AWAEM AWARENESS

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

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AWAEM
Academy for Women in Academic Emergency Medicine

President's Column

By Kinjal Sethuraman, MD, MPH

I want to congratulate SAEM and AWAEM for a very successful annual meeting in Orlando. It was a very productive meeting and I saw many new faces eager to get involved and we all reconnected with friends and mentors. The energy was positive and the comradery was strong. I want to thank Basmah Safdar for being such an inspiration. Her energy, dedication and love for Google Drive showed me what real leadership looks like. I hope I can come close.

I almost didn't run for President of AWAEM. I normally take my rightful place in the background helping less self-conscious, smiling people take the forefront. Aside from feeling like an imposter and that I would acquire having to fill the very big shoes of the presidents before me, I didn't want to do it because of my fear of writing. This Column scared me.

I've used the "English is my second language" for an excuse for grammatical and spelling mistakes for years- I still say it

now, half-jokingly when I manage to mix up common American idioms.

Leading the largest Academy of SAEM or talking to The Very Important People of Emergency Medicine didn't come close to choosing -in correct order- these requisite 400 or so words. So I did what any self-effacing writer does: I asked for help from my "people".

How does one acquire "people?" These aren't your family, or even childhood friends. These are the people that get you, both personally and professionally. They become your people not by how long they have known you, but your shared disposition in life and having common professional and personal goals. I watched the Legacy Video and recognized myself in many of the women that spoke about their personal experiences. Our stories are the same but different. We learn from each other and teach each other. We are happier and stronger together in joy and misery. Most of all, we are comforted in knowing that we do not stand alone.

I stay in SAEM and AWAEM because they are Home. Every year, I come to our annual meeting to be rejuvenated- to recharge professionally. I stay here because my people are here. If you think about your education and career path, you have self-selected not just into Emergency Medicine, but Academic Emergency Medicine. AWAEM is then the subgroup of people that are ambitious, collaborative and inclusive. We are data-driven in identifying problems, and goal-oriented in implementing solutions. We are successful because we stand by the belief that "your success and my success are not mutually exclusive." We believe in the mission of AWAEM and as my people have put it, "AWAEM gives back." Join Us. Let's Get Things Done. Be Happy to Help.

Kinjal

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Feature Article

Hierarchy and a Culture of Wellness

By Amy Faith Ho, MD

When I was a medical student, trying to forge my path on the clinical wards as a third year, there was a lot to turn me off the idea of a career in medicine entirely – sleep deprivation, early mornings, late nights, standing for hours on rounds, subsisting on diets of hospital graham crackers and off-brand peanut butter. However, what frosted me the most was constantly playing 6 degrees of separation from the attending.

As a student, you reported to the intern who reported to the junior resident who reported to the senior resident who reported to the fellow who then discussed with the attending. After all that work, you spent most of your time just trying to keep track of the medical decisions that happened at the attending level, as that information slowly trickled back down the ladder to you.

In the emergency department, such is not usually the case – students, interns, residents, fellows and attendings alike all work side by side for 8-12 hours at a time. On inpatient units, your only interaction with the attending was often only at rounds (and even then, you weren't convinced the attending knew your name by the time he or she was expected to fill out your evaluation). But in the emergency room, the team dynamic usually has a more egalitarian feel. Often the attending is bedside helping interns and students with procedures, and in general everyone is easily accessible and usually approachable and open.

One of the things we've done better than any other specialty is form the team dynamic where order exists, but it doesn't oppress.

However, as we rise in the ranks (myself becoming an attending in just a few short months), we often forget what it feels like to be at the bottom of a totem pole.

While all levels of providers (as well as our highly-valued nurses and techs) have the feel of being in the trenches together in the emergency room, there is still carryover of hierarchy that is just endemic to the medical training system as a whole. Emergency medicine is exceptional at valuing all players as team players, but we still sometimes just as guilty of rudeness masquerading as part of the "accepted hierarchy". Below are some examples of insults and how we, as a field, can continue to improve:

1. *Calling the medical student "Student".* "Hey, Student!" is incredibly demeaning. Especially when we know we will be working with someone for an entire shift, it really is worth learning and remembering their name. Just think how much nurses hate it when patients call out from a room, "Nurssse! Nurrrse!". Don't do the same to the students. We can address people with names, not labels.

2. *Same as #1 for consultants.* We are a department that only calls on our colleagues to give them more work and we should try to be respectful of that. We exist in a symbiotic relationship, and at a certain point, "Hey, Neuro!" starts to seem too impersonal for those 4 am phone calls.

3. *Dropping the mic out the room once the procedure is done.* Attendings and senior residents alike are incredibly guilty of this – when we are doing a procedure with a more junior person, we have a nasty habit of leaving them and our mess after the fun/main part of the procedure is done. Junior residents are not janitorial staff. Students are not janitorial staff. While everyone understands that if things are busy, it is completely reasonable to ask someone to clean up so you can go do something else. However, often this happens as well when it is not busy. It's a bit insulting when the student emerges from a room covered in dust from cleaning up all the trash that fell on the floor (read: that you threw on the floor) during the procedure, that they find you at the desk looking at Facebook and telling them to go see another patient.

4. *Not recognizing the efforts of your ER techs, radiology techs, and respiratory therapists.* The department literally cannot function without radiology techs pushing those behemoth machines around for our portable x-rays, our techs doing our countless EKGs and other work, and our respiratory therapists taking the time at bedside to do all that deep suctioning we frankly don't have the time for. They can absolutely make or break a department, but we too often overlook them.

5. *Not looking after your own team.* The ER gets to be an incredibly chaotic place – as team leader, remember everyone on your team is still a person and you're responsible for their patients but also for them. Check in to make sure everyone has eaten something, drank something and urinated at least once during a shift! Not doing so is a recipe for burnout.

Of all the specialties, emergency is the best poised to help change the culture of bullying and abuse of hierarchy. These may be small changes, but small gestures can make a big difference for overall wellness and culture of a department – and hopefully, as a field.

Amy

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fix

feminem idea exchange 2017

October 4-6, 2017
New York City

Guaranteed to be the most inspiring women's development course in emergency medicine!

DAY 1-2: FIX Talks

FIX 2017 starts at the **SVA Theater** in NYC. A single track course with a combination of short talks (8-10 min), longer talks (15-20 min) and expert panels. The Workshops will affirm!

DAY 3: The Workshops

FIX 2017 culminates at the **Innovation Loft** in NYC. Pick your own adventure! Select from well curated workshops on presentation style and design, speaker development, leadership, academic writing and time management.

SPEAKERS INCLUDE:

Diane Birnbaumer, Ross Fisher, Sara Gray, Resa Lewiss, Lynne Richardson, Gillian Schmitz, Mizuho Spangler, & Scott Weingart.

Two Registration Options:

FIX TALKS: October 4-5

Includes:
2 days of talks for our FemInEMS at the SVA Theater.

October 4 at Night:
FIXinNY Dinners: Pre-Organized Networking Dinners throughout NYC! Dinner for groups of 8-10 to facilitate networking and mentorship.

October 5 at Night:
All FIXed Dinner and Drinks
Our FIX2017 Event for speakers and participants at SLATE NYC.

THE FULL FIX: The FIX Talks + Workshops: October 4-6

Includes the above and:
Single Day of Small Group Workshops at the Innovation Loft.

"Our content will be relevant, empowering and inspirational. After they are *All FIX*ed, participants will ready to take on the world!"

- Dara Kass, '17

feminem Registration will open April 1st at **www.feminem.org**

Resident Corner

#Shemergency: The Unstoppable Movement

By Amy Waldner, MD

I'm excited to introduce you to an unstoppable movement that I've been a part of throughout my residency tenure: #Shemergency.

I am incredibly fortunate at my residency program to be surrounded by an abundance of highly successful and all-around phenomenal female mentors, with a substantial percentage of women in leadership positions. However, I recognize this may not be the case everywhere. When I started residency, there was an awesome tradition of "ladies' nights". In the past few years, we have lovingly started to refer to these as #Shemergency nights. A slight change in the name has brought with it a sense of empowerment. We have moved beyond a 'social' group to a 'support' group of sorts.

I'm hoping to convince women in other residency programs to start a similar #Shemergency tradition. This group has created a safe and supportive environment where we can share and grow together.

Steps to create a resident-driven #Shemergency group:

For Residents:

1. Be the driving force!!!
2. Find 2-3 interested attendings who are supportive and willing to commit.
3. Communicate to your attendings how valuable this group is to you (and also to them!).

4. Review the resident/attending schedules to find times when most women residents/attendings are not scheduled.
5. Plan quarterly, potentially kid-friendly, inexpensive events and ensure your core female attendings/residents are available (2-3 residents and 2-3 attendings at minimum). Create a listserve of all female residents and attendings to invite.
6. Enlist suggestions from attendings/residents for activities and delegate one person to plan each event.
7. Encourage other specialties to do the same and have joint activities:

#Shemedicine #Shediatrics #Anesshesia #ShENT.

8. Go Viral! Share what you are doing on social media.

For Attendings:

1. Schedule times that are best for your schedule and encourage participation.
2. Schedule activities that are easy for you to participate in and get to, as well as kid-friendly. I guarantee your residents will be willing to entertain your kids during these events at no additional cost ;) Think about holding events at your house if that's an easier option.
3. Work with 2-3 residents across different years to ensure the group continues.
4. Know how much your residents will appreciate your time and presence!

Potential barriers/criticisms:

1. "We have a limited number of female EM attendings"

Reach out to female attendings and residents in other departments. They likely have similar challenges/successes in their careers that they can share with you.

2. "Why not include males? Won't this create a larger divide along gender lines?"

Okay then, include them! We all recognize that both men and women are needed when it comes to tackling gender inequality issues. If they are interested in joining, they are always welcome. There may be some benefit for them to create a similar group. Our male counterparts have created quarterly #MenofEM activities thanks to our lead and are excited for co-ed events.

3. "We are too busy"

Time will always be the biggest barrier so plan in advance and don't use it as an excuse to not do this!

4. "I can't think of any events"

Great, we've created a list of activities that include wellness, service and career advancement activities. Contact me if interested!

Amy

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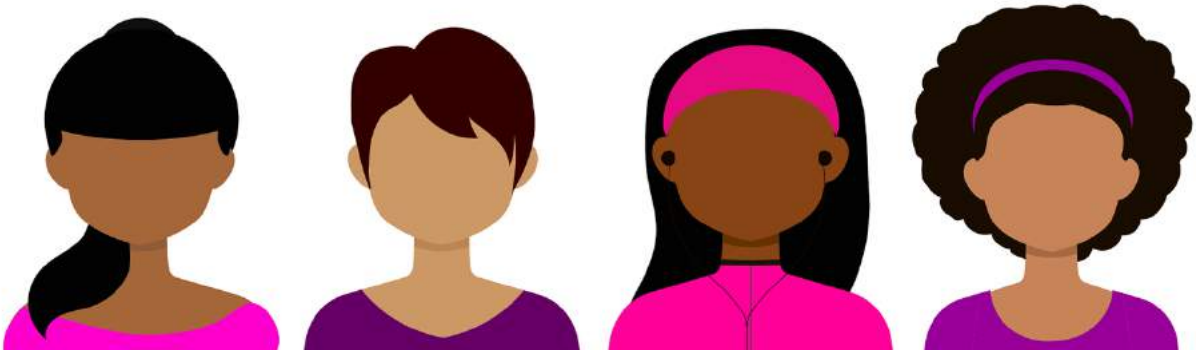

Clinical Article

Point of Care Ultrasound for the Diagnosis of Nasal Septal Hematomas

By Maria Tama, MD and Devjani Das, MD

Falls are common emergency department complaints for patients of all ages. The severity of injuries sustained in a fall can vary and point of care ultrasound (POCUS) may aid in the finding the extent of injuries in these patients. One new application for POCUS is in the assessment of facial trauma, specifically nasal septal hematomas. A nasal septal hematoma is a collection of blood within the septum of the nose. These hematomas can obstruct the small blood vessels that supply the nasal cartilage and can lead to necrosis of this cartilage. Patients can present with nasal swelling, tenderness, or a visible deformity. These can often be seen during the primary survey but the injuries are often in the early stages of development and a thorough physical examination can be painful especially in the pediatric population. The use of POCUS can aid in rapid detection of abnormalities such as fractures and fluid collections below the surface without waiting for an x-ray or a computed tomography (CT) scan.

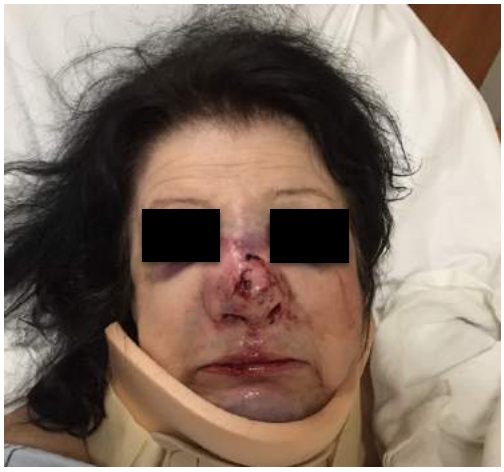

Figure 1: Facial Injury concerning for Nasal Septal Hematoma

Ultrasound basics

Ultrasound evaluation of soft tissue and other superficial structures are best done with the higher frequency linear probe. In patients with gross deformities and obvious trauma, placing the probe in direct contact with this area can yield results. In figure 1, the probe was placed directly over the ecchymosis and swelling of the nasal septum in the sagittal plane. Examination of the nasal cavity, located lateral to the septum in both directions should also be done. The affected area should be evaluated in two planes, sagittal and transverse. Evaluation of the bony structures is made easy in this imaging modality. Locate the hyperechoic line (line that is brighter in relation to other structures) and follow it, observing for any disruptions or irregularities. A disruption is consistent with a fracture and can be seen by the yellow arrow in figure 2. The area surrounded by red arrows is hypoechoic (darker in relation to other structures in view) and heterogenous consistent with a fluid collection.

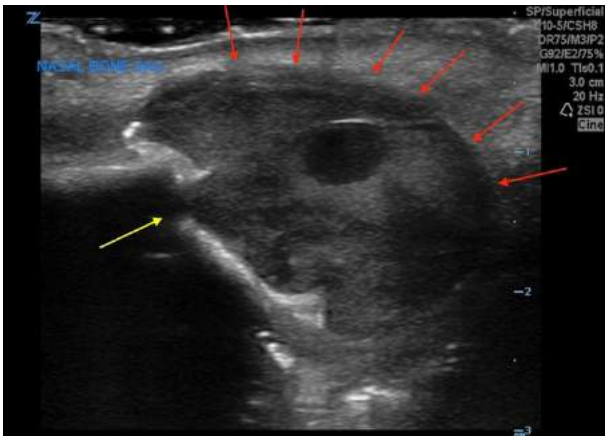

Figure 2: Nasal Fracture and Septal Hematoma

In this case, a nasal septal hematoma is present. Using color flow in this ultrasound evaluation can be very helpful in evaluating for active bleeding. Figure 3 shows color flow of an active bleed depicted by the blue arrow which shows a rapidly growing nasal septal hematoma.

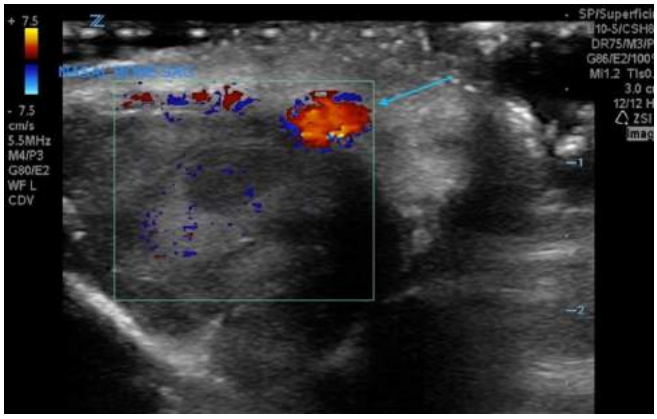

Figure 3: Active Bleeding in Nasal Septal Hematoma

Why should I use ultrasound for this?

Though nasal septal hematomas are rare, early diagnosis and treatment is important to prevent complications. Utilizing POCUS as a rapid imaging modality for evaluation of facial trauma allows for rapid diagnosis and can expedite treatment and decrease the associated risks of complications, i.e. infections, avascular necrosis. Treatment of a nasal septal hematoma can vary from close observation to surgical drainage. POCUS can allow for shorter time to diagnosis and ultimately, to treatment and improve the overall prognosis of these patients.

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Maria

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Professional Development Article

Time Management: Separating Urgent from Important

By Laura Medford-Davis, MD, MS

Our new professional development column focuses this month on effective time management using a prioritization principle from Stephen R Covey's *The 7 Habits of Highly Effective People*.

To improve time management and productivity, Covey suggests that you plot all of your pending tasks on a matrix of urgent/not urgent and important/not important.

Urgent tasks have a deadline or are highly visible to you, while important tasks contribute to your long-term goals. Spending time defining your medium and long-term goals will help you to effectively prioritize all the tasks on your plate. Start by applying this framework to all your current tasks. Then when you are asked to do additional things, apply the framework to prioritize any new tasks among your existing tasks.

	Urgent	Not Urgent
Important	1	2
Not Important	3	4

1. All tasks that are both urgent and important, for example a K award deadline or an ED patient in respiratory failure, receive first priority. With time, however, the goal (at least outside of an ED shift) should be to anticipate deadlines and crises before they occur, so that all of your tasks remain in category 2 instead of category 1. This requires you to be *proactive,* so that you can avoid being *reactive.* Review your calendar frequently, keeping an eye on tasks 2-4 weeks in advance, and start devoting an hour a day to work toward deadlines while they are still far out in the future, before they become crises.

2. Tasks that are important but not necessarily urgent should be where you focus the majority of your time and attention. These tasks are important to you and your life goals, so they are the most personally fulfilling and will make you feel as though you have accomplished the most with your time. Because they are not urgent, however, we often fall into the trap of focusing on areas 1 or 3 when we really should be focusing here. Things like building relationships, spending quality time with friends and family, exercise, and vacations fall into this category, as do long-term professional goals such as publications and promotions.

3. Noticeably in Covey's model, not all urgent things are actually important. Receiving five email reminders requesting that you complete a survey about your recent flying or dining experience does not mean that the survey is worthy of your time. Similarly interruptions at

work, which we experience frequently during our shifts and due to the 24/7 ping of text messages and emails, can push themselves into our 'right now' bucket. Give yourself permission to deprioritize these types of tasks. When someone is pushing for your time, rather than shifting your attention to provide a full response immediately, offer up a future timeslot after you complete your more important tasks: "can I get back to you next week?"

4. Finally, recognize that some tasks on your to-do list are neither important nor urgent. If they do not meet your goals nor recharge your batteries, give yourself permission to deprioritize these tasks forever. Say no. Delete them from your inbox without guilt and save your time for the things that matter to you.

Laura

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Connect!
@MedfordDavis

AWAEM Award Winners

Outstanding Department Award

The Emergency Medicine Department that has shown support of women in academic EM through organizational initiatives that address the recruitment, development and advancement of its women physicians, promoting gender equality, diversity, opportunity and inclusion.

Brown Alpert Medical School

Early Career Faculty Award

Tracy Madsen, Brown Alpert Medical School

Mid-Career Faculty Award

Angela Mills, University of Pennsylvania

"Hidden Gem" Award

For outstanding contributions through clinical work, teaching, mentorship, role modeling, or administration, having great impact locally or regionally.

Kelli O'Laughlin, Harvard University

Constance Nichols, University of Massachusetts

Richelle Cooper, University of California Los Angeles

Emergency Department Director Award

To honor female faculty who serve as ED medical directors who have shown significant career achievements in EM, and more importantly, have improved working environments in their departments.

Lynne McCullough, University of California Los Angeles

Outstanding Research Publication of the Year Award

The first author of an outstanding research manuscript published in the past year.

Laura Walker, Mayo Clinic

Outstanding Resident Award

Amy Ho, University of Chicago

Congratulations to All!

Luncheon Discussion Summary

Academic Careers with Young Children

Moderator: Flavia Nobay, MD

By Devjani Das, MD

Connect! @flavster19

This particular topic at the annual AWAEM/ADIEM luncheon sparked lively conversation amongst EM physicians at all different stages of their career. Participants at the table ranged from medical students just graduating medical school and entering residency to mid-career faculty trying to navigate their future academic career, all with either young children or with children on the way. All members of the table agreed that despite what stage of your career you may be in, it really never gets any easier. Though there is no universal standard by which it is feasible to have a successful career and be the parent that you strive to be, finding the individualized approach that works in your life is paramount. A few of the strategies that were discussed were as follows:

1. **Ask for help!** Help may come in many different forms – family, friends, nannies, babysitters, daycare, etc. Whatever the form of help that works for you is fine; just don't be afraid to ask for it.

2. **Appreciate those around you who are helping you!** In the midst of how busy we find ourselves and how much we think about our own struggles, don't forget to appreciate all those who are helping to allow you to do what you love to do. Paying attention to your spouse or family and their needs will go a long way in fostering healthy relationships and ultimately benefit your entire family.

3. **Organize!** Five minutes of prep in the morning to schedule your day will go a long way in saving you valuable time that you could be spending doing work or with your family.

4. **Communicate!** Instead of expecting those around you to understand what you may be going through, it is better to start the conversation on your own. This may apply to the intern just starting out residency and letting his or her chief resident know of how they may facilitate prioritizing family time. It may also apply to junior faculty who are currently pregnant and need to figure out a maternity leave schedule that will optimize the amount of time she may have at home to spend with her newborn while balancing her responsibilities as a faculty member. Remember, only you know what your particular needs are and what may work for you. This may include taking less desirable shifts on nights or weekends for a period of time while allowing you to have time off during the week when your baby is at home.

5. **Return to work when <u>you</u> are ready!** This may be different for each person. Some of us may want/choose to take a longer maternity or paternity leave while others may want/need to come back to work sooner. Again, there is no universal standard for all of us. If you are able to, taking longer stretches of time off when your children are younger may be ideal. However, this may be at the expense of taking a pay cut or working less desirable shifts. On the other hand, some of us may need to come back sooner for financial reasons. Whatever the ultimate decision is of when to return to work, make sure you are in the mindset to return to work. When you arrive back at work remember that those around you expect that you are fully back in work mode. If you return too soon, you may risk feeling unfulfilled at work and feel negligent with your family life.

6. **Be present!** If you are at work, be at work. If you are at home, be at home. Both parts of your life will expect your undivided attention and deserve to have it. The myth of multitasking is exactly what it sounds like.

The conclusion of our conversation hinged on all of us realizing that, despite how stressed we may feel day to day, everything will really be ok. Our children will only really be young once and years from now when we look back, the minutiae of our daily struggles will seem like nothing more than a distant memory.

Devjani

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Project Update

Emergency Medicine X: Creating Innovations Towards Equity (ExCITE)

By Neha Raukar, MD, MS

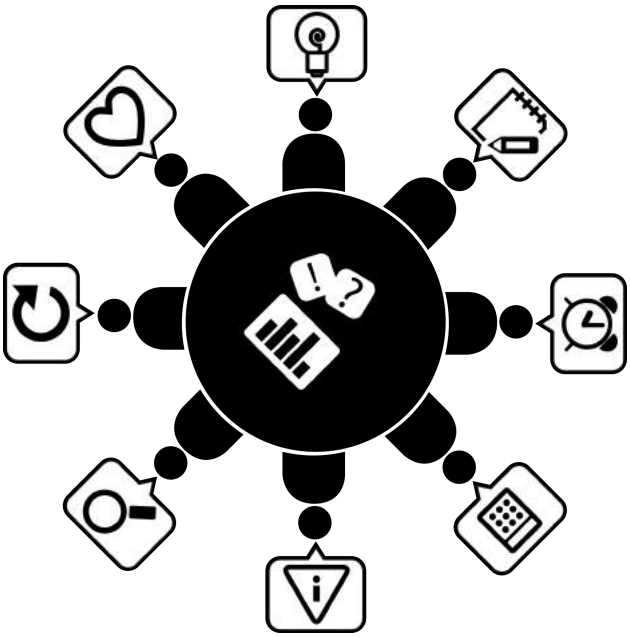
Goal: To identify and address gender gaps and organizational practices that hamper the advancement of women emergency medicine practitioners and researchers through the development and promotion of best practices for women in Emergency Medicine

At the AWAEM business meeting this year, we heard a progress report about the inaugural Emergency Medicine X: Creating Innovations Towards Equity (ExCITE) project. Cosponsored with ADIEM, the purpose of this innovative didactic is to promote creative thinking and implementation strategies to improve diversity, disparity, and bias within emergency departments around the country. Similar to the Lion's Den didactic, ExCITE has a *Shark Tank* theme with the intent to reward and financially support the implementation and research of innovative ideas developed through the didactic. By encouraging collaboration and diversity, this project was able to directly affect the immediate goal of enhancing the career success of academic EM physicians.

We had three Department Chairs who have agreed to participate in the didactic, bid on a practical and well-organized proposal, and implement the proposal in their department. For SAEM '16, these Chairs were Brian Zink from the Warren Alpert Medical School at Brown University, Annie Sadosty from the Mayo Clinic, and Peter Sokolove from UCSF.

We had 7 proposals and our department chairs invested in a total of four of the ideas. Below you will see a summary of the idea and an interim progress report.

The investor/entrepreneur combinations were:
Brian Zink - Tara Overbeeke/Kendra Parekh (WAM) and Indira Gowda (EMNinjas)
Annie Sadosty – Tricia Smith (AWE) and Dara Kass (FeminEM)
Peter Sokolove - Tricia Smith (AWE) and Dara Kass (FeminEM)



Tara Overbeeke and Kendra Parekh (Vanderbilt) proposed WAM, Women in Academic EM. They had a successful year, bringing their ideas to the Brown EM program and presenting their accomplishments at NERDS. The group was able to have the promotions committee restructured and the Executive Physician Leadership group to include more female faculty members. There

was a creation of a lactation space with a refrigerator in the ED. Through mentoring breakfasts with grand rounds speakers they were able to enlarge the pool of available mentors. Finally, they were able to successfully complete a full year of educational programming driven by a needs assessment.

A speaker development program was instituted by Dara Kass (NYU) at the Mayo Clinic. Four female junior faculty members were recruited to give grand rounds, and were then critiqued by Dr. Scott Weingart. Critique included commentary on slide design, appearance, body language, voice projection, among other details, in addition to helping reshape the lecture to have a more focused, powerful message.

Academic Women Engage (AWE) was a program created by Tricia Smith from UConn involved in creating mentorship connections between residents and faculty, with the goal of building clinical knowledge, bolstering research productivity, creating career opportunities for themselves and their colleagues, encouraging resident leaders, and improving faculty satisfaction. The major hurdle in establishing mentorship relationships was finding time for the mentors and the mentees to meet and converse. Tricia will be taking this program to Emory and will be working on creating this national platform.

Finally, Indira Gowda from Mt. Sinai wanted to create an electronic platform to host mentor-mentorship connections in the NYC area. The mentorship project fell short given the time constraints of the mentors and the mentees.

Do you have an idea to help support and advance women in academic emergency medicine? Ready to have a department chair implement your idea at their program? Please contact Neha Raukar (nraukar@gmail.com) or Esther Choo (echomd@gmail.com) for more information and an application packet.

Neha

Associate Professor
Department of Emergency Medicine
Brown Alpert Medical School

AWAEM Resident Scholarship Winners

The AWAEM Resident Travel Scholarship is designed to expose residents interested in issues related to the advancement of women in Academic Emergency Medicine to travel to SAEM. Congratulations to these three residents on receiving the scholarship and participating in AWAEM's activities at SAEM!

Alexandra Mannix
University of Florida

Omobolawa "Mobola" Kukoyi
University of Chicago

Nicole Cimino-Fiallos
University of Maryland

Member Highlights:

AWAEM Resident Travel Scholar Award

By Nicole Cimino-Fiallos, MD

My goals for the SAEM conference in Orlando seemed a bit ambitious. I wanted to personally experience the juxtaposition of being a representative of the Academy of Women in Academic Emergency Medicine while attending a conference that focuses on research, a traditionally male dominated aspect of our specialty. Research is the way we move forward as doctors; the way we develop new techniques, fine tune our current practices and fight back against anecdotal evidence. Why does the agenda for a conference designed to aim for the future look so much like the past, with a majority of male speakers and attendees? If our most forward- thinking conference in Emergency Medicine can't move past gender inequities, how can the rest of the field?

I felt a bit discouraged after attending the plenary session. One abstract confirmed what I had suspected- of all the speakers at major Emergency Medicine conferences over the past 5 years, only 29.4% of all speakers were female and, of the female speakers, a paltry number were invited to speak as the keynote or plenary speakers. I started to feel like women might never gain enough respect to command the attention and the support we need from our beloved field of Emergency Medicine.

Luckily, AWAEM did not disappoint and inspired me to keep fighting for gains for women in Emergency Medicine. I attended the women's luncheon, where my table discussed how to get ahead at work, to ask for what you deserve, to gain the respect of older male chairmen, to become a chairwoman and to do it all without compromising at home. Women from all different levels of training- medical students, residents, fellows, and attendings- sat together and traded experiences and ideas. We each had something to contribute and the wealth of knowledge communicated during our fiery discussion was inspiring.

Now that I was motivated and empowered, I needed direction. I attended a panel discussion about why women are still underrepresented in Emergency Medicine. After the presentation, I sat down with Dr. Reede, a Harvard pediatrician and head of the Harvard Office of Diversity Inclusion. When I asked her how someone like me, a resident, could effect change at my program, she offered some sage advice. "We don't talk about things enough. We don't communicate to our programs and departments that we want diversity. We don't make it a part

of our mission statements. We just wish things were different and hope for change, but as a strategy, this approach is ineffective."

The final part of my SAEM journey centered around a brief chat I had with Dr. Vicken Totten. We were both involved in a panel discussion about how to incorporate more gender-based curricula into medical education. At end of the discussion, Dr. Totten pulled me aside to share her experiences. She encouraged me to make waves in my current program and even offered her own form of resistance (purple hair) as a way for me to draw attention to the issues that matter to me and my training. Hearing her story about how she forged her own path as a young female Emergency physician and never gave up her trailblazing tendencies reminded me of the struggles of the women who started work in this field before me and how brave they had to be to earn a place at the table of Emergency Medicine.

SAEM was a rejuvenating experience and I've already started to apply what I learned to my approach to residency. I've written a proposal to my residency leadership asking them to include the following question in every evaluation of our conference speakers- "Did the speaker include relevant topics of diversity in the lecture content?" I'm confident that including this question in our evaluations will improve the applicability of our lectures to the broad population of patients that we see. I've also started a new lunchtime group at my residency called "Reflections." In these sessions, my co-residents and I can sit down and talk about our common experiences. As Dr. Reede said, "We don't talk about things enough." I'm hoping these sessions will bring my co-residents and I closer together and, through the formation of common bonds, perhaps we can find more ways to spark change.

Nicole

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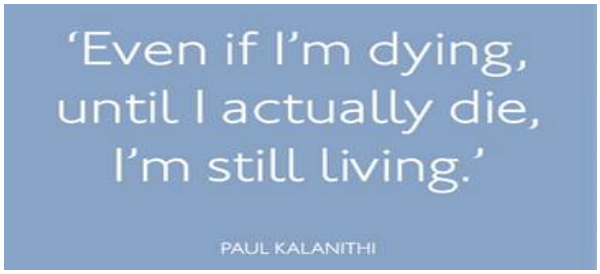
Book Corner

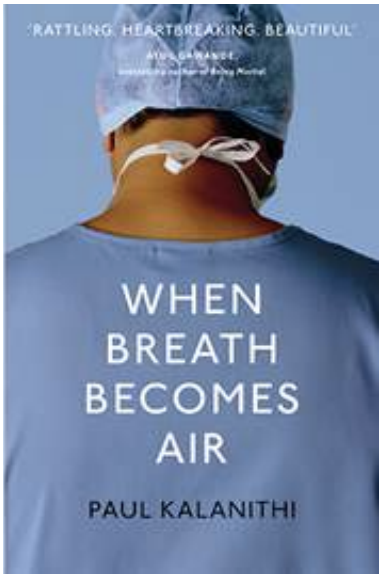
When Breath Becomes Air by Paul Kalanithi, MD

By Devjani Das, MD

I have recently found that reconciling time for my cherished hobbies, one being reading, while having a full time career and taking care of my newly expanded family (we currently have an 8 month old happy baby boy) is not always feasible. So in order to keep my sanity, I have had to become more innovative. I have learned to save time, not only by fitting in a pumping session on my drive into work, but also to listen to my favorite books via audiobooks! Granted, these are clearly not new inventions but I used to secretly make fun of those who could not spare the time to read a book, I mean how busy could one be? I have now learned humility in many forms and have fully embraced the audiobook phenomenon.

All that being said, I recently listened to a book that I could not "put down." If you have not already heard about *When Breath Becomes Air*, a quick summary of it is that it is an unfinished memoir written by a neurosurgeon, Dr. Paul Kalanithi, in his final months after he was diagnosed with advanced stage lung cancer. Dr.Kalanithi's memoir is exceptionally affecting as he was an amazingly articulate, introspective, and well-spoken writer. Though it is a heart-wrenching book, it is not simply a book about dying but also about living. Few of us can only imagine how devastating it would be to find ourselves in a similar situation but even fewer of us would truly know what to do with the remaining time we had. Dr. Kalanithi





and his loving family make multiple fateful decisions on how to spend the remainder of his life after his diagnosis, including deciding to finish out the final year of his neurosurgery residency and having a baby. Many of us can relate to the constant need to move forward in our lives, making sacrifice after sacrifice to further our careers. Being able to figure out how to spend the final months of your life, even if being forced to do so, can truly give one perspective on who and what are really the important aspects of our lives. Dr. Kalanithi gives us a window into seeing how this is possible and does it in such a fashion, we are left saddened not only by his passing but also of not having any further gift of his talent in writing. I do not wish anyone to have to experience the pain that he and his family endured, and continue to endure, but I hope we may learn to appreciate all that we have and truly take the time out of our busy lives in order to show that appreciation.

Devjani

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Wellness Kit

By Jeannette Wolfe, MD

"Never doubt that a small group of thoughtful committed citizens can change the world. Indeed, it is the only thing that ever has."

Margaret Mead

Meditation

Letting life live through you

Snack

Sandwich-free lunch

Yoga Pose

Yoga for beginners

Mini Indulgence

Books to listen to during drive home

Artsy Movie

Four Weddings and Funeral

Jeannette

Associate Professor
Emergency Medicine
University of Massachusetts

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