



Alliance of Clinician-Educators in Radiology

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Newsletter Volume 7, Issue 1

April 2017



Eric Stern, MD first president of ACER, at the inaugural executive committee meeting of ACER, held during the 2007 RSNA meeting in Chicago. Read Dr. Stern's reflections on page 3.

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 Aine Kelly (ainekell@umich.edu) ACER president.

Members are also invited to send their contributions to the upcoming ACER newsletters. These contributions may be sent to Matthew Heller (hellermt@upmc.edu) or Ana Lourenco (alourenco@lifespan.org).



ACER's Mission and 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

- As of March 2017, the AUR total membership stands at 1798.
- ACER has 290 members, consisting of 217 full time members and 73 junior members.
- ACER's membership is second to AMSER's (340) among the AUR Affinity Groups; other Affinity Groups include RRA (208), RAHSR (126) and A³CR² (45).

10th Anniversary Reflections

By Eric Stern, MD

During this 10th anniversary for ACER, it is with both pride and humility that I take this opportunity to reflect on the 10 years of success for our alliance.

In the mid 2000's, there was a small group of passionate radiology educators that would regularly sit together over coffee at the AUR meetings and discuss all things related to academic radiology. We noted the success and growth of the various alliances and associations under the AUR umbrella, but with the incredible growth of the radiology clinical enterprise, we also saw a widening gap between the rapidly growing segment of radiology clinician-educator faculty around the country and relevant AUR programming specifically dedicated to their own needs and career success. Formalizing such a growing group of academic faculty, we felt, would help lend credibility and respectability to this career path by provide opportunities for collaboration and sharing of best practices, directly translating to improved success of our trainees, all while helping the AUR itself to grow and maintain vibrancy.

After several years of bouncing ideas off of each other, we formed a working group that to my increasingly fuzzy recollection included Janette Collins, Felix Chew, Gautham Reddy and Beverly Wood, and me, to develop a proposal to the AUR Board of Directors to form a new alliance, the Alliance of Clinician-Educators in Radiology.

It is interesting to read from the original written proposal to the AUR Board of Directors, in April 2007:

“AUR is a strong voice for many in academic radiology, but there are many academic radiologists who are either not members, or do not regularly attend or participate in the annual meeting. One of the reasons for this may be lack of relevant programming at the annual meeting. The existing alliances and umbrella organizations are successful because they provide programming highly specific to member needs that address the challenges of the members' daily work.

To this end, we propose to create a new alliance for clinician-educators, under the AUR umbrella that is organized around this large and growing segment of academic radiologists to advance their interests and efforts. In concordance with the mission of the AUR to encourage excellence in teaching and clinical practice, and to stimulate interest in academic radiology, this proposed new alliance will dovetail with other AUR groups

and focus on the growth and advancement of clinician-educators in radiology.”

At the 55th Annual Association of University Radiologists (AUR) meeting in Denver, the AUR Board of Directors, under the leadership of then AUR President Reed Dunnick, approved the creation of the Alliance for Clinician-Educators in Radiology to join the AUR family of organizations, with the mission to advance the interests and efforts of this large, underrepresented, and growing segment of academic radiology faculty. The rest, as they say, is history.

From my notes, we started with a list of 22 founding members, which grew to 48 members by the end of calendar year 2007. From this group, we elected the following members to lead the nascent alliance.

Eric J. Stern, M.D. Founding President
Gautham Reddy, MD President-Elect
Jannette Collins, MEd, MD Secretary/Treasurer

We set about writing the governing rules of operation. This was no easy task and we are grateful to Robert Novelline for guiding us in this process, through his prior experience in leading the formation of our sister AUR alliance, AMSER.

Over the ensuing years, under the leadership of many outstanding members, the very collaborative ACER community grew quickly. To highlight just a few accomplishments from the past 10 years, ACER programming has become a vital component of the AUR annual meeting programming. We developed an annual education issue for the journal *Academic Radiology*, a mentoring program, various web-based resources, regularly contribute to innovation fund projects, and support a “teach the teacher to teach” international outreach effort. I hope and suspect that there are many members whose careers and career satisfaction have greatly benefited from their participation in ACER and its activities.

It has been a very enjoyable personal experience for me to have worked with so many fantastic and dedicated colleagues from around the country who continue to share a passion for teaching, and to participate in the transformation of ACER from an idea into such a vibrant community of radiology educators. I will be the keenest of observers in watching the next 10 years, and more, of continued ACER success. Congratulations to all of you for helping to make ACER a strong and vibrant community of radiology educators.

ACER 2017 PROGRAM

Monday, 5/8/17

10:30 AM – 12:00 PM

Location: Atlantic Ballroom 1

“Maximizing Educational Productivity” (#109)

- Moderators: David S. Sarkany, MD; Timothy P. Kasprzak, MD
- Basic Metrics for the Clinician-Educator; Kristen L. Baugnon, MD
- Educational Scholarship; Puneet Bhargava, MD
- Educational Opportunities for Career Advancement; Petra J. Lewis, MD
- Embracing Technology: Tips and Tricks; Brent P. Little, MD
- Essentials of Educational Research: Surveys and More; Corrie M. Yablon, MD

2:00 PM – 3:30 PM

Location: Atlantic Ballroom 1

“Faculty Survival Skills 101” (#116)

- Moderators: Allison M. Grayev, MD; Lucy Spalluto, MD
- Negotiation Basics; Mary C. Mahoney, MD
- Group Dynamics: Fostering Collaboration and Avoiding Crises; James V. Rawson, MD
- Mentoring; Mark A. Reddick, MD, MS
- Avoiding Burnout and Promoting a Culture of Wellness during Residency; Jessica B. Robbins, MD

4:00 PM – 5:30 PM

Location: Regency Ballroom 2

“Simulation in Radiology: How to Create a Robust Curriculum (Hands-on Workshop)” (#121) – Preregistration Required

- Moderators: Katherine A. Klein, MD; Carolyn L. Wang, MD
- Faculty: Deborah O. Jeffries, MD; T. Shawn Sato, MD; Zachary L. Bercu, MD; Carina W. Yang, MD; Meryle J. Eklund, MD; Ashish P. Wasnik, MD; Mai A. Elezaby, MD; Mishal Mendiratta-Lala, MD

4:00 PM – 5:30 PM

Location: Atlantic Ballroom 2

“Team-based Learning (Hands-on Workshop)” (#122) – Preregistration Required

- Moderator: Pedro J. Diaz-Marchan, MD
- Faculty: Christopher P. Ho, MD; Angela Giardino, MD; Perry G. Pernicano, MD; Timothy Ziemlewicz, MD

Tuesday, 5/9/17

8:30 AM – 10:00 AM

Location: Grand Ballroom West

“AMSER Lucy Squire and APDR/ACR Keynote Lecture: Changes in Radiology Education” (#209)

- Moderator: Emily M. Webb, MD
- Faculty: Catherine Lucey, MD

10:30 AM – 12:00 PM

Location: Atlantic Ballroom 1

“Teaching Evidence-based Medicine” (#214)

- Moderators: Marta E. Heilbrun, MD; Matthew T. Heller, MD
- Hierarchy of Evidence in Diagnostic Radiology; Jeffrey G. Jarvik, MD, MPH
- Limitations of Published Evidence: Sources of Bias; Marta E. Heilbrun, MD
- Developing Imaging Algorithms and Integrating Decision Support into Practice; William W. Mayo-Smith, MD
- Navigating Contradictions between Experience and Evidence; Hillary K. Kelly, MD
- Panel Discussion

2:00 PM – 3:30 PM

Location: Atlantic Ballroom 3

“Instilling Resiliency in Our Learners” (#223)

- Moderators: Mark E. Mullins, MD, PhD; Jeannie K. Kwon, MD
- A Recipe for Building Resiliency; Ana P. Lourenco, MD; Priscilla J. Slanetz, MD, MPH
- Coaching; Rebecca Leddy, MD
- Sharing and Reflecting on Our Failures; Eric J. Stern, MD
- Role Models and Mentors; Ruth C. Carlos, MD, MS
- Finding Your Moral Compass; Keith D. Herr, MD
- Lifelong Wellness; Shawn E. Kamps, MD
- Q&A

4:00 PM – 5:30 PM

Location: Grand Ballroom West

“Brogdon Panel: What Industry Consolidation Means for Radiology” (#227)

- Moderators: Chris N. Gu, MD; Benjamin J. Morrissey, MD
- Faculty: Richard Duszak Jr, MD; Jason N. Itri, MD, PhD; Giles W. Boland, MD

Wednesday, 5/10/17

7:00 AM – 8:15 AM Location: Grand Ballroom West

“Teaching and Integrating Imaging 3.0™ into Residency Training” (#303)

- Moderators: Lori A. Deitte, MD; Eric B. England, MD
- Engaging Residents in Patient-centered Care Initiatives; LeAnn S. Stokes, MD
- The Consultant Radiologist: Integral Member of the Interprofessional Team;Carolynn M. DeBenedectis, MD
- Communication with Patients: In Person and via Radiology Reports; Pamela W. Schaefer, MD
- Beyond Traditional Communication: Social Media in Residency Programs; Tessa S. Cook, MD, PhD
- Research Ethics in the 21st Century: Authorship and Beyond; Leon Lenchik, MD

8:30 AM – 10:00 AM Location: Atlantic Ballroom 3

“Educator's Toolkit: Part 1” (#308)

- Moderators: C. Alexander Grieco, MD; Smyrna Tuburan, MD
- How to Teach Millennials from the Perspective of a Millennial; Po-Hao Chen, MD, MBA
- How to Put Together a Lecture; David M. Naeger, MD
- How to Succeed at Case-based Teaching; Mahan Mathur, MD
- How to Make Your Teaching More Interactive; Andres R. Ayoob, MD

4:00 PM – 5:30 PM Location: Atlantic Ballroom 3

“Educator's Toolkit: Part 2” (#318)

- Moderators: Eve D. Clark, MD; Christopher M. Straus, MD
- How to Write a Great Letter of Recommendation; Caroline W. Carrico, MD
- How to Advance in Education: From Clerkship Director to Dean; Leonie Gordon, MBChB
- How to Review Education Manuscripts; Aine M. Kelly, MD, MS
- How to Develop an Advising Program; Donna Magid, MD, MEd

5:30 PM – 6:15 PM Location: Diplomat Ballroom 3

ACER Speed Mentoring

ACER Business Meeting

6:15 PM – 7:30 PM Location Diplomat Ballroom 3

AMSER/ACER Reception and Open House

Thursday, 5/11/17

10:30 AM – 12:00 PM Location: Regency Ballroom 2

“The Role of Values in Physician Resilience (Hands-on Workshop) (#413)

Preregistration Required

- Moderator: Nicole Restauri, MD

Combating Microaggressions in Training Programs

By Matthew T. Heller, MD, FSAR

Many medical schools have taken measures to increase awareness of unconscious biases regarding multi-culturalism, gender, sexual orientation, religion and race. Despite such efforts, however, microaggressions often permeate the post-graduate environment of our underrepresented trainees and faculty. The term 'microaggression' was first used by psychiatrist Chester Pierce and co-authors during their work on racism in television commercials in the late 1970s. Since then, the term has evolved to loosely encompass casual racism and debasement of any minority group. In contrast to macroaggression (or overt discrimination), microaggressions are regarded as "brief and commonplace verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults that potentially have harmful or unpleasant psychological impact on the target person or group." As clinician-educators and medical education leaders, it is imperative that we foster an environment that combats the occurrence of microaggressions.



As a practical exercise, I would like to share some real-life, radiology training anecdotes of microaggression antips of which I've become aware during my time as a residency program director (these anecdotes are collated from various institutions):

- A resident of Asian heritage voices his discontent that a faculty member repeatedly calls him by the name of another resident of Asian heritage. In doing so, the faculty member is attacking the residents' identity and implying that these residents are interchangeable and look alike. Tip: Extend respect to your trainees by taking the time to learn their names.
- A resident who is fluent in a language other than English is repeatedly asked to provide interpretation for patients. The resident eventually states this is not something she is comfortable doing. Tip: Don't assume the comfort of a trainee; a discussion regarding roles and responsibilities must happen before the trainee is thrust into this position.
- A minority interviewee provides feedback at the end of the interview day that she was offended when the interviewer said, 'I'd like to ask what you thought of the hockey game last night, but I know you don't follow that kind of thing.' Such a statement marginalizes the candidate and invokes many stereotypes based solely on appearance. Tip: Don't use racist or culturally insensitive faculty to conduct interviews. Next, educate them.

Microaggression and unconscious bias are great topics for faculty development and training. Clinician-educators may consider developing a series of on-line modules, workshops or live micro-lectures to educate faculty, especially prior to interview season!

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The Art of Failing

By Puneet Bhargava, MD, FSAR

Failure and invention are inseparable twins. We all know that if you swing for the fences, you're going to strike out a lot, but you're also going to hit some home runs.

- Jeff Bezos, Amazon CEO

Failure is a prerequisite for success and how we respond to failure predicts our ultimate success. No one said success is easy but in academia failure is often not discussed openly while we celebrate and over reward success. Why does this matter?



When young upcoming faculty only see the successes of their more senior accomplished peers, there is a missed learning opportunity to learn the adaptive responses from failure, which can hinder academic growth and maturity. I so vividly remember coming back home feeling inadequate after my first few quarterly faculty meetings.

An honest discussion of failure and its mere acknowledgement stimulates a growth mindset. Such a mindset requires effort, a willingness to undertake challenges, and encourages a constant pursuit towards the mastery of goals. Not discussing failure propagates the fixed mindset which makes us risk averse and more focused on performance goals rather than leading us towards a creative path. Passion is also often overemphasized. Early on in our careers, if passion is hard to come by, we should find something interesting and stick to it over the long-term. Finding our focus which might lead to us becoming passionate over time.

The problem with celebrating success too much is that it makes it look easy. A lot of what we do, can be done with persistence but it is often not easy. Harvard's "How to Fail Guide" describes five essential steps to failing:

1. Feel bad.
2. Learning to see the signs.
3. Admit the truth.
4. Articulate what you have learned.
5. Fail again.

Mentors can serve as a coach and as a spotter of failure.

I am not suggesting that we choose to fail all the time, just enough that we are pushing our limits, and operate just a little out of our comfort zones. Failure is necessary. Failure is an opportunity. Let's not shy away from admitting our failures and admit that what we do it is hard but it can be done. I acknowledge I fail and will continue to fail often. Is there anyone willing to join me to acknowledge their failures?

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The Business of Radiology

By Jeffrey D. Robinson, MD, MBA

Medical school education focuses on teaching students about disease and health. Radiology residency trains future practitioners in the art of imaging diagnosis and image-guided treatment. Upon completion of these programs, young doctors are well equipped to deal with the 'medicine' part of the practice of medicine, but not necessarily as well equipped to deal with the 'practice' part. Running a medical practice is a complex undertaking, particularly in the United States with our complex and dynamic regulatory and economic environment (to put it politely). Physicians must understand these aspects of the practice of medicine in order to protect themselves against larger and more organized interests.



Our radiology residency program offers a biennial elective on The Business of Radiology. The course comprises 5 to 8 one-hour lectures at the end of the work day (5-6PM) once a week. This scheduling allows the residents to attend without sacrificing significant evening or weekend time. The every-other year schedule gives each resident two chances to attend the lectures. Our curriculum has included topics such as:

- The Revenue Cycle: How (any why) we get paid
- Alternative Payment Models
- Personal Financial Planning
- Responding to declining reimbursements
- Payer models: Insurance, HMO, Medicare and Medicaid models
- Competition in Health Care: Antitrust Law and Policy
- Health Care Reform
- Fundamentals of Negotiations
- Negotiating Your First Employment Contract
- Hospital contracts
- Payer contract negotiations
- Fundamentals of Health Care IT
- Organized Radiology: the alphabet soup of societies

We also co-ordinate with our state ACR chapter to include residents in our annual lobbying day at the state capital in Olympia. This activity is particularly effective in that residents can learn about specific issues that are not yet settled, have some impact on the solution and meet practicing radiologists in a casual environment not related to job interviews.

There are publications which address the general topics (1, 2), although in rapidly changing economic environments, certain material will be dated. The Journal of the American College of Radiology regularly features articles on business topics and can be a great source of material.

However you design your offering, providing access to these other topics in medical education will serve your residents in the long term.

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10 Tips For Mentoring Your Radiology Residents Successfully Through Residency

By Jordana Phillips, MD



Demands on radiology residents continue to increase as clinical volumes grow, research and teaching expectations rise, and new exams are administered. You can use these 10 tips to help your residents navigate successfully through the challenges of residency.

1. Find a Mentor

Quality mentoring is associated with improved salary levels, promotion rates, job satisfaction, and academic success [1]. Each resident should find a mentor that can help him/her achieve personal goals.

2. Get a Study Guide

Residents should begin with study aids that provide a framework for their knowledge. Our first-year residents begin with the Core Radiology review text and supplement this with journal articles, books, and case reviews.

3. Study One Hour Per Night

This recommendation continues to be relevant. Review of any kind is helpful to improve fluency with the material.

4. Try to Get Exposed to as Many Areas of Radiology as Possible

Now that the core exam is in the third year, many programs provide exposure to all areas of radiology prior to the test. Residents should be encouraged to speak up if they are interested in a specialty but are not getting early exposure to it.

5. Get Engaged in Your Rotation

Residents should be engaged from day one in as many exams as possible and encouraged to articulate imaging findings, differentials, and management recommendations.

6. Take Risks

The days of oral board preparation are over. Although case conferences continue, the pressures to vocalize an opinion have lessened and residents' fears about 'looking bad' have increased. Encourage your residents to take risks. It is OK to be wrong.

7. Get Involved in One to Two Research Projects

Academic involvement is important. Residents will learn about a specific area in more depth and the research process while participating in the larger radiology community.

8. Present and Teach as Much as Possible

Imaging 3.0™ is here. Residents should be encouraged to be more visible during their training through interdisciplinary conferences, medical education, and academic meetings as each opportunity highlights the radiologist's value within the larger medical community.

9. Give Back

Charity makes people feel good [2,3]. Encourage your residents to contribute to the larger community, either the medical community or the non-medical community.

10. Relax

Most importantly, residents must develop healthy methods of relaxation when not at work to balance the hefty demands of residency. Having fun is at the heart of it all!

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- [1] Allen TD, Eby LT, Poteet ML, Lentz E, Lima L. Career benefits associated with mentoring for protégé: a meta-analysis. *J Appl Psychol.* 2004 Feb;89(1):127-36.
- [2] Aknin LB, Dunn EW, Sandstrom GM and Norton MI. Does social connection turn good deeds into good feelings?: On the value of putting the `social´ in prosocial spending. *International Journal of Happiness and Development.* 2013 1(2):155-171.
- [3] Harbaugh WT, Mayr U, Burghart DR. Neural responses to taxation and voluntary giving reveal motives for charitable donations. *Science.* 2007 Jun 15;316(5831):1622-5.

Business of Radiology References (page 10):

1. Yousem D, Beauchamp NJ. *Radiology Business Practice: How to Succeed*: Saunders; 2007.
2. Yousem D. *Business of Radiology 2010* [Available from: <http://webcast.jhu.edu/Mediasite/Catalog/Full/7e18b7d59c63487eaf177a86f83b01121>].

But I gave feedback in real time... What went wrong?

By Ana P. Lourenco, MD

Knowing that providing feedback to our trainees is critical to improving their skills, and also knowing that very few educators actually take the time to provide feedback in real time (1,2), I have always prided myself on providing real time feedback when working with trainees. So, imagine my shock and surprise when I recently walked out of a biopsy with a resident and started to debrief the procedure, specifically focusing on what needed improvement, only to have the resident get visibly upset. I went home that day not quite sure what had gone wrong. I began to feel that it was no surprise many staff avoided giving any substantive real time feedback.



In reading and learning more about how to give effective feedback (3,4), I gained some insight into why that interaction was suboptimal for both the resident and for me. While my intentions were good and I was trying to *provide feedback* in real time and *promptly following a directly observed procedure*, I had not *prepared the resident for receiving feedback*. We should have had a conversation immediately before the procedure about debriefing and providing feedback at the conclusion of the case. The process of giving and receiving feedback can be stressful for both parties, and knowing when this discussion will occur can help curb that anxiety. Such a discussion would have *established expectations* for both of us that we would be reviewing the case and providing formative feedback at its conclusion. In addition, I did not solicit the *resident's self-assessment* of how the procedure went, nor did I *review what the resident did well*. Always striving for efficiency, I simply overlooked an important opportunity to review the things the resident had done well – appropriately explaining the procedure to the patient as well as communicating clearly with the staff and the patient during the procedure. What I failed to recognize at the time was that providing positive feedback is just as critical for resident education and development. While I was *specific* in regards to which portions of the procedure needed improvement, and why those changes were necessary, I did not *conclude with an action plan*. It would have been better to conclude with a plan for what to do differently in the next biopsy. That way, there would be ample opportunity for improvement and re-evaluation. Rather than leaving the trainee feeling dejected about what he/she did not do well, having a future plan leaves them with hope for improvement next time!

As with so many experiences in medicine, there are humbling cases and interactions each and every day. With appropriate *reflection on your skills giving feedback*, one can learn from each wrong turn and do better next time!

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1. Peter A. M. Anderson. Giving Feedback on Clinical Skills: Are We Starving Our Young?. Journal of Graduate Medical Education: June 2012, Vol. 4, No. 2, pp. 154-158.

2. Mariana G Hewson, PhD and Margaret L Little, MD Giving Feedback in Medical Education: Verification of Recommended Techniques. *J Gen Intern Med.* 1998 Feb; 13(2): 111–116.

3. SUBHA RAMANI & SHARON K. KRACKOV. Twelve tips for giving feedback effectively in the clinical environment. *Medical Teacher* 2012; 34: 787–79

4. Jane DeLima Thomas, M.D. and Robert M. Arnold, M.D. Giving Feedback Volume 14, Number 2, 2011 *JOURNAL OF PALLIATIVE MEDICINE*

Summary: How to provide effective feedback

Prepare the resident for receiving feedback

Establish expectations

Provide feedback in real time following a directly observed procedure

Solicit the resident's self-assessment

Review what the resident did well

Be specific

Conclude with an action plan

Reflect on your skills giving feedback

Microaggression references (Page 8):

1. Montenegro RE. A piece of my mind: my name is not interpreter. *JAMA* 2016 May 17; 315(19):2071-2.

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3. <https://www.psychologytoday.com/blog/microaggressions-in-everyday-life/201010/racial-microaggressions-in-everyday-life>

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1. Fessler H. Failing to succeed. Medical Grand Rounds. University of Washington. March 23, 2017.

2. Bhargava P. The psychology of creativity. *Journal of American College of Radiology* 2015 Sept;12(9):1001-1009. PMID: 25582813



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