November 11, 2011

Review Committee
C.O.R.D. Distinguished Educators

Dear Committee Members:

Please accept this application for nomination for membership in the CORD Academy for Scholarship in Education in the "*Teaching and Evaluation*" category. I believe my professional goals are consistent with the goals of this new academically focused group:

1. Foster and value the scholarship of teaching and learning.
2. Provide role modeling and support for educators in emergency medicine education programs.
3. Foster networking and collaboration among institutions of emergency medicine education by providing a forum for the exchange of ideas about educational endeavors including teaching, evaluation, curriculum design and implementation, faculty development and educational research.

I f selected to this new academy, I am dedicated and committed to be a fully engaged member of the CORD Distinguished Educators group and would work to support the growth of both the academy and our specialty as a whole. I have taken a careful look at my educational efforts thus far in my career and believe I meet the criteria, spirit, and intent of this award.

Sincerely,

[redacted]
Professor and residency Program Director
[redacted]

Standard-setting Example #1 Teaching & Evaluation

[redacted], *MD, FACEP, Professor and Residency Program Director,* [redacted]

Match to standard-setting example(s): In column 1 check 1 or 2 of the standard-setting examples (which are found on the introductory page of material of this category). Determine which you believe matches the type of teaching and evaluation you do and have included in your mini-portfolio. In column 2, briefly identify major similarities and differences in the type of teaching and evaluation between your mini-portfolio and the example(s)	
☐ Example 1 PhD in basic science department who actively participates in both medical school and graduate school courses. ☐ Example 2 MD in clinical department who teaches both students and residents in lecture, small groups, and at the bed-side. ☐ Example 3 Faculty in 8th year at Baylor in basic science department who teaches almost entirely in the graduate school, ❖ Example 4 **MD in clinical department who primarily works with learners in a clinical setting.**	Like the standard setting example of the MD in a clinical department, I regularly teach residents and students at the bedside during patient care shifts, and have scored very highly on teaching evaluations. Also like this example physician, I deliver many didactic presentations to learners within my academic department. Unlike the example, I also speak widely on a variety of topics at other EM residencies via invited grand rounds, as well as at regional and national meetings (e.g. ACEP Scientific Assembly). Also unlike the example, I am a course co-director for two annual medical CME courses in Emergency Medicine.

Personal Statement	
Personal Goals	Develop the knowledge base and problem solving skills for EM residents and medical students to make them outstanding clinicians and experts in the delivery of emergency medical care. Identify any weaknesses in a learners knowledge base or skill set and provide information or experiences to improve these areas. Disseminate expertise in emergency medical topics beyond the “four walls” of my hospital to a wide variety of learners to improve the specialty of Emergency Medicine.
Personal Preparation	Own specific areas of expertise in our specialty. This means knowing the historic background of the topic as well as staying current on any and all possible changes to the paradigm that are identified in the literature. Maintain board certification in Emergency Medicine and maintain a CAQ in Sports Medicine. Participate in faculty development sessions that address teaching at the bedside as well as delivery of content to small (and large) groups. Identify learners needs before constructing agendas/lectures (both for lectures I deliver and courses I co-direct)
Personal Reflection/ Process for Improvement	Collect, analyze and incorporate evaluations of my abilities as a bedside teacher, small-group discussant, and large group lecturer. Use provided feedback to constantly improve the “teaching product” that I deliver. Constantly seek feedback (written and verbal) from course participants in the Emergency Medicine courses I co-direct.

Standard-setting Example #1 Teaching & Evaluation

Structured Summary Template for Teaching and Evaluation Portfolio **(Last Revised 6/15/07)**

Descriptions of Quantity		Evidence of Quality
Attending Emergency Physician (one-on-one bedside teaching)		
1999-Present	I have worked full time in emergency medicine for 13 years teaching residents, medical students, PA's, and NP's at the bedside. Over my career this has been as many as 30 hours per week, and as few as 16 hours per week, depending on other administrative responsibilities.	Scored 8 or higher on a Likert scale (1-9) for teaching as evaluated by residents throughout teaching career. 5-year average = 8.66 (48 ratings per year) (see appendix A, table 1) Departmental teaching award received 3 times at 2 different institutions. (**see CV**)
2003-2011	For 9 years I volunteered as an associate team physician for the [redacted] Professional Hockey Team, as well as provided ring-side coverage for boxing and on-field coverage for high school football. During this time I taught EM and FP residents interested in sports medicine as a possible career choice the skills necessary to provide such coverage. This represented 3-4 hours per week Nov-March during this time period.	Positive verbal comments on resident evaluations (see summary in appendix A, table 2)
Lecturer		
2002-present	ACEP speaker on a variety of topics, with the constant being the "Head CT Course". I have delivered 30+ national lectures to this group, which represents more than 10,000 learners at many levels (Attendings, Residents, Nurses/Nurse practitioners, PAs, and medical students). Each new lecture requires a minimum of 15-20 hours preparation time. Recurrent lectures require 5-10 hours annually to update and improve)	ACEP speaker of the Year, 2006-2007 (see appendix B and CV) High course evaluation scores 96 (out of 100) course score average and 97 (out of 100) speaker score average. (appendix A, table 3) Positive verbal comments from participants. Also included are *negative* comments that I incorporated in subsequent lectures (appendix A, table 4) See support letter from ACEP. (appendix C)
2000-present	Speaker to a wide variety of national meetings (AAEM, ACOEP). I have delivered 30+ lectures to these national organizations at their annual assemblies. Each new lecture requires a minimum of 15-20 hours preparation time. Recurrent lectures require 5-10 hours annually to update and improve)	High course evaluation scores. Always in the top quartile of scores for content/speaker. (appendix A, table 3) Positive verbal comments from participants. (appendix A, table 4)

2000-present	Speaker to a very wide constituency of learners at regional meetings. These groups have included NPs, PAs, Emergency Nurses, as well as EM physicians. I have given 52 such regional lectures. Each new lecture requires a minimum of 15-20 hours preparation time. Recurrent lectures require 5-10 hours annually to update and improve)	High course evaluation scores. Always in the top quartile of scores for content/speaker. (appendix A, table 3) Positive verbal comments from participants. (appendix A, table 4)
1996-present	Invited grand rounds speaker. To date I have been invited to present grand rounds 58 times at 25 different institutions. Each new lecture requires a minimum of 15-20 hours preparation time. Recurrent lectures require 5-10 hours annually to update and improve)	High course evaluation scores. Always in the top quartile of scores for content/speaker. (appendix A, table 3) Recurrent invitations to many institutions (see CV) Positive verbal comments from participants. (appendix A, table 4)
1999-present	Lecturer to my own department (grand rounds, morbidity and mortality, etc). To date I have presented 100+ lectures to colleagues, residents and medical students during didactic sessions. Each new lecture requires a minimum of 15-20 hours preparation time. Recurrent lectures require 5-10 hours annually to update and improve)	High course evaluation scores 8.5 (out of 9) average score for lectures. (appendix A, table 3) Positive verbal comments from participants. (appendix A, table 4)
Course director/Co-director		
2009-current	Resuscitation for the Emergency Physician. An AAEM-sponsored 2-day course that teaches advanced resuscitation techniques and concepts to board-certified emergency physicians. Requires 20 hours of planning and preparation annually.	High course evaluation scores (appendix A, table 3) Positive verbal comments. (appendix A, table 4)
2007-2009	Emergency Medicine Update and LLSA at [redacted] College. A week-long EM refresher course for community physicians in [redacted]. Requires 20 hours of planning and preparation annually.	High course evaluation scores (appendix A, table 3) Positive verbal comments. (appendix A, table 4)
Discussion of Breadth		
My contributions in Emergency Medicine have been to a wide variety of learners during my 15 years as a teacher. I have specifically lectured to nurse practitioner and physician assistant groups, medical students (both osteopathic and allopathic), residents (in EM, IM, Family Medicine, Pediatrics, and Surgery) as well as attending physician groups in Emergency Medicine (both community and academic learners). I have taught groups as large as 2,000 at ACEP Scientific Assembly and as small as one-on-one at the bedside.	

Personal Statement
[redacted], MD, FACEP

"*Face your deficiencies and acknowledge them; but do not let them master you. Let them teach you patience, sweetness, insight*"
- Helen Keller

I work in the only Level 1 Trauma Center in our state, as well as the only tertiary care medical center in the region. With residents I see patients, we do heroic procedures, we deliver babies that come into the world too soon, and we pronounce people dead who come in too the ED too late. But when friends, relatives and neighbors ask me what I do, I say I am primarily a teacher.

Teaching takes on many forms. In academic emergency medicine, a primary directive I have is to take learners at multiple levels (medical student, intern, resident) and shepard them on to the next learning level by teaching them everything I can about what I do. I teach medical students how to take a history and do a physical, how to reverse everything they have learned in medicine thus far and go with a "worst-first" thought process. They need to learn the basics such as how to close lacerations, make splints, and ease pain. Moving on, I try to help interns stop reporting "just the facts" to me, and start to formulate treatment plans that are evidence-based and patient-centered. I teach them time-critical procedures (e.g. intubation) and prod them to act as independent care givers. Finally, as senior residents I try to streamline the thought processes that occur in the care of a critically ill patient. In the end, I try to "*teach the rules*" of great patient care to the residents, make sure they know when to follow those rules, and know when to completely ignore those rules when it is for the good of the patient.

This kind of teaching is stressful but immediately fulfilling. It results in great care for an identified patient and great learning for the identified learner. I think I have done this bedside teaching well, as evidenced by winning the "teacher of the year" award from EM residents on 3 different occasions and at 2 different institutions. This type of award is <u>exactly</u> why I went into academics.

Beyond the clinical arena I have tried to be a successful teacher to a wide constituency of learners. I look at part of my job as becoming an expert in an area or areas of my specialty, knowing as much as I can about those areas, and then teaching others what I know. During residency I wanted to find a way to teach my fellow residents how to identify emergencies on head CTs (prior to emergency medicine, I had spent 3 long years suffering through a neurosurgery residency that was clearly not a fit for my interests in medicine). What began as my resident research project ("can emergency medicine residents learn how to read a head ct?") has become my academic "calling card" in the specialty. This local resident course proved the axiom "*if you build it, they will come*". Having validated the head CT course first locally, then regionally at 4 other residency programs, it took on a life of its own. Since publishing my work, I have subsequently

been asked to teach this skill to other EM residencies (more than 50 times at 25 different programs), as well as to regional, national, and even an international group. It has been delivered to learners at every level I can think of and in groups as small as 10 as well groups as large as 2,000.

Of course, teaching something a great deal does not guarantee quality. What I am proud of is that this course has changed year to year as technology has changed, and the disease processes that we are on the front line for have changed (when I started out, stroke was a "so what" diagnosis, as we had no therapy to offer. Now we need to identify the visible vessel and early stroke changes to the cortex, all in an effort to determine who is a candidate for thrombolysis). This course has also changed by necessity as emergency physicians have developed more expertise and experience with interpreting this imaging modality. I seek feedback constantly as to where this moving target resides currently. The talk I will give in 2012 will bear only a superficial similarity to the one I gave in 2008, and looks almost nothing like the one I gave in 1997. The principle remains the same (mnemonic and algorithm) but the way it is taught evolves based on feedback from course participants.

As a further test of quality, I asked ACEP to help me gather statistics regarding my teaching both this course as well as others I have prepared and delivered for our specialty group. To date I have taught head CT reading to approximately 4,400 learners at our national meeting over the past 9 years, and received faculty and course scores of 97% and 96% respectively. These scores were enough to support my being awarded the "speaker of the year" award in 2006-2007, which is awarded to the one ACEP speaker with the highest composite course and speaker scores for that year. I was extremely humbled to be recognized by a group that invites so many outstanding and well-known speakers to teach our colleagues.

There is an old idiom that says "those who can, do. Those who can't, teach". As someone who identifies himself as a teacher first, I sincerely hope this is not true. I have tried to produce a track record as someone who can provide excellent care at the bedside (and teach others how to do so), someone who can take a complicated topic and make it understandable, and someone who constantly takes feedback from his learners to provide a better teaching product.

Structured Summary Template for Teaching and Evaluation Portfolio **(Last Revised 6/15/07)**

Appendices/Documentation

Appendix A	**Table 1**: Resident numeric ratings for bedside teaching (last 5 years) **Table 2**: Summary of resident comments for bedside teaching (last 5 years) **Table 3**: Course/speaker ratings with norm group comparisons (when available) by course and year **Table 4**: Summary of verbal comments from lectures
Appendix B	ACEP Speaker of the year award notification.
Appendix C	**Solicited letters from:** ➢ Dr. [redacted] ➢ Dr. [redacted] ➢ ACEP ➢ Dr. [redacted] ➢ Dr. [redacted]