

A quarterly newsletter of current activities of our Academy, an organization of strong advocacy for women in academic emergency medicine

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President's Welcome Kinjal Sethuraman, MD



Dear AWAEM Members,

I hope many of you are gearing up for a vacation-filled holiday season full of rest and relaxation. Since we are in a 24/7/365 specialty, many of us will be working. That can be hard for some, but rest assured, someone else out there is right there with you. We are all in this together.

Over the last couple of years, I have discovered the near critical need for us to connect with others. By attending conferences like our upcoming SAEM meeting in Indianapolis and others like FIX, ACEP, AAEM, CORD and many others, we give ourselves the gift of allowing these connections to seed and grow naturally.

In this issue and over the next few months, keep an eye out for announcements about our Awards, our Pre-Conference (you will be blown away by the list of women who are speaking!), AWAEM/ADIEM Luncheon, didactics, and SAEM Jeopardy- held during the opening reception. Start planning your trip now so you can make the most of your experience at SAEM18.

For now, I ask you to think of someone to nominate for one of the AWAEM awards and keep an ear out for the SAEM regional meetings in the Spring. We will also ask members to join AWAEM committees so we can set up time to meet in Indianapolis.

Our Newsletter Committee has worked very hard to put this issue together. There is a TON of information here and on our website. We know you are out there and we want you to get involved and get connected. We can't wait to meet you.

Kinjal

2018 AWAEM Awards

We are now accepting nominations for the [2018 AWAEM Annual Awards](#)!! There are so many fabulous candidates awaiting your nomination. Now is the time to start thinking about these awards and reaching out to the many deserving potential nominees. The nomination criteria for each award typically includes submission of the nominees CV, one nomination letter, and completion of a brief online form.

Resident Award: To honor a senior female EM resident (PGY 3 or PGY 4) who has shown promise for significant career achievements in EM and/or has worked to promote the role of women in academic EM.

Early Career Award: To honor early career female faculty who have shown promise for significant career achievements in EM and/or has worked to promote the role of women in academic EM.

Mid Career Award: For a mid-career female faculty member who has shown promise for significant career achievements in EM and/or has worked to promote the role of women in academic EM.

Outstanding Research Publication Award: This award recognizes the first or last author of an outstanding research manuscript published in the past year.

ED Medical Director Award: To honor female faculty who have shown significant career achievements in EM as ED medical directors, who have taken the lead on improving working environments and patient care in their departments.

Hidden Gem Award: To honor female faculty members who have significant but quiet contributions that may escape traditional models of recognition.

Outstanding Department Award: To honor the EM Department that has shown support for women in academic EM through organizational initiatives that address recruitment, development and advancement of women physicians.

Deadline for Submission: February 1, 2018 at 5PM PST



Resident Column

SPEAKING TO THE SCIENCE
WORKSHOP REFLECTION

Amy J. Zeiden, MD
University of Pennsylvania

As a senior resident thinking about starting my academic career, there are multiple things that terrify me. One of those is paper writing. Just thinking about it induces major imposter syndrome. Fortunately, three academic SHeroes appeared at the FIX2017 conference and demystified the process for me. Enter Teresa Chan, Ellen Weber, and Anna Marie Chang. Queens of study design, protectors of high quality research, breakers of academic writing chains, and mothers of publishing pearls.

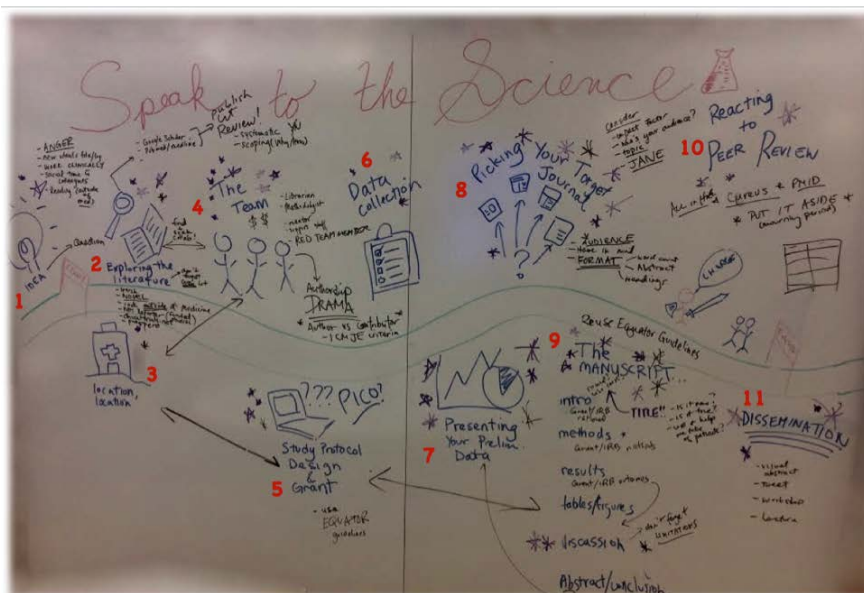
The first miracle they achieved was breaking down the process in an understandable step by step manner with an accompanying visual! Something tweetable! The process map provides a step by step guide in the form of a checklist that can be adapted for individuals at any point in the process. Below is the checklist with high yield pearls:

1. **Good Idea:** You don't need help with this – you already have so many!
2. **Explore the Literature:** Meet with your university's librarian, an invaluable resource to help with this part of the process.
3. **Pick a Study Location:** Start with the easiest, which is where you already are.

4. **Find a Study Team:** Find a content expert, someone who is an expert in the research project, a research assistant (or two), and a statistician.
5. **Design a Study Protocol and Find a Grant**
 - a. This is so important. Poor design = difficult to interpret data.
 - i. Meet with a statistician and/or experienced researcher to go through this in detail. Present it at your departments research meeting to find the holes.
 - b. Call the IRB! Pitch them the idea and they can help you.
6. **Collect the Data:** Check if your institution has a HIPPA protected research database (like redcap).
7. **Present Your Preliminary Data**
8. **Pick Your Journal**
9. **Write the Manuscript:** Your IRB is essentially most of your manuscript
10. **React to Peer Review**
11. **Disseminate**

My top 3 takeaways from this phenomenal workshop are:

- 1) **You CAN do it.** You preform heroic, lifesaving, challenging, and stressful tasks on every shift. If you can do that, you can write! Once you figure out the process, writing seems much more manageable. Use the process map as a checklist and identify barriers and solutions at each stage.



- 2) **You CANNOT do it alone.** Find a mentor/sponsor (or two or three) who will help you through it. It can be an online mentorship, in person, over the phone, etc. Just find someone who will commit to helping you. They don't have to be a content expert; they just have to be an expert in the process.
- 3) **Make a timeline of how this can fit into your busy life.** It's a marathon, not a sprint. Planning it out will make it seem more possible.

Amy



AWAEM and GEMA Team Up for Global Health Travel Grant

Alison Schroth Hayward, MD MPH

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U.S. physicians have come to expect compensation packages that include funding for continuing medical education (CME) to attend conferences to keep current on the latest knowledge in their specialty. Unfortunately, across much of the rest of the world, not only are these funds lacking, the opportunities for receiving CME themselves can be sparse. Physicians in low and middle income countries often must forgo opportunities to support their salary to attend CME. They may be forced to use the meager public funding they receive or leave the large and needy local population that they serve without any physician replacements. These barriers are some of the reasons why many such physicians find attending medical conferences an opportunity that is all but inaccessible. And yet, the same physicians work hard to serve populations who are disproportionately affected by later stage and more severe disease, by dint of their poverty.

The AWAEM Global Health Committee created a goal this year to address this challenge. We have teamed up with the Global Emergency Medicine Academy (GEMA) to offer a travel grant to women physicians pursuing a career in emergency care who are native to and practicing in a low and middle income country. **The travel grant will provide \$2000 in support for the physician to whom it is awarded.** The funding will preferentially be awarded to a physician who has an opportunity to present a didactic, poster, or other presentation at the Society for Academic Emergency Medicine conference in the coming year.

Applications are currently being accepted for this opportunity. The deadline for applications is February 1, 2018. Applicants should send a CV to awaem.globalhealth@gmail.com to apply. Feel free to distribute this opportunity to any eligible person interested in applying.

Clinical Column

ULTRASOUND DIAGNOSIS OF SMALL BOWEL OBSTRUCTION

Devjani Das MD, RDMS

Guest Author: Brittany Choe, MD PGY I, Northwell Health-Staten Island University Hospital, Staten Island NY

Small Bowel Obstruction

Small bowel obstruction (SBO) is estimated to account for nearly 300,000 hospitalizations annually in the U.S. Patients may present with symptoms such as nausea, vomiting, abdominal pain, and obstipation. Diagnosis of SBO must be done quickly in order to prevent life-threatening complications as well as to provide appropriate treatment. While relatively new, the use of ultrasound to diagnose SBO's has been shown to be just as sensitive and more specific than abdominal radiographs and can be readily used at the bedside. While CT is the gold standard for diagnosis, the safety and ability to repeat point of care ultrasound makes this an incredibly useful tool in diagnosing as well as monitoring the progression of SBO.

Technique

In the supine position, small bowel pathology can be safely examined by scanning the central region of the abdomen. Bowel abnormalities can often be identified initially with a low-frequency curvilinear probe. If the patient is able to localize their pain, this can be a helpful starting point. While there is no single way to scan the abdomen, using a systematic approach such as the "lawnmower" approach and scanning slowly with pressure on the abdomen to displace gas or fluid (graded compression) can help make images clearer and ensure optimal visualization of the bowel.

Normal Bowel

In order to identify pathologic bowel, it is important to understand how normal bowel appears on ultrasound. Normal bowel shows an inner hyperechoic layer, a second hyperechoic layer of deep mucosa, a third hyperechoic layer of submucosa, a fourth hypoechoic layer of muscle and a final hyperechoic layer of serosa. The bowel lumen is hypoechoic with hyperechoic bowel contents passing through. Peristalsis should be present and unidirectional. Normal bowel wall thickness during peristalsis is 2-3 mm. Healthy bowel is easily compressible and shifts with transducer pressure.

Signs of Small Bowel Obstruction

Bowel loop dilation and thickening can be both diagnostic and prognostic. Bowel loops in SBO can often be dilated > 2.5-3 cm. Dilated small bowel loops is the most sensitive and specific sign of SBO. Dilation greater than 2.5 cm measured outer wall to outer wall is indicative of SBO and may or may not be accompanied by hypoechoic free fluid, also known as the tanga sign (Figure 1, white arrow). Bowel wall thickening >3 mm can also be indicative of bowel wall ischemia and necrosis, prompting need for more urgent evaluation and treatment (Figure 1).



Figure 1: Bowel loop dilation with hypoechoic free fluid and wall thickening

The dynamic, real time ability of ultrasound is beneficial in monitoring disease progression. Initially, SBO can present as hyperperistalsis. As the obstruction worsens, peristalsis slows proximal to the obstruction. "To and fro" movement of bowel contents on ultrasound is a sign of dysfunctional peristalsis. No peristalsis for 5 minutes can be indicative of akinesis of bowel wall and is a sign of bowel wall ischemia requiring emergent surgical treatment. Repeat scans can also be done to monitor the progression of bowel wall obstruction. Bowel wall that had peristaltic or hyperperistaltic movement on initial scan but is now akinetic can signify progression to ischemia and necrosis of bowel wall.

Transition points can be identified on ultrasound (although difficult to do) and can give diagnostic

information on location and cause of obstruction. The transition point is the point between dilated proximal bowel and collapsed distal bowel. Ultrasound can also be used to detect masses, Crohn's disease, intussusception, hernias, and other pathological causes of bowel obstruction, allowing for disease management decisions to be made quickly.

In the jejunum, fingerlike projections in the bowel wall can also be visualized in patients with SBO. Valvulae conniventes (plicae circulares) inside the jejunum become visible in patients with SBO. This is known as the keyboard sign. (Figure 2)



Figure 2: Keyboard sign with dilated bowel loops in SBO

In conjunction with history and physical exam findings providers can use these diagnostic findings to aid their clinical decision making. The dynamic capability of ultrasound also provides relatively quick prognostic signs and information about disease progression, making it a valuable bedside tool.

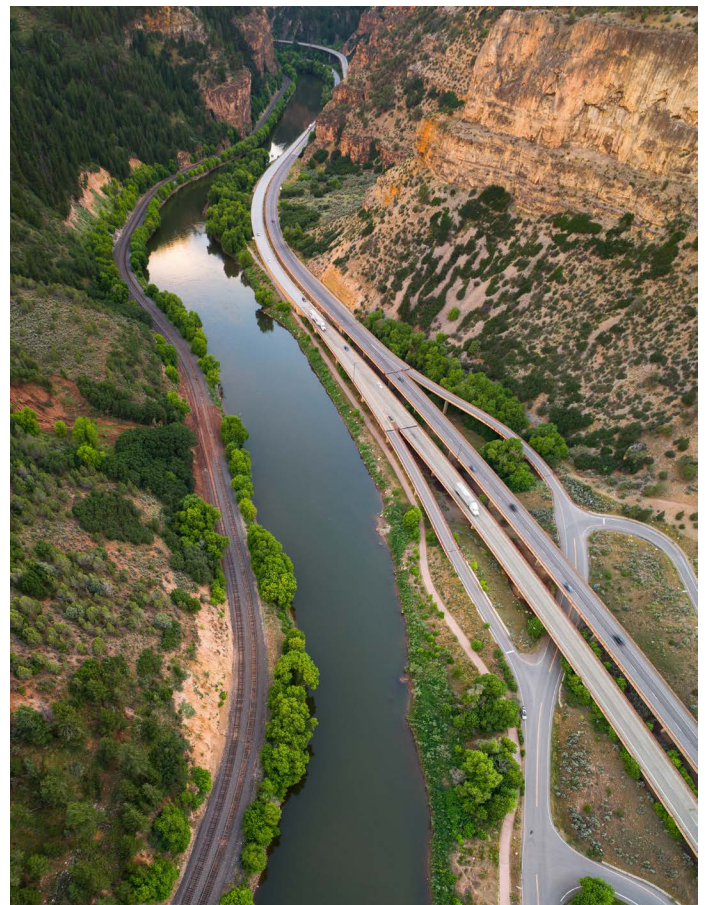
Clinical Pearls

- Ultrasound can provide quick and dynamic diagnostic and prognostic information about patients with SBO
- Signs of bowel ischemia may be seen such as the following: intraperitoneal free fluid, wall thickening >3 mm, decrease or no peristalsis especially on previously active or hyperactive bowel

- Ultrasound is just as sensitive and more specific for SBO than upright abdominal xrays
- Can decrease need for contrast, radiation, and transport from the ED
- Can decrease time to diagnosis and allow for expedited surgical consultation and management

Resources

- <https://www.acep.org/Content>
- <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3299163/>
- <http://www.ajronline.org/doi/pdf/10.2214/AJR.11.6594>
- <https://www.aliem.com/2014/09/small-bowel-obstruction-diagnosis-ultrasonography/>
- <http://www.mdedge.com/emergency-ultrasound-bedside-ultrasound-diagnose-small-bowel>



Feature Article

FIVE TIPS FOR CREATING YOUR “WOMEN IN EM” COMMUNITY

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In an era of Free Open Access Medical Education (FOAMed), exclusively online communities, and remote lecture attendance, in-person networking is often undervalued. This was underscored during a trip to New Orleans and the AWAEM luncheon at SAEM, when meeting several other Chicago-based physicians interested in forming a city-wide “Women in Emergency Medicine” event series.

Chicago has a high concentration of hospitals and Emergency Medicine (EM) residencies, but there was little collaboration between the many groups of female emergency medicine physicians throughout the city. The “Women in EM All-Chicago” events were started to create a community to explore the unique challenges facing the female emergency physician. The first four events in our series were well received and were successful in creating a network of mentors and mentees to support female EM physicians across the city. Through our experience with this event series, we have identified five important principles to help you build your own communities. Although Chicago is unusual in its high concentration of hospitals and EM residency programs, these concepts can be applied to create a community of Women in EM in smaller cities or rural areas as well.

FIND YOUR CHAMPIONS. Every successful collaboration needs a solid base of individuals who will champion the cause and lead to the successful creation of a community. The ideal planning team consists of fully engaged stakeholders from among the group who can amplify the effect of one or two main leaders. To find these individuals, circulate an email to a wide circle of possible contacts including department chairs, residency program directors, and chief residents. Interested team members may be senior residents, female program directors and faculty, or interested community physicians who are dedicated to the success of the collaboration.

Seek at least one member of your planning team from each residency and major institution in your area, to assist you in selecting resident-friendly times and formats and spreading the word via mass email about events. While this group will be an important source of guidance during planning, expect to have about one or two lead planners for each event. Finally, be sure to keep your champions updated. Following each event, send this team a summary of the event, as well as the cost, attendance, and any funds carried over. The longevity of your community requires consistent follow-up communication since planning team members will not be able to attend every event.

SIMPLIFY FUNDING. Consider an attending-sponsored funding model. Residency sponsorship can be tricky to secure, often requires receipts or certified checks and may limit your purchases. Instead, when planning the event, establish a suggested attending contribution of \$30-50, approximately double the estimated cost per person. As long as your communication with the attendees notes that the higher attending contribution facilitates resident attendance, the attending physicians gladly contribute and residents are able to attend free of charge. For reference, total budget for our events has ranged from \$300-



1800, with average attendance of 15-45 individuals. We consistently experienced a 70% turnout relative to the number of RSVPs, which is a helpful estimation for budgeting and food-ordering purposes. Additional budget-friendly strategies we recommend include ordering from daily specials or a catering menu in advance and using tickets to monitor and control beverage expenses. If there is left-over money from a gathering, it is deposited for future events.

KNOW YOUR AUDIENCE. The women you are seeking to connect are from diverse backgrounds and in many different stages of life, from beginning residency to early career to well-seasoned veteran. Your planning team, drawn from these diverse backgrounds as well, will be critically important to ensuring that the events under development will appeal to a broad base. Seek to vary the format, timing, venue and goals of each event. For example, our events have varied from a dinner with a lecture, to a networking cocktail hour, to a child-friendly intern welcome brunch. The lecture-style event was the best attended of the four, likely due to bringing in a nationally known speaker. Variety in venues is also helpful; while bars and restaurants are usually simple to book, they can be more expensive. One alternative is to consider hosting a catered event in a member's home or community room.

ADVERTISE YOUR OPPORTUNITIES. In order to reach a broad range of female EM residents, fellows, and attending physicians, create an event or "Save the Date" flyer that can be easily forwarded via email and an easy-to-use RSVP link to an online form. Ask your contacts on the planning team to forward the email invitation to their respective residents, faculty, and affiliated or moonlighting community sites. An advance notice "Save the Date" allows for interested attendees to request the evening off when making their schedules, or in some cases for residency programs to protect female residents' time during the event. Attendees from prior events can be directly notified of subsequent events, which is a great way to amplify each initial invitation. Through these methods, our physician attendees for the events included representatives from all 8 area residencies and over twenty academic and community hospital practices.



FACILITATE CONNECTIONS. Networking is a skill that most recent graduates are still developing. While networking connections can occur spontaneously, the opportunity or challenge to make a new and meaningful contact can produce great results for community members. We suggest the concept of table topics, which have also been used to facilitate focused discussions at AWAEM's luncheons. This allows mentees and mentors to seek common ground, thereby making new connections in the process. Alternately, after a more formal portion of your event, such as a lecture or panel, consider challenging attendees to make one new contact before leaving. This deliberate practice of networking can then form the basic strategies women physicians need to develop a professional network throughout their career.

The success of the initial four well-attended events of our newly created city-wide "Women in EM" community has shown us that there is certainly a need for such a group. We have seen that the new connections formed at these events are already proving to be of great benefit to the community members. Potential mentors and mentees alike attend with the intention of meeting peers and asking advice, and also with an eagerness to help other women physicians who are in an earlier stage in their careers. We look forward to continuing this tradition in our own Chicago "Women in EM" community. We hope that our recommendations serve to inspire you to begin or amplify a similar opportunity in your own community.

-Sara and Shana

Wellness Kit

WELLNESS CORNER

Jeannette Wolfe, MD

**Mini-Meditation**[Walking Meditation](#)**Learn how to do**[Tactical Breathing](#)**Personal Growth Book**[Thanks for the Feedback](#)**Fun book**[The Woman in Cabin 10](#)**Ten recipes to make in**[10 minutes or less](#)**Mini indulgence**[Artisan stethoscope name tag](#)

Make the most of yourself by fanning the tiny, inner sparks of possibility into flames of achievement.

- [Golda Meir](#)

Wellness Article

WELLNESS UPDATES AND RESOURCES

Amy Ho, MD | amy@amyfaithho.com | AWAEM Wellness Committee Co-Chair

Wellness is influenced by many factors – workplace satisfaction, flow of work, and interpersonal interactions including sexual harassment. In the context of many national news headlines – publicized sexual harassment, mass violence, and (unfortunately) much more – the ER can become a dark place to work. Below we list some updates and resources for Wellness.

- Organizational changes for wellness. American Medical Association issued [this paper](#) (worth 0.5 CME!) regarding organizational changes for physician satisfaction! Great for administrators and helping to implement a wellness-focused culture at your institution!
- Holy interruption, Batman! Emergency physicians experience an average of [84 interruptions](#) per shift in a recent study. These interruptions can result in [mistakes](#), but also are a big contributor to our satisfaction with our shifts and feeling like we have control over our workroom! An emergency physician assistant makes recommendations for minimizing interruptions [here](#).



- The majority of healthcare providers have experienced workplace violence, with a [Canadian survey](#) revealing many experiencing more than nine instances within a year! Likely changes need to occur at a [policy level](#), but in-department changes can be implemented as well, including ideas like metal detectors, on site security and police officers, etc.
- [Thirty percent](#) of female physicians have faced sexual harassment, and many more likely have experienced it but have not reported it. A recent JAMA study published this finding, with social media commentary focusing on how thirty percent seemed (anecdotally) low! This study focused on superiors and colleagues, but when including harassment from patients and across all healthcare personnel including nursing and physical therapists, the studies are [much more dire](#). Report these instances at your institution and make sure there are safe mechanisms for reporting. It's a contributor to our safety and satisfaction with shifts!

AWAEM/ADIEM Luncheon**TIPS ON DEVELOPING AS A SPEAKER****Dara Kass MD & Amy Ho MD****Writing the Talk**

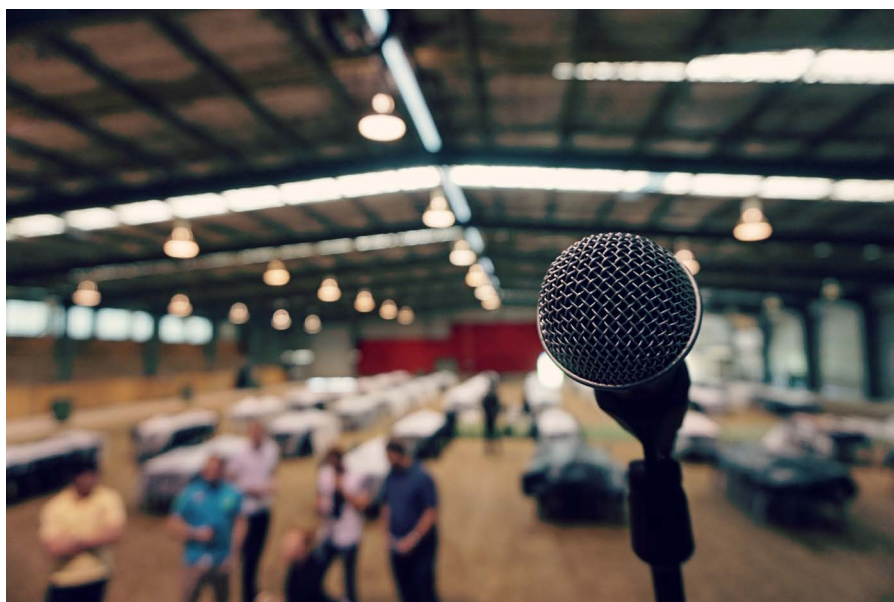
1. Pick a topic you want and like to speak on
2. Develop the talks into different versions such as in length, a variety of medical backgrounds, and conference cultures (academic v. community)
3. Read about developing a talk and check out the [FemInEM bookstore](#) for more materials!
4. As a base, develop a 20-minute talk with 20 slides. Longer talks are falling out of favor and 20 minute talks are a good place to expand or cut down from if needed
5. Procrastinator? Most places require only a pitch for consideration of a talk but once accepted you will need to develop the full talk

Marketing yourself for talks

1. Video ALL talks, no matter how small to give you ammunition for submitting to bigger places!
2. Save EVERY evaluation from your talks to also better vet yourself for future talks
3. Join Speaker's Bureaus like the [FemInEM's](#) to increase your profile and chances of getting invited to speak!

Finding a place to give your talk

1. Start with low hanging fruit such as regional conferences, grand rounds, and hospital M&M's and expand from there. Open-calls for speakers are also great opportunities. For example, ACEP has a first-come-first-serve New Speaker's Forum (June traditionally) that is an open application to speak at a national conference.
2. Understand the differences between various conferences and how they fund speakers.
 - A. Be aware of the "Three Talks" rule where you are expected to give three talks to get funding for a conference (and subsequently, be ready with three talks when you submit)
 - B. Learn how they select speakers -- some require you to be in their speaker's "bureau", some are selected by a committee (so write to the chair to let the know you are interested), and some are submissions
3. Get on the alternate list for other people in your shop - if they can't make it, you could be asked to step in



Professional Development

PARADIGM FLIP: FROM EMAIL DEPENDENCE TO EMAIL MANAGEMENT



Laura Medford-Davis, MD, MS

Today emails pour into our inboxes at a breakneck speed. Constant access to email via smartphones gives these emails an (often false) sense of urgency, but there are a few key steps you can take to organize your inbox and save you countless future hours. While many emergency physicians like myself may balk at the structure and discipline outlined, these tips and tricks are necessary to reclaim control of your time from your inbox.

Key Steps:

1. Define and maintain your own boundaries.

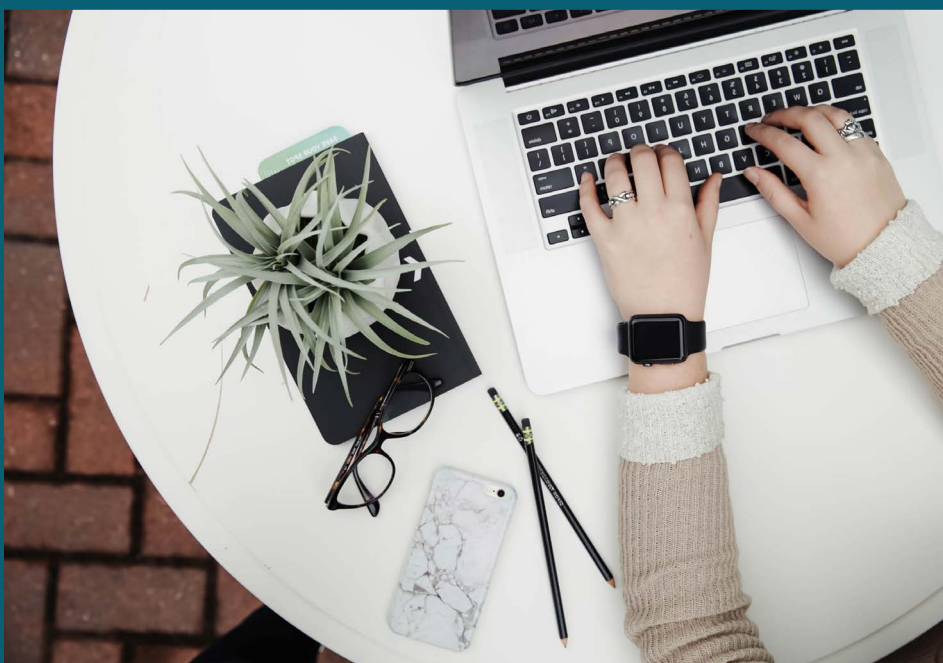
- As emergency physicians, working nights and weekends might make you feel as though you should always be available for email, too. If you do not set boundaries for when you will not respond to emails (weekends? After 7pm?), and how quickly you need to respond (48hrs? a week?), email will feel much more daunting than it needs to. Define your boundaries and share them with your colleagues so they know what to expect.
- Set an auto-response when you are on vacation so that people know you are away, and then give yourself permission to unplug.
- In addition, not everyone who asks you for something

needs your time. You are not the only person available or able to help, and some requests from strangers can be deleted without responding at all. Requests to write for junk journals or to include students you haven't met in your research come to mind. Get comfortable with saying no, and with hitting delete without even writing the word no. It may feel mean, but enacting such a policy will reclaim a lot of your time.

2. Decide on the first pass: Do, Delegate, or Delete.

When opening your emails, spend no more than 2 minutes on each message. This is a **quick triage to decide what the message requires**, and can be more efficient on a smartphone where you can quickly swipe to delete based on the sender, subject, and first two lines.

- If it's a quick question that can be answered in under 2 minutes, respond and archive the message. Similarly if you need to put something on your calendar or perform a fast, simple action, go ahead and take care of it. Do it now while you're engaged with the message, otherwise you will double the total amount of time the message takes because every time you reopen it you need to reread it and reengage.

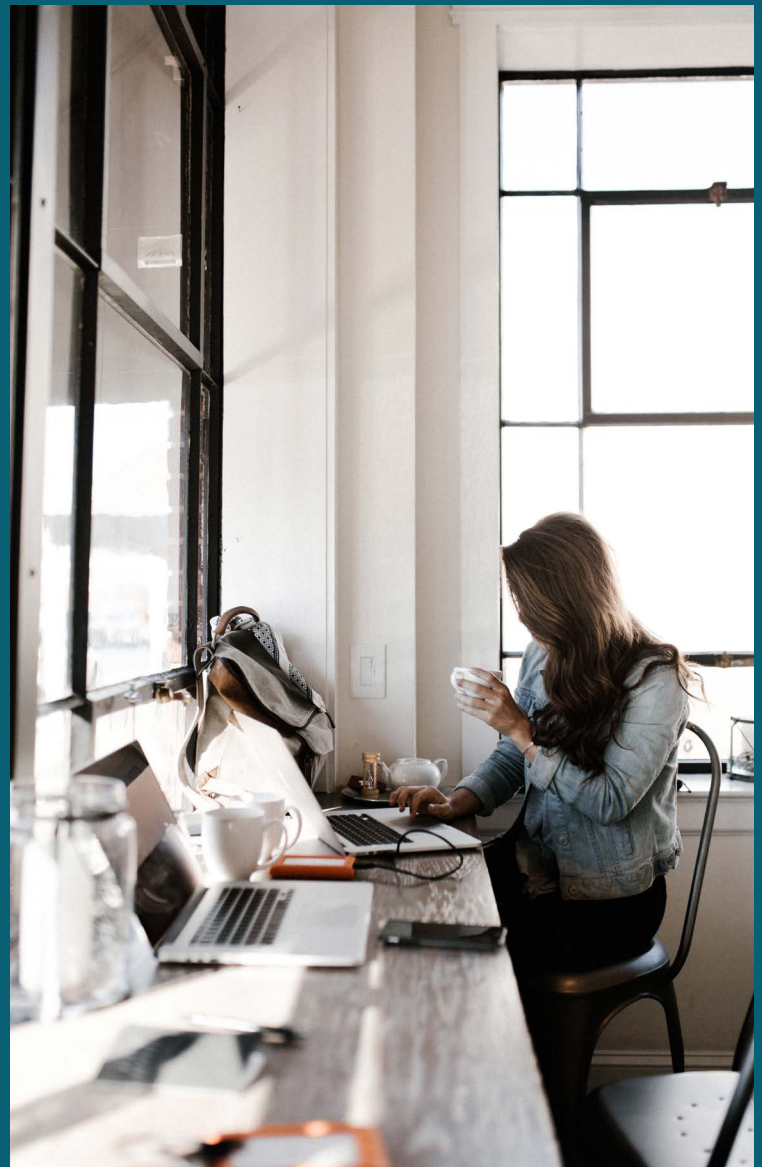


- If there is someone else who is better equipped to handle it (e.g., your assistant, a coworker, a family member), **forward** it on and add a one-line summary of your request for that person to the top of the email.
 - If it's junk or does not require a response, **delete** it immediately.
3. **Utilize folders.** For all other emails that require more than 2 minutes and a smartphone, archive them into folders. In addition to subject-related folders (I have one for each hospital where I work, one for each paper or research project, etc.), there are a few helpful additions:
- **Do today** – urgent and important tasks that must be completed ASAP. Before signing off from work for the day, review this folder to ensure you are not missing anything.
 - **Do soon** – important tasks that are less urgent. Some people subdivide this folder into exact deadlines. You could go as far as to make a different folder for every day of the year and file messages in each based on their exact deadline. I choose to keep this as a single folder that I review every few days and at the end of the week.
 - **Wait** – this folder is for messages where you have responded, but need to receive another reply before you can fully cross it off your list (e.g., scheduling a meeting).
 - **Someday Maybe** – use this to archive things that look like they might be interesting to read, but are not urgent or important (e.g., research articles, news articles).
 - **Nice** – Optional and not related to efficiency, but I save all emails that say something nice about me (thank yous, compliments, etc.) to review on bad days.

4. **Aggressively unsubscribe.** Review all the ads and newsletters that you receive and take two minutes to unsubscribe from any that are not useful to you or that you are not consistently reading. This decreases your total email volume over the long-term.

Several of the strategies I am sharing come from David Allen's *Getting Things Done*. You can learn more at <http://gettingthingsdone.com/tag/email-management/>

-Laura



FemInEM Idea Exchange

THE POWER OF FIX



Danya Khoujah, MBBS

FemInEM Idea Exchange (FIX) was hands-down the most inspirational conference I have ever attended! Thanks to all the women and men of FIX17 for sharing these phenomenal insights. I can't wait for FIX18 - October 16, 2018 can't come soon enough!

1. The power of networking: There are a lot of smart, accomplished, hardworking women in emergency medicine who are genuinely interested in the advancement of women in the workplace, academia, leadership and life in general. Find ways to connect with like-minded women, whether in person or at conferences like FIX, AWAEM, AWAEP, etc. Who you know is just as important as what you know.
2. The power of mentorship: Leaders grow by standing on the shoulders of others. This fact is well recognized by the well-accomplished men and women in our field, and they welcome opportunities to give back to the community.
3. The power of Twitter: There have been hundreds of original tweets, close to one million impressions and 300K potential reach for FIX since the conference. In plain English, that's a lot of people reading about FIX (and you!). If you have not used Twitter before, do not be scared. There are a lot of online resources, and even better, people willing to help. Recruit one of your social media active colleagues. A cup of coffee and sincere interest will take you a long way.
4. The power of advocacy: Women tend to undersell themselves, not ask for opportunities, and give in to "bullying" to conform to social expectations. Explanations vary from

anthropological aversion to risk-taking behavior to subtle cultural disdain for assertive women. Gender equity will not happen if we do not advocate for ourselves. Remember, you cannot project your voice unless you believe you have a voice!

5. The power of choice: FemInEM come in all different shapes and colors. From working in a rural hospital to an academic center, from being a Jane of all trades to picking an unusual procedure as a niche, there's something for everyone. The inquisitive nature of the great women (and men) at this conference led them to explore areas of interest that may not be typically geared toward physicians and find their niche outside the realm of "typical" interests. Don't be constrained by the script into which you were born. The moment you take responsibility for everything in your life is the moment you can change anything in your life.
6. The power of leadership: We tend to think of leaders as chairpersons, program directors, or CEOs. Recognize the leadership role you lead on a daily basis; the director of flow in your emergency department, the leader of a resuscitation, and the clinical mentor for the day. Humility and the ability to give good feedback are essential. Be authentic, kind, humble, truthful and helpful.



7. The power of speaking: People fear public speaking more than they do death. That said, it's the best way to advocate for yourself and your cause. Whether it's a keynote lecture at a major national conference or sharing your opinion at a meeting they are both two ends of the same spectrum. The only way to get better at public speaking is to do repeatedly and put yourself out there. There are numerous resources, some open to all comers while others are targeted toward a specific group such as emergency physicians or women. Identify a "dream" speaking opportunity and ask yourself, how can I get there? Reach out to prominent speakers in your field of interest (see #2) and ask them to show you the ropes. Remember the elusive charm of the "out of town" expert - that could be you!

A few resources to check out are Angela Lussier's Speaker Sisterhood and the AAEM Speaker Development Group.

8. The power of writing: Dr. Amy Faith Ho and Dr. Christine Ngaruiya shared their tips on writing

for the media. Greatest tips? Engage, be you, be passionate and be aware. Learn more at <http://ed.gr/f1he>

9. The power of reading (or those with long commutes listening to audio books): Speakers and workshop directors shared a few of their favorites books, which cover a range of topics, from finance, to writing, to female empowerment. Some are sure to make your "Must Read" list. These made it to mine:
- Smart Women Finish Rich by David Bach
 - Women Don't Ask by Linda Babcock and Sara Laschever
 - You Are a Badass by Jen Sincero
10. The power of planning: Whether it's in tackling a big project, the next step in your career, or combating stress on a daily basis, being deliberate and mindful of our actions is at the core of getting things done.

- *Danya*

Dr. Danya Khoujah was born and raised in Jeddah, Saudi Arabia. She completed her medical school education at the King Abdulaziz University College of Medicine. She went on to complete her residency training in emergency medicine at the University of Maryland Medical Center, followed by a Faculty Development Fellowship. She is currently enrolled in a Master of Education in Health Professions at Johns Hopkins University. Her interests include medical education, geriatrics and neurologic emergencies



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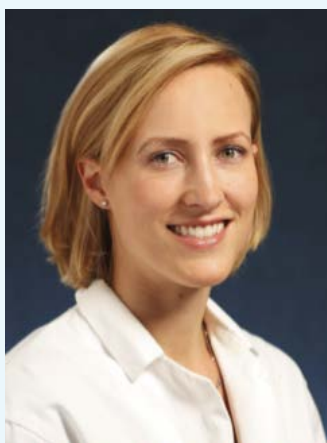


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