A Virtual Book Club for Professional Development in Emergency Medicine

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SUMMER 2021

WELCOME new members!

100% GROUPS

Alvarado Emergency Medical Associates  
Beach Emergency Medical Associates  
Centinela Freeman Emergency Medical Associates  
Central Coast Emergency Physicians  
Chino Emergency Medical Associates  
Coast Plaza Emergency Physicians  
Corona Regional Emergency Medical Associates, Inc.  
Emergency Medicine Specialists of Orange County  
Glendale Adventist Emergency Physicians  
Hollywood Presbyterian Emergency Medical Associates  
Los Alamos Emergency Medical Associates  
Maui Memorial Emergency Medical Associates  
Montclair Emergency Medical Associates  
Napa Valley Emergency Medical Group  
Newport Emergency Medical Group Inc  
Orange County Emergency Medical Associates  
Pacific Coast Emergency Medical Associates  
Pacific Emergency Providers APC  
Pacifica Emergency Medical Associates  
Redondo Emergency Physicians  
San Dimas Emergency Medical Associates  
Shasta Regional Emergency Medical Associates  
Sherman Oaks Emergency Medical Associates  
Tarzana Emergency Medical Associates  
Temecula Valley Emergency Physicians  
Valley Presbyterian Emergency Medical Associates  
Vituity Emergency Medicine Advocacy Physicians  
Vituity Idaho-LLP  
West Hills Emergency Medical Associates
In 1982 Johnson & Johnson had a problem. Their beloved Tylenol was killing people. While it would later be attributed to an employee tampering with the bottles, in the thick of it, the company leadership was in a serious pickle. In front of them were some tough decisions that would have some significant consequences for their company.

At the time, Tylenol held 35% of the pain/fever control market share and was also their most profitable product. The public was panicking. The leadership team had two options. The first was to protect their customers and the public by pulling Tylenol off the shelves, but the trade-off was most certainly a share price drop and very angry shareholders. The alternative was to keep the product on the shelves, do as much PR damage-control, try to prevent a share price drop, try to maintain public trust, all the while hoping no further harm would come to those who took Tylenol.

Undoubtedly for any leader, this would be a difficult decision. But for the leaders of the J&J team, the decision shouldn’t have been that complex. All they had to do was look at their credo statement developed by Robert Wood Johnson himself in 1943, the year before the company went public. Easy to find, the credo is literally carved into stone in their headquarters.

While you may scan the QR code to read the statement yourself, the simple summarized message is the following: patients first, shareholders last.

Following the wisdom laid out for them, the J&J leaders swiftly pulled Tylenol from the shelves to protect patients. It resulted in a loss of about $100 million, but by staying true to their founder’s credo, they were able to come out on the other side retaining the trust of their customers and shareholders.

I highlight the Johnson & Johnson example because I believe our specialty and our organization are currently at a crossroads, faced with some very difficult decisions ahead of us. Over the last year, we have seen an unprecedented contraction in our job market. This is a complete turnaround from just five years ago when there was a running joke that if you had a heartbeat and were ABEM board certified/eligible, you could get a job anywhere. The COVID pandemic fast-forwarded a workforce trend that has been silently growing. Just when we thought the worst was behind us at the beginning of 2021, a gut-punch occurred when the *Emergency Medicine Physician Workforce: Projections for 2030* was released with its projection that there will be a surplus of 9,000 emergency physicians.

I, like many of you, experienced a whole host of emotions when the report was released. I was not immune to the departmental shift cuts brought on by COVID and scrambled like everyone else to find alternative employment models. I felt angry that after everything we gave during the pandemic, it seemed like we could be tossed off to the side. I was frustrated that somehow the specialty got to this point, and that we hadn’t prevented it. I also felt scared about what this would mean financially after having invested so much money and time into this profession.

As I expressed these thoughts to those around me, one of my close confidants asked me to find the positives of the situation. On reflection, I realized the important research and findings presented in the workforce report position us well to deal with the situation. The timing of its release is fortuitous. The report was commissioned, and the work began, before the pandemic started. But had the results been released in a “normal time,” without the added stress of decreased shifts due to pandemic-induced declined volumes, the results might not have been felt so acutely and perhaps many would not have paid close attention. As additional shifts begin to return, it will be important that we maintain our attention and focus on this very serious and core issue.
We must be honest with each other. As we start to evaluate and consider changes to prevent the predicted outcome, the choices we will be faced with will be difficult. There will be no one solution; there will be no perfect solution. Just like Johnson & Johnson, some solutions will come with short-term pain for a long-term gain for the specialty. And just like Johnson & Johnson, figuring out the correct choice may not be as difficult as it feels. The trick for all of us will be to remember what unites all of us. That common goal is very well embodied and articulated in the California ACEP mission and vision statements.

The Mission

California ACEP’s mission is to support emergency physicians in providing the highest quality of care to all patients and to their communities.

The Vision

California ACEP’s vision is that all people in California have timely access to high-quality emergency care, which is recognized as an essential public service. The emergency physician is the recognized leader and coordinator of a healthcare team capable of a comprehensive response to the medical needs of our patients and community. We promote and protect the personal and practice rights, safety, wellness, and longevity of emergency physicians.

Since the start of my Presidency, I have been making it a point to read our mission statement out loud prior to the start of each board meeting and I have requested each chair of any committee do the same. It is important that we put our emergency physician colleagues first. It doesn’t matter in what capacity they are providing emergency care in California; they must always remain the leader.

Six themes emerge that we will need to focus on as workforce discussions progress:

1. Scope encroachment by NPs and PAs seeking independent practice
2. The proliferation of residency programs and the concern that the standard for residency training is being diluted
3. The potential conflict between the business interests of medicine and the ethical interests of our specialty
4. The desire to maintain a rewarding practice career with appropriate compensation
5. The need to increase demand for emergency physicians, including expanding areas of practice
6. An examination and re-evaluation of the healthcare reimbursement model

Of course, the specialty is broader than just emergency medicine in California. California is a key and large component, however there are many stakeholders that will be looking at this complex question from their own lens. I am pleased by the desire of all emergency medicine stakeholder groups to work together, which has not always been the case with every challenge facing our specialty. Much of this has been under the leadership of ACEP who has engaged and invited participation in the formulation of the above workforce recommendations. ACEP has encouraged a high level of communication and has convened multiple meetings between chapter and national leadership. In addition to holding a national town-hall on the topic, ACEP is also encouraging state chapters to engage with the membership through chapter town halls. We must be cognizant and honest about what is under each stakeholder’s control and what would be better done by others. When possible, we should not shy away from our ability and responsibility to influence those who do have control to make change. Lastly, we must recognize what we have no control or influence over and redirect our energy toward those areas where we can make an impact.

One of California ACEP’s strengths has always been calculating where to maximize our efforts to achieve the best possible outcome. While the Board of Directors will have the final responsibility to determine resource allocation, it will be imperative that all members continue to engage with us frequently so we can best represent our members through those decisions.

I look forward to hearing from you all about what you see as the future of Emergency Medicine. At this point, I see California ACEP continuing its advocacy for our communal benefit in the following ways.

Scope of Practice | Can others be us?

Across the country, many state legislatures have been advancing the idea that nurse practitioners (NP) and physician assistants (PA) should be granted independent practice authority. Recently, the American Academy of PAs voted to change their name to “Physician Associates” for this reason. National ACEP recognizes that the battles over scope of practice will occur at the state level. ACEP is providing resources to the states but a lot of the work in California will fall on California ACEP and us as individual physicians.

2020 was not a good year for us in this battle. Nurse practitioners were able to convince the legislature to pass AB 890, which the Governor signed into law. AB 890 sets up a pathway for independent nurse practitioner practice in California. While the debate largely centered around access to primary care, the bill was broader, and the entire house of medicine was dealt the blow.

California ACEP remains committed to ensuring that patients are treated by an emergency physician led team: either being seen directly by an emergency physician or by a PA/NP that is safely supervised. We have heard from legislators that they agree with this sentiment and their decision to support AB 890 was not as much about emergent situations but rather the lack of access to primary care. We have started the conversation with legislators that this sentiment needs to be codified into law, but the political climate as of now makes this difficult to push through. That doesn't mean we give up, just as the NPs and other groups have mounted a sustained effort for years, we will need to do the same.

Even while we continue to request a legislative fix to protect patients when they seek emergency care, there are still multiple opportunities to advocate for patient safety. AB 890 did not create immediate, unrestricted practice opportunities for NPs in California. It only set up a pathway for it to occur and deferred many portions to the regulatory process, which is projected to take 2 years. California ACEP has been
Ultimately, approval of residencies and certification of an individual emergency physician will fall on the ACGME and ABEM, respectively. Neither ACEP nor California ACEP will have direct control over the decisions by these organizations, but we have the power to influence.

When it comes to the expansion/creation of residencies, ACEP plans to take the lead on the engagement with the ACGME on this issue. In March 2022, the ACGME is set to do its 10-year review on the requirements of EM residencies. Prior to this, ACEP will be convening a workgroup to evaluate what is needed to be an Emergency Physician with the goal of making a recommendation to the ACGME by the end of the year. The workgroup will look at issues such as the length of time of training, patient visit volumes, and procedure minimums. California ACEP will provide feedback from our many members who are heavily involved in residency programs and directly with the ACGME.

In California, funding for additional residency slots has come from the tobacco tax imposed when voters approved Prop 56 in 2016. This created CalMedForce which is empowered to direct funding towards the creation of new residency programs or additional training spots at existing residencies in select specialties, including emergency medicine. California ACEP has been a member of the CalMedForce Advisory Committee since its inception. We are constantly evaluating the proper balance between provider shortages that NPs and PAs use to argue for independent practice and training surpluses that are contributing to our workforce challenges.

We must also continue to ensure that the emergency physician brand and the value we bring to healthcare delivery remain strong. Much of this has come from our certification process. Therefore, we must be careful to respond to calls that occasionally arise to weaken this standard. While that doesn't always mean we need to keep the status quo as we have seen with the recent MyCert changes, we do need to think through potential unintended consequences and not act in haste.

### Business Interests | Medicine is a business balancing ethics

Healthcare is a business. In the United States, it is a big business. Healthcare spending is on average just shy of 18% of the gross domestic product (GDP). In 2020 the US GDP was reported to be about $20.93 trillion, which means $3.75 trillion went towards healthcare spending. Even more specifically, there have been a lot of changes to business interests.

Medicine is a business balancing ethics.
establishing a gold standard will create healthy competition between groups to maintain ideals we all collectively agree are best practices.

We could similarly discuss the pros and cons of these types of standards being codified by California legislation. These types of discussions are not new to the Chapter. We are part of the reason a physician is required to be on-site at every basic emergency department. We could even expand upon this concept and have a robust discussion about ratios and whether there is a correlation between patient ESI volume averages and certain staffing requirements.

We may also decide to mount a campaign to raise awareness and support for our efforts - whether with legislators or the public. Campaigns are costly and it will be your membership dollars that will be spent to achieve this goal. We want to hear from you now and in the future to ensure we are prioritizing your concerns and being good stewards of your dues.

**Demand | Four walls don’t define us**

If you go back to my opening Presidential address, or any Lifeline article, this has been the theme of my year. While emergency departments should always be synonymous with an emergency physician, the inverse is not true. When I heard the workforce webinar hosted by ACEP in April of 2021, this was the first time I heard ACEP focus on expanding the role of an emergency physician outside the walls of an ED.

There are a multitude of benefits when we expand our value to other areas of healthcare. Most immediately, the expansion creates opportunities for jobs in health care sectors previously untapped. Telemedicine was a relatively easy transition that was accelerated by the pandemic. High-functioning urgent cares continue to be a trend as hospitals partner more with health plans to try to manage resources. I hope we can continue to expand to all places that patients access care. Another opportunity is to partner with our EMS colleagues and help with real-time virtual consultation in cases that require nuanced care. Another opportunity is to partner with our EMS colleagues and help with real-time virtual consultation in cases that require nuanced care.

This is a culture shift for all of us. We must embrace our colleagues who have entered these alternative spaces. As an organization, we need to re-evaluate how we handle our advocacy in the legislative and regulatory arenas so we include all our emergency physician colleagues in these efforts. If we have learned anything this year, words matter, and it will be up to all of us to change our lingo and in turn our culture. If we can do this, it will lead to more employment opportunities and less burnout to provide that rewarding career we are all striving for.

**Reimbursement | Is our current system working?**

In the nine years I’ve been part of California ACEP, one thing that has always stood out to me is how we are the think tank for the specialty. One of our strengths has been our reimbursement advocacy and we have had a lot of influence on national ACEP on this topic over the years. As a health economist, I see that our current reimbursement and health care financing model are at the core of the workforce dilemma. I understand that considering new reimbursement models is probably the most controversial and difficult aspect of the larger workforce discussion, but the pandemic highlighted how the current funding model isn’t working for patients, physicians, or even hospitals. The current system is only working for insurance companies.

The EM workforce has been suffering from decreasing wages in the current structure. We need to start focusing more on how we can protect the fair wage of those who are doing the work, over those who are profiting from the physician-patient trust. Part of this comes with forcing transparency. It can also mean examining and restructuring how the money is flowing from the patient through the system.

We can be leaders on this topic. Our diverse practice styles, and the unique knowledge base of our members, makes our organization the appropriate place to have these conversations and vet alternative models. If we can agree on changes, we may be able to use California’s leadership within the country to test and then promote it for a national standard.

**Final Thoughts**

Undoubtedly, there is a lot of uncertainty about the future. There is hope. It will require a lot from all of us, but this is what we are good at: taking the constraints, adjusting, pivoting, and maximizing to the best possible benefit. In the end we must always circle back to our mission and vision. We will have to start looking beyond how it impacts emergency department practice and be very cognizant to ask the question “how does it impact emergency medicine practice?” It does become more challenging but including all our EM colleagues in advocacy will be key as we try to meet ACEPs pillar of promoting a rewarding practice in all communities and practice styles.

Previous generations of emergency physicians have had to deal with creating changes in medicine and have laid the groundwork for us. We must do the same. These tough times are directly impacting the next generation of eager physicians looking to begin their careers. I want them to continue to believe in a prosperous specialty as much as I do. Even more so, I want to be able to look back many years from now and see that we met this moment.
Dr. Moulin and the UC Davis Medical Center team in Sacramento recognized that patients presenting to the ED are more likely to have substance use-related problems than those presenting to primary care. In addition, these ED visits provide an opportunity for a “teachable moment” due to the crisis that precipitates the visit. For example, a drunk driving accident or an opioid overdose can be the catalyst needed for the patient to seek treatment. Therefore, the UC Davis Medical Center ED applied for a grant through the UC Office of the President in 2017 to employ a certified drug and alcohol counselor to provide interventions in their ED. This counselor would meet with patients that presented with substance-use-related issues and offer to connect them to treatment resources. The results of these brief interventions were impressive, including a 60% reduction in utilization after the intervention and over $350,000 in cost savings to Medi-Cal from reduced ED visits.

Even before the impact of the grant had been fully compiled, Dr. Moulin could tell that having a certified drug and alcohol counselor in the ED made a big difference in her practice and the outcomes for her patients. She began to champion the idea of introducing legislation to recreate the UC Davis Medical Center grant on a statewide level at CalACEP Board meetings. In 2019, California ACEP sponsored AB 389 (Arambula) to provide grants for peer navigators in California EDs for patients needing behavioral health or substance use treatment to be linked to services directly from the ED. Throughout the legislative process, Dr. Moulin was actively involved with the bill. She joined CalACEP staff at meetings with legislators, provided feedback on what would make the bill successful, and testified in committee hearings for the bill.

Dr. Moulin continued to be involved when funding for the grant program was included in the Governor’s 2019 Budget. She was an active participant in developing the grant application and distribution process through CA Bridge, the program overseeing the funding she secured. In fact, Dr. Moulin is now a Director/Co-Principal Investigator on the Clinical Leadership team. She worked with CalACEP to protect grant funding when it was threatened by COVID-related budget cuts. Other organizations have sought Dr. Moulin’s insight and support when exploring aid from the State for similar programs. Dr. Moulin has become a subject matter expert on the use of drug and alcohol counselors in the ED.

Getting involved in advocacy can seem overwhelming, but as emergency physicians, you are the subject matter experts. You see unique solutions to the problems facing your patients and your specialty that others might miss. Starting out in advocacy leadership can be as simple as finding an issue you are passionate about.
The theme of our anniversary project is “meet the moment.” we will be celebrating all the ways in which emergency medicine has and will continue to rise to meet the moment.

California ACEP wants to hear from you and share your experiences throughout our 50th Anniversary celebration in the months to come.

Any contribution to this project is greatly appreciated!

1. What do you enjoy most about emergency medicine? What inspires you?
2. What does CalACEP mean to you?
3. Where do you see emergency medicine in 50 years?
4. What one moment in your career stands out the most?
5. How has CalACEP met the moment at some point in your career?

You can answer one or all the questions below by following this link:
https://www.surveymonkey.com/r/CalACEP_50th

We cannot wait to hear from you! Your answers will be shared in the next issue of Lifeline which will be dedicated to our 50th Anniversary.

If you have any questions, please contact Kelsey McQuaid-Craig at kmcquaid@californiaacep.org.
HABITS FOR EFFECTIVE PHYSICIAN LEADERS

Medical school and residency training prepared me well for a career as an emergency physician. Still, little time was spent fitting me for my role as a physician leader during that education. Fortunately, I am grateful to have been mentored over the years by a cadre of skilled and passionate physician executive role models. I have found being a physician leader has fortified my career in innumerable ways, and I hope I can pass on some of the lessons I have learned to those starting out.

SET ASIDE TIME MONTHLY FOR CLINICAL EDUCATION.
Being respected clinically by your team is instrumental in your role as a physician leader. The balance of clinical versus administrative time is one of the most significant challenges a physician executive faces. Protect the number of clinical shifts required of you to continue your growth as a clinician. Commit to a monthly educational regimen based upon your own learning preferences. Seek out the highest acuity patients on a given shift and attend sim lab training for infrequently used lifesaving procedures.

BE CANDID WHILE KIND IN YOUR COMMUNICATIONS AND TAKE TIME TO LISTEN.
Practicing compassionate candor can help ensure productive outcomes in the difficult conversations that are inherent in the role of a medical director. Communicate honestly to your providers and explain the "why" behind the initiatives you are asking them to embrace. Listen carefully to perceived obstacles and be willing to change your approach when the situation dictates.

GRIP UP, NOT DOWN.
An effective leader moves their team optimistically through complex challenges. Core measures and system metrics are examples of goals in whose choosing you may have little input but are expected to champion. You may not always agree with the mission but reserve your concerns and complaints for those above you in the chain of command.

TAKE CARE OF THE PROVIDERS AND THEY WILL TAKE CARE OF THE SITE.
Be a servant leader. Nourish and care for your providers. Take concrete steps regularly to communicate appreciation to your team, both formally in the form of public recognition and appreciation gifts, as well as with daily acts of random kindness. Finish every encounter with a team member with a parting "Is there anything I can do for you?"
BE AN INTERNIST RATHER THAN AN EMERGENCY PHYSICIAN WHEN EVALUATING AND TREATING ADMINISTRATIVE ISSUES.

As emergency physicians, we are inclined to make rapid decisions based upon incomplete information. This serves us well when managing a high volume, high acuity ED, but less so as a physician leader. Most administrative issues are not emergent in nature and usually have long histories. Therefore, system issues are more effectively addressed with a slower, more thoughtful, and deliberate approach than is typical of our emergency physician personality. Slow the pace, prioritize, and take time to get thoughtful input from those involved before making your disposition of administrative issues.

YOUR ROLE AS LEADER IS NOT DISSOCIABLE.

Realize that your role as leader cannot be turned on and off as it suits you. When you speak, it is always in your role as leader. You have lost the luxury of expressing yourself personally in your professional setting. As a physician leader, you are under a microscope and your behavior is constantly being observed. It can be easy to revert into being “one of the gang” with the nurses, techs, and providers, but nothing comes for free. Behaviors that were acceptable as a clinician can backfire and threaten the effectiveness of a physician leader.

CONSIDER THE PATIENT FIRST WHEN MAKING ADMINISTRATIVE DECISIONS

As a medical director you serve four customers: the patient, the hospital, the medical staff, and your group of providers. When confronted with difficult decisions, always consider first what is best for the patient. In doing this, you will stay true to your mission as a physician, and your other customers will benefit as well.

While the day-to-day grind of meetings and conflict resolution can be taxing, it is crucial to appreciate the bigger picture. Though it may not always be obvious, the role of a physician leader is ultimately clinical. As a physician executive, you build teams and systems that care for an exponentially greater number of patients and have a greater impact on public health than is possible as a solitary clinician.

I have found my role as a physician leader to be the most challenging and rewarding of my career. I am thankful for the physician executive mentors that have contributed to my development. The relationships formed with my providers and hospital colleagues nourish me and are something for which I am grateful daily. I know the same can be true for you.

Dr. Tamkin is vice president for provider development for US Acute Care Solutions and the statewide medical director of the California Highway Patrol. He is a Past-President of CalACEP and recipient of the Chapter’s Walter T. Edwards award for meritorious service. He can be contacted at tamking@usacs.com.
Decades ago, choices for a career in medicine were limited to small private practice or large academic, primarily research, settings. So, physicians in training could focus on acquiring vast amounts of clinical knowledge as well as technical skills. If they wanted to go into research, there was always the option of choosing an MD-PhD path. If a career in public health was the goal, it was highly recommended to get an MD-MPH.

**THE ADVENT OF MANAGED CARE**
The advent of managed care in the 80s opened up a slew of new career opportunities on the business side of medicine. Suddenly, doctors could be health plan medical directors, experts in utilization management, or Chief Medical Officers. They could run large practice groups or even run hospitals.

Soon after the managed care revolution, the country went through serial efforts to reform our increasingly dysfunctional healthcare system (remember the Clinton plan?). This opened up opportunities for careers in health policy and health services research.

**THE DIGITAL HEALTH EXPLOSION**
Later, the explosion of digital health teed up entrepreneurial opportunities unimaginable to prior generations of physicians. Now, docs could start companies, fund companies, or become advisors to start-ups.

This was so enticing that a number of young doctors I met in the health tech field decided not to complete their training. They told me they felt they could help many more people by developing and deploying their innovative health technology solutions.
TV ANYONE?
The current pandemic has opened up a new possibility – becoming a medical pundit on cable news. We have had medical experts talking to us from TV for a long time (think Sanjay Gupta), but the number of MDs who get this gig has been small compared to what is going on now. Of course, many of these docs don’t get paid for their appearances. However, some of them may be able to parlay their experiences into a full or part-time job.

So, it is an exciting time for physicians, but it is also a confusing time. How can doctors prepare themselves both for the present and the future? What types of skills, beyond clinical, should they be acquiring? When should they acquire them? And, how?

CAREERS IN MEDICINE CAN LAST A LIFETIME
I like to answer these questions by reminding people that careers last a lifetime. You don’t have to do everything all at once. And, you don’t have to do anything forever. You can take left turns. And, you can reinvent yourself.

You can do this in a planned or in an opportunistic way. I know a lot about the latter because that was the serendipitous and convoluted path that I have followed.

MY LONG AND COMPLICATED CAREER IN MEDICINE
I trained in academic endocrinology at the University of California San Francisco, working with some of the giants in the field (Peter Forsham, John Karam, Claude Arnaud). At the same time, I was moonlighting in the ER at Kaiser Permanente in San Francisco to bring in some extra cash.

It was the early days of emergency medicine. There was not even a residency in San Francisco at the time. So by day, I was working up complex endocrinology cases. But at night, I was intubating asthmatics and treating desperately ill patients in heart failure.

One day, after getting back ambiguous results after a year-long workup for a rare endocrine tumor, a giant light bulb went off in my head. Emergency medicine thrilled me, endocrinology did not.

So I left UCSF and became a Permanente Medical Group emergency physician, a position I held for the next 15 years. I also got involved in my specialty society, eventually becoming the first woman President of the American College of Emergency Physicians in California.

This opened up a chance for me to do a 2-year Pew Fellowship in Health Policy at UCSF’s Institute for Health Policy Studies under Phil Lee who went on to serve as Undersecretary of Health in the Clinton administration.

LEAVING CLINICAL PRACTICE
Once again, these experiences led to an opportunity to leave clinical practice and start a new career as a Physician Executive for the national Kaiser Permanente organization. I was the first director of National Accounts. In that role, I helped sell the health plans to large employer groups by talking about our clinicians and clinical programs.

That position led me to yet another position – one that was quite unique. General Motors was struggling with the cost and quality of their health plans. They worked with Kaiser to bring on a team of people to help them with their managed care strategy. I was the doctor of the group and the team lead.

I spent the next six years as an executive on loan to General Motors. Along the way, I picked up a healthcare-focused MBA from the University of California Irvine.

FAILED ENTREPRENEUR
I made two attempts to start companies, but, in retrospect, I have discovered, sadly, I am missing a key ingredient of a successful entrepreneur—sticking with it at all costs.

In between my attempts to build a company, I moved in and out of healthcare consulting, probably the most lucrative and educational of all of my endeavors. I also had several different positions with different health plans, including serving as Chief Medical Officer of a Medicare Advantage plan in Houston.

In 2006, in the early days of blogging, I created The Doctor Weighs In. I have been running it ever since. It has morphed from a diet and weight loss blog to what it is now – a multi-authored health news site. I, now, consider myself a full-time health journalist. I tell you all of this not to puff myself up because you are probably thinking I am a flake or at least a bit crazy. Rather, I tell you this to emphasize that the opportunities for physicians to make contributions to healthcare are endless and everchanging. You just have to be willing to try new things. It is a very exciting time to be a physician.

A few words about how and when to add new skills as you prepare for your chosen career in medicine
I have had some intense discussions with medical students, residents, and early career doctors about whether they should complete their
2021-22
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Installed September 9, 2021

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Jon Ludwig, MD, FACEP (At-Large)
Taylor Nichols, MD
Valerie Norton, MD, FACEP
Rebecca Ruiz, MD
Sue J. Spano, MD, FACEP, FAWM
Katherine Staats, MD
David Terca, MD
Patrick Um, MD, FACEP
Lori Winston, MD, FACEP
Randall Young, MD, MMM, FACEP
training. However, I still believe that a strong foundation in clinical medicine is part of what differentiates doctors from others who go into the business of medicine. Yeah, the internship is a drag. And you may be chafing at the bit to get started in real life. But I have found that really knowing medicine has been a cornerstone for my career.

At least get the MD, a license, and practice a bit even if it is in an urgent care center or a retail clinic. It is simply invaluable to have the experience of actually taking care of patients.

**HOW THE MONEY FLOWS**

If you think you would like to work on the business side of medicine—for a health plan, medical group, or hospital, you need to know these two things:

- the politics of healthcare, and
- how the money flows

That means formal or informal training in health policy and specific knowledge of the financial aspects of the type of organization you want to work in. Consider getting an MBA, but be sure you find a program that focuses on healthcare and offers some hands-on experience with the industry. Internships, if you can find them, are invaluable.

**PREP FOR OTHER CAREER PATHS**

If public health is your thing, the club card is an MPH. Be sure to find a program that can give you real-life experiences and provide you opportunities to network with people who can help you get a job.

Join the American Public Health Association and go to their meetings. Volunteer with a non-profit doing public health advocacy work—these organizations would be thrilled to have a physician working with them.

If your dream is starting the next big thing in digital health, move to Silicon Valley (just kidding). Healthcare entrepreneurship opportunities are available all over the country. Volunteer to help a start-up, join an incubator, participate in Hackathons, and hang out with the people who are doing the work.

If you dream of being a real TV doctor, invest in getting a PR agent who specializes in getting doctors on various news shows. Take some classes and practice the needed skills. I actually had to take lessons on how to control my blinking!

Foundational to whatever career path you choose is developing leadership skills. The types of leadership skills that will propel you forward in business, public health, or in the media are very different from the ones that make you successful in the OR. Take classes, read books, or better yet, find yourself a good leadership coach.

**EARLY TO MID TO LATE – ALWAYS KEEP LEARNING**

No matter what stage of your career you are at, it is never too late to learn new things, take on new challenges, and acquire new skills.
My name is Dr. Kimberly Sokol, and I have a confession to make: For the first time in my seven-year career of being an emergency physician, I judged my patient.

Was it the 65-year-old male with a history of CHF and medication noncompliance that came in for the seventh time in a month with shortness of breath and lower extremity swelling? No. Was it the 23-year-old homeless female with a history of opioid use that swore at me multiple times and is now on a Narcan drip? No. Was it the 52-year-old male that hadn’t exercised or eaten a salad a day in his life that came in as a STEMI activation? No.

It was the unvaccinated 42-year-old female with absolutely no barriers to health care that had presented with shortness of breath, cough, fever, and loss of taste and smell for the last two days. She also complained to multiple staff members about having to wear her mask in the emergency department (ED). She is now intubated on a ventilator in room 23.

Donning one of the same six N-95 masks I have been wearing since the beginning of the pandemic, I provided a definitive airway to the patient in room 23, then painstakingly doffing that same PPE to avoid getting droplets on any nearby surfaces. Then, a 33-year-old healthy male came in requesting a COVID swab after going to a party with multiple COVID-positive patients, stating, “It wasn’t that big of a deal. It’s just a virus”. Afterwards, a mother with a 12-year-old girl exhibiting cough and nasal congestion asked why she had to stay outside of the ED until it was her turn to be seen. Finally, one of our own nurses came to me to complain about the new mandate set by the State of California requiring all healthcare workers to be vaccinated. She said, “It’s my body! My choice!”, despite 18 months of witnessing the virus wreak havoc on our patients, including killing several of our co-workers in this fourth surge of the pandemic.

I was left with guilt, leaving my shift, having judged not just one patient, but everyone that followed her.
As an emergency medicine physician in the United States of America, I have the honor of treating all patients that come through the ED, regardless of their age, gender, sexual orientation, or insurance status. While that honor is one of the reasons I entered this field, it also means that I cannot choose my patients, which inevitably leads to passing judgment on those patients, regardless of how hard I try to avoid it.

This leads me to the titular question of the article: how do we treat the patient that we're judging?

First, recognize that you are passing judgment on that patient and have compassion with yourself for doing so. It is that same “judgement” that allows you to deem someone “sick or not sick” within several minutes of seeing them, therefore enabling you to differentiate between the 60-year-old female with chest pain that needs to be admitted from the 60-year-old female with chest pain that can be safely discharged to home. Yes, you are judging that patient for not getting the COVID-19 vaccine – recognize that you are doing it and be kind to yourself. We’ve all been there. It’s okay.

Now that you have recognized that you are in fact judging your patient, it’s time to compartmentalize that judgment and move on. As emergency medicine physicians in the United States of America, we have the honor of being able to treat all patients that come through the door of the emergency department, regardless of their age, gender, sexual orientation, insurance status vaccination status. This means that regardless of your judgment of the patient, your treatment of the patient must remain without any bias whatsoever. This is what defines our profession as emergency medicine physicians.

This is a human being sitting in front of you entrusting you with their care, regardless of any decisions that they made prior to coming into the emergency department, or any judgments that they may very well be passing on you in the moment. Try and establish common ground with the patient and focus on shared goals of treatment: Do they simply want to be tested for the virus? Do they want to talk about their fears about the vaccine? Do they want to feel better? Once the encounter is complete, reflect on the experience. Whether through meditation, journaling, or talking about it with a colleague (maintaining patient privacy, of course), set aside time to take note of various scripting or behavioral changes you can make the next time you are faced with a similar experience.

Dr. Francis W. Peabody, a physician celebrated for his compassion, once said in a lecture at Harvard Medical School that “the secret of the care of the patient is in caring for the patient”¹. While I still find that to be an excellent way to practice, remember that we will not actually care for our patients at times, and when that happens, we need to practice self-compassion, compartmentalize, and move on so that we can still take care of those patients. At the end of the day, we are all in this pandemic and profession together. It is our responsibility and privilege to care for our patients throughout this crazy time and beyond.

REFERENCES

A VIRTUAL BOOK CLUB FOR
Professional Development
in Emergency Medicine

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**INTRODUCTION:** Professional development is an important component of graduate medical education, but it is unclear how to best deliver this instruction. Book clubs have been used outside of medicine as a professional development tool. We sought to create and evaluate a virtual professional development book club for emergency medicine interns.

**METHODS:** We designed and implemented a virtual professional development book club during intern orientation. Afterward, participants completed an evaluative survey consisting of Likert and free-response items. Descriptive statistics were reported. We analyzed free-response data using a thematic approach.

**RESULTS:** Of 15 interns who participated in the book club, 12 (80%) completed the evaluative survey. Most (10/12; 83.3%) agreed or strongly agreed that the book club showed them the importance of professional development as a component of residency training and helped them reflect on their own professional (11/12; 91.7%) and personal development (11/12; 91.7%). Participants felt the book club contributed to bonding with their peers (9/12; 75%) and engagement with the residency program (9/12; 75%). Our qualitative analysis revealed five major themes regarding how the book club contributed to professional and personal development: alignment with developmental stage; deliberate practice; self-reflection; strategies to address challenges; and communication skills.

**CONCLUSION:** A virtual book club was feasible to implement. Participants identified multiple ways the book club positively contributed to their professional development. These results may inform the development of other book clubs in graduate medical education. [West J Emerg Med. 2021;22(1)108-114.]

**BACKGROUND**

Professional development, defined by the US Centers for Disease Control and Prevention as “a systematic process that strengthens how professionals obtain and retain knowledge, skills and attitudes,” is essential for trainees in order to meet the challenges of medical practice and develop into physician leaders. Professional development can help engage trainees in reflective and deliberate practice, allowing them to be better prepared for their future careers. It also serves to encourage the growth of physician advocates and leaders to meet the ever-changing, complex needs of the field of medicine. These demands require physicians to be capable of conducting self-directed development of their clinical competency, interpersonal dynamics, and overall professionalism. By improving engagement and continuing to develop the skill set required to meet the challenges of medical practice, professional development can help mitigate burnout and has been identified as a strategy for resilience in medicine.

Similarly, personal development is also a lifelong learning process that incorporates self-reflection and external feedback to promote awareness of identity, achievement of goals, and enhanced quality of life. Personal and professional development are often intertwined in medicine, and both are important for medical trainees. The importance of professional development in emergency medicine (EM) residency education is supported by the regulatory requirements of the Accreditation Council for Graduate Medical Education (ACGME).

Professional and personal development are complex constructs with little data to guide optimal teaching modalities. However, randomized controlled trials have revealed that teachers who received direct developmental interventions received higher overall teaching quality scores. Professional development opportunities abound in other business sectors using a wide spectrum of experiences, varying from online forums and longitudinal courses to conferences, mentoring groups, and case studies as well as book clubs. Book clubs have been used in other industries including business and teaching as a professional development tool that encourages active engagement, self-reflection, and team building.

Book clubs have also been used for longitudinal professional development in other allied health professions and as a way to improve interprofessional communication, leadership skills, and learner’s understanding of the patient perspective. However, there is limited literature regarding the use of book clubs in graduate medical education (GME).

**Population Health Research Capsule**

**What do we already know about this issue?**

Professional development is an important component of graduate medical education, but it is unclear how to best deliver this instruction.

**What was the research question?**

Can a virtual professional development book club be successfully implemented for EM interns?

**What was the major finding of the study?**

A virtual professional development book club was feasible to implement and perceived to be valuable.

**How does this improve population health?**

These results may inform the development of other book clubs in graduate medical education.
The literature that does exist primarily consists of curricular descriptions and limited outcome data, which have generally been positive.\textsuperscript{21-24} As an example, Kan et al describe a book club for psychiatric trainees consisting of 90-minute, bimonthly sessions incorporating trainee led, instructor facilitated, indepth discussions of nonfiction book content and application to psychiatric and clinical practice, which was felt by participants to positively contribute to training.\textsuperscript{23}

**OBJECTIVES**

The emergence of the COVID-19 pandemic has led to the transition of many medical education experiences to the virtual environment.\textsuperscript{25} This transition has created an opportunity for educators to develop remote learning methods to ensure high quality education at the GME level.\textsuperscript{26-27}

To meet the demands of professional development education in a virtual setting we sought to create and evaluate a virtual professional development book club for EM interns. The goals of the book club were as follows: 1) to introduce residents to the importance of personal and professional development as a component of residency training; 2) to encourage the use of personal and professional development materials outside of medicine; and 3) to foster a culture of metacognition.

**CURRICULAR DESIGN**

Our study team of medical educators designed the book club with input from our resident team member. We purposefully identified a broad range of books that addressed professional development topics based on national bestseller lists, book reviews, and the authors’ prior experiences with other professional development book clubs. We selected the final list of five books by group consensus (Appendix

![Figure 1. Participant perspectives of virtual book club.](image-url)
A). We chose to allow learners to select a book from our suggested list to augment learner agency and engagement. The use of multiple books also allowed the group to learn from each other as each book was discussed during the session. We planned the book club to be conducted over two hours and include an introduction, small-group breakout discussions on individual books, report out in a large group discussion, and summary and reflection of impact on learners as physicians and trainees. The book club director (NW) created the discussion questions based on the goals of the sessions with input from the study team. Open-ended questions were used to maximize depth of response and promote discussion. Discussion questions are available in Appendix B.

We contacted all 15 incoming EM interns one month prior to intern orientation and invited them to participate in the book club. In an effort to promote self-reflection and inquiry, we provided them the book list with a short description of each book and asked that they rank their book preferences. To ensure equal distribution of books, the book club director then assigned participants a book according to their preferences. All participants received their first or second choice. Participants read their book and participated in the virtual book club as outlined above. We implemented the book club, using the Zoom platform (Zoom Video Communications Inc., San Jose, CA) in June 2020 during intern orientation and prior to any clinical experiences.28 We chose Zoom as our virtual platform as this was already being used by the residency program for virtual didactics and all the faculty facilitators were familiar with the format. Faculty facilitators read the books, were oriented to the goals of the session, and moderated all discussions. The major resource requirements for the book club were faculty time and a virtual platform.

After the book club, we invited participants by email to complete a confidential online evaluative survey. We did not find any existing assessment tools that were appropriate for our context and setting during our literature review. Therefore, one author with advanced training in evaluation and survey design (JJ) developed an evaluative survey, incorporating established guidelines for survey research.29 The survey developer reviewed the literature and gathered input from the study team to maximize content validity. Building off of other book club evaluative instruments in the literature, consisting of agreement survey items and verbal feedback, we chose to include Likert agreement and free-response items in our evaluative survey.17,22,23 We read the survey aloud with study team members and piloted with a small group of reference subjects prior to implementation to optimize response process validity. We revised the survey for clarity based on feedback from piloting. The final version of the survey is available in Appendix C.

The study was deemed exempt by the Institutional Review Board of the David Geffen School of Medicine.

**IMPACT/EFFECTIVENESS**

To assess the impact of our book club, we calculated and reported descriptive statistics for survey items with discrete answer choices. For free-response data, we performed a thematic qualitative analysis. Two researchers experienced in qualitative methods (JJ and SV) independently analyzed free-response data line by line to identify recurring concepts and assign codes that were further refined into themes using the constant comparative method.30 After initial independent review, the two analysts met to review codes and establish a final coding scheme. The two analysts then independently recoded all data using this final coding scheme. Subsequently, the

<table>
<thead>
<tr>
<th>Strongly disagree n (%)</th>
<th>Disagree n (%)</th>
<th>Neutral n (%)</th>
<th>Agree n (%)</th>
<th>Strongly agree n (%)</th>
<th>Total n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This book club showed me the importance of professional development as a component of residency training.</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>2 (16.7)</td>
<td>7 (58.3)</td>
<td>3 (25.0)</td>
</tr>
<tr>
<td>This book club helped me reflect on my own professional development.</td>
<td>0 (0)</td>
<td>1 (8.3)</td>
<td>0 (0)</td>
<td>9 (75.0)</td>
<td>2 (16.7)</td>
</tr>
<tr>
<td>This book club helped me reflect on my own personal development.</td>
<td>0 (0)</td>
<td>1 (8.3)</td>
<td>0 (0)</td>
<td>8 (66.7)</td>
<td>3 (25.0)</td>
</tr>
<tr>
<td>I plan to read another professional development book in the next 12 months.</td>
<td>1 (8.3)</td>
<td>4 (33.3)</td>
<td>2 (16.7)</td>
<td>4 (33.3)</td>
<td>1 (8.3)</td>
</tr>
<tr>
<td>This book club contributed to bonding with my peers.</td>
<td>0 (0)</td>
<td>1 (8.3)</td>
<td>2 (16.7)</td>
<td>7 (58.3)</td>
<td>2 (16.7)</td>
</tr>
<tr>
<td>This book club facilitated my engagement with the residency program.</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>3 (25.0)</td>
<td>6 (50.0)</td>
<td>3 (25.0)</td>
</tr>
<tr>
<td>I would like to participate in additional book clubs during residency.</td>
<td>1 (8.3)</td>
<td>0 (0)</td>
<td>3 (25.0)</td>
<td>6 (50.0)</td>
<td>2 (16.7)</td>
</tr>
</tbody>
</table>

Table 1. Participant perspectives of virtual book club.
two analysts met again to discuss their findings and establish their agreement. The overall percent agreement between the analysts for the second round of coding was 91.7%. During this second meeting the analysts resolved discrepancies by in-depth discussion and negotiated consensus.

All 15 interns in the incoming class participated in the book club and 12 (80%) completed the evaluative survey. Participant perspectives are displayed in Figure 1 and Table 1. Most (10/12; 83.3%) agreed or strongly agreed that the book club showed them the importance of professional development as a component of residency training. The majority of participants felt the book club helped them reflect on their own professional (11/12; 91.7%) and personal development (11/12; 91.7%). Participants also noted that the book club contributed to bonding with their peers (9/12; 75%) and engagement with the residency program (9/12; 75%). Two thirds of participants said they would like to participate in additional book clubs during residency. A minority (5/12; 41.7%) of participants planned to read another professional development book in the next 12 months.

Results of qualitative analysis are displayed in Table 2. Our qualitative analysis revealed five major themes regarding how the book club contributed to professional and personal development: alignment with developmental stage; deliberate practice; self-reflection; strategies to address challenges; and communication skills. Participants noted that the book club was also valuable in helping them engage with the program's faculty and residents. Participants noted they planned to directly apply content discussed in the session. For example, related to the discussion on growth mindset, one participant remarked, “[I plan to] have a positive outlook and prepare to learn and grow throughout residency.” The one theme that emerged for improvement of the book club was the suggestion to hold it in an in-person setting.

GME training programs in EM require learners to simultaneously learn the core content of EM as well as develop the personal and professional skills necessary to safely navigate the multifaceted milieu of the emergency department (ED), an environment with multiple types of workers including nurses, technicians, clerical staff, and physician colleagues. Emergency physicians must develop robust professional

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Table 2. Results of qualitative analysis of interns’ perceptions regarding the use of a virtual book club for professional development.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Major themes</th>
<th>Exemplar quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribution to professional and personal development</td>
<td>Alignment with developmental stage</td>
<td>“This book was appropriate for someone about to start residency.”</td>
</tr>
<tr>
<td></td>
<td>Deliberate practice</td>
<td>“Applying a more intentional perspective towards learning in a meaningful manner in residency.”</td>
</tr>
<tr>
<td></td>
<td>Self-reflection</td>
<td>“…thinking more about how to organize my goals in relation to my overall purpose. I believe this will be helpful in terms of prioritizing where I direct my energy;” Self-reflection “Insight into how my professional development has been influenced by my personal characteristics;” “It helped me reflect on my own tendencies in difficult interactions and how those can be improved;”</td>
</tr>
<tr>
<td></td>
<td>Strategies to address challenges</td>
<td>“The book made me reflect on how to deal with challenges in life and how to persist and use the opportunity to grow;”</td>
</tr>
<tr>
<td></td>
<td>Communication skills</td>
<td>“[This book club] improved my communication skills;”</td>
</tr>
<tr>
<td>Additional value of book club</td>
<td>Opportunity to engage with program faculty</td>
<td>“I enjoyed getting to know the faculty better in small groups;”</td>
</tr>
<tr>
<td></td>
<td>Opportunity to engage with program residents</td>
<td>“I appreciated participating with my peers;”</td>
</tr>
<tr>
<td>Plans for change after book club</td>
<td>Direct application of discussed content</td>
<td>“I will try and take a step back and remove my emotion from the situation when faced with a difficult interaction;”</td>
</tr>
<tr>
<td>Improvement of book club</td>
<td>In-person setting</td>
<td>“I think this was a great idea, however, I think this would be much better in person;”</td>
</tr>
</tbody>
</table>
skills to effectively interact with and lead multidisciplinary teams as well as to mitigate such factors as burnout in order to sustain a successful career in medicine. As opposed to procedural skills, medical knowledge, and concrete aspects of patient care, professionalism and communication based competencies are relatively intangible and difficult to “teach.”

A professional development book club such as the one developed and evaluated in this study provides a potential strategy for developing these skills. While there is literature describing the importance of humanities in medical education and utilization of a book club experience in GME programs, we believe this is the first such experience to incorporate professional development books as the substrate for learning and discussion.\textsuperscript{23,31,32} Our results demonstrate that this type of educational offering was feasible to implement, well received by trainees, and has the potential to support trainees in self-reflection, deliberate practice, communication, and addressing challenges. Additionally, while we did not directly measure metacognition, the free-response data from participants indicated metacognitive activities such as planning an approach to learning, self-assessment and correction, and using appropriate strategies to solve a problem. Participants felt this book club positively contributed to their professional development in several ways including the encouragement of deliberate practice, which has been identified in the literature as a key component in the development of expertise.\textsuperscript{33-35} Fostering this practice early in training may compound results.

Participants also noted the book club promoted self-reflection, which has been described as being essential for improvement.\textsuperscript{36-37} Additionally, participants felt this session contributed to their development by introducing specific, actionable strategies to address challenges and build communication skills. The strategies introduced may be particularly beneficial in the ED where the ability to handle the unpredictability and critical nature of disease presentations, endure frequent interruptions, manage conflict, and use a team approach to patient care is crucial.\textsuperscript{38-42} Finally, both quantitative and qualitative results demonstrate that participants viewed this experience as an opportunity to engage with faculty and peers. Holding such an event early in training may help to more effectively and efficiently integrate new interns into the residency program. Forming bonds with faculty and peers can enable a strong support network and foster community, which can decrease burnout.\textsuperscript{43-45}

The majority of participants felt that the session helped them think about how to deploy new professional skills as they entered into residency training. Given the perceived utility of the exercise, it was surprising that fewer than half of the cohort indicated that they planned to read another personal or professional development book in the coming 12 months. This most likely reflects their preconceived thoughts that they will need to spend what little time they have as interns reading medical content rather than professional development books. This finding emphasizes that the period of time prior to starting clinical rotations was the ideal time to hold this exercise in order to introduce the importance of professional development on EM practice. It may also be beneficial to incorporate such a session during the final months of medical school when student responsibilities have waned, as a deliberate attempt to jump start their subsequent postgraduate development.

We believe that it is our role as educators to ensure that our trainees are receiving a comprehensive medical education including EM core content and professional development. Deliberate attempts by program leadership to incorporate professional development into the curriculum may be necessary to ensure that these important topics are addressed. The majority of participants reported that they would like to participate in additional book clubs during residency. An in-person setting was recommended for improvement, which likely reflects the less personal nature of the virtual environment. Although the book club experience would likely have been richer as an in-person event, the participants’ experiences with this version showed that value was maintained using a virtual platform.

We developed this book club as a novel experience to encourage our interns to embark on a path of personal and professional development from the very beginning of residency training. We also hope this experience fosters an awareness of the opportunities to develop these less tangible skills in the clinical environment, as well as the benefit of reaching outside of the medical sphere for expertise in skill development. It is our hope that an increased knowledge of variances in mindset, learning style, negotiation tactics, and communication skills will allow our interns to observe, reflect on, and model others’ behaviors as they progress through their training. In the future we plan to evaluate objective learning outcomes, as these were not assessed in the current study, and to expand the scope of a professional development-themed book club.

**LIMITATIONS**

There are several limitations that must be considered. This study was conducted at a single academic institution so the results may not be generalizable. Additionally, the sample size was small and only consisted of interns; thus, it is unclear whether these same results would be found across postgraduate year levels. We believe these limitations are acceptable as an initial assessment of a novel educational session. Although the response rate was good, it is possible that non-responders may have answered differently than those who completed the evaluative survey. Additionally, while the survey was confidential and it was explicitly communicated to participants that we were interested in honest and candid feedback as this was a new educational session, there is the possibility of response bias. Finally, based upon feedback, holding this session in person may have been beneficial and it is unclear how the setting influenced the impact of the book club.

**CONCLUSION**

In summary, a virtual book club was feasible to implement and participants perceived positive contributions to their professional development. Potential positive outcomes include encouragement of deliberate practice and self-reflection, improved communication skills and strategies to address challenges, and engagement with each other as well as residency program leadership. These results may inform the development of other book clubs in graduate medical education.
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Benjamen Schoenberg, MD wrote the article “CODE BLUE: An Intern’s Reflections from Nights in the COVID-19 ICU” published in *EMResident*.

Viveta Lobo, MD, FACEP launched her podcast “Stocks4Docs”.

Christopher Bennett, MD, MA and Tim Jang, MD published their article “Clinical prediction rule for SARS-CoV-2 infection from 116 U.S. emergency departments 2-22-2021” in *PLOS ONE*.

Andrea Fang, MD was elected treasurer of the Academy for Women in Academic Emergency Medicine.

Jonathan Hootman, MD; Sarabeth Maciey, MD; Nicole Prendergast, MD; and Jason Yuan-Jye Teng, MD were selected to be the 2021-2022 Chief Residents at Stanford Emergency Medicine.

Rahul Nayak, MD had their first manuscript during residency accepted for publication in the *Visual Journal of Emergency Medicine*.

Kimberly Allen, MD and Travis Eurick, MD were matched with Kaiser Permanente San Diego Emergency Medicine.

Whi Inh Shirley Bae, MD; Noah Ghossein, MD; Benjamin Herzel, MD; Grace Kim, MD, FACEP; Natalie Oberhauser-Lim, MD and Alejandro Perez, MD were matched with Loma Linda University Emergency Medicine.

Nagehan Ayakta, MD; Daniel Brownstein, MD and Drew Weinstein, MD were matched with University of California, Los Angeles Emergency Medicine.

Amy Chuang, MD; Giulia Di Bella, MD; Oliver Marigold, MD; Melissa Mueller, MD; Aubtin Saedi, MD; and Christina Seto, MD were matched with Kaweah Delta Emergency Medicine.

Ashley Advincula, MD; Evan Chua, MD; Eric Jenkins, MD; Mi Song Kim, MD; and Thien Nguyen, MD were matched with Riverside Community Hospital Emergency Medicine.

Benson Chen, MD; Kyle Herout, MD; and Peter Vuong, MD were matched with Kaiser Permanente Central Valley Emergency Medicine.

Robyn Coelho, MD; Cassandra Dewitt, MD; Marcus Olivares-Perez, MD; and Liliana Samano, MD were matched with University of California, San Francisco, Fresno Emergency Medicine.

Andrew Abayan, MD; Elizabeth A Avakoff, DO; Melody Jia Fang, MD; Natalie Hernandez, MD; Lyolya Hovhannisyan, MD; Dan Im, MD; Aaron Katrikh, MD; Niresh Perera, MD; Karen Tate, MD; and Joyce Wahba, MD were matched with Harbor University of California, Los Angeles Emergency Medicine.

Ellen Asselin, MD; Alex G Gimelli, MD; Lilya Klimkiv, MD; Angelina Mikityuk, MD; Caroline Volkos, MD and Jazmin White, MD were matched with University of California, Davis Emergency Medicine.

Megan Bocchicchio, MD; Donya Enayati, MD; Madeleine Heller, MD; Louis Nguyen, MD; Benjamin Partiali, MD; Andrew Rosales, MD; and Vian Zada, MD were matched with Los Angeles County + University of Southern California Department of Emergency Medicine.

Amy Kaji, MD, PhD, MPH was elected president of the Society for Academic Emergency Medicine Board of Directors.

Morgan Carlile, MD was named University of California, San Diego Health’s House Officer of the Year.

Brian Lentz, MD published his article “A systematic review of the cost-effectiveness of ultrasound in emergency care settings” in PubMed.

Carolina Ornelas, MD received the 2021 ACEP/EMRA National Outstanding Medical Student Award.

Cherrelle Smith, MD was appointed Assistant Medical Director for the Stanford Pediatric Emergency Department.

A’hai Alvarez, MD, FACEP and Holly Caretta-Weyer, MD were appointed to Associate Program Director at Stanford Emergency Medicine.

Christopher Bennett, MD joined Stanford Epidemiology & Population Health.

Jordan Justice, MD, FACEP is now a FACEP designee.

Nathan Kuppermann, MD, FACEP won the Society for Academic Emergency Medicine 2021 Best Pediatric Research Study Award for his study, “Respiratory Viral Detection Does Not Alter PECARN Febrile Infant Rule Accuracy for SBI.”

Let California ACEP know and we will include it in this new section of Lifeline. Tweet your accomplishment or post it on Instagram and tag @californiaacep or submit your accomplishments at: https://californiaacep.site-ym.com/surveys/?id=Accomplishments.

MEMBER Accomplishments

**MEMBER Accomplishments**
CEMAF DONORS

The California Emergency Medicine Advocacy Fund (CEMAF) has transformed California ACEP’s advocacy efforts from primarily legislative to robust efforts in the legislative, regulatory, legal, and through the Emergency Medical Political Action Committee, political arenas. Few, if any, organization of our size can boast of an advocacy program like California ACEP’s; a program that has helped block Medi-Cal provider rate cuts, lock in $500 million for the Maddy EMS Fund over the next 10 years, and fight for ED overcrowding solutions! The efforts could not be sustained without the generous support from the groups listed below, some of whom have donated as much as $0.25 per chart to ensure that California ACEP can fight on your behalf. Thank you to our 2019-20 contributors (in alphabetical order):

- Antelope Valley Emergency Medical Associates
- Culver Emergency Medical Group
- Emergent Medical Associates
- Mills Peninsula Emergency Medical Associates
- Napa Valley Emergency Medical Group
- Pacific Emergency Providers, APC
- Riverside EP
- Temecula Valley Emergency Physicians
- Torrance Emergency Physicians
- US Acute Care Solutions
- VEP Healthcare Inc.
- Vituity

CEMAF

DONORS

SUBMIT A LIFELINE ARTICLE
Looking for a way to share your emergency medicine experience? Want to share a story from your last shift? Or maybe career or life advice? We are looking for member and guest articles, including letters-to-the-editor. Please note that all articles and letters are reviewed and may be edited for grammar and content.

If you would like more information or would like to submit a guest article, email info@californiaacep.org.

UPCOMING LIFELINE TOPICS
Fall
CalACEP’s 50th Anniversary
Reimbursement and Billing

Winter
NOMINATE A CALEMRA ALL-STAR
Do you have an EM all-star hiding in your program and want to get their name out there? We’re looking for residents or medical students that deserve recognition!

Nominations can be submitted at bit.ly/nominate4calemra.
For more information on upcoming meetings, please e-mail us at info@californiaacep.org; unless otherwise noted, all meetings are held via conference call.

### SEPTEMBER 2021

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>7th at 9am</td>
<td>Reimbursement Committee Conference Call</td>
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<tr>
<td>9th at 10am</td>
<td>Board of Directors Meeting San Diego</td>
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### OCTOBER 2021

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<tr>
<td>8th at 10am</td>
<td>Council Delegation Subcommittee A Conference Call</td>
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<tr>
<td>8th at 12pm</td>
<td>Council Delegation Subcommittee A Conference Call</td>
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</tr>
<tr>
<td>8th at 2pm</td>
<td>Council Delegation Subcommittee A Conference Call</td>
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<tr>
<td>14th at 10am</td>
<td>Government Affairs Committee (GAC) Conference Call</td>
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<tr>
<td>15th at 10am</td>
<td>Council Delegation Meeting Conference Call</td>
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<tr>
<td>23rd &amp; 24th</td>
<td>ACEP Council Boston, MA</td>
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### NOVEMBER 2021

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<tr>
<td>2nd at 9am</td>
<td>Reimbursement Committee Conference Call</td>
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<tr>
<td>3rd at 9am</td>
<td>Executive Committee Conference Call</td>
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<tr>
<td>11th</td>
<td>Veteran's Day Office Closed</td>
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<tr>
<td>18th at 10am</td>
<td>Board of Directors Meeting Conference Call</td>
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</tr>
<tr>
<td>25th &amp; 26th</td>
<td>Thanksgiving Holiday Office Closed</td>
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</tbody>
</table>
TUNE IN!

LISTEN ON THE CALACEP WEBSITE TO GET FREE CME ON MEDICATION ASSISTED TREATMENT.

WWW.CALIFORNIAACEP.ORG
Looking for an ITLS course?
EMREF offers the following California providers list:

American Health Education, Inc
Perry Hickey, EMT-P
7300B Aramid Plaza Road, Dublin, CA 94568
Phone: (800) 483-3615
Email: info@americanhealtheducation.com
Web: www.americanhealtheducation.com

Compliance Training
Jason Manning, EMS Course Coordinator
3188 Verde Robles Drive, Camino, CA 95709
Phone: (916) 429-5895
Fax: (916) 278-4846
Email: thomasffp@sbcglobal.net
Mobile: (916) 316-7388
Office: (916) 278-4846
Thomas Oakes, Program Director
CSUS Prehospital Education Program
Email: Kurgan911@comcast.net
Phone: (916) 429-5895
3188 Verde Robles Drive, Camino, CA 95709

Loma Linda University Medical Center
Lyne Jones, Administrative Assistant
Department of Emergency Medicine
11234 Anderson St., A103, Loma Linda, CA 92354
Phone: (909) 558-4344 x 0
Fax: (909) 558-0102
Email: L.Jones@ahs.llumc.edu
Web: www.llu.edu

Medic Ambulance
James Pierson, EMT-P & Helen Pierson
506 Couch Street, Vallejo, CA 94590-2408
Phone: (707) 644-1761
Fax: (707) 644-1784
Email: jpierson@medicambulance.net
Web: www.medicambulance.net

Napa Valley Fire
Gregory Rose, EMS Co-Director
2277 Napa Highway, Napa CA 94558
Phone: (707) 256-4596
Email: gprose@napavalley.edu
Web: www.winecountrypcr.com

NCTI – National College of Technical Instruction
Lena Rohrabaugh, Course Manager
2955 Foothills Blvd Suite 100, Roseville, CA 95747
Phone: (916) 960-6284 x 105
Fax: (916) 960-6296
Email: jlcasa@caltel.com
Web: www.ncti-online.com

PHI Air Medical, California
Eric Lewis, Course Coordinator
801 D Airport Way, Modesto, CA 95354
Phone: (209) 550-0884
Fax: (209) 550-0885
Email: elewis@philhelico.com
Web: http://www.phiairmedical.com

Riggs Ambulance Service
Greg Petersen, EMT-P, Clinical Care Coordinator
100 Riggs Ave, Merced, CA 95340
Phone: (209) 725-7010
Fax: (209) 725-7044
Email: GregP@riggsambulance.com
Web: www.riggsambulance.com

Rocklin Fire Department
Chris Wade, Firefighter/Paramedic
3401 Crest Drive, Rocklin, CA 95665
Phone: (916) 625-5311
Fax: (916) 625-7044
Email: Chris.Wade@rocklin.ca.us
Web: www.rocklin.ca.us

Rural Metro Ambulance
Adrian Ayllon EMT-P
1345 Vander Way, San Jose, CA 95112
Phone: (408) 645-7345
Fax: (408) 275-6744
Email: adranayllon@yahoo.com
Web: www.metro.com

NorCal MedTac
Brian Green, EMT-P
3107 Scotts Valley Dr, Scotts Valley, CA 95066
Phone: (831) 970-0440
Email: bschel90@hotmail.com
Web: www.norcamedtac.com

Accredited EMS Fire Training
Brian Green, EMT-P
4461 Post Street #4464 Rocklin, El Dorado Hills, CA 95762
Phone: (925) 708-5377
Email: Amrmedic2003@yahoo.com
Web: www.americanhealtheducation.com

Search for upcoming courses: http://cms.itrauma.org/CourseSearch.aspx

EMREF is a proud sponsor of California ITLS courses.

Please call 916.325.5455 or E-mail Emma Daly: edaly@californiaacep.org for more information.
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