SAEM PULSE
Society for Academic Emergency Medicine
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EDUCATOR SPOTLIGHT

Lead, Serve, *Inspire*

An interview with Sorabh Khandelwal, MD

Leading the advancement of emergency care through education and research, advocacy, and professional development in academic emergency medicine.

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PRESIDENT'S COMMENTS

Andra Blomkalns, MD

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

Apples, Oranges, and Persimmons

Last month, SAEM responded to the events pertaining to the Summa Health Emergency Medicine leadership change and, in particular, focused on its impact on the residency training program. I have since received a number of comments—many supportive and some not—regarding the specific phrase, "The recent, rapid growth of corporate medicine represents a potential threat to academic practices." While most of the comments have been in support of the SAEM statement, I have deeply reflected on the replies of those who felt differently.

I confess to have trained and worked in strictly university-based EM programs, so I queried graduates and clinicians of corporate residency programs in an effort to learn and understand the differences when compared to traditional, university-based programs. As one of the "not-exactly-a-fan" letters stated, "Corporate medicine is here to stay," and with that I agree. The same applies to academic medicine. Perhaps we can all educate ourselves, our colleagues, and our mentees of the differences in residency training in these two environments. The follow descriptions are meant to generally illustrate two of the differences as I understand them. I am sure you can think of many others. Certainly, permutations exist and most programs have their residents rotate at more than one clinical site. This simply serves to get the conversation going.

It seems that one of the principal differences between corporate- and university-based programs is in the basic philosophy of didactic education and the clinical environment. At a university-based program, learning activities may be from EM faculty, fellows, and EM residents as well as educators from other specialties. The treatment for epistaxis may be delivered by an ENT fellow. Splinting may be taught by orthopedics residents. Pulmonary embolism may be addressed by a visiting EM researcher in that field. EM fellows in subjects such as, but not limited to, research, education, ultrasound, or simulation might provide content expertise and focused education.

In a corporate-based program, these learning opportunities may be more likely to be provided by an experienced EM faculty member or a well prepared EM resident, capitalizing on valuable cumulative experience. The same themes extend to the clinical environment. University-based programs are often referral centers with many consulting services available. Corporate-based programs may have individual centers of excellence, and largely function independently without a backbone of resident coverage and availability for consultation. If we are truthful with ourselves, arguments can be made illustrating the benefits of one model over the other in various circumstances.

Another area of predicted disparity is exposure to scholarly activities. In a corporate-based program, a resident's scholarly activivity might tend to sway towards quality and performance, metrics, retrospective chart review, or protocol development. A university-based system may allow exposure to existing clinical trials, research resources for prospective studies, critical evaluation of the recent literature, and opportunities for publication in peer-reviewed journals.

What does the future bring? Corporate- and university-based programs will co-exist, recruit residents and faculty, and strive to train and mentor the future clinicians and academicians of our great specialty. Each model is responsible for its own value proposition and students evaluating programs should place emphasis on this appraisal as they do geography and family proximity. The decision to attend a university- or corporate-based program will fundamentally define that applicant's future career path. The models are not the same and do not result in the same emergency physician. The most honest thing we can do is educate ourselves and perhaps collectively draw from the strengths of each model to advance our specialty and its members in this unpredictably morphing health care environment.

"Corporate- and university-based programs will co-exist, recruit residents and faculty, and strive to train and mentor the future clinicians and academicians of our great specialty."

The above reflects the views of Andra Blomkalns alone, and not necessarily those of the SAEM organization.

EDUCATOR SPOTLIGHT

Lead, Serve, *Inspire*

As learners change, our skills as educators must change as well.

Sharon Atencio, chair of the SAEM Pulse Editorial Advisory Task Force talks with Sorabh Khandelwal, MD. Dr. Khandelwal is The Samuel J. Kiehl III MD Professor of Emergency Medicine and Program Director of the EM Residency Program at The Ohio State University (OSU) Wexner Medical Center. He is a proud member of Buckeye Nation, having completed his undergraduate and medical school studies at Ohio State. He completed an EM residency at MetroHealth Medical Center in Cleveland, Ohio and has been on faculty at Ohio State since 1998. Since arriving at OSU, he has served as Clerkship Director of the mandatory fourth year EM clerkship, directed a required third year clinical procedural course, and served as Assistant Dean of Clinical Sciences in the College of Medicine, where he helped develop Ohio State's "Lead. Serve. Inspire" medical school curriculum. Dr. Khandelwal also developed and introduced two new courses at Ohio State: Introduction to Medicine and the Physician Shadowing Course. In addition to his primary role as PD, he also serves as Director of the Patient Care Competency in the College of Medicine. He has received the EM Teacher of the Year on numerous occasions, Distinguished Faculty Award from the College of Medicine, ACEP National Teaching Award, Ohio State Faculty Alumni Award, and most recently was designated a Master Teacher by the College. He has been very active in CDEM (past president), SAEM, CORD, ABEM (item writer, oral examiner), the NBME, and he serves on the Editorial Board and as a decision editor for Academic Emergency Medicine Education & Training. His scholarly interests focus primarily on medical education.

SAEM Talks with Sorabh Khandelwal, MD

How did you develop your skills as an educator? Did you have formal training?

My skills as an educator developed over time, and they continue to develop. As learners change, our skills as educators must change as well. When I first started in academics back in 1998, I was fortunate to have been given some leadership opportunities like directing the mandatory fourth year EM Clerkship. And I did a lot of learning on the job. Over my career, I have tried to be more deliberate about developing my skills. Examples include attending the Harvard Macy Program for Educators in the Health Professions, attending the ABIM faculty development course in observational assessment, and enrolling in the MHPE program at UIC. In addition, I have met so many wonderful educators over time and have been fortunate to collaborate with many of them and learn from them.

Do you have a specific teaching philosophy, and if so, what is it?

Not sure I have a specific teaching philosophy. In the end, you have to be honest, genuine, and altruistic. Teaching really is never about you, but about the learner.

"Praise is sometimes equally as important (and at times more important) than criticism."

"… communication and touch are important components in building a meaningful relationship with a patient."

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

Several people have influenced me in the past. I'll name two but there are so many others. Dr. Rita Cydulka was my program director during residency and she saw something in me I didn't – that I would be a natural fit in academic medicine. Dr. Daniel Clinchot, Vice Dean for Education at Ohio State, has been a wonderful mentor and role model. During my life, I have been inspired by many talented people both in and out of medicine and I have taken something away from each of them. And the funny thing is that I have not met all these people. Reading books from thought leaders can influence how you teach.

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?

I do think that people learn better in different ways. Someone may learn things better by seeing the information, others by hearing it, for example. Knowing that people may have a preference for how they learn best, it makes sense to teach material in a way that fits their liking; this may give them the confidence to learn the material. However, I do think the best learners are those that are able to learn from all methods because in real life, you can't often control the mode of information delivery headed your way. So I think it is our responsibility to create an educational environment that allows a learner to strengthen all methods.

How do you engage learners and keep them motivated?

Learners need the following to be motivated in completing a task or project: autonomy, mastery, and purpose. So you can help a learners stay motivated by creating an environment that fosters these three principles. You simply can't force a learner to be engaged; they have to want to be engaged. But you can give them time and the independence to learn, offer encouragement, teach in a way that shows you care, and teach with passion. You need to help them find the relevance or importance of the material.

How much value do you think lies in the physical exam? In the history?

I think most would argue that a history is crucial. I do think there is some controversy on the importance of the physical exam. I think a physical exam is important if done correctly and there is understanding of the evidence behind the findings. It is becoming a lost art. Regardless of how you feel about both, I think communication and touch are important components in building a meaningful relationship with a patient.

Tell us about a specific training challenge you encountered and how you dealt with it.

I'll tell you about three:

1. Language barrier. I am sure many have been in a situation where a language barrier becomes a possible obstruction to teaching and learning. Language barriers can be very frustrating for both the teacher and the learner. I think recognizing your own limitation with teaching towards people who may have a language barrier is an important. For me, that was being more patient, more understanding. I think learners can sense frustration on the face of the teacher and that creates a tenser environment that hinders learning.

2. Students who are not interested in the EM rotation. This training challenge happens every year. I think to disconnect with the learner is not the right answer. The answer lies in working to find something that the learner finds interesting. Also, spending some time with the learner and showing that you are interested in him/her can help build some interest and enthusiasm.

3. Learners who lag behind their peers. It can be very frustrating to work with learners who are behind their peers academically (e.g., a PGY2 functioning as a PGY1). Again, it is important not to get frustrated and to teach at a level that makes sense while still pushing for improvement. You have to treat the learner as an individual and avoid outward emotions that may hinder learning.

What behaviors do you try to model for your trainees?

As a leader: accountability, fairness, transparency, and forgiveness. As a clinical educator: compassion, integrity, positive attitude, clinical competence, teaching ability, enthusiasm.

What's a valuable lesson you've learned from your patients?

Everyone deserves your full attention; your time.

What's a valuable lesson you've learned from your trainees?

Praise is sometimes equally as important (and at times more important) than criticism.

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

I think it is very important to make sure trainees don't allow mistakes to define them. We all make mistakes and it is important not to internalize them but rather to learn from them. Mistakes are how we learn.

What do you think about FOAMed in general? Do you have any particular favorites? Hidden gems?

I think FOAMed is great. There are so many fabulous offerings out there – EMRAP (not true FOAMed), EMCrit, keyLIME, The Bottom Line, TheSGEM.

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

Being a parent has allowed me to be a better teacher. I have four kids (ages 9–16)


MANN POULTRY
DISCOVER

"Teaching really is never about you, but about the learner."

and they have made me a better educator. They have made me think about different approaches to teaching, the importance of having patience, the importance of really listening, and the importance of mindfulness.

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

Invest in it. Take courses, read, enroll in a master's program or a medical education fellowship.

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

I'll give you two. The topic of feedback has been a passion of mine—how to give it, receive it, changing the culture. I had a learner once after a clinical rotation come to me and say, "I know feedback is important to you, so I would like to give you some feedback on your teaching." All good. This came from a student who was having serious difficulty with hearing and accepting feedback. The student told me that he finally had an aha! moment about how important feedback was in his professional growth and wanted to let me know. Another example involves an undergraduate college course I developed, Introduction to Medicine. After the semester-long course, one of the students wrote me a letter thanking me for the course, telling me that it was most impactful course she had taken in college.

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?

I am not sure that some personality types are naturally suited for EM. Someone wrote online that the average emergency physician tends to be inventive, efficient, energetic, friendly, and confident. I am not sure that EM has ownership of these traits but I think that having some if not all of these traits is important in the field. But these are traits that can be practiced and learned to different levels. As far as other qualities that I think make a successful EM resident—honesty, relentless work ethic, curiosity, ability to accept and act on feedback, humbleness.

What can be done to help motivate a student who's lost passion for learning?

Complicated question. As I mentioned earlier, motivation is internal, although we can help with building a more receptive environment. It would be important to investigate the question of "why." So spending time with the student, and showing him/her that you care is really important. Over time, I hope we can discern the underlying factors, which can then be addressed.

Learners need the following to be motivated in completing a task or project: autonomy, mastery, and purpose. So you can help learners stay motivated by creating an environment that fosters these three principles.

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

I am not sure I have successfully employed unconventional methods in my bedside teaching. I did start a course called "The Art of Analysis" in UME, using art as a medium to increase students' skills in observation and increase empathy/compassion.

One of your many hats is Director of Patient Care Competency at the OSU College of Medicine. What does this job entail?

Our College adapted AAMC's list of eight general physician competencies and assigned Directors to each one. My role is to oversee the Patient Care competency over 4 years—history, examination, communication, and clinical reasoning—to ensure thoroughness and appropriate integration.

What do you do to manage stress, achieve work-life balance, and contribute to your overall health and well-being?

This is a really tough question and one that I don't think I have managed wonderfully well over the years. I don't think I am alone. A recent crisis has forced me to look at my life in greater detail. I am focusing on "happiness." "What is happiness?" a wonderful book by Douglas A. Smith, defines happiness as having peace with your past, being optimistic about the future, and living in the moment. So that's what I am focusing on. Living in the moment is complex but includes eating well, exercising regularly, surrounding yourself with good people, limiting the multi-tasking, and practicing mindfulness. Not sure is anyone really gets to pure happiness, but the journey is well worth it.

At the end of your career, how would you like to be remembered?

Not to sound too cliché, but I want to be remembered as someone who loved himself, loved others, and loved the world. By doing this, I hope that I will leave a lasting impression on others and the world. I don't need an airport or library named after me—haha.

SAEM17 PREVIEW

Judd Hollander to Headline SAEM17

The Future of Emergency Medicine

9-10 am, Wednesday, May 17, 2017

It's been more than 55 years since emergency medicine began its rise as a distinct new specialty in medicine and almost 20 years since a task force of the Society for Academic Emergency Medicine (SAEM) looked into the future of emergency medicine. That task force accurately predicted the growth and importance of electronic information systems, the crowding of EDs with greater numbers of elderly patients, and the growth of home care, telemedicine, and EM research. What the task force didn't foresee was the growing number of uninsured, an overall physician shortage, and an increase in hospital-centered care, among other challenges. What are the implications of these challenges on the future of EM? What forces will mold the future of EM over the next decade, or two, or three? Where is emergency medicine heading and what will it look like when it gets there?

Former SAEM president, Judd Hollander, MD, opens SAEM17 by offering his prognostications of "The Future of Emergency Medicine" in what promises to be an insightful and entertaining keynote address. Dr. Hollander completed his residency in emergency medicine back when the specialty was at its genesis and the future of EM was unknown; today he is among the most respected and prolific members of the emergency medicine specialty.

- Associate Dean for Strategic Health Initiatives at Sidney Kimmel Medical College at Thomas Jefferson University
- Vice Chair of Finance and Healthcare Enterprises in the Department of Emergency Medicine
- Author of more than 400 peer review papers and book chapters
- An associate editor for Academic Emergency Medicine and reviewer for many EM, cardiology and medical journals
- Deputy Editor at the Annals of Emergency Medicine
- Former president of the Society for Academic Emergency Medicine (SAEM) and a member of the SAEM Board of Directors
- Chair of the SAEM Program Committee
- Member and past chair of the Emergency Medicine Foundation Scientific Review Committee
- Past recipient of the ACEP Award for Outstanding Research
- Previous winner of the Hal Jayne SAEM Academic Excellence Award and the SAEM Leadership Award

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"This is Not a Drill!"

Didactics Highlight Emergency Physician Experience in the ED the Night of the Orlando Mass Shooting

On June 12, 2016, Pulse Orlando nightclub was the scene of the deadliest mass shooting by a single gunman in U.S. history, and the deadliest terrorist attack on U.S. soil since the events of September 11, 2001. Forty-nine people were killed and 53 were injured. Orlando Health's Orlando Regional Medical Center, located in close proximity to the shooting, received and treated the majority of the victims who presented for medical attention. On the cusp of the one-year anniversary of that tragic event, SAEM17 will highlight two timely didactics presented by emergency physicians who describe what it was like in the emergency department on the night of the Orlando mass-casualty incident (MCI) and what they learned from the experience that can help other EDs.

Wednesday, May 17, 3–3:50 pm

Managing the Unexpected: MCIs in the Orlando ED from the Resident Perspective

Ritu R. Sarin MD, FACEP, Amanda Tarkowski MD, Amanda Stone MD, Thomas Smith, MD Christopher Ponder MD, Tory Weatherford MD

This panel features the resident physicians who were working in the ED that night and managed the casualties. Attendees will have the opportunity to learn about mass casualty response and management, as well as current practices in emergent treatment of the penetrating trauma patient, trauma preparedness and teamwork. Additionally, attendees will have the opportunity to understand the effect of such an event on trainees and the impact of working during a mass casualty over time on a training program.

Wednesday, May 17, 4–4:50 pm

The Orlando MCI Experience: From Prehospital to ED Management to Incident Command

Gary A. Parrish MD, PhD, Kathryn Bondani MD, Timothy Bullard MD, Christopher Hunter MD

This panel features emergency medicine physicians who filled a variety of critical roles during the response: from the field, to the emergency department to the broader hospital response. Attendees will have the opportunity to learn about mass casualty response and management, as well as current practices in emergent treatment of the penetrating trauma patient, trauma preparedness and teamwork. Additionally, attendees will have the opportunity to understand the effects of a mass casualty incident and critical organizational, operational, communication and logistics challenges of responding to a mass shooting.

Have a Great Research Idea? The Lion's Den Wants to Hear About it!

Do you have a great research idea that you believe is worthy of investment? Tell us about it! If your idea is selected, you will have five minutes (and eight slides) to convince the Lion's Den—a group of experienced emergency medicine researchers—that your research idea is worthwhile, your approach is good, and that you are worth mentoring. Then, in the spirit of the popular television show "Shark Tank," the Lion's Den will constructively critique your project, critically discuss its merits with one another, make offers and counter-offers, and if you're fortunate, may consider investing in you and your research idea through mentorship opportunities. Application deadline is April 1, 2017. Questions? Email Megan Ranney, SAEM Research Committee chair.

SAEM17

Visit SAEM17 for details of all annual meeting education and events. Early bird registration ends March 20.

SAEM17 PREVIEW

Pre-Meeting Workshops

AEM 2017 Consensus Conference – Catalyzing System Change Through Healthcare Simulation: Systems, Competency, and Outcomes

Simulation-based interventions can impact healthcare and replicate key elements of the healthcare environment, creating opportunities for professionals to study and improve delivery of care. Emergency medicine is a leader in the use of healthcare simulation to improve patient care processes and outcomes. Healthcare educators, scientists, and engineers will come together at the 2017 AEM Consensus Conference to propose research questions, suggest avenues of exploration, and set priorities for the field of healthcare simulation.

1. Educational Boot Camp
2. EM Talk: Difficult ED Conversations
3. Grant Writing Workshop
4. Wilderness Medicine: Learning the Fundamentals and Implementing Innovative and Practical Educational Curriculums into Residency and Medical School
5. Geriatric Trauma: A Special Population
6. Strategies for Implementing the Geriatric ED Guidelines: Education, Best Practices, Quality Improvement
7. Diversity 401
8. Negotiate Your Way to Success: Maximize your Opportunities as a Female Emergency Physician
9. Conceptualized Emergency Ultrasound: Integrating Scenario-Based Learning
10. Ten Commandments of Acute Pain Management in the ED
11. More than Accuse, Blame, Criticize — Moving beyond the ABC's of Physician Peer Review

*Add any pre-meeting workshop to your SAEM17 registration for an additional fee.

Events

NEW! Chair Fair

Interested in a position in academic emergency medicine? Visit with chairs from academic departments across the country at the inaugural Chair Fair at SAEM17!

AWAEM/ADIEM Luncheon

The Academy for Women in Academic Emergency Medicine (AWAEM) has invited the Academy of Diversity and Inclusion in Emergency Medicine (ADIEM) to join them for this year's luncheon. This joint event is an excellent opportunity to network with new and old friends, and explore common issues. The luncheon sells out each year, so register before March 21 to guarantee a seat.

Residency & Fellowship Fair

Medical residents and residents can explore residency and fellowship programs across the nation, meet current residents and fellows, ask questions, seek application and interview advice, all in one place! The Residency & Fellowship Fair also offers institutions the opportunity to showcase their programs in front of hundreds of medical students and emergency medicine residents looking to find their perfect residency or fellowship.

NEW! Speed Mentoring

Residents and medical students, engage in quick-fire, 10-minute mentoring sessions with faculty leaders in medical education, career development, and academic research from around the country. *Hosted by the Resident and Student Advisory Committee*.

Dodgeball

SonoGames®

Resident and Medical Student Yard Party

Rum Runner Exhibit Hall Reception

Opening Reception

Clinical Images Exhibit/Competition

The best original, high-quality clinical images relevant to the practice of emergency medicine, selected from more than 120 submitted images will be on display at this popular exhibition. Winners receive several prizes, including a one-year membership in SAEM and a free registration to attend SAEM18 in Indianapolis.

SAEM17 PREVIEW

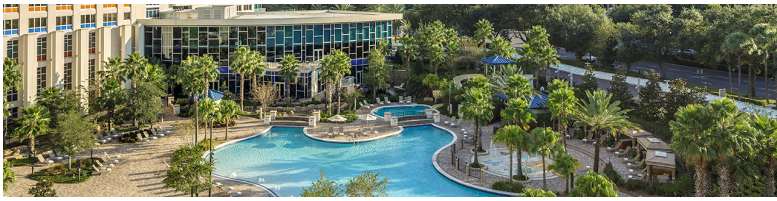
Host Hotel

World-class Luxury in a Convenient Setting

The Hyatt Regency Orlando is the Official Host Hotel of SAEM17. TripAdvisor rates it one of the 10 best conference hotels in Orlando, with spacious guest rooms, close proximity and easy access to dining, shopping, and entertainment, seven on-site restaurants, a 24-hour StayFit™ Gym, and plenty of places to relax, including three tropical-inspired pools and a luxurious spa and salon. Reserve your sleeping room at our special SAEM17 rates. Additional hotel rooms with special conference rates are available at the Rosen Plaza Hotel and the Rosen Centre Plaza. Both of these hotels are located a short walk from the Hyatt Regency Orlando.

Without departing the Hyatt Orlando, you can enjoy a range of international flavors and cuisine types. Enjoy coastal Floridian Cuisine at Urban Tide, or dine on Italian fare with a twist at Fiorenzo Italian Steakhouse. The 24-hour B-Line Diner offers a retro setting and comfort food. Try the signature cocktail—the Rocks Burning—at Rocks, or relax in the casual atmosphere of the Lobby Bar. Coconuts Poolside Bar & Grill, at the Grotto Pool, boasts a full menu. In the morning, to start your day off before that first session, grab a cup of joe to go from Coffee Etcetera. Within walking distance or a short Uber or cab ride, there are also several spots for eats. We've scanned Yelp and Trip Advisor to vet a few of the best for you!

- **Boma** – Flavors of Africa offers African cuisine in buffet format, served under a thatched roof with eclectic décor throughout
- **Café Tu Tu Tango** – Enjoy live music and tapas while local artists paint throughout the restaurant.
- **Cask & Larder** – Southern cuisine favorites and craft brews
- **Chatham's Place** – American cuisine featuring produce taken right from the chef's garden



- **Hawkers Asian Street Fare** – From Baos, to barbecue, to noodle dishes
- **Keke's Breakfast Café** – The quintessential Orlando brunch with all the classics represented
- **Norman's** – Caribbean cuisine in an elegant atmosphere.
- **Padrino's Cuban Bistro** – Authentic Cuban cuisine
- **Q'Kenan Restaurant** – Quaint eatery serves authentic Venezuelan and Latin cuisine.
- **Seito Sushi** – Delectable sushi menu, a chef's table experience, and a fun happy hour scene.
- **The Ravenous Pig** – Trendy gastropub with handcrafted cocktails and an innovative menu.
- **Victoria & Albert's** – Upscale dining with special prix fixe menus and dishes crafted in an artful format.
- **Wine Room** – Sample any of 160 wines by the glass, artisan cheeses and small plate dining in a charming atmosphere
- **Yellow Dog Eats** – Barbecue, seafood, and American cuisine and live music in the garden (and if you brought your pet with you to the pet-friendly Hyatt Regency Orlando, canine guests are welcome!)

With everything the Hyatt offers, you don't even have to leave the hotel, but if you decide to venture out, Visit Orlando is the place to go first, for maps, safety tips, transportation options, Orlando guides, guest services, discount attraction tickets, dining offers, things to do, group dinner reservations… Everything you need to go out and about in Orlando!

"It has been argued that microaggressions are actually more damaging than overt prejudice, since they are frequently downplayed or completely ignored, isolating their victims even further."

Microaggressions in Medicine

By Jen Nykiel

In "Microaggressions in Everyday Life," Dr. Derald Wing Sue defines micro-aggressions as "the constant and continuing reality of slights, insults, invalidations and indignities visited upon marginalized groups." Despite the fact that these casual and often unconscious statements are usually delivered by "well-intentioned, moral and decent" people, the statements themselves can do harm to our relationships with our colleagues, patients, and communities. They damage relations between members of dominant and minority culture.

I am currently a resident in one of the largest cities in the country, at an institution where people are far from unaware of issues related to race, gender, and other forms of identity. Even so, as I go about my day-to-day work, I hear comments that undermine the environment of inclusivity that medicine aims to create: a male attending telling a female resident to "put on your white coat so patients don't think you're a nurse," a male colleague constantly commenting on the appearance of female coworkers, a genderqueer lesbian applicant described as "too edgy."

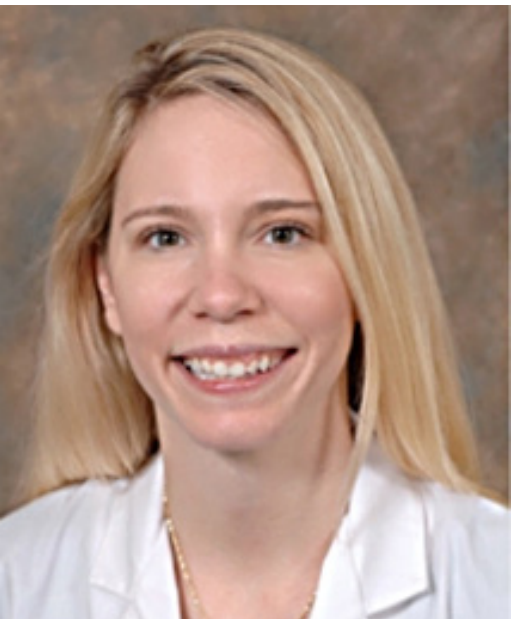
It is a widely acknowledged fact that hospitals, medical schools, and residency programs are currently struggling with a lack of representation among minority groups, especially at higher levels of administration. When this is the case, it creates additional obstacles to building a more culturally competent workplace. Departmental leaders may not understand the significance of microaggressions, in what they perceive to be an absence of overt and outright discrimination, and out of the belief that theirs is an inclusive program.

Dismissing others' well-founded concerns as illegitimate discourages people from speaking up and silences the very voices we should be hearing more from in academic medicine. We are saying, "You are different and do not belong here." Over time, the experience of being discriminated against—whether implicitly or explicitly—has been shown to lead to increased stress, poor self-esteem and mental health issues. It has been argued that microaggressions are actually more damaging than overt prejudice, since they are frequently downplayed or completely ignored, isolating their victims even further.

"It is a widely acknowledged fact that hospitals, medical schools and residency programs are currently struggling with a lack of representation among minority groups, especially at higher levels of administration."

This is not the type of environment we want to create for ourselves, our colleagues or our patients. If we want to live up to our commitment to fostering wellness in our hospitals and offices at every level, we should first be willing to listen to and learn from one another. A simple comment in support of a coworker, or a willingness to self-reflect when confronted, is the beginning of creating a healthier and more welcoming workplace for everyone.

ABOUT THE AUTHOR: Jen Nykiel is the LGBT committee chair of Academy for Diversity & Inclusion in Emergency Medicine (ADIEM). She is a senior resident at the University of Chicago and a graduate of Alpert Medical School and Brown University. Wellness, safety and rural medicine are additional passions of hers. She enjoys spending her free time outdoors or with her wife and pets.



Search and Seizure in the Emergency Department

By Natalie Kreitzer, MD

The Case: A 30-year-old-male presents to the emergency department (ED) during an overnight shift. He is in the custody of law enforcement officials after being arrested for public intoxication while wandering around in the middle of a nearby street. He is loud and belligerent to staff as he is escorted to his room in handcuffs. The accompanying officer reports that when police approached him on the street, they witnessed him pull a clear bag from his pocket and insert it into his rectum. Law enforcement officials suspect that the substance that was inserted is heroin, but cannot confirm this, and per protocol, cannot process the patient due to a concern for a delayed drug overdose.

Although he is noticeably intoxicated, the patient is alert and oriented. He reports no complaints, denies suicidal intention, and denies that he is a "body packer." He is adamant that the arresting officer made up the entire story. He allows nursing to check his vital signs, and these are within normal limits. His pupillary exam demonstrates equal, mid-range size, and reactive pupils bilaterally. His abdomen is nontender to palpation. He appears to have been drinking alcohol, but is otherwise stable, and has no clinical findings suggestive of a heroin overdose. He does not allow a rectal exam to be performed, nor will he allow an abdominal x-ray to be taken to evaluate for a foreign body. When his provider discusses the possibility of death resulting from a possible opiate overdose, the patient gets very angry, and repeatedly denies that he has used any illegal substances. He refuses to drink GoLytely to promote a bowel movement.

Meanwhile, the police officers who accompanied the patient to the ED are growing restless, and they urge the physician to 1) assume that the patient is incompetent to refuse an abdominal x-ray and rectal exam, 2) perform both of these exams, and 3) remove the illegal substance they believe to be in the patient's rectum so that they can take him to jail. Although the patient is under arrest and is intoxicated, he is able to clearly, consistently, and coherently express that he does not wish to comply with these requests. When he is left alone in his room, he remains awake, calm, and quiet. He requests to speak with his lawyer regarding the charges that he now faces.

This case presents both ethical and legal issues. Certainly, the patient is at risk of a drug overdose if the bag, which the officers believe to be in his rectum, should break. However, the patient's autonomy would be violated by forcing him to comply with an abdominal x-ray and rectal exam against his will. Although he is intoxicated and under the influence of alcohol, he does not appear to be in imminent danger secondary to the drugs, which are believed to be in his rectum. It would be difficult to medically justify performing a cavity search without the patient's consent. Further, given the nature of the exam required to remove the foreign body, and because the patient has refused to give his consent for the exam, he could file a report of battery. Given the degree of agitation the patient is displaying, if the exam were to be performed, the patient would likely need to be held down by several people and/or sedated. On the other hand, the patient is in police custody, and the jail has refused to accept him if there is a possibility of the bag rupturing and leading to a sudden, catastrophic overdose. Given this conundrum, the providers inform the police officers that they, and the patient, will all need to wait in the ED until the patient is either clinically sober enough to refuse care, has a bowel movement, or is released from police custody.

At this point, one of the police officers informs the ED provider that he has arranged for a search warrant, which will require the provider to do a rectal exam and remove the alleged foreign body. In response, because the requested exam seems to represent a threat to the patient's autonomy, the provider calls Risk Management to determine the appropriate course of action.

The ED provider discusses the possibility of a search warrant with the hospital's Risk Management, and learns that warrants are very rarely issued in these types of circumstances except when there is a high level of interest in obtaining the evidence of the crime, as delineated in Bell v. Wolfish, which described a prisoner's Fourth Amendment rights regarding unreasonable search and seizure, as "compelling evidence." Law enforcement officers are not allowed in most states to perform a

"While a prisoner might be compelled to undergo a rectal exam, the physician on duty at the hospital cannot be compelled to conduct the exam; it is up to the police to find a willing doctor."

cavity search, so typically a physician must perform it. However, there are no laws that force a physician to act as an agent of the state in this circumstance. Thus, while the prisoner might be compelled to undergo a rectal exam, the physician on duty at the hospital cannot be compelled to conduct the exam; it is up to the police to find a willing doctor. Should an injury occur in relation to sedation or to the exam itself, if given without the patient's consent, the physician could suffer a malpractice lawsuit or even battery charges.

The Conclusion: The patient remained in the ED for several hours until he was no longer clinically intoxicated. Once sober, he still refused consent to an x-ray or body cavity search. Several hours later, he simply removed the rectal foreign body himself, which was noted to be a clear bag of white powdery substance verified to be heroin.

ABOUT THE AUTHOR: Natalie Kreitzer is a current T32 Neurocritical Care Fellow at the University of Cincinnati Medical School. She completed emergency medicine residency training in 2014, and plans to stay with the University of Cincinnati Department of Emergency Medicine and Division of Neurocritical Care following fellowship completion in June 2017.

SGEM: DID YOU KNOW?

Sex-Specific Differences Play Several Roles in Concussion

William Logan Riley, MS-3, The University of Alabama School of Medicine at UAB
Neha Raukar, MD, MS, CAQSM, FACEP, Associate Professor, Warren Alpert School of Medicine of Brown University

Concussions, including sports-related concussions (SRCs), account for an increasing number of emergency department visits annually and can be responsible for significant disability, often in previously healthy young athletes. While rates of SRC differ depending on sport and level of play, when comparing male and female athletes in similar sports, evidence suggests that women have a higher risk for concussion, prolonged recovery, and postconcussion syndrome (PCS) than men.

Sex differences in biomechanics have been shown to play a role in SRCs as female athletes tend to have less neck muscle mass as compared to male athletes. Studies reveal correlative sex differences in head-neck stabilization during head acceleration, noting that women exhibit greater peak acceleration and head-neck displacement as compared to men. Other studies have demonstrated a lower biomechanical threshold for concussion in women through the use of helmets instrumented with sensors that calculate linear and rotational acceleration.

Sideline sports medicine research has also shown that women are much more likely to report concussion symptoms than men. Hypotheses are that women tend to be more honest about their symptoms, suggesting that social and cultural pressures on male athletes to return to competition may be greater than those on the female athlete.

Finally, while several international studies show mixed results with regards to PCS, two recent U.S. studies (study one and study two) demonstrated that women had approximately 2.5 times the risk of PCS as compared to men. Concussed female athletes are more likely to report persistent anxiety, headache, dizziness, fatigue, difficulty with concentration, and cognitive impairment.

Please send contributions for this column to coeditors Lauren Walter and Alyson J. Mcgregor at sgem@lifespan.org. If you are an SAEM member and are interested in adding the Sex and Gender in Emergency Medicine Interest Group (SGEM IG) to your membership, simply sign in to your profile and join today. SAEM members who are already part of the SGEM IG can find more information and resources by visiting the SGEM IG Community Site.

Opioid-free EDs and Older Adults: A Quandary in Emergency Pain Care

By Alex Domanski, MS-2

As one of the larger ambulatory sources of opioid analgesics, the emergency department (ED) is an important setting for combatting the rapidly rising rates of opioid abuse. Lately, the concept of the "opioid-free" ED has been garnering attention as a promising method to help curb the opioid epidemic.

The term "opioid-free" is a bit sensationalistic. The goal of this movement, which is catching on in EDs across the nation, is not to withhold opioids altogether—the patient in severe pain after sustaining a long bone fracture, for instance, is still a candidate for IV morphine. Rather, "opioid-free" policies are designed to discourage the routine use of these drugs and to alter prescribing practices that could further worsen an already rampant epidemic. In Seattle, for example, EDs at several Swedish Medical Centers have enacted guidelines that caution emergency physicians against providing opioids for the treatment of chronic pain and accordingly forbid the prescription of long-acting or controlled-release opioid analgesics, such as oxycodone. Meanwhile, Sergey Motov, an emergency physician at Maimonides Medical Center in Brooklyn, has taken a different approach, drafting and implementing protocols that call for combinations of two or three non-opioid analgesics as first-line treatment for acutely painful conditions.

For proponents of the "opioid-free" ED, the benefit is clear: cut back on prescriptions, curtail the problem. However, the issue of prescription opioid abuse in this country is complex and will require us to not only reduce the incidence of misuse and addiction but to do so without compromising the crucial role these medications play in relieving pain and suffering. Historically, pain has been grossly undertreated; and while fear that the pendulum has now swung too far from under treatment to overtreatment may be warranted, it also risks perpetuating the marginalization of certain patient populations that are already prone to receiving inadequate pain care. One group in particular comes to mind here: older adults.

There are a few reasons why the move toward "opioid-free" EDs is concerning for the future of acute pain management in the elderly. The first is that, even with opioid prescribing rates at an all-time high, disparities in ED pain care persist between older patients and their younger counterparts. Indeed, a study published in 2012 by Platts-Mills and colleagues, found that patients 75 and older were 19.6 percent less likely to receive any analgesic and 14.6 percent less likely to receive an opioid during a pain-related ED visit than patients aged 35-54. This followed a publication in 2010 by Hwang and colleagues which showed a smaller reduction from initial to final pain scores in older ED patients than in those under the age of 65. Polypharmacy, higher rates of cognitive impairment, and physiological alterations in drug metabolism all complicate pharmacologic pain management in older adults. To avoid adverse effects, pain medications, and opioids in particular, require careful dosing and monitoring. These figures likely reflect, among other things, hesitancy on the part of physicians to initiate analgesic and opioid therapy in a medically complex population—a hesitancy that will only grow with the advent of policy that discourages opioid use in the emergency setting.

This is a setback that older patients, who are disproportionately affected by pain, cannot afford. It is estimated that 25-50 percent of community-dwelling older adults experience chronic pain, while rates in nursing home residents may be as high as 80 percent. Although persistent pain is best treated by a single, long-term medical provider, acute flares often send chronic sufferers to the ED. "Opioid-free" guidelines risk delaying or outright denying adequate pain treatment, especially in the case of breakthrough pain that is refractory to more mild analgesics. For our older patients, there's more at stake here than unrelieved suffering. Pain that goes untreated has a considerable impact on morbidity and mortality and can lead to delirium, loss of independence, and longer hospital stays.

"With opioids taken out of the mix, older patients are more likely to receive inappropriate and even dangerous analgesics."

To complicate matters further, analgesic options for older patients are limited. Nonsteroidal anti-inflammatory drugs (NSAIDs), a cornerstone of pain management in the general population, are potentially inappropriate in older adults and should only be used with extreme caution due to their ability to cause serious side effects, including life-threatening GI toxicity. As such, opioids become a much-needed source of pain relief for these patients when first-line treatments like acetaminophen fail. This is another reason why "opioid-free" EDs prove troubling in the context of geriatric emergency medicine: with opioids taken out of the mix, older patients are more likely to receive inappropriate and even dangerous analgesics. Despite safety concerns, NSAIDs are already commonly used in older ED patients, and restrictions on opioid-prescribing would only encourage this practice. Indeed, Dr. Motov's own opioid-sparing treatment modalities rely instead on large doses of NSAIDs like ketorolac, along with other medications that the American Geriatrics Society has flagged as unsuitable for use in older adults, including methocarbamol, metoclopramide, and diphenhydramine.

This isn't to say that a push for alternative analgesic therapies is all bad for older ED patients. While opioids are recommended by the American Geriatric Society for the treatment of moderate to severe persistent pain, their utility is limited by their own list of adverse effects. These include nausea, vomiting, dizziness, somnolence, and their resultant association with falls and fall-related injuries. Reducing physician dependence on opioids can help pave the way for more nuanced approaches to acute pain management that circumvent these unwanted effects, which can be particularly devastating for older adults. An example from Dr. Motov's protocols is the use of regional nerve blocks in the setting of musculoskeletal pain. When appropriate, regional nerve blocks are preferred in older patients due to their lack of systemic side effects and their demonstrated effectiveness over conventional oral and parenteral analgesics.

> "The issue of prescription opioid abuse in this country is complex and will require us to not only reduce the incidence of misuse and addiction but to do so without compromising the crucial role these medications play in relieving pain and suffering."

There's also the question of addiction—perhaps the most feared side effect of all. To what extent are older adults affected by the opioid epidemic? There's little data to suggest that the potential for opioid abuse in the elderly is significant enough to necessitate more stringent prescribing practices. Reports place the rate of drug use in patients over the age of 50 at less than 5 percent, with those 65 and older are least likely to abuse any type of illicit substance. And when it comes to pain medications themselves, studies indicate that the older patient tends to underuse rather than overuse these drugs. Even so, the elderly are not immune to the grips of addiction, and with the aging of the baby boomers, the prevalence of substance abuse among older adults is expected to rise. "Opioid-free" EDs could prove useful in counteracting this rise, although less drastic measures—such as performing more thorough screenings for medication and alcohol misuse prior to initiating pain care regimens—remain preferable.

In the end, emergency physicians find themselves in a precarious position, pulled in seemingly opposite directions. There is, at once, the need to confront the damaging effects of opioids and the responsibility to provide optimal pain care to patients of all backgrounds and ages. Improving ED pain care will rely on striking a balance between these two obligations. Thus, as the opioid epidemic continues to influence the practice of acute pain management—resulting in greater restrictions on opioid prescribing and wider use of alternative analgesic modalities—it is imperative that we remain vigilant to the quality and effectiveness of how we treat pain in the ED, especially in our older patients.

ABOUT THE AUTHOR: Alex Domanski is a second year medical student at the Icahn School of Medicine at Mount Sinai, New York, NY. *The author would like to thank Ula Hwang, MD, MPH for reviewing this piece and for inspiring him to write on the topic.*

FOAMed in a Pinch

By Catherine Parker, MD

We've all had those days... You are working a busy Monday morning when a child presents with a rash you just can't quite place or there is new jaw dislocation reduction technique the intern wants to try but you don't remember exactly how it's done. In situations like these, when you need to look something up in a hurry, FOAMed resources can be extremely helpful. Unfortunately, given the rapid growth of available blogs, podcasts, and other online medical sources, determining which resources to use can be a daunting task. Just in Time - A FOAM Resource Review highlights some of the available online resources for emergency medicine learners; here are some others that might be useful:

" When you need to look something up in a hurry, FOAMed resources can be extremely helpful. Unfortunately, given the rapid growth of available blogs, podcasts, and other online medical sources, determining which resources to use can be a daunting task."

"FOAMed is great for independent study but it is equally important when in need of on-demand information during a shift."

WikEM

As its name implies, this is a website modeled after Wikipedia (a free online encyclopedia) but dedicated specifically to emergency medicine. WikEM offers several categories of information, including: Journal Club, which provides summaries of recent emergency medicine literature as well as evidence based analysis of each article; an Antibiotic Guide, which can be viewed by diagnosis or organism; and Quick Critical Care, provides dosing for vasopressors, ACLS medications, sedation, antiepileptics and other medication drips commonly used in critical care medicine.

ALiEM Paucis Verbis Cards

The Academic Life in Emergency Medicine (ALiEM) blog provides handy PV (paucis verbis), cards which serve as quick reference guides on a variety of topics ranging from the Ottawa ankle rules to the use of methotrexate in ectopic pregnancy. These cards are categorized by subject as well as listed in alphabetical order and can be viewed as either a blog post or downloaded as pdf files.

One Minute Ultrasound

This is a free app for your smartphone that provides quick, one minute videos on how to perform some of the most common bedside ultrasounds, including the FAST exam, DVT, gallbladder and the aorta. These videos cover probe placement as well as the windows that should be obtained on the ultrasound. The app was co-created by Drs. Mike Mallin and Matt Dawson whom are well known for their ultrasound podcast, which provides more comprehensive ultrasound education and information.

FOAMed is great for independent study but it is equally important when in need of on-demand information during a shift. There are many resources available to aid both the EM physician-in-training and the seasoned physician who needs an occasional refresher; these are merely a few. For additional reviews and perspectives on these and other medical education resources listen to the podcast FOAMcastini-FOAM, Just in Time.

ABOUT THE AUTHOR: Catherine D. Parker, MD, is chief resident, R3, in the Department of Emergency Medicine at the University of Missouri.

BRIEFS AND BULLET POINTS

SAEM NEWS

Have You Cast Your Vote?

It's time to select your SAEM leaders for 2017-2018. Play an active part in the direction and future of SAEM by casting your vote. To access your ballot, your login information was sent to the email associated with your SAEM membership. If you haven't received this email, please contact elections@saem.org. As a reminder, please add announcement@associationvoting.com to your address book to avoid emails going to your junk mail or getting blocked by your institution's spam filter. Elections close on Monday, March 6 at 4 p.m. CST.

I Am SAEM

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. Visit the I Am SAEM webpage to see how your peers find work-life balance. If you or someone you know has a unique or noteworthy hobby, outside interest, or activity that fits the criteria for this campaign, please share your story with us at marketing@saem.org.

SAEM's Directories Have Been Upgraded and Improved

SAEM's directories have been transformed into powerful, highly searchable online databases with improved functionality and completely updated data. These comprehensive listings of emergency medicine Clerkships, Fellowships, and Residencies contain new, detailed content and search functions. Give them a try and see for yourself!

Research Resources Are Now Online

The SAEM Research Committee has collated a list of research resources that provides junior investigators with everything they need for study design, implementation, evaluation, and dissemination. For suggestions or feedback, please contact us.

Update Your Member Profile

In addition to several new programs and initiatives, SAEM launched a freshly branded, easier-to-navigate website at the beginning of the year. The new website includes 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! To take advantage of all of these new features, please make sure your member profile is up-to-date.

SAEM PUBLICATIONS

Don't Miss a Single Issue of AEM or AEM E&T!

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 issues of Academic Emergency Medicine Education and Training (AEM) and Academic Emergency Medicine Education and Training (AEM E&T) are available. 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, please visit AEM and AEM E&T and click "Get New Content Alerts" under Journal Tools on the upper left of the page.

AEM and AEM E&T are on Twitter

Are you following us on Twitter? Stay up-to-date with SAEM's journals via their Twitter feeds: Follow Academic Emergency Medicine (AEM) @AcademicEmerMed Follow Academic Emergency Medicine Education and Training (AEM E&T) @AEM_ETOnline

Academic Emergency Medicine (AEM)

2016 Outstanding Reviewers Announced

Academic Emergency Medicine is pleased to announce its Outstanding Peer Reviewers for 2016:

- Fernanda M. Bellolio
- Polly E. Bijur
- Michelle Blanda
- Karen Cosby
- Deborah Diercks
- Brian Driver
- William Grant
- Alan Heins
- Brian Hiestand
- Damon Kuehl
- Brandon Maughan
- Dan Mayer
- Michael Puskarich
- Kristin Rising
- Jill Stoltzfus

The Outstanding Peer Reviewer designation is given annually to peer reviewers who meet the following criteria for excellent performance:

1. Provided at least four high quality reviews
2. Had no more than one late review
3. Had an overall mean score of 85% or higher
4. Accepted two-thirds of all review requests

We extend sincere appreciation to these exceptional reviewers for their dedicated, conscientious, and exceptional service to AEM in 2016 by contributing timely, rigorous, and thoughtful peer reviews. Peer reviewers are essential to presenting the high-quality, original research and academic contributions that fill the pages of AEM journal each month. AEM thanks the 452 reviewers who performed a total of 1,016 peer reviews for Academic Emergency Medicine (AEM) in 2016.

EM CAREER CORNER

Four Tips to Job Searching in 2017

1. Set 1, 3 and 5 year goals for your career. Write them down and hold yourself accountable each quarter for moving in the right direction.
2. Review and quantify your achievements in 2016. Update your resume with them and post it on EM Job Link where employers will see it.
3. Sign up for at least one professional development opportunity or course to learn a skill that will make you better at your job.
4. Create a job alert on EM Job Link to receive emails when the right jobs for you are posted.

Find a Job, Post a Job at EM Job Link!

Academic Emergency Medicine Education and Training (AEM E&T)

Introducing SAEM's Newest Journal

After months of planning and preparation, SAEM's newest publication—Academic Emergency Medicine Education and Training (AEM E&T) published 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. If you wish to submit a manuscript to AEM E&T, please review our Author's Guidelines.

SAEM PULSE

Notice Anything New?

Effective with the January/February issue, SAEM Newsletter has a new name: SAEM Pulse AND is now distributed in online, digital-only format. The digital version will be in the same format you are familiar with and will continue to be produced six times a year. Members will be notified through social media and will receive an email alert each month when the publication becomes available online. If you want a hard copy of an article, simply print the pages you want and skip the rest! This change will allow for more interactive features like clickable links and the ability to embed video, plus you will be able to share articles more openly and easily with your colleagues.

We Want to Celebrate Your Success

Have you recently been promoted, received a grant or an award, been appointed to a committee or new position? We'd like to share your good news with your SAEM peers! Please send your academic appointments and announcements, along with a brief bio and your professional headshot, to Pulse@saem.org. The next content deadline, for the May/June issue of SAEM Pulse is April 1, 2017.

CORRECTION

An article titled "Academic EM and the AAMC: What You Should Know," on page 9 of the January/February issue of SAEM Pulse, omitted coauthor David Sklar, MD. Dr. Sklar is editor-in-chief of Academic Medicine, a journal of the AAMC, and is an associate dean of graduate medical education and a distinguished professor at the University of New Mexico School of Medicine. SAEM Pulse regrets the omission.

IN OTHER NEWS

Call for Applications

Do you dream of earning a senior faculty position in medicine? Would you take joy in mentoring early-career medical professionals who will be the next generation of leaders? Applications are now open for the 2017 cohort of Harold Amos Medical Faculty Development Program Scholars. This program works to increase diversity among medical, nursing, and dentistry faculty. For more information: www.amfdp.org Application deadline is March 15, 2017 (3 p.m. ET)

Up to 10 selected program scholars are eligible for:

- A four-year postdoctoral award of up to $420,000
- An annual stipend of $75,000
- An annual grant of $30,000 to support research
- Additional awards available through partnership organizations

Shock Symposium

On May 5, 2017, Beth Israel Deaconess Medical Center, in partnership with the American Heart Association, will be leading a one day CME course titled "2017 Shock Symposium: The Latest in Resuscitation and Critical Care" at the Joseph B. Martin Conference Center in Boston. Visit the event webpage for detailed information and to register.

Junior Faculty Collaboration Opportunity

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 contact Dr. McLean.

SAEM REGIONAL MEETINGS

Meeting	Date	Location	More Info
Mid-Atlantic Regional Meeting	March 11	Georgetown University School of Medicine	Register Online Meeting Agenda midatlanticregion@saem.org
New England Regional Meeting	March 29	Worcester, MA	Register Online Amy Michaluk or education@saem.org
Western Regional Meeting	April 7-8	Stanford, CA	Meeting Agenda Viveta Lobo or Nikita Joshi

CALLS AND SUBMISSIONS

CALL 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: March 1-April 14, 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. All submissions will undergo peer review. 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. To submit a paper, choose the "Consensus Conference" category at the submission site. Questions? Contact Rosemarie Fernandez, MD or Robert Cloutier, MD.

CALL FOR PROPOSALS

2019 Academic Emergency Medicine Consensus Conference

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

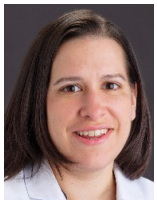
Submission deadline: April 30, 2017

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. Submit proposals to the consensus conference review subcommittee.

ACADEMIC ANNOUNCEMENTS

University of Missouri-Columbia

Christopher Sampson, MD, FACEP was promoted to associate professor at the University of Missouri-Columbia. Dr. Sampson is currently the associate program director and was recently appointed as the Director of Clinical Integration for the Emergency Department.



Alisa Hayes, MD, was promoted to associate professor at the University of Missouri-Columbia. Dr. Hayes was recently appointed as Director of Medical Student Education for the Emergency Medicine Department.

Thomas Jefferson University

Bernie Lopez, MD, MS, professor and executive vice chair in the Department of Emergency Medicine at Thomas Jefferson University (TJU), was appointed as Associate Provost for Diversity and Inclusion at at TJU. In his new role, Dr. Lopez will oversee the expansion of diversity and inclusion in the six colleges of TJU to advance diversity and inclusion throughout the academic sector of the enterprise. He will continue his role as Associate Dean for Diversity and Community Engagement in the Sidney Kimmel Medical College of TJU, a position he has held since 2013. Dr. Lopez is currently the president of the SAEM Academy of Diversity and Inclusion in Emergency Medicine (ADIEM).

SAVE THE DATES

SAEM Annual Meetings

2017 May 16-19,
Hyatt Regency, Orlando, FL

2018 May 15-18,
The JW Marriott Hotel, Indianapolis

2019 May 14-17,
The Mirage Casino-Hotel, Las Vegas, NV

2020 May 12-15,
The Sheraton Denver Downtown Hotel, Denver, CO

MEDICAL COLLEGE OF WISCONSIN

ACADEMIC EMERGENCY MEDICINE

AT THE MEDICAL COLLEGE OF WISCONSIN IN MILWAUKEE

The Academic Department of Emergency Medicine is one of the oldest Departments in the United States. Our residency program was established in 1978, and recently expanded to ten residents per year with strong hospital affiliate support, including the VA Medical Center.

We are interested in recruiting new faculty to our Department.

Our ED at Froedtert Hospital, our primary affiliate, recently completed an expansion and we are increasing our daily physician coverage hours. We are recruiting for two faculty candidates to complete our coverage at this primary academic site. In addition, the Froedtert Health System recently opened a free-standing ED at the Moorland Reserve Health Center in July, 2016. Our faculty is responsible for staffing this ED. Faculty members have the opportunity to work at one or both of these sites.

The Department of Emergency Medicine at MCW is nationally and internationally recognized in academic areas including EMS and Disaster Medicine, Toxicology, Injury Prevention and Control, Cardiac Resuscitation, Global Health, Ultrasound, Medical Education, and ED Process Improvement. The Department is ranked in the top 20 NIH funded departments of emergency medicine.

Interested applicants should submit a curriculum vitae and letter of interest to Dr. Stephen Hargarten, Department Chairman at hargart@mcw.edu

BRIGHAM AND WOMEN'S HOSPITAL
HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

BRIGHAM AND WOMEN'S HEALTHCARE EMERGENCY PHYSICIAN DIVISION OF INTERNATIONAL EMERGENCY MEDICINE AND HUMANITARIAN PROGRAM

The Department of Emergency Medicine at Brigham and Women's HealthCare (BWHC) is seeking an emergency physician to join the department's Division of International Emergency Medicine and Humanitarian Programs (DIEMHP).

Successful candidates must have successfully completed a four-year residency training program in Emergency Medicine, or a three-year program followed by a fellowship or one year in practice, and must be board eligible or certified in Emergency Medicine by the American Board of Emergency Medicine. The appropriate candidate will have a minimum of 5 years of field experience in humanitarian response and global health, working with major international organizations; a strong history of academic publications in international emergency medicine, global health, and humanitarian response; a global health-related Masters degree; and a strong track record of successful funding proposals.

Interested candidates should send a letter and curriculum vitae to Michael VanRooyen, MD, MPH, Professor and Chair, Department of Emergency Medicine, Brigham and Women's Hospital. Please apply by confidential email to mdeloge@bwh.harvard.edu

More information maybe found at http://fa.hms.harvard.edu/files/hmsofa/files/430jr_bwh_inst.asst_.assoc_.emergmed.diemhp_1-19-17.pdf

We are an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religions, sex, sexual orientation, gender identity, national origin, disability status, protected veteran status, or any other characteristic protected by law.

UNIVERSITY OF Nebraska Medical Center

The University of Nebraska Medical Center, Department of Emergency Medicine is recruiting a board certified/board eligible faculty member who has completed an ultrasound fellowship and is committed to developing an academic career.

We are an accredited three-year emergency medicine residency program with 10 residents per year. The Center for Clinical Excellence houses the Emergency Department and provides services for about 60,000 annual visits.

Our ultrasound program currently uses Qpath and sends images to the hospital PACS system. QA, credentialing, billing, and EMR integration are established. The ED currently has four ultrasound systems. Our department is leading the medical school's ultrasound education and would look to develop a fellowship program and engage in ultrasound related scholarly activity. This position will offer generous protected time, compensation, and the opportunity to develop and execute a departmental vision.

Applications are being accepted on-line at http://unmc.peopleadmin.com/postings/32405. Individuals from diverse backgrounds are encouraged to apply.

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! Read Ann's full story at "I am SAEM".

Watch Ann's Video!

The Ohio State University

WEXNER MEDICAL CENTER

Assistant/Associate Residency Program Director

The Department of Emergency Medicine (EM) at The Ohio State University College of Medicine is currently seeking candidates for the position of Assistant or Associate Director of our Emergency Medicine Residency Program. The candidate will be part of a residency leadership team that is responsible for the training of 48 categorical residents (16 per year) as well as 10 EM IM residents. The Ohio State Department of Emergency Medicine provides clinical services at two ED's with a combined volume of 130,000 visits per year.

The successful candidate should have a demonstrated track record of involvement with resident and/or medical student education. Preferred qualifications include associate or assistant PD experience, medical education fellowship training, clerkship director experience, core faculty or experience as a chief resident.

Pease send a letter of interest and updated (CV) to Daniel R. Martin, MD, MBA, FAAEM, FACEP, Professor and Vice Chair of Education, Department of Emergency Medicine, The Ohio State University College of Medicine (Daniel.Martin@osumc.edu) and to Jennifer Journey, EM Program Manager (Jennifer.Journy@osumc.edu).

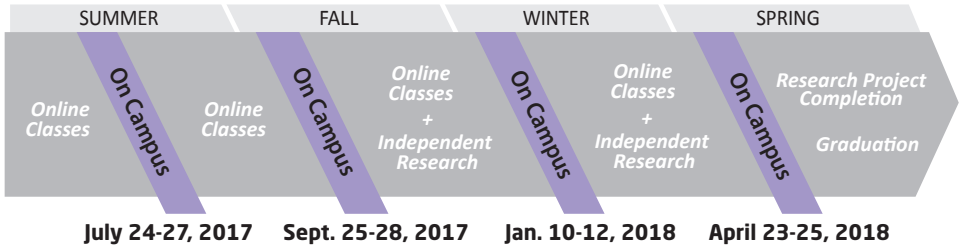
Executive Master's Degree in Health Services and Outcomes Research

Northwestern University Feinberg School of Medicine

Northwestern's Master of Science in Health Services and Outcomes Research (HSOR) trains students to:

- Conduct methodologically sound research,
- Create new knowledge aimed at improving health services and outcomes, and
- Pursue grant funding to support their research.

2017-2018 Executive Master's Schedule



Apply Now

Summer 2017
Application Deadline:
April 23rd

Scholarships and travel stipends offered

The program features an executive + online format designed for working clinicians. Students convene in Chicago once per quarter for intensive instruction, collaborative learning, and professional development. Between residency sessions, students complete online work, participate in synchronous online classes, and correspond with instructors and mentors. The degree can be completed in either two years (part-time) or one year (full-time). Master's cohorts enter each summer.

Find us online: **feinberg.northwestern.edu/hsor**
Contact: **hsor@northwestern.edu**

Northwestern Medicine®
Feinberg School of Medicine

Chair of Emergency Medicine

Perelman School of Medicine
University of Pennsylvania

The **Perelman School of Medicine** at the **University of Pennsylvania** invites applications for the position of Chair of the Department of Emergency Medicine.

Uncompromisingly committed to providing the highest quality, advanced emergency care in the Philadelphia region, the Department of Emergency Medicine is positioned to be the national leader in the practice of emergency medicine and in the training of the next generation of leaders in the field. Penn Medicine's Emergency Medicine Department pursues the highest standards in the integrated delivery of efficient, safe, collaborative professional emergency care to anyone in need, while fostering an un- paralleled training environment attracting the best residents and subspecialty fellows. The Department is consistently ranked as one of the top 5 research departments in Emergency Medicine as measured by grant funding and publications, and is dedicated to supporting a collegial, and intellectually exciting environment in which to work.

With oversight of Penn Medicine's state-of-the-art emergency services, including a Level 1 Trauma Center, the Chair plays a critical role in the health system-wide operations. The Chair will provide vision and leadership for the Department, working in partnership with other health system leaders to foster integration, collaboration, a supportive environment and sense of community. Applicants must have a MD, and/or MD, PhD, be a respected active practitioner with a distinguished national reputation in emergency medicine. Candidates should possess dynamic leadership skills, administrative expertise, and a clear commitment to – and excellence in – the education and mentorship of students, fellows and faculty. The applicant must have the demonstrated ability to manage complex clinical operations and to foster collaborative interactions among emergency medicine physicians and other clinicians and investigators in Penn Medicine. The candidate should articulate a compelling vision for the future of the Department of Emergency Medicine, the role of a clinical department within a highly regarded academic medical center and the field of emergency medicine in general. The candidate must be qualified for appointment as a full Professor in the Standing Faculty in the Department of Emergency Medicine in the Perelman School of Medicine.

All interested applicants are invited to submit their curriculum vitae and letter of interest to the attention of Michael S. Parmacek, Chair of the Search Committee. Apply for this position online at: **https://www.med.upenn.edu/apps/faculty_ad/index.php/g/d4591**

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.

The University of Florida
Department of Emergency Medicine

Advancing Health Care in Florida, our nation and the world through excellence in education, clinical care, discovery and service.

Seeking Emergency Medicine Faculty – All Ranks, Emergency Medicine Clinical Faculty for community practices and Emergency Medicine Fellows to support our existing programs.

The University of Florida Department of Emergency Medicine in Gainesville Florida is seeking talented, highly motivated emergency medicine physicians to join our robust dynamic department of 44 Faculty, with an expanding residency program and increased fellowship opportunities.

The UF Department of Emergency Medicine is part of the UF Health Shands Hospital and Academic Health Center which is North Central Florida's largest teaching institution, a Level 1 trauma center and burn center, and the major referral center for North Central Florida Region.
Emergency medicine faculty and fellows will enjoy the academic benefits of working in one of the country's few academic health centers with six health-related professional colleges, nine major research institutes and versatile research facilities located on a single contiguous major university campus. There are numerous opportunities within our department and within the College of Medicine for emergency physicians with teaching, research and administrative interests. Fellowship opportunities include:

Emergency Medical Services, Research, Ultrasound, International Emergency Medicine, Critical Care, Sports Medicine as well as Toral Foundation Sponsored Fellowships in Neuro Critical Care and Neuro Sports Trauma.

Gainesville is a beautiful, dynamic and vibrant college town, centrally located in North Florida. Residents are close to major airports, family entertainment and some of the best beaches in the world. Home of the "Gator Nation:' award-winning college sports and year-round outdoor activities, Gainesville has repeatedly been voted as one of the best places to live in the U.S.

Join the UF College of Medicine faculty and earn an extremely competitive salary commensurate with experience and duties. Enjoy the full range of University of Florida state benefits.

When applying, please address correspondence including a CV and cover letter to Joseph A. Tyndall, MD, MPH, Chair Department of Emergency Medicine.

UFHealth
UNIVERSITY OF FLORIDA HEALTH

UF UNIVERSITY of FLORIDA

The University of Florida requires all applications to be submitted online.

For additional information or to apply for a position, visit emergency.med.ufl.edu/opportunities.

Questions? Please email Amy Smith at amysmith@ufl.edu.

Women and minorities are encouraged to apply. The University of Florida is an Equal Opportunity Employer.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May 16-19 • Hyatt Regency • Orlando