, where stakes are high, this pathway can be especially tempting.

There is a response to these two opposing dangers that help guide decision-making down the narrow path between doing too little and doing too much. Clinical decision tools exist which help to make decisions more objective, thus removing the temptation for bias. In the emergency department there are commonly used clinical decision tools that are implemented frequently and effectively. The specificities of the PERC rule, for example, can easily be recited by any emergency department intern in evaluating the need for a d-dimer in a patient deemed to have low risk for a pulmonary embolism. There are other less commonly used clinical decision rules, however, with potential for great benefit that are currently underutilized in many emergency departments. While these decision tools should not replace

experience and gestalt, they should be part of the decision-making process to streamline thinking, avoid bias, and prevent the dangers and expense that result with emergency department physicians too often.

### Trauma: The ABC Rule

The ABC rule for massive transfusion in trauma patients is one such clinical decision rule that has the potential to play a crucial role in emergency department decision-making. In trauma, where mortality occurs early, it is especially important to quickly identify those who would benefit from massive transfusion of blood products. The clinical decision tools previously used to identify this subgroup of trauma patients relied upon laboratory testing that delayed initiation of massive transfusion. The ABC rule requires four pieces of information, three of which can be obtained almost immediately. The protocol advises massive transfusion in any patient with two or more of the following: 1.) penetrating trauma, 2.) heart rate greater than 120, 3.) systolic blood pressure less than 90, or 4.) positive findings on FAST exam. The FAST exam is the only delaying criteria and in many trauma centers is performed within minutes of patient arrival. A retrospective cohort study of 596 patients found that using two or more criteria to initiate massive transfusion protocols was shown to have a sensitivity of 75% and specificity of 86% in identifying patients who required massive transfusion. Furthermore, it was not statistically different from the older, slower methods. The ABC massive transfusion rule can be used quickly and effectively in identifying trauma patients with massive transfusion needs.

### Community Acquired Pneumonia: CURB-65

Though community acquired pneumonia (CAP) is a common emergency department diagnosis, disposition decision-making for these patients can be challenging. Decompensation can occur rapidly and dramatically and so it is essential to identify those who are most at risk of having a bad outcome and therefore would benefit from

*“Overdoing poses dangers to our patients and places undue stress on the medical system. In the emergency department, where stakes are high, this pathway can be especially tempting”*



"In the high stakes environment of the emergency department it is of paramount importance to make decisions that are both experience-driven and evidence-based to protect both the patient and our medical system's finite resources."

in-hospital care. It is for this reason that many emergency department physicians err on the side of admission rather than discharge when there is even a modicum of doubt. There are multiple clinical decision rules that can aid in stratifying individual risk for CAP patients and help determine who most necessitates admission. CURB-65, a clinical decision rule that uses four easily measurable clinical features as well as age to assess risk of mortality, is one tool that can be used effectively in the emergency department. CURB-65 is validated by a study of 1068 patients with CAP at multiple institutions in both the UK and New Zealand. Data was collected both retrospectively and prospectively to assess for a primary outcome of death. The score is derived by assessing for confusion, urea greater than 7 mmol/l, respiratory rate greater than 30, blood pressure less than 90 systolic (or 60 diastolic), and age over 65. It was determined that patients with zero points on the curb-65 point scale had a 1.2% chance of mortality and therefore were less likely to require admission. Those with one or two points on this scale had an 8.15% chance of mortality and so are more appropriate for admission. A score of three and greater carries a mortality risk of 31% and so admission to an intensive care unit might be considered. There are other clinical decision tools which are also used to assess for severity of community acquired pneumonia such as PSI/PORT score. This scoring system, however, is more complicated using 20 variables for assessment and thereby making it less convenient in the emergency department setting.

#### **Atrial Fibrillation: The CHA2DS2-VASc Score**

Atrial fibrillation (afib) is one of the most common dysrhythmias identified on the emergency department ECG. While some of these patients have an established diagnosis of afib and are on anticoagulation prior to presentation, there are others for whom this is a new diagnosis. In large academic institutions there are often cardiologists on-site who are available to help guide in the management and discharge plans for these patients. In

many emergency departments however, it is left to the discretion of the emergency department physician to decide appropriate disposition and anticoagulation for these patients. The CHA2DS2-VASc score can be a useful guide in this determination. This scoring system was best validated in a study including over 180,000 patients with nonvalvular afib of which 90,000 were not anticoagulated. At a score of one there is a 0.9% chance of developing ischemic stroke, TIA or systemic embolism within one year. This number increases to 2.6% at a score of two, which is considered intermediate risk and so anticoagulation might be considered. While the decision to anticoagulate must be weighed against the risk of bleeding, the CHA2DS2-VASc scoring system is most useful in identifying those who likely do not require anticoagulation.

#### **Chest Pain: The HEART Score**

Chest pain is one of the most frustrating and challenging chief complaints seen in emergency departments, despite being one of the most common. This is because severe cardiopulmonary disease can have a similar presentation to less ominous disease processes such as reflux or anxiety. These patients confound us because imminent or ongoing cardiac disaster cannot always be easily and immediately identified. The challenge then becomes what to do with the emergency department chest pain patient when our diagnostic studies do not point us in a specific direction. The HEART score has been developed to help tease out which chest pain patient is at greater risk of developing significant cardiac events and therefore require admission for further workup and management. "Significant cardiac events" is defined here as acute myocardial infarction, percutaneous intervention, coronary artery bypass graft or death. In the retrospective multicenter study that validated this tool, 0.99% of the 303 patients who scored three or less using the HEART score progressed to have major cardiac event within six weeks. Of the 413 patients with

a score of 4-6, 11.6% progressed to have significant cardiac events within six weeks. The HEART score is controversial and has not been universally implemented as an emergency department scoring system because it is not used to identify those who are having active cardiac disease (such as NSTEMI) but instead identifies those who are most at risk of having specific outcomes. Furthermore, the scoring includes subjective features such as the degree to which the history is suspicious for active coronary disease and ECG interpretation which inevitably will vary by physician. Despite these limitations it seems that the outcome specific approach is appropriate for these patients as long as other dangerous cardiac pathology has been considered and ruled out. The HEART score therefore has the potential to significantly reduce emergency department admissions, thus freeing up resources and protecting patients from unnecessary testing and hospital stays.

In the high stakes environment of the emergency department it is of paramount importance to make decisions that are both experience-driven and evidence-based to protect both the patient and our medical system's finite resources. There is a litany of clinical decision rules that help remove subjectivity from medical decision making and provide real world numbers and statistics that can be used to help guide physician choices. By demonstrating adherence to current clinical evidence, and therefore standard of care, decision rules have the added benefit of protecting physicians who practice in an environment in which litigation is a real and looming danger. While some, like PERC, are ubiquitous in many emergency departments, others are less frequently used but can have great utility if implemented appropriately in the emergency department setting. I believe the clinical decision tools above improve the quality of decision-making while deterring over testing and over treating. All of the tools mentioned above can be accessed instantly on mdcalc which can generate scores in moments. Especially for new attendings and residents, clinical scoring tools can help close the gap of experience and focus decision-making away from the type I thinking that can result in mistakes and misses. ▀

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*About the Author: Zac Wilson, MD, is assistant professor and ED Medical Director, at UF Health Shands Emergency Center-Springhill.*

## FOAMed for the Newbie

By Catherine Parker, MD

With the rise of social media, podcasts, and blogs dedicated to emergency medicine, there is now an immense amount of freely distributed information available online. For those new to this nontraditional approach to education or FOAM (free open access meducation) all of this information can be a bit overwhelming. There are hundreds of blogs and podcasts delivering similar content, debates, and recent literature about emergency care. It is difficult to know where to begin. Googling "FOAMed for beginners" brings up 256,000 hits on Google alone. Fortunately, the FOAM community has recognized this information overload and, in response, has posted blogs, videos, and published papers to help navigate the FOAM world. In reading through these various publications three pieces of advice were continually reiterated:

### Start with what you are interested in.

A good place to start is [Life in the Fast Lane Weekly Review](#). Another exceptional resource is [FOAM EM RSS](#). This site aggregates all of the FOAM blogs on the internet and provides a platform which allows the user to browse through the current foam literature.

### Organize your information so that it is easily accessible.

There are several applications that allow for easy download, playing, and categorization of your favorite podcasts; these include: [Downcast](#), [Pocket Cast](#), [Overcast](#) and [Podcast Republic](#). These applications allow the user to store assorted podcasts and organize them into various folders. For websites and Blogs, the FOAM community recommends applications such as [Feedly](#), which allows the user to store all their favorite websites in one, central place.

### Get a Twitter account.

Twitter is where the conversations about emergency medicine and emergency care are happening and where controversial topics and recent literature is discussed. If you don't have a Twitter account, you're missing out. For example, some of the recent chatter on Twitter includes the currently disputed [PESIT trial](#) and the [IDSA's new guidelines](#) where HCAP is no longer included. Twitter is also a great place to connect with colleagues, share ideas, and hear about recent news in emergency medicine. ▶

*About the Author: Catherine D. Parker, MD, is chief resident, R3, in the Department of Emergency Medicine at the University of Missouri.*

*"Twitter is where the conversations about emergency medicine and emergency care are happening."*



## For Further Information...

- [R.E.B.E.L. EM—Got FOAM?](#) by Dr. Salim Rezaie, Creator and Founder
- [Getting started with Consuming FOAM](#) by Dr. Andy Neil
- [DR INFOLOVE: Or How I Learned To Stop Worrying And Love The FOAM](#) by Dr. Chris Nickson
- [Five Strategies to Effectively Use Online Resources in Emergency Medicine](#) by Thoma, Brent et al. *Annals of Emergency Medicine*, Volume 64, Issue 4, 392 - 395

# BRIEFS AND BULLET POINTS

## SAEM NEWS

### New Year, New SAEM

The start of 2017 begins with the launch of several new programs and initiatives for the Society for Academic Emergency Medicine. Please see Andra Blomkaln's President's Comments on page 3 of this issue of SAEM Pulse for a complete run down... and stay tuned to this space for ongoing updates. ▶

## SAEM17

### Annual meeting registration is now open!

#### Host a Satellite Symposium at SAEM17

Host a meeting, symposium, or other satellite event in the days before, during, or after SAEM17 for a unique opportunity to interact with the thousands of emergency medicine physicians and researchers from around the world who attend SAEM's annual meetings. For more information visit our [website](#) or contact [Holly Byrd-Duncan](#). The application to host one of these events is due by February 1, 2017. ▶

## SAEM PUBLICATIONS

### Academic Emergency Medicine (AEM)

#### Beginning in January: AEM Converting to Online-only

Effective in January 2017, Academic Emergency Medicine (AEM) will cease the supply of AEM print copies and convert to an online-only journal. A print on demand option on a per issue basis will remain available for any members who wish to receive a print copy of the journal from January 2017 going forward. The price is \$167 (equal to the price of a personal online-only subscription). In addition to having the obvious benefit of reducing AEM's carbon footprint and contributing to environmental sustainability, this transition will also allow us to enhance your member benefit through digital initiatives such as the [AEM journal app](#), enhancements to the user and author experience such as [Altmetric tracking](#), the enhanced online

[Anywhere Article format](#), and author-based initiatives such as [Kudos](#) and Wiley's [Author Promotional Toolkit](#). Wiley Online Library, the journal's content platform, is optimized to make the most of online content and the AEM journal will continue to be available online, undisrupted. In addition, mobile formats, through the [Anywhere Article](#), which will be available to members at no charge, as well as through institutional and personal subscriptions. Get all the FAQs about AEM's migration to an all-digital format [here!](#) ▶

### SAEM Pulse

#### Call for Editorial Advisory Task Force Members!

We are looking for a broad representation of SAEM members who are interested in an opportunity to help guide the direction of SAEM Pulse—the society's bimonthly member publication—and provide the editor with their insights, knowledge of topics, and suggestions of possible authors, articles, and interview subjects. If you are interested, please [email](#) us! ▶

## SAEM REGIONAL MEETINGS

### Southeastern

[Register now](#) for the Southeastern Regional Meeting, February 10-11, 2017, in Jacksonville, FL. Regional meetings provide opportunities, particularly for young investigators, to present their original research and to participate in sessions designed to teach them essential research skills. The Southeastern Regional Meeting is accepting abstracts until January 13, 2017. Send your submissions to [southeasternregion@saem.org](mailto:southeasternregion@saem.org). Questions? Email [Jay Khadpe](mailto:Jay.Khadpe@saem.org), MD or [education@saem.org](mailto:education@saem.org)

### New England

[Registration opens](#) January 6 for the 21st Annual New England Regional Meeting, March 29, 2017, at the Hogan Campus Center at College of the Holy Cross in Worcester, Massachusetts. Regional meetings conducted in areas where there are multiple residency programs will provide access to a wide audience of young investigators and promote academic

## AEM Transition to Online Only: The FAQs

### How will I access Academic Emergency Medicine (AEM) starting in January 2017?

All AEM content will continue to be hosted on [Wiley Online Library](#) and SAEM members will continue to be able to access content by logging in at [saem.org](#) and accessing the journal via the trusted proxy server link.

### How can I keep up to date with the publication of new content?

The easiest way to keep up-to-date with the latest AEM content is to sign up to receive New Content Alerts via email. These alerts can be customized so you'll be notified on a monthly basis when the latest issue is available, or, if you want more frequent updates, you can be notified when the latest Accepted and Early View articles are published online. To sign up for the New Content Alert service, please visit [saemjournal.com](#) and click "Get New Content Alerts" under Journal Tools on the upper left of the page.

### Can I use my mobile devices to access content?

Yes. The online [Anywhere Article](#)-responsive HTML format adapts to any device—desktop, tablet, or mobile—to provide the optimal reading experience. Additionally, the AEM app is available in iOS by downloading via the Apple App store. SAEM members can sign in using their member login and password in order to gain access to content.

### Can I keep a print subscription?

Yes. Print-on-demand subscriptions will continue to be available for order at an additional cost from the [Sheridan Press](#).

### I see the latest issues posted online, but what are Early View and Accepted Articles?

Early View articles are the final published versions of articles that post online prior to their being compiled into an issue of the journal. Accepted Articles are the unedited final versions of authors' manuscripts that are posted upon acceptance. Accepted versions of articles are replaced with their Early View equivalent once full editing, typesetting, and proofing has been completed. Both versions are fully citable and discoverable on [PubMed](#).

## Save the Date: 2017 AEM Consensus Conference

The [2017 Academic Emergency Medicine \(AEM\) consensus conference](#), "Catalyzing System Change Through Healthcare Simulation: Systems, Competency, and Outcomes" will be held on May 16, 2017, at the Hyatt Regency Orlando, immediately preceding the SAEM Annual Meeting. The conference will focus on the measurable impact that simulation can have on healthcare systems. Through a rigorous consensus-building process, conference attendees will examine novel ways to leverage simulation as a mechanism to improve healthcare delivery and patient safety in emergency medicine. Specifically, sessions will focus on a) defining critical system-level outcomes and assessment approaches related to simulation-based interventions, and b) mechanisms to address dissemination and sustainability issues noted as major limitations to the implementation of simulation-based interventions, including exploring virtual reality-based simulation.

Session leaders will include medical education experts, patient safety organizations, emergency physicians, simulation-based research experts, systems engineers, human factors scientists, and implementation science researchers. There will be clinicians across various disciplines such as emergency medicine, anesthesia, critical care, pediatrics, and quality improvement. Finally, the conference will include national policy makers and other stakeholders with the expressed goal of developing a multidisciplinary, consensus-based, high-priority research agenda to optimize the impact of simulation-based interventions and explore novel ways simulation can be leveraged to improve healthcare systems.



exchange among residency programs and their faculty and residents. Questions?

Contact [Amy Michaluk](#), meeting coordinator or email [education@saem.org](mailto:education@saem.org)

## ACADEMIC CHAIRS

### Association of Academic Chairs of EM

#### Register Now for the AACEM/AAAEM Joint Retreat

Chairs and administrators... Register for the AACEM/AAAEM Joint Retreat, March 19-22, 2017, at Trump International Beach Resort in sunny Florida. The theme of this year's 2017 AACEM/AAAEM annual retreat is Innovation, March 19-22, 2017 at Trump International Beach Resort in sunny Florida. There will be more programming than in the past, but with plenty of time to relax, network and socialize. Register [online](#) or by faxing or emailing the [registration form](#). Registration ends Jan. 20, 2017.

## SAEM FOUNDATION

#### Shop at Amazon and Support EM Research and Education

The next time you shop online, start at [smile.amazon.com](http://smile.amazon.com), search for SAEM Foundation, select and pay for your purchase, and Amazon will donate 5% of your purchase price to emergency care research and education. ▶

#### Donate Your Honorarium and Save \$\$\$ During Tax Season

Award recipients and conference speakers who receive speaker fees or honoraria may donate their prizes to one or more of the designated funds of the SAEM Foundation. To find out how you can donate your honorarium, and potentially avoid the taxable income, please visit the [SAEM Foundation](#). ▶

#### Legacy Giving

The SAEM Foundation offers charitable giving opportunities to help you achieve your financial and estate planning goals. Please consider including the SAEM Foundation in your estate planning. For more information, please visit the [SAEM Legacy Society](#) or contact the SAEM office at 847-813-9823 or by [email](mailto:email). ▶

## IN OTHER NEWS

### Self-assessment Credits Covered by LLSA Activities

As part of the ABEM Maintenance of Certification CME requirement, diplomates were asked to attest that eight of their 25 annual CME credits were self-assessment credits. Because LLSA tests are self-assessment activities, the self-assessment credit requirement is automatically being met by physicians who have met their LLSA requirement. For this reason, as of August 30, 2016, ABEM no longer requires that diplomates attest to completing "self-assessment" CME credits. ▶

### First Combined Program in EM/ Anesthesiology

ABEM and the American Board of Anesthesiology approved the [Guidelines for Combined Training in Emergency Medicine and Anesthesiology](#) early in 2016. The first combined program in Emergency Medicine and Anesthesiology was recently approved for the Johns Hopkins Medical Institutions. Program Director Linda Regan, M.D., expects the first residents will begin training July 1, 2018. ▶

### EM Combined Training Programs Review

ABEM is currently collaborating with other medical specialty boards that sponsor combined training programs with ABEM to review the combined training program guidelines to reflect the most current ACGME program requirements of each specialty. The guidelines are reviewed and approved by the respective ABMS Member Boards, not by the ACGME. Once approved by each sponsoring Member Board, ABEM will review all EM combined training programs to ensure that the programs are compliant. This review will be conducted using an application form and process similar to the one combined programs submit for their original request for approval. ▶

## SUBMIT CONTENT

The SAEM Newsletter "Briefs and Bullet Points" section publishes academic appointments and announcements, calls and submissions, event and meeting dates, deadlines, and SAEM Academy, Committee, Interest Group, and Task Force news and information. Send all content (50 to 75 words each) to [newsletter@saem.org](mailto:newsletter@saem.org). The next content deadline is February 1, 2017 for the March/April 2017 issue.

# CALLS AND SUBMISSIONS

## Calls for Papers

### 2017 Academic Emergency Medicine Consensus Conference

**Catalyzing System Change Through Healthcare Simulation: Systems, Competency, and Outcomes**  
**May 16, 2017, Hyatt Regency Orlando**  
**Submission deadline: March 1, 2017**

Accepted manuscripts will present original, high-quality research in healthcare simulation, including performance assessment validation studies, evaluations of individual, team, and systems processes, comparative effectiveness studies of simulation versus other training modalities, and rigorous multicenter studies. Novel conceptual papers and systematic and thematic reviews that support the advancement of simulation will also be considered. (Note: It is important that theoretical and conceptual papers clearly reference the role of simulation in healthcare systems.)

All submissions will undergo peer review and publication cannot be guaranteed. Original research papers on this topic, if accepted, will be published together with the conference proceedings in the December 2017 issue of Academic Emergency Medicine. For queries, please contact the [Rosemarie Fernandez, MD](#) or [Robert Cloutier, MD](#), guest editors for the special issue. ▶

## Calls for Proposals

### 2019 Academic Emergency Medicine Consensus Conference

**May 14, 2019, The Mirage Casino-Hotel, Las Vegas**

**Submission deadline: April 30, 2017**

Proposals must advance a topic relevant to emergency medicine that is conducive to the development of a research agenda, and be spearheaded by thought leaders from within the specialty. Consensus conference goals are to heighten awareness related to the topic, discuss the current state of knowledge about the topic, identify knowledge gaps, propose needed research, and issue a call to action to allow future progress. Importantly, the consensus conference is not a "state of the art" session, but is intended primarily to create the research agenda that is needed to advance our knowledge of the topic area. Submit proposals to the consensus conference [review subcommittee](#). ▶

# ACADEMIC ANNOUNCEMENTS

## Brown University



*Adam Chodobski, PhD, Gregory D. Jay, MD-PhD, and Joanna Szmydynger-Chodobska, PhD, from the Department of Emergency Medicine at*

Brown University were awarded R21NS099605-01 \$429,330 for "Use of Multifunctional rhPRG4 Biologic for Treatment of TBI" from the National Institute of Neurological Disorders and Stroke. When administered peripherally in a rat model of TBI, rhPRG4 crosses the blood-brain barrier (BBB) in the injured brain parenchyma, but is absent from the uninjured parts of the brain. Preliminary data show that rhPRG4 dramatically decreases the post-traumatic production of pro-inflammatory mediators and matrix metalloproteinases, and reduces the influx of inflammatory cells into the injured brain parenchyma. rhPRG4 also has a unique ability to stabilize the BBB, whose function is affected by TBI. These observations suggest that the rhPRG4 biologic could limit the destruction of neural tissue observed in TBI and, consequently, improve neurological outcome after injury.

## Albany Medical College



*Andrew K. Chang, MD, MS, professor of emergency medicine, has recently accepted the Vincent P. Verdile, MD Chair of Emergency Medicine endowed*

position of Vice Chair for Research and Academic Affairs at Albany Medical College. In his new role, Dr. Chang will lead the research and scholarly efforts in the Department of Emergency Medicine at Albany Medical College. Dr. Chang received his undergraduate degree at Stanford University and his medical degree at the University of California, San Diego. He was part of the inaugural class

of emergency medicine residents at the Harvard Affiliated Emergency Medicine Residency Program. Dr. Chang then spent three years at University of California at Irvine and 13 years at Montefiore Medical Center in the Bronx, New York. During that time, Dr. Chang completed a two-year Masters in Clinical Research program at the Albert Einstein College of Medicine and is currently in a one year extension of a K23 award from the NIA focused on improving the treatment of older adults presenting to the ED with acute pain.

## University of Calgary



*Eddy Lang, MD, has been promoted to "full professor" in the Department of Emergency Medicine at the Cumming School of Medicine, University of*

Calgary where he is the Academic Department Head. Dr. Lang is also the Clinical Department Head for Emergency Medicine, Calgary Zone, Alberta Health Services and a senior researcher at Alberta Health Services. Dr. Lang co-chaired the 2007 Academic Emergency Medicine Consensus Conference on Knowledge Translation which remains an ongoing interest.

## University of North Carolina



*Samuel McLean, MD, is organizing PI of a \$21 million U grant recently awarded to UNC from NIMH. The goal of this work is to gain a deeper understanding of the*

mechanisms that give rise to post-traumatic stress-related disorders, and to develop prediction tools to identify those at high risk. McLean's other current R01s examine mechanisms mediating stress-related disorders after MVC and sexual assault. Junior faculty interested in potential collaboration should [email Dr. McLean](#).

I am a  
Surfboard Artisan

I am  
Chris Kabrhel

I am an  
Academic  
Emergency  
Physician

I AM  
SAEM  
Society for Academic Emergency Medicine  
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TEAMHealth

The "[I am SAEM](#)" campaign is sponsored by TEAMHealth and EmCare. The purpose of the "[I am SAEM](#)" campaign is to emphasize the importance of stress management, to improve provider well-being, and to promote academic emergency medicine as a career path. If you or someone you know has a unique or noteworthy outside interest or activity that helps you achieve work-life balance, please [share your story](#) with us!

## SAEM CLASSIFIEDS

### Emergency Department Medical Director Opportunity – John Peter Smith Hospital (JPS) – Ft. Worth, TX

Integrative Emergency Services is seeking a highly skilled executive physician with proven leadership ability for the Emergency Department at JPS in Ft. Worth, TX. The Medical Director's role will be to oversee the day-to-day operation of the Academic Emergency Department. Duties to also include quality improvement, patient satisfaction, productivity and participation in hospital committees.

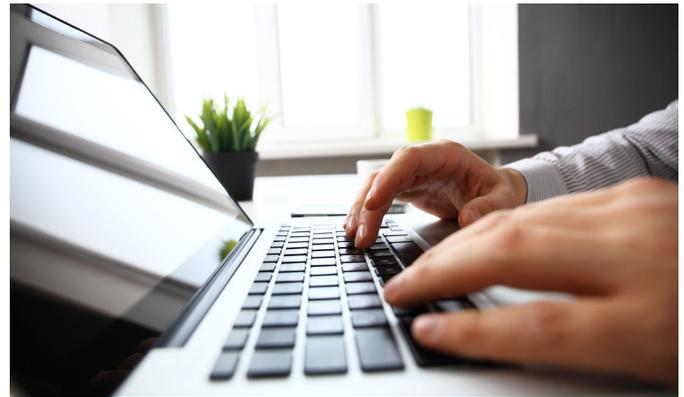
Requirements: Board Certified and Residency Trained in Emergency Medicine. Minimum of 2 years' experience as Director or Associate Director.

For additional information, please contact:

Jennifer Bullard

469-420-5503

[jbullard@ies.healthcare](mailto:jbullard@ies.healthcare)



## SUBMIT CONTENT

The SAEM Pulse “**Briefs and Bullet Points**” section publishes academic appointments and announcements, calls and submissions, event and meeting dates, deadlines, and SAEM Academy, Committee, Interest Group, and Task Force news and information. Send all content (50 to 75 words each) to [newsletter@saem.org](mailto:newsletter@saem.org). The next content deadline is February 1, 2017 for the March/April 2017 issue.

## ADVERTISE YOUR JOB OPENING!

SAEM has two opportunities available for the posting of fellowship and academic positions:

[SAEM Pulse](#) | [EM Job Link](#)



The University of Washington School of Medicine  
Division of Emergency Medicine



### SEEKING ASSISTANT OR ASSOCIATE RESIDENCY PROGRAM DIRECTOR

The University of Washington (UW) School of Medicine (SoM), Division of Emergency Medicine is seeking qualified applicants for the position of Assistant or Associate Program Director for the UW Emergency Medicine Residency. Successful applicants will be board certified in Emergency Medicine, highly motivated, academically focused, and have previous graduate or undergraduate medical education experience. This is an outstanding opportunity to join an already talented and vibrant residency leadership team in shaping and implementing the UW emergency medicine residency program. The UW SoM, Harborview Medical Center (HMC) and the University of Washington Medical Center (UWMC) offer excellent, wide ranging and unique opportunities for resident education. Additionally, there are exceptional and varied opportunities for academic growth for faculty, including collaboration with the UW Department of Biomedical Education and Medical Education (BIME), the Center for Leadership in Medical Education (CLIME), and the WWAMI Institute for Simulation in Healthcare (WISH). Full-time faculty may be recruited at the rank of Assistant, Associate or Full Professor commensurate with experience.

The Assistant/Associate PD will work at HMC Emergency Department, which is the only Level I Trauma Center for a 4-state region and sees approximately 66,000 patients per year, and the UWMC Emergency Department, which sees approximately 27,000 patients per year.

The UW SoM is a regional resource for WA, WY, AK, MT, and ID - the WWAMI states and is recognized for its excellence in clinical training, for its world-class research initiatives, and for its commitment to community service.

If you are interested in joining the leadership team for a world-class Emergency Medicine Residency program at the highly acclaimed UW SoM please send your CV to: Susan Stern, MD; Professor and Head, Division of Emergency Medicine; Harborview Medical Center; 325 9<sup>th</sup> Avenue; Box 359702; Seattle, WA 98104-2499 ([sstern@uw.edu](mailto:sstern@uw.edu)).

The UW is building a culturally diverse faculty and strongly encourages applications from women and minority candidates. The University is an Equal Opportunity/Affirmative Action employer.

## CRITICAL CARE & EMERGENCY MEDICINE PHYSICIAN OPPORTUNITY

Innovative practice model utilizing  
dual-training & experience

Provide expertise in Emergency Medicine &  
Critical Care at the award winning  
St. Joseph Mercy Health System, Ann Arbor

Serve as attending physician for the  
ICU & step down unit, and work  
clinically in the ED

### ST. JOSEPH MERCY ANN ARBOR & CHELSEA HOSPITALS

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- Level I Trauma Center

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# RUTGERS

Robert Wood Johnson  
Medical School

## Emergency Medicine Faculty

The Department of Emergency Medicine at Rutgers Robert Wood Johnson Medical School, one of the nation's leading comprehensive medical schools, is currently recruiting Emergency Physicians to join our growing academic faculty.

Robert Wood Johnson Medical School and its principal teaching affiliate, Robert Wood Johnson University Hospital, comprise New Jersey's premier academic medical center. A 580-bed, Level 1 Trauma Center and New Jersey's only Level 2 Pediatric Trauma Center, Robert Wood Johnson University Hospital has an annual ED census of greater than 90,000 visits.

The department has a well-established, three-year residency program and an Emergency Ultrasound fellowship. The department is seeking physicians who can contribute to our clinical, education and research missions.

Qualified candidates must be ABEM/ABOEM certified/eligible. Salary and benefits are competitive and commensurate with experience. For consideration, please send a letter of intent and a curriculum vitae to: **Robert Eisenstein, MD, Chair, Department of Emergency Medicine, Rutgers Robert Wood Johnson Medical School, 1 Robert Wood Johnson Place, MEB 104, New Brunswick, NJ 08901; Email: Robert.Eisenstein@rutgers.edu; Phone: 732-235-8717; Fax: 732-235-7379.**

*Rutgers, The State University of New Jersey, is an Affirmative Action/Equal Opportunity Employer, M/F/D/V*

# UNIVERSITY OF Nebraska Medical Center

The University of Nebraska Medical Center, Department of Emergency Medicine is recruiting an additional faculty member committed to developing an academic career.

With an accredited three-year emergency medicine residency program with 28 residents, this is a great opportunity to help shape the future of emergency medicine in this region. The Center for Clinical Excellence, which opened in November 2005, houses the Emergency Department and provides services for approximately 60,000 annual visits. Applications will be accepted online at <http://unmc.peopleadmin.com/postings/30839>. Individuals from diverse backgrounds are encouraged to apply.

## Associate Professor or Full Professor of Emergency Medicine, Tenure or Non-Tenure Track



**Perelman**  
School of Medicine  
UNIVERSITY of PENNSYLVANIA

The Department of Emergency Medicine at the **Perelman School of Medicine, University of Pennsylvania** seeks candidates for an Associate Professor or Full Professor position in either the non-tenure clinician-educator track or the tenure track. The successful applicant will be accomplished in the area of Emergency Medicine. Expertise in the specific area of critical care is required. Responsibilities include experience in the field of Emergency Medicine and a proven track record of emergency medicine based research. Applicants must have an M.D. degree and have demonstrated excellent qualifications in research, education, and clinical care. Board Certified in Emergency Medicine.

Ideal candidates are expected to have in place a foundational scientific vision for building a robust and competitive program to unearth new and fundamental research in the following areas: critical care, clinical research (particularly clinical trials), medical education, resuscitation, or rural-urban medicine partnerships.

*We seek candidates who embrace and reflect diversity in the broadest sense. The University of Pennsylvania is an EOE. Minorities/Women/Individuals with disabilities/Protected Veterans are encouraged to apply.*

Apply for this position online at:

[https://www.med.upenn.edu/apps/faculty\\_ad/index.php/g/d4439](https://www.med.upenn.edu/apps/faculty_ad/index.php/g/d4439)

Penn Medicine is comprised of 3 hospital emergency departments and observation units (Hospital of the University of Pennsylvania-HUP; Penn-Presbyterian Medical Center-PPMC; & Pennsylvania Hospital-PAH) with a combined annual emergency department census of 145,000 visits. Each site has a unique, diverse, highly acute patient population consisting of local and referral patients. Penn Medicine is a world class academic institution with superb clinical facilities and programs, one of the top medical institutions in the United States, and a rich and collegial research environment. The Department of Emergency Medicine has a 4 year, highly successful, academically oriented residency program with 44 residents, multiple fellowships including 1 of only 6 NIH funded K12 clinical research fellowships and several nationally acclaimed research programs housed within its Center for Resuscitation Science and the Center for Emergency Care Policy Research. There are over 90 faculty across the 3 sites and there are close academic affiliations and programmatic alliances with the Children's Hospital of Philadelphia and the Philadelphia Veterans Affairs Medical Center. Faculty positions will be structured across multiple sites according to skills, interest and clinical availability.

# SAEMATV

REGISTRATION NOW OPEN  
MAY 16-19 · HYATT REGENCY · ORLANDO

