



Focus

Emergency Medicine



June 2016

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If you have any suggestions for how we could enhance the newsletters moving forward or any corrections, comments, or suggestions for articles of interest, please do not hesitate to contact any of the Career Services Committee members.

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Connect with the Department of Surgery

James Brown, M.D., chair



medicine.wright.edu/emergency-medicine

From the Chair: James Brown, M.D.



Dr. James E. Brown is a graduate of the University of Louisville Medical School and completed his residency there as well. In addition, he has a Masters in Medical Management degree. He has been the chair of the Emergency Medicine Department since 2010 and served as residency director from 2000-2013.

Dr. Brown did not have a direct path into the field of medicine. He graduated from Covington Latin School at the age of fifteen and then entered seminary for five and one-half years. He left the seminary and worked in a bank while completing paramedic school. He then worked as a paramedic in Louisville for the next four years. While working as a paramedic, he took premed courses and subsequently entered University of Louisville Medical School by early decision. He worked as a flight paramedic while in school. After completing medical school and residency, he and his wife, Dr. Judith Masset-Brown moved to Dayton, Ohio because she matched into Wright State University's pediatric residency program. He was at match day in Louisville when he noticed a job posting by Dr. Glenn Hamilton, then chair of emergency medicine at WSU, seeking an EMS trained emergency physician to act as a liaison with the EMS community and to teach residents about emergency medical services.

Dr. Brown said that emergency medicine physicians serve as medical directors for all of the EMS agencies and that residents need to know what is involved in properly fulfilling that role. Emergency medicine physicians supervise EMS training, go on some ambulance runs, do disaster training, review CME opportunities and do protocol reviews. Every time there is a change in ACLS protocol or a change in drug availability, these protocols need to be updated. In addition to this, Dr. Brown is also a tactical medic who works with several local SWAT teams. He goes on runs with them in case of injuries or accidents and trains with them. He said that residents work with members of the SWAT teams an average of one to two times per week. Any resident is able to do this, as long as they are in good academic standing, but it is more common for the military residents to choose to do so.

Academically, there are so many options in the field of emergency medicine. There are both three and four year programs. Dr. Brown says that the primary reason to do a four-year program is if you are considering academic medicine or research. There are both joint EM-IM and EM-Peds programs. In addition, there are a number of fellowship and sub-specialty trainings, including: medical toxicology, emergency medical services, pediatric emergency medicine, undersea and hyperbaric medicine, emergency ultrasound, sports medicine and critical care medicine. Dr. Brown stressed that the training bar is set so high in emergency medicine that you will get good training no matter where you go. You are looking instead for a program in which you find a "good fit." He compared the University of Louisville program to the WSU program to demonstrate this. He described the University of Louisville program as resident run. The residents see all of the patients in the emergency department. If the emergency department is extra busy the residents just have to work harder. WSU's program is a community program that is more spread out so it does not use the same model.

The field of emergency medicine is on the cutting edge of new trends and diagnoses. Dr. Brown enjoys the fact that every day he goes to work and sees something he has never seen before. Emergency medicine physicians must be able to deal with uncertainty. They can do an entire shift in the emergency department and not make a single diagnosis. If this makes you uncomfortable then perhaps it is not the field for you. If you choose to take

Brown continued

another path, an emergency medicine physician can go into administration, work in an urgent care or consider the field of occupational medicine. Emergency medicine is a field of medicine where you treat people from all walks of life. Good communication skills are vital as well as knowing that you are treating someone who might not have anyone else to help them. Emergency medicine is not primary care, but it is generalist medicine. Dr. Brown said that Emergency medicine physicians know the second most about every field, especially ophthalmology and pediatrics. The malpractice rate is higher in EM than in most fields because there is no long-term physician-patient relationship and the level of acuity is high. The average EM physician is sued for malpractice once every five years. Dr. Brown compares physicians (especially Emergency Medicine physicians) to police officers in that there is an inherently increased risk for malpractice just for doing your job.

Emergency Medicine physicians are adventurous, action-oriented people who thrive in a fast-paced environment where there is a lot of uncertainty. Emergency Medicine physicians must be comfortable with working in a “fishbowl” and dealing with feedback from many parties. With all this said however, Dr. Brown ended the interview with the statement “I have the best job in medicine.”

—L. Poston

Interview with Jason R. Pickett, Emergency Medicine, Wright State Physicians

What drew you to emergency medicine (EM)?

I started my career as an EMT and after spending time in the emergency room, I really caught the bug. I then became a paramedic and after a few years, I realized I'd taken this paramedic thing as far as it could go. I wanted to do more, learn more, and the logical choice was medical school. I kept an open mind, but ultimately kept coming to emergency medicine.

What is your favorite part now about EM?

Depends on the day and the time of day. I like the variety. I like the resuscitations and the activity. I really like the fact that I get to interact with people across the spectrum of cultural, racial, and socioeconomic boundaries. Folks that I wouldn't necessarily get the chance to interact with in my personal life, I get to take care of and form a bond with them.

The physician patient bond is often an area that may be questioned in EM, is it a concern?

The emergency physician has to paint in broad strokes. My running joke is that I know the first 20 minutes of every disease process. There are a lot of times when I wish I could follow that patient in the hospital and the course of their recovery. There are patients that I wonder what happened to them. I've cultivated a good relationship with my colleagues which has helped as well. It's sometimes a subject of reproach from other specialties that EM physicians don't have the depth of knowledge that they do. Everyone thinks they're a master of their own craft. Put a surgeon in a delivery or give an internist a trauma patient who needs to be resuscitated, and they wouldn't be quite so dismissive of the emergency physician skill set.

If I was to boil the specialty down, it comprises two things.

Resuscitation. First. Before everything. Second is diagnosis. People rely on us for that. Primary care physicians send their patients to the ER for a workup to determine the diagnosis. Determining the diagnosis can be facilitated with not only the immediate access to medical tests available in the ER, but also the EM physician's broad mindset. It's probably just _____, but they need to be watched overnight just in case it's _____. One of my preceptors

once said as we were filling out discharge paperwork, “This is your last chance to save their life.”

What is something that people may not know about EM?

A lot of folks look at the number of hours EM physicians are scheduled in the ER and it's a fairly decent lifestyle when you compare it to 80-hour work weeks, but the rotating shifts take their toll. You also tend to be involved in a lot of things like hospital committees, teaching, EMS, disaster training, all of which add to the amount of work time that we have. Honestly, we're busier than we look. This can be a positive as well because of the wide variety of practice settings that we have, from exciting areas like SWAT and searchand rescue to fellowships like critical care and sports medicine. It allows you to get out of the office and work in cool environments like on cruise ships, in the military, in rural settings, or in international locations.

Best advice? Never listen to a physician's advice on a specialty that is not their own.

Maybe you want to be an ER doctor, don't listen to what a surgeon has to say about EM. Just like you shouldn't listen to me about what it's like to go into surgery. Listen to the people in that specialty about what they like and don't like about it. On that note, the broader your perspective, the better your skillset. Use your time in medical school and residency to learn as much as you can about other specialties, because it allows you to appreciate your own.

Any advice in general for medical students?

Keep an open mind. During your rotations, if you liked everything, that's a good reason to go into EM. If you hated everything, that's a horrible reason to go into EM. We certainly see both types. Even if you're not ending up in EM as a specialty, understand the ER is the front door for your patients that get admitted or may be the way they access you as a specialist. We will bend over backwards for you, do what's right for the patient and are more than happy to talk about their treatment with you. We get that we lack the depth that you may have, but we're the ones who had to figure out who to send them to in the first place!

—Ryan Brinn, MS3

Interview with Dr. Josh Klepinger, WSUBSOM alumnus

How did you choose the field of Emergency Medicine (EM)?

I worked as a firefighter and paramedic before entering medical school. That got me interested in EM. There were definitely other specialties along the way that I really enjoyed and probably could have been happy in. I kept an open mind throughout the first three years of medical school, but when it came down to comparing some of the other specialties the PRO column for EM was pretty heavily favored. This certainly wouldn't be the same for everybody, but it was ultimately the best fit for me. Ultimately I made my decision by first deciding which demographic of society I really wanted to work for. This can be a very helpful technique for figuring out what you want to do. EM sees anybody, for anything, at anytime. I loved this about it. I also saw that there is a rung of society who will only ever interact with a doctor by making a visit to the local ED. Homeless people, drug and alcohol addicts, sex workers, victims of abuse and their abusers... this is a very marginalized group of people. I wanted to work for this group of people and EM was the best way for me to do that.

What experiences influenced your decision to pursue this field over others?

My experience during third year of being in clinics on some clerkships really made me realize that I would not survive a practice that required clinic work. We need primary care providers, but I realized that it was not a good fit for me. I also loved my experiences in the OR and had to come to terms with the fact that I was choosing a non-surgical specialty. Eventually I was ok with this but it took a while. I realized I liked the OR, but I didn't love it. A huge gap exists between liking and loving surgery. I wish I could give you a really feel good, tear-jerker story about some patient encounter that really helped me choose, but I really never had that happen. I think a lot of us expect that one day the clouds will burst open and the specialty that was made for us will be lowered down from heaven on a ray of sunshine. Don't wait around for this epiphany. The way to be the best possible doctor is to pick the specialty that you really enjoyed the most. None of us need to be a martyr when it comes to choosing. Don't go into something for any other reason other than simply loving it. If your loving what you are doing you are going to pass that love on to your patients. If you pick a specialty based on someone else's expectations of

you, on what you perceive the need in society to be, or on how you want other people to perceive you, then you will almost certainly be unhappy sooner rather than later, and this unhappiness will show through in the way you treat your patients.

Did you have any mentors along the way who helped shape your decision to go into EM?

It definitely took a village to raise this child. Surprisingly it wasn't so much EM doctors that influenced my decision but happy, purposeful, successful doctors in several other fields. One of my greatest mentors is an OB/Gyn in the area. He practices medicine with joy. I wanted to be that kind of doctor, I just ended up choosing a different specialty. You also have some very incredible faculty who are exceptional people in addition to being good doctors: Toussaint, Binder, Kirkham, Donnelly. These are some pretty high caliber people. Seek some of them out. If you don't find yourself connecting with them, they will certainly be able to help you find the mentor you need.

What's one aspect of EM that medical students may not know?

EM is really about solving problems. The first problem with every patient is figuring out exactly what it was that brought them in. When people are sick or scared or intoxicated, they can't always tell you what it is they hoped to get out of their visit to the ER. Learning to solicit this from people of all backgrounds, in all stages of illness or in varying degrees of sobriety is an art form. The second problem is this: the emergency department is societies' safety net. When there is nowhere else to go, you can always go to the ER. This results in some pretty unique problems coming through the door. No shift is ever the same, and in most cases the medicine you practice really ends up being secondary to solving a problem you have never seen before. Think about it... when you call your doctor, if they don't have the resources to help you, or don't have a clinic appointment available right away, where do they tell you to go? The ER! In only a year of residency I have seen problems ranging from patients bringing their own self removed random body part in a baggie, to mothers cradling their child with a gunshot wound as they run thru the hall screaming for a doctor, to families bringing their loved one in from hospice care because they just are not ready to let them

go. Ultimately these are problems that you are tasked with helping your patients solve, and the answer isn't in "First Aid for Step One."

What aspects of EM have you found to be most unique? Likewise, what aspects have you found to be most rewarding or challenging?

We often have to make rapid decisions based on very little information, and then contact a specialist to discuss admission or further care. Because of this, EM has to work with every other specialty very closely, but we are sometimes "Monday morning quarterbacked" by people who were not there when we had to act. This seems rather unique to EM, and can be challenging at times. However, we are a well trained specialty and more often than not we make the right call in the midst of crisis when everyone else around us is losing their cool. This can provide some great satisfaction. In addition, because of our close work with consultants we are always getting feedback, learning, growing and getting better. This makes for a rich environment to work in when approached with the right attitude.

If you were talking to a student looking to go into EM, what's one piece of advice you would give them?

Stay humble, work hard, do the right thing. Doing well in academics is important, and crushing your Steps is great too, but if you are a pompous mule with a 250 on step one, then you are still a pompous mule, and the ER is probably not where you should be spending your time.

—Uma Jasty, MS1

Simulation Lab

Dr. Ten Eyck is a graduate of Georgetown University School of Medicine. He had initially intended on specializing in internal medicine, but when he took a required emergency medicine rotation in his fourth year, he knew that he had found the field for him. As an Air Force ROTC graduate, he completed his internship year at Wilford Hall USAF Medical Center, Lackland AFB, Texas. The Air Force then sponsored him in a civilian emergency medicine residency at Northwestern University. Upon completing residency, he was assigned to Keesler Air Force Base in Biloxi, Mississippi. His six years in Mississippi provided him with the opportunity to do a lot of patient care in addition to research, resident teaching and developing emergency medical systems. He served in clinical teaching positions for most of his career with an additional duty as the emergency medicine consultant to the Air Force Surgeon General for 14 years. After being transferred to Wright-Patterson Medical Center, he became a faculty member in the WSU Emergency Medicine Residency program. His additional assignments at Wright-Patterson included a research position in the Armstrong lab and serving as the medical director for the Region 5 TRICARE office. When he and his wife moved to Dayton, they had three young children and one on the way. He came to Dayton to chair an emergency department in an emergency medicine residency program, but found that Dayton was a great place to raise a family and they have been here ever since.

In 2002, Dr. Ten Eyck, retired from the Air Force and worked as a full-time clinician while teaching in the EM residency as an affiliated faculty member. Working with Dr. Hamilton, he started the EM simulation lab. At the time, it was one of the earliest simulation labs around. He worked on a voluntary basis for four years, then in a part-time position which evolved to a full-time faculty appointment in the Department of Emergency Medicine.

What advice do you have for students interested in Emergency Medicine?

Since your exposure to emergency medicine in the curriculum is relatively late, learn more about the specialty through the Emergency Medicine Interest Group and take advantage of opportunities to shadow emergency physicians. The field of emergency medicine

has become very competitive, but there are still opportunities available for most students who are dedicated and willing to consider all the potential training locations in the US. There are many resources provided by the Department of Emergency Medicine to help interested students learn more about the specialty and to help them in seeking a career in EM.

What is your least and most favorite part of the field?

The best part about being an emergency medicine physician is the opportunity to intervene when people need you the most. The worst part is the amount of time that must be spent with the chart instead of the patient and the inability to get consistent follow-up care for all patients when they leave the emergency room.

What topics do you wish that you learned more about in medical school?

Dr. Ten Eyck was a student and resident when the field of emergency medicine was in its infancy, but he is grateful that Georgetown had a required EM rotation in the fourth year. He wishes that he would have had the opportunity to benefit from the quality of training available to students and residents today. The strong development of the science of emergency medicine in the past 30 year as well as the training standards including things such as simulation training, a strong core curriculum and more comprehensive supervision help today's trainees to be better prepared for their careers as independent practitioners.

The Simulation Lab?

The training in the simulation lab can be divided into two main categories: partial task training and case-based simulation. Partial task training can include such things as placement of a chest tube, airway management, doing a lumbar puncture, and other technical skills. Dr. Ten Eyck describes it as an 80 percent solution to teaching these skills to medical students and residents. The goal is to help our students and residents to be further along the learning curve when they work with real patients. Case-based simulations can teach medical students and residents how to manage various disease scenarios. Simulation is particularly helpful for practicing the less common, but higher risk

scenarios. Although simulation is an expensive learning environment, it is an efficient way to help students and residents learn how to manage these cases. Learners can practice medical skills, ability to act under pressure, communication skills, teamwork and how to find and index pertinent information while in the simulation lab. He said that it gives the students and residents the ability to be in a realistic situation without any risk to real patients if errors are made as these skills are developed. The Wright State Emergency Medicine residents have approximately 60 encounters in the simulation lab spaced throughout their three years of residency.

Dr. Ten Eyck said that his lab has done approximately 20,000 case simulations in the past 14 years. During the fourth-year emergency medicine clerkship, each medical student runs his/her own case and participates in a procedure day during which each student can practice major emergency procedures. During the final part of second year, the medical students participate in several facilitator-guided simulations where they can apply their newly acquired knowledge in a safe clinical setting. Dr. Ten Eyck has also offered a two-week elective designed to help prepare fourth year students for Internship. In this elective, a group of four to five students at a time complete a series of cases following the Washington Manual's Internship Survival Guide. The students have an opportunity to follow patients throughout a hospital stay while they practice writing orders, hospital notes and providing care in a variety of settings. Finally, he offers inter-professional modules for emergency medicine residents and nursing students and anticipates providing the same opportunity to medical students during the internal medicine clerkship starting this summer as part of the BSOM interprofessional curriculum.

As you can tell, Dr. Ten Eyck has been on the leading edge of his specialty, emergency medicine. He has served as both a military and civilian physician. He has worked in academia, in the simulation lab as well as in direct patient care. He is a wonderful resource for any student considering this specialty.

—L Poston

Emergency Medicine Interest Group

Current board:

Michael Schneider
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Will Trautman
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Tyrel Fischer
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Intro to Emergency Medicine (EM)

At the initial event of the year, Dr. James Brown M.D., the chair of WSU EM, speaks about the subtle ins and outs of the Emergency Medicine lifestyle. We know you will bring lots of questions so an extended Q&A session is always incorporated.

When: August



CareFlight Tour

This meeting is held at Miami Valley Hospital with Dr. Hawk, an EM attending and the director of CareFlight helicopter EMS services out of Miami Valley. Learn about regional air care, the grind of being a full-time EM physician, check out the view from the landing pad on the roof of MVH and get personal with one of the state-of-the-art choppers. It's spacious enough to transport two patients on one flight!

When: September



Suture Lab

Get the basics of suturing and knot tying down cold. We use synthetic, reusable skin so you can practice at your own pace while being taught by residents as well as experienced MS4s. The instructor to student ratio is typically 1 for every 5 students, so you can get quick help when you get stuck.

When: October

24/7/365 Movie Night

24/7/365 is an interesting and powerful documentary about the origins of Emergency Medicine and how the specialty has evolved into today's EM. Through interviews, it gives a glimpse of how EM physicians deal with the emotional rollercoaster that they've made their career.

When: November

CAP Lab

Non-EMIG run, but facilitated by the EM program at WSU. Students are offered the chance to assist and participate with CAP lab. It's mainly an opportunity for local EMS to come to White Hall and get hands on experience in the anatomy lab, with EKGs, cricothyrotomy, advanced scenario airway management, and more. This is a three-day opportunity that students can participate in when they can.

When: December

EMS Fire Station Visit

Ever seen the inside of a fire station? Ever worn a flame-retardant suit? We head to a local station and chat with EMS personnel about how the dynamic works between the teams on the front line and the ED. It's a critical time for the patient. Learn about what happens before they even come through the ED doors!

When: January

Sim Lab

Run by Dr. Ten Eyck, director of the Emergency Medicine Simulation Center at the Cox Building in Kettering. It's a perennial student favorite. Opportunities for students to practice intubation and airway management, lumbar punctures, ultrasounds, chest tubes, and to practice a life-like patient simulated scenario.

When: February



EKG Lab

Scheduled to coordinate with the MS2 as they review for their cardiology exam. EM residents facilitate with an EKG PowerPoint, sharing their tricks and mnemonics to help students better understand one of the essential tests in EM, the electrocardiogram.

When: March

Match Panel

Facilitated by the MS4s who applied to Emergency Medicine. It provides a valuable opportunity for Q&A with the recently matched EM group. Pick up tips on how to navigate the gauntlet of matching into Emergency Medicine. They are excellent sources of information and advice.

When: April

What if I am interested in emergency medicine?

Where do I begin?

MS1:

- Begin taking the self-assessments on the AAMC Careers in Medicine webpage
- Work on your CV and have it reviewed by Dr. Poston
- Join the Emergency Medicine Interest Group (EMIG)
- Contact Amber McCurdy to learn about research opportunities
- Look for shadowing opportunities (see form on EMIG webpage)

MS2:

- Review self-assessments
- Go onto Career Essentials Pilot page and begin researching the specialty

MS3 and MS4:

- Meet with Dr. Brown and Dr. Poznanski
- Review competitiveness data (see handouts on Pilot)
- Complete the Specialty Indecision Scale if you are undecided or having difficulty deciding
- Network during your Emergency Medicine clerkship
- Seek advice from fourth-year students going into Emergency Medicine

What to do next:

- Join the Society for Academic Emergency Medicine

Research: Emergency Medicine

Emergency medicine offers students the environment to learn many skills in many disciplines in one place. Because of this, it lends itself to being one home for students who want to work with a broad knowledge base in a fast-paced environment, and to research factors that affect both. Research in emergency medicine takes many forms. It can be anything from literature and chart reviews, to case studies, financial impact, calamity training efficacy, and wound care, among so many others. The ability for medical students to be involved in innovative research has been growing as students

drive the field forward with every project. To just name a few of the ongoing projects, there are projects in brain trauma, stroke care, eye trauma, opiates, advance directives, and drug studies.

If you have questions or think you might like to become involved in research in emergency medicine, you can **contact Amber McCurdy, Medical Student Research Coordinator.**

medicine.wright.edu/emergency-medicine/center-for-immersive-medical-education-and-research

What exactly is a SLOE (A Standard Letter of Evaluation)?

A standard letter of evaluation or SLOE for short is written by EM faculty as either a composite letter (done at Wight State) or an individual letter. The SLOE was developed to standardize the evaluation of applicants, improve inter-rater reliability and discourage grade inflation. (1)

The letter writer is specifically asked to compare you to your applicant peers. The first section of the SLOE includes background information and ask such questions as: length of time you have known the applicant, the nature of the contact, did the candidate rotate in your ED, their grade, which rotation was EM for them and what percent of students rotating in the ED received honors, high pass, pass, low pass and fail. The second section asks the evaluator to compare you to other EM applicants on the following qualities: commitment to EM, work ethic, ability to develop and justify a differential diagnosis and cohesive treatment plan, ability to work as a team, communication skills, amount of guidance you will need as a resident, and their prediction of your likelihood of success. The next section is a global assessment of

where you would rank compared to all EM candidates over the last year and the final section is written comments. It is recommended that in order to score high in these areas you must have demonstrated genuine interest and enthusiasm for the specialty, worked hard and taken on patient care consistently, functioned at an intern level in a team, presented the differential diagnosis and treatment plan in a focused way and was a model of professionalism and kindness to all. The SLOE appears to be the most important tool in the EM program directors armamentarium for determining which candidates should be interviewed for a residency position (2).

1. Keim SM, Rein JA, Chisholm C, et al. A standardized letter of recommendation for residency application. *Acad Emerg Med.* 1999;6(11):1141-1146.
2. Love J, Smith J, Howell J, et al. Council of Emergency Medicine Residency Directors' standardized letter of recommendation: the program director's perspective. *Academic Emergency Medicine: Official Journal Of The Society For Academic Emergency Medicine* [serial online]. June 2014;21(6):680-687. Available from: MEDLINE with Full Text, Ipswich, MA. Accessed May 31, 2016.