



Alliance of Clinician-Educators in Radiology

Newsletter Volume 5, Issue 1

March 2015

Inside This Issue:

Mission, Goals Membership	2
Resident Teaching	3
Economic Milestones	4
Promotion as Clinician Educator	5
Patient Centered Radiology Training	6
MCQ Writing Guide	7
PQI: Resident's Reflection	8
Effective CV	9
ACER Award	10
ACER @ AUR	11-13
ACER Officers	14-15
Editorial Board	16



Dr. Petra Lewis (standing left) teaching at the ACER-SMRI Educational Symposium

This newsletter serves to highlight the current ACER goals and available resources and to keep members informed of ongoing projects.

Members and potential new members are encouraged to get involved in the stimulating and worthwhile activities of ACER. One way this can be achieved is through committee membership and organizational leadership, please contact Mahesh Thapa (thapamd@uw.edu) incoming chair of the nominating committee.

Members are also invited to send their contributions to the upcoming ACER newsletters. These contributions may be sent to Puneet Bhargava (bhargp@uw.edu) or Matthew Heller (hellermt@upmc.edu).



ACER's Mission & Goals

- Providing a formal organization and forum for clinician-educators to meet, exchange ideas, and learn new skills that promote and advance the careers of clinician-educators.
- Providing programming at the annual AUR meeting targeted towards the needs of clinician-educators.

ACER: Benefits of Membership

- Access to information and networking database for the benefit, awareness, and nurturing of clinician-educators.
- Opportunities for involvement in educational research activities relevant to clinician-educators.

Membership Update

- The AUR gained 69 members in January 2015, bringing the grand total to 1515.
- ACER has 254 members, consisting of 178 full time members and 76 junior members.
- ACER's membership is second only to AMSER's (308) among the AUR Affinity Groups; other Affinity Groups include RRA (135), RAHSR (110) and A³CR² (52).

Less is More: A Program Director's Perspective on Lecturing

By **Matthew T. Heller, MD**



Residents are masters of multimedia and can harness incredibly vast amounts of information that is at their fingertips. Our job is not always to provide more information, but to distill it. So, when it comes to resident education, I believe that less is more. Here are some practical ways to simplify:

1) Decrease lecture length

The educational literature has shown that two things have decreased over the years: attention spans and retention rates following a standard lecture. Since clinician-educators are typically asked to fill a finite amount of time (ie, a 1-hour lecture slot), it's not always practical to actually decrease the lecture length. However, mechanisms exist for making the traditional hour long lecture more digestible:

- Divide the lecture into two, 30-minute or four, 15-minute segments
- Provide the audience with a brief break (ie, for questions or refreshments)
- Intersperse examples cases to which the resident can apply the teaching points while briefly discussing in front of the group

2) Slide parsimony

Simply put: the learner learns better from slides that neat and well organized. This one seems to be so simple, yet so difficult to master, occasionally eluding even some of the most respected names in our field. With so much information available, there is a tendency for the lecturer to cram as much information as possible into each slide. Upon seeing this, the learner becomes quickly overwhelmed and begins to read the mountain of slide text instead of listening to the lecturer. Strategies for increasing slide efficiency include using:

- Only 3-4 bulleted points per slide
- Key words or phrases instead of full sentences
- Fonts that are legible for those in the back row
- A dark background with light text
- No distracting slide transitions and animations

3) Increase theatrics, decrease information

Teaching is often more judged on its theatrics than information. Knowing your audience means assuming that residents are usually familiar with the topic being presented; in fact, they may be actively fact checking you on-line as you present the material. One of the deadliest assassins of attention span is the lecturer who directly reads the busy slides to the audience. Residents are looking for pearls and pitfalls, not a sleepy recitation.

Here are some ways to avoid it:

- Lead, don't read; engage by leading frequent discussions
- Leave the podium and roam
- Embed multiple choice questions to simulate training examinations

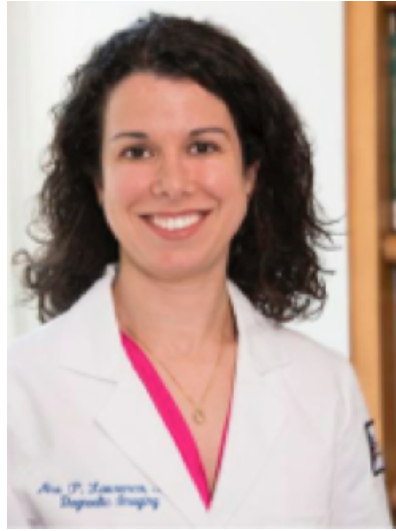
4) Eschew obfuscation

This is the slogan of a favorite bumper sticker that I see around town. A simple way to get rid of confusion is to remove esoteric nonsense from our lectures. Rather, let's give our residents high-yield, practical clarity.

Using the iPad to Teach the Healthcare Economics Milestones

By **Ana P. Lourenco, MD**
and **Priscilla J. Slanetz MD, MPH**

With few exceptions, most physicians are far from experts in healthcare reimbursement. Most of us are attracted to medicine for the science and human interactions, not the numbers! Medical school curricula rarely focus on the direct and hidden costs of medical care. Discussions about salary in different specialties are often hushed and brought up only in informal settings.



Yet as educators, we are in-charge of teaching residents and fellows about the finances of medical care. The ACGME's diagnostic radiology milestones require that residents be able to describe the reimbursement system and different types of payors (Level 1), describe relative costs of common procedures (Level 2), describe the technical and professional components of imaging costs (Level 3), describe measurement of productivity, such as RVUs (Level 4), and describe the radiology revenue cycle (Level 5). These are lofty goals and clearly many practicing radiologists probably do not even possess this level of understanding. In addition, teaching about health care economics is certainly not high priority on most clinical rotations.

Like many other residency programs, we have often had to select "Unable to assess" for the health care economics milestones for a majority of our trainees. Although one approach would be to assign articles or offer didactic lectures on these topics, these approaches are not appealing to most millennial learners. Therefore, we sought a more creative solution that would directly appeal to this generation of learners. A recent graduate of the BIDMC Radiology Residency program & the Tufts Healthcare Institute Program, "Practicing Medicine in a Changing Health Care Environment", Mark Ashkan MD recently created an App called, "Healthcare Economics," which is available free of charge on iTunes. As iPad use is increasingly common and many residencies now provide trainees with iPads for educational use, this App could serve as an effective way for all trainees to meet the milestones in this area. As of January 2015, we have integrated this App into our residency programs to teach the key milestones in healthcare economics. We are also undertaking a formal assessment looking at whether 1) this interactive learning is more appealing to trainees than the more traditional passive methods, and 2) this interactive learning style improves retention of knowledge. In the meantime, we hope that other programs find this App a useful tool for teaching this important aspect of radiology practice. Clearly, radiology literature lacks this aspect of knowledge and more training programs need to focus on this.

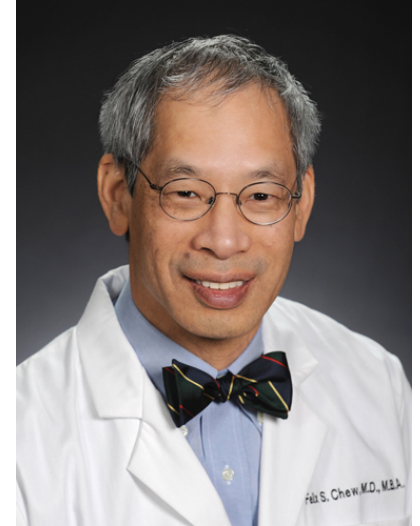
Five Rules for Promotion as Clinician-Educator

By **Felix Chew, MD, EdM**

Specific promotion criteria vary from one department or institution to another, but these five general rules will keep you on the right path.

Rule 1. Do more than teach.

Showing up for teaching does not lead to promotion. It is important to do it well and in a scholarly fashion. For effective teaching, choose not only the criteria for excellence but also the reference population. You need to innovate and develop your teaching skills. For the clinician-educator who is simply not an excellent teacher, alternatives might include educational leadership, curriculum development, preparation of teaching materials, editorial or other journal work, and educational research. As an effective educator, regular feedback from the residents and staff is equally necessary to further develop and modify teaching styles and content.



Rule 2. You still have to publish.

A fatal misperception about clinician-educator pathways is that publishing is not necessary. Publishing is absolutely necessary, but what is different from physician-scientist or basic science pathways is that the publications do not need to be grant-supported and do not need to report the creation of new knowledge. Rather, your publications can contribute to the understanding, dissemination, organization, or application of existing knowledge. Publications may also describe the development, implementation, or evaluation of educational techniques, or the results and implications of research in education. The venues and type of publications where such work appears may be broader and not simply restricted to peer-reviewed scientific journals. A simple example to this effect is publishing a case report.

Rule 3. Develop a coherent body of work.

To demonstrate the independent scholarship that is necessary for promotion to associate professor or professor, you should develop an intellectual area of expertise that can be easily described to and understood by the non-radiologists, who would likely be judging your work for promotion. This also translates to better communication and interaction especially with the sub-specialty clinical groups in your area of interest/expertise. Having published in such area, maybe along with the clinician, definitely helps.

Rule 4. Build a national reputation. For promotion to associate professor, a regional reputation building towards a national reputation is necessary; for the professor level, a national reputation is necessary. Your reputation is what people think of you; those thoughts must be captured in actions that can be documented. Events such as invitations to speak at national meetings, leadership, committee membership or other volunteer work for national organizations, or authorship of national recognized publications are important components of one's national profile.

Rule 5. Be an excellent clinician. For the typical clinician-educator, more time is spent on clinical activities than on education. This would also help in fostering a good relationship with the clinician, and in fact is more important than the work you publish.

Making a Case for Patient-Centered Radiology Training

By **Don J. Perry, MD** and
Puneet Bhargava, MD

In today's rapidly evolving healthcare environment, "added value" has become a mantra echoing through most practices. Reasons for this paradigm shift from *efficiency and volume* to *efficacy and value* are multifactorial with changing healthcare policy and trends in reimbursement being most influential. There are multiple resources to guide radiologists including the ACR's Imaging 3.0 © initiative and RSNA's Patient-Centered Radiology Toolkit.



We discuss three related methods that increase visible value and provide opportunities for trainees to practice Patient-Centered Radiology. Detailed description of these will be published in our upcoming JACR article, cited below.

First, multidisciplinary conferences and clinical rounds provide an opportunity for collaboration where providers truly focus on the patient and discuss evidence based work-up and treatment. Finding ways to increase radiology resident participation in these efforts can foster understanding of comprehensive care. Residents learn to tailor their reports and recommendations as they listen to referring providers share their clinical thought processes and see which findings directly impact clinical management.

Second, some subspecialties within radiology are successfully providing more visible value through face-to-face clinical interactions. Resident participation in IR or Breast Imaging clinics provides a unique experience where trainees are reminded of clinical logistics, workflow and skills required for appropriate diagnosis and workup, as well as patient interaction. In some situations, appropriate participation in clinics of other referring provider clinics may also offer additional insights for a given radiology rotation.

Third, restoring the historical, but fading, consultative role of the radiologist has been strongly encouraged by many radiology leaders. Some have expressed concerns about various models, but most have been thoroughly addressed or even discredited. Residents can learn from models that increase radiologist-to-patient interactions or reach out to referring providers. When handled appropriately both parties appreciate efforts to improve communication, follow up and more personal interactions.

The volume of diagnostic knowledge required of trainees is continually expanding and time to acquire core competency has been constrained. Walking the tight rope suspended between the daily 'work-list grind' and providing more visible value is challenging, but finding this balance is essential to the success of radiology. Efforts to train radiologists in more patient-centered environments will shape the specialty's culture and future practices.

References:

Perry DJ, Kwan SW, Bhargava P. Patient-Centered Clinical Training in Radiology. Journal of American College of Radiology 2015. *In press*

Bare Bones of Multiple Choice Question Writing Guide

By Petra Lewis MD

As the boards have moved to a multiple-choice format, learning how to write good, psychometrically sound questions has become more important. Unfortunately, writing good quality question items that test well is not that easy, but there are some basic rules that can improve question writing significantly. The following is an outline based on the psychometric principles used by the ABR and NMBE. For more information see this [movie](#) or the guides [here](#).

Question format

Items should be written in SINGLE **POSITIVE ANSWER** format. Do not write: questions that are negatively written – e.g. “all of the following EXCEPT” or “which of the following is NOT...” ; true/false questions; or questions that include “all of the above”/ “none of the above”, or “a, b and c” etc. as options.

Question content

1. Is this knowledge or application of knowledge that is important for the examinee to know or is it a trivial fact?
2. Is this question testing recall of a fact, interpretation of images/data or application of knowledge? The ABR is more interested in testing application of knowledge than recall of facts. This especially applies to physics based questions.

Stem construction

1. Is the stem clearly, unambiguously and concisely written? Can it be shortened?
2. Do not teach in the stem (The author may want to explain this in another line or two).
3. The conventional presentation of a case is structured to include in this order:
 - a. Age and sex of patient
 - b. Relevant past history
 - c. Presenting complaint
 - d. Imaging test they underwent
 - e. Lead in question based on this test
4. Standardize lead in question e.g. “Based on these images, the MOST likely diagnosis is:” or if normal is an option “What is the BEST interpretation of these images”? Also remember to steer away from images with multiple differentials, try to narrow it to single st answer based on history and imaging finding.
5. For non-image based questions, could a knowledgeable examinee answer the question without looking at the choices (they should). This is called the cover test. “Which of the following statements is true” does not pass the cover test
6. For an image-based question, would an examinee with good test-taking skills be able to answer the stem without needing to look at the images (they should NOT)

Answer construction

1. 4, 5 or 6 answers is fine. Only use 3 if no alternative (e.g. increase, decrease, no change)
2. Keep options short, put words that repeat in all answers into the question if possible (e.g. units, laterality).
3. Is there ‘cluing’ that narrows choices for good test-takers, e.g:
 - a. One line is longer/shorter than the others. Make answers of similar length, or have pairs/triplets of similar length
 - b. Repetition of words or phrases clues that this is one of the correct answers
 - i. Avoid this by having pairs or triplets, e.g. ‘Left’ in two answers, ‘right’ in two answers.
 - ii. Avoid repeating a word in the answers that appears in the stem
 - c. One or more items don’t follow grammatically from stem (these get excluded)
 - d. The use of absolute terms such as ‘always’ and ‘never’
4. Avoid vague words such as ‘usually’, ‘sometimes’, ‘occasionally’
5. Do not use abbreviations
6. Avoid negatives in the answers
7. Numerical answers: do not overlap values, keep ranges wide and put in ascending order with the same units.
8. Only test one knowledge set – e.g. anatomy, or risks or best test, not all 3 in one question.



Practice Quality Improvement: A Resident's Reflection

By **Allison Simons, MD** and
Hal Kipfer, MD

Residency is often a blur and some may recall it as something they simply had to survive. One memory that has stuck with me is my first day reading emergency room imaging. The staff began lecturing about chest radiographs. I was determined to capture every ounce of knowledge, so I eagerly reached for a pen to take notes. He slapped my hand and said, "No notes. This is an apprenticeship." He was right. Radiology is learned during literally 10,000 hours at the workstation and mentorship from experienced radiologists. Quality improvement is an important part of learning and practicing radiology.



During my second year of residency, I seized an opportunity to audit breast MR imaging at our institution. By sharing my experience, I hope to encourage staff to mentor and residents to take initiative to implement quality improvement. I have four recommendations: be patient, persistent, positive and proactive.

Be patient. Setting up and performing a quality improvement project takes time. It is better to establish defined goals at the beginning of the process. Realizing half-way through a project that crucial information was not collected may significantly delay or necessitate complete revision of the project. Project logistics or other obligations may cause brief delays requiring patience.

Be persistent. It is helpful to segment large projects into conquerable chunks. This provides an intermittent feeling of accomplishment and is evidence of progress.

Be positive. A positive word from the staff may encourage the weary resident to press forward. Likewise, residents should express their appreciation to busy staff for their guidance and time.

Be proactive. Creating or completing a project may require the staff or resident to be proactive. At the "end" of our project, the total numbers were too small to have significance. With my mentor's agreement, I have recruited two additional residents to accelerate the project. It is a great opportunity for me to learn more about audit set up. It is a great introductory opportunity for my fellow residents, sparing them the pitfalls that I have already encountered.

Quality improvement will forever be part of my radiology practice. I am fortunate to learn techniques in residency from experienced staff. I encourage staff to recruit residents to their ongoing quality projects. I encourage residents to get involved in quality projects already established or to establish a new project with staff mentorship. Remember to be patient, persistent, positive and proactive.

Using SMART Goal Tools to Create an Effective CV

By **Claudia F.E. Kirsch, MD**

“ The best way to predict your future is to create it”

-Abraham Lincoln

The curriculum vitae, (CV), Latin “course of life” is your representation to Promotion and Tenure (P & T) Committees. Therefore, be SMART creating an effective CV. This essay presents SMART goals in making a CV.

In SMART goals, 5 questions are asked:

- Is it **S**pecific ?
 - “What” are you presenting?
- Is it **M**asurable?
 - Bottom-line - **M**etrics required for promotion i.e. how many papers, etc, expected.
- Is it **A**ttainable?
 - Obtain assessment from Chairman, and counsel from trusted advisors, if you have YET to meet requirements, find what is needed for promotion.
- Is it **R**elevant?
 - Ensure documents support requirements , though you played the flute and rock climb, these are not relevant, teaching experiences are.
- Time management

Do institutional time constraints for obtaining grant funding make you ineligible? Do not assume time means promotion; the P & T committee sees the CV. Creating an accurate CV takes time and effort, allow this prior to submission.

Let’s apply SMART goals. **S**pecifically CVs versus resumes. A CV contains academic achievements, emphasizing full *spectrums* of accomplishments. An employment resume is short , describing competencies, and may have narratives. In academic CVs YOU are responsible for reporting your metrics!

Measureable metrics include teaching records, scholarship, and service. Do not submit NIH biosketches; that’s a research resume. Eliminate irrelevant information including age or social security numbers. First demographics are name, office contact address, educational training from college, licenses and certifications. Teaching **M**etrics include student didactics, precepting, graduate student mentoring, curriculum design, and continuing education. Scholarship metrics include research funding, peer-reviewed publications, percentage effort, role, impact factor, citation index, books, book chapters, invited research, abstract platform and poster presentations. Maintain consistent format throughout and recheck for errors. All data must be verifiable.

Relevant data includes administrative, professional or clinical service student evaluations, peer and annual performance reviews, published articles, continuing education credit certificates, lectures including dates, topics, audience, location, attendance numbers, course number/name, media appearances, and top 5 or 10 achievements; Do not be humble; ensure the committee is aware of verifiable accomplishments. **T**ime wise, be SMART (pardon the pun),! Start early, get going, allow time to revise. Good luck and I wish everyone success! In conclusion, as quoted by Abraham Lincoln: “Always bear in mind that your own resolution to succeed is more important than any other.”



2015 ACER Achievement Award - Dr. Gautham P. Reddy, MD, MPH

By **Eric Stern, MD**

If ever someone should be recognized and honored for their passion and commitment as a consummate educator, mentor, and leader in our speciality, it is Dr. Gautham Reddy. Our best teachers and mentors do more than impart facts - they inspire by example. Dr. Reddy is the quintessential radiology educator and leader and I am proud to call him my colleague and friend.

Dr. Reddy is a Professor of Radiology, Vice Chair for Education, Director of Medical Student Education, and Chief of Thoracic Imaging at the University of Washington. He is the co-author of over 100 articles and three textbooks. Incredibly, he has presented more than 500 lectures at international, national, and regional meetings, and has been honored with five teaching awards.



Beyond these successes, Dr. Reddy's impact and passion in the AUR is further evidenced as past president of ACER (as one of the founding members) and long standing Senior Faculty Advisor of A3CR2.

Not being one to seek the spotlight, Dr. Reddy also serves our entire specialty through important, yet less heralded and more behind the scenes national leadership roles as a member of the ACGME Residency Review Committee for Radiology and as chair of the cardiac committee for the ABR Core Exam. Additionally, he is the President-elect of North American Society for Cardiovascular Imaging (NASCI) and member of the executive council of the Society of Thoracic Radiology. In his spare time, Dr. Reddy is Deputy Editor of both the Journal of Thoracic Imaging and the Journal of Magnetic Resonance Imaging.

Education is the foundation upon which we build our future. In this sense, Dr. Reddy is a master craftsman. From advising medical students on career choices to helping create the ABR Core Exam, to being a founding leader of ACER, Dr. Reddy is the embodiment of the impactful, truly selfless radiology educator and leader.

There is no one more deserving of this award. On behalf of the leadership and members of ACER and the AUR, congratulations on your outstanding achievements!

ACER Sessions at the Upcoming AUR Annual Meeting

Tuesday, 4/14/15

10:30 AM – 12:00 PM | Location: Mardi Gras Ballroom D

“Promotion and Career Development as a Radiology Educator in Academia” (#110)

- Moderator: Ramesh S. Iyer, MD
- CV, Teaching Portfolio & Service Portfolio: Claudia F. Kirsch, MD
- Tracks: Jessica B. Robbins, MD
- Educational Philosophy: Robert A. Novelline, MD
- Innovation, Organization and Productivity: Leonie Gordon, MBChB
- Getting Credit and Recognition for Your Work: Joshua P. Nickerson, MD

2:00 PM – 3:30 PM | Location: Bissonet

“Innovative Teaching Methods” (#118)

- Moderator: Bethany L. Niell, MD, PhD
- Team-based Learning: Pedro J. Diaz-Marchan, MD
- Interprofessional Learning: Priscilla J. Slanetz, MD, MPH
- Simulation Training: Katherine A. Klein, MD
- Peer Observation: Priscilla J. Slanetz, MD, MPH
- Games: Timothy P. Kasprzak, MD
- Using Technology to Enhance Learning: Ana P. Lourenco, MD

4:00 PM – 5:30 PM | Location: Bissonet

“Vice Chairs for Education: ADVICER” (#122)

- Moderator: Donald J. Flemming, MD
- Job Description: Georgeann McGuinness, MD
- Working with your Chair: Carolyn C. Meltzer, MD
- Working with Residencies: Jeremy B. Nguyen, MD, MS
- Working with Fellowships: M. Vicki Marx, MD
- Working with Medical Students Courses and Clerkships: Kitt Shaffer, MD, PhD
- Budgeting: Gilberto Sostre, MD

ACER Sessions at the Upcoming AUR Annual Meeting

Wednesday, 4/15/15

8:30 – 10:00am | Location: Bissonet

“AMSER Lucy Squire and APDR/ACR Keynote Lecture: Engaging the Digital Learner: How Growing Up Digital Impacts Learning” (#208)

- Moderator: Caroline W. Carrico, MD
- Faculty: Curtis L. Whitehair, MD

10:30am – 12:00pm | Location: La Galerie 3

“Medical Education and Publication: The Backbone of the Academic Radiology Team” (#214)

- Moderators: Rebecca Leddy, MD; Stella K. Kang, MD
- Traditional and Nontraditional Venues for sharing Educational Materials: Petra J. Lewis, MD
- Teaching House Staff: The Critically Appraised Topic: Aine M. Kelly, MD, MS
- *Academic Radiology* and Education Articles: Submission and Review Criteria: Stanley Baum, MD
- Being a Good Reviewer for Education-related Manuscripts: Richard B. Gunderman, MD, PhD

2:00 – 3:30pm | Location: Mardi Gras Ballroom E

“The Radiologists Role in Gross Anatomy, Pathology and Physiology Education” (#223)

- Moderator: C. Alexander Grieco, MD
- Year 1: Radiology in the Gross Anatomy Laboratory 1: Nancy J. McNulty, MD
- Year 1: Radiology in the Gross Anatomy Laboratory 2: Allison M. Grayev, MD
- Year 2: Radiology in an Organ-based System: Andres R. Ayoob, MD
- Year 3: Radiology in the Gross Anatomy Laboratory – Revisited: Kitt Shaffer, MD
- Year 4: Radiology-Surgical Pathology Elective: Matthew S. Hartman, MD

4:00 – 5:30pm | Location: Bissonet

“Brogdon Panel: Diversity in the Radiology Workplace” (#226)

- Moderators: Michael B. Nichols, MD; Matthew S. Layman, MD
- Faculty: Gautham P. Reddy, MD; Marc Nivet, EdD

ACER Sessions at the Upcoming AUR Annual Meeting

Thursday, 4/16/15

7:00 AM – 8:15 AM | Location: Bissonet

“CCC + CLER” (#303)

- Moderator: Kristen L. Baugnon, MD
- Diagnostic Radiology Milestones: Bruno A. Policeni, MD
- Nuclear Medicine Milestones: Jon A. Baldwin, DO
- Radiology Fellowship Milestones: James C. Anderson, MD
- Forming and administrating a CCC: William F. Auffermann, MD, PhD
- CLER: Lori A. Deitte, MD

8:30-10:00am | Location: Bissonet

“Engaging Medical Students: Beyond the Gross Laboratory and Reading Room” (#308)

- Moderator: Carl R. Fuhrman, MD
- Reviving Your Radiology Interest Group: Katherine A. Klein, MD
- Sharing the Healer’s Art as a Physician Teacher, Tutor, and Student Coach: C. Alexander Grieco, MD
- Mentoring Medical Students for Radiology Research Projects and manuscript Preparation: Rathan M. Subramaniam, MD, PhD, MPH
- Including Medical Students in International Medical Education Experiences: Charles Maxfield, MD

4:00-5:30pm | Location: Mardi Gras Ballroom E

“What and How Should we Teach the Medical Students? Teaching Imaging Principles and Skills in Medical Education” (#317)

- Moderator: Sravanthi Reddy, MD
- The Importance of Teaching Noninterpretive Skills Such as Utilization, Radiation Safety, Professionalism, Risk-Benefit Analysis, and Evidence-based Medicine: David M. Naeger, MD
- The Importance of Teaching Interpretive Skills in Radiology: Kimi L. Kondo, DO
- Risks and Benefits of an Online or Virtual Curriculum: Emily M. Webb, MD

5:30 – 5:45pm | Location: Balconies J-K

ACER Business Meeting

5:45 – 7:00pm | Location Balconies J-K

AMSER/ACER Reception and Open House

Friday, 4/17/15

10:30am-12:00pm | Location: TBD

“Nearpod: Interactive Classroom Lecture Tool Workshop” (#412) – Preregistration Required

- Moderator: Erin O’Connor, MD
- Faculty: Caroline W. Carrico, MD



ACER Leadership

President:	Mahesh M. Thapa, MD University of Washington (thapamd@uw.edu)
President-Elect: Chair, Program Committee	Mark E. Mullins, MD, PhD Emory University (memulli@emory.edu)
Secretary: Co-Chair, Program Committee	Aine M. Kelly, MD, MS University of Michigan (ainekell@umich.edu)
Treasurer: Chair, Finance Committee Co-Chair, Publications Committee	Priscilla J. Slanetz, MD, MPH Beth Israel Deaconess Medical Center (pslanetz@bidmc.harvard.edu)
Immediate Past President: Chair, Nominating Committee	Angelisa M. Paladin, MD University of Washington (apaladin@uw.edu)
Past President:	Petra J. Lewis, MD, MS Dartmouth-Hitchcock Medical Center (petra.j.lewis@hitchcock.org)
Chair, Awards Committee:	Jocelyn D. Chertoff, MD, MS Dartmouth-Hitchcock Medical Center (jocelyn.d.chertoff@hitchcock.org)
Chair, Education Committee:	Katherine A. Klein, MD University of Michigan (kleink@umich.edu)
Chair, Electronic Communications	Jonathan H. Chung, MD National Jewish Health: (jonherochung@yahoo.com)
Chair, Long Range Planning Committee:	Eric J. Stern, MD University of Washington (estern@uw.edu)



Chair, Membership Committee:	Ramesh S. Iyer, MD University of Washington (riyer@uw.edu)
Co-Chair, Publications Committee: ACER, Member-at-Large	Puneet Bhargava, MD University of Washington (bhargp@uw.edu)
Chair, Rules Committee:	Syed A. Bokhari, MD Yale University School of Medicine (jamal.bokhari@yale.edu)
ACER, Members at Large:	Paul P. Cronin, MBBCh University of Michigan (pcronin@umich.edu) Jessica B. Robbins, MD University of Wisconsin (jrobbins@uwhealth.org)
ACER, Ad Hoc Members:	Jannette Collins, MD, MEd, FCCP (janni7133@gmail.com) Robert A. Novelline, MD Massachusetts General Hospital (novelline.robert@mg.harvard.edu) Gautham P. Reddy, MD University of Washington (reddyg@uw.edu)
President, AMSER:	Sravanthi Reddy, MD University of Southern California (sravanthi.reddy@usc.edu)
President, APDR:	Janet E. Bailey, MD University of Michigan (jbailey@umich.edu)
President, SCARD:	Norman J. Beauchamp, Jr., MD, MHS University of Washington (nbeauch@uw.edu)



ACER Newsletter Editorial Board

Chairs:	Puneet Bhargava, MD and Priscilla J. Slanetz, MD
Editors-in-charge:	Matthew T. Heller, MD and Ana Lourenco, MD
Recruitment Committee:	Harprit Bedi, MD and Michael Richardson, MD
Reviewing Committee:	C. Alex Grieco, MD and Surpiya Gupta, MD
Other Members:	Lily Belie, MD Felix Chew, MD, MBA Aine Kelly, MD Claudia Kirsch, MD Stacy Smith, MD Rajeev Suri, MD Mahesh Thapa, MD Don Yoo, MS