

# Advice for Young Academic Faculty

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**Y**ou get a lot of advice in life and in emergency medicine, much of it not worth having. Here's some good advice from an old academician.

"If you don't toot your own horn, nobody will."

My mother gave me this advice when I was 16. We had driven to Arthur Treacher's, a fast food store that was opening on Second Street Pike in Southampton, Pennsylvania, a few doors down from the McDonalds. There were signs in the window: "*Coming Soon! North Atlantic Whitefish!*" The sign that interested me said, "*Help Wanted.*"

I was in high school saving for college and needed a job for nights and weekends. My mother sat outside in the car chain-smoking while I filled out an application. When I got back, her ashtray was piled with Marlboro stubs, Brick Red lipstick on the tips.

"Did you do it?" she asked.

"Yes," I mumbled.

"Good," she said. "Good."

She looked over. I did not look back.

"Did you put down you are an 'A' student?" she said. "That you are in the Honor Society?"

"Mom!" I said. "They don't care about that. This is Arthur Treacher's. It's a job wiping tables and serving fish."

"**If you don't toot your own horn, nobody will,**" she said. "Get back in there."

I have quoted my mother *many* times when telling junior faculty how to keep track of their work performance: *everything* you do, count it! *Toot your own horn*, because both academic and corporate medicine are all about "deliverables."

Examples:

- You and a colleague are asked to write up protocols for APP's to see children in a newly built urgent care. You meet a few times to do the work. Not only do you count the protocols themselves as a "deliverable," you *also* count the cooperative effort. Perhaps it wasn't an official "committee," depending on the size of the project and the number of individuals involved. But it was at the very least a "working group." A larger working group is a "task force." Put it on your CV!

- Every single time *someone else* toots a horn for you—every text message, every thank-you email, every handwritten note—whether it is from a nurse, a consultant, a patient, a family member—scan these into PDF's and put them on your hard drive under a folder called "Thank You." Accumulate them. Use them when it is time to go up for promotion to reflect your excellent patient care. Read them when you are discouraged. Keep those notes!

## "Don't sweat the Hotdogs."

I was working in the ED one steamy day in 1985—a typical Philadelphia broiler when the back of your neck drips and even the windows sweat. I was an intern.

My patient was asthmatic, gasping, bug-eyed, her neck muscles sucking in with every breath. She looked bad. I put her on oxygen and told the nurse to give her sub-Q epinephrine. I started an IV and pushed some corticosteroids. We hung an aminophylline drip, one of the recommended treatments back then. The respiratory therapist set up a nebulizer treatment.

We watched.

The second year resident wandered over. He was broad-shouldered and self-confident—a Brooks Brothers model in rumpled scrubs. Curious and eager to criticize.

He was a Grade-A Hotdog.

He glanced at the aminophylline bag—calculating the patient's weight in his mind, asking the nurse about the bolus dose, squinting. The patient was weeping with anxiety. I was nervous. The attending walked over, Dr. David Wagner.

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“**But external presentations, committee membership, student and resident interviews, workshops, enrolling patients in clinical trials, developing clinical guidelines, quality improvement reviews, mentoring students and residents, participating in faculty development, and writing manuscripts—these things are all ‘your job’ too.**”

“Isn’t there evidence to suggest that aminophylline’s primary effect is diuretic?” the resident said, addressing Dr. Wagner and ignoring me. He was very full of himself. “Increasingly, I see support for continuous beta agonists—and not for intravenous aminophylline.”

Dr. Wagner smiled. He was kindhearted and soft spoken. “Well,” he said. “That might be.”

The resident harrumphed. “I read an important article about this just last week,” he said to Dr. Wagner, before walking back to his own patients.

I nearly passed out.

Dr. Wagner was the Chair of the Department and a full professor. He is one of the founding fathers of emergency medicine. We might have called him “Daddy Wags” behind his back, but that was pure affection. We admired him even if we didn’t fear him.

“Dr. Wagner,” I whispered. “Doesn’t it upset you when your residents correct you?”

He grinned. “I expect my residents to out-book me,” he said. “The day they can out-doctor me, I’ll hang up my stethoscope.”

Young faculty, you will meet residents (both your own and consultants) and faculty (ditto) who are Hotdogs. Do not engage emotionally with Hotdogs—neither their attitudes nor their expertise. *They might be right!* Listen to them and don’t take umbrage. You are a faculty member. You are ABEM-boarded or soon to be. Do not sweat the Hotdogs. **Be open-minded and willing to listen.**

### “Don’t burn your bridges.”

At the end of my fellowship year in 1989, I was worn to pieces. After three years of residency (pre- 80-hour work week), another tough year as an EMS fellow/new attending, and big personal demands at home—a spouse who was a full-time physician *and* an infant daughter—I was beleaguered. Burnt out. Ok, I was angry.

While I never said anything out loud that was unkind or derogatory about my training or my co-workers, it must have been obvious to the people who cared about me that I was at the end of my rope. One of them was Dr. Steve Davidson, my fellowship director at the Medical College of Pennsylvania (MCP). He offered some unsolicited but very important advice: “Don’t burn your bridges.”

In life, and in medicine, you never know where your path is going to lead. I didn’t want to follow Dr. Davidson’s advice, but boy am I glad I did!

A few years later, I was asked to start an emergency residency program in NJ. In those days, aspiring programs had to write their own curricula *from scratch*—there was no standard national curriculum. Pre-internet, this meant combing through every textbook you owned or could borrow—hard copies of Tintinalli, Roberts and Hedges, Schwartz’s Surgery, Fleisher and Ludwig’s Pediatrics, Merrill’s Radiology, Harrison’s

and Cecil’s Internal Medicine. Old journals. Old conference schedules. Anything you could find in the library on microfilm (old school). If you were well connected with your emergency medicine colleagues, you looked at examples of curricula from other programs. If I had let my temper and fatigue get the better of my professional relationships at my old program, I would have had no one to rely on in my hour of need. The generosity and encouragement of my MCP friend Dr. Bob McNamara *saved* me. He opened his intellectual coffers and shared everything, which helped me both write a new curriculum *and* navigate the RRC successfully.

Don’t burn your bridges!

### Say “Yes.”

When you are a new faculty member, your department and your institution expect a certain amount of “citizenship” from you. Yes, your primary job is seeing patients in the emergency department and bedside teaching. But external presentations, committee membership, student and resident interviews, workshops, enrolling patients in clinical trials, developing clinical guidelines, quality improvement reviews, mentoring students and residents, participating in faculty development, and *writing manuscripts*—these things are all “your job” too. It is confusing to new faculty who know they want to do academic medicine but aren’t always sure what that means. My advice: in the beginning of your career, to the extent you are able, you should say “yes” as professional opportunities present themselves. It is very unusual for a new faculty member to know exactly which direction their career path will lead. I have been a residency program director, an EMS county medical director, an oral examiner, a vice-chair for faculty affairs, a public health researcher, an international public policy advocate, and a senior associate dean. I could not have imagined any of this as a new faculty member. My academic career has been interesting and fruitful because when unexpected opportunities presented themselves, I said “yes.”

### Say “No.”

Academic medicine has three missions—clinical care, education, and research. There is an expectation that a faculty member will do all three. But the key to sustainability in academics is *balancing* these activities so that you maintain personal wellness. How much you can say “yes” is a direct function of your health, your outside responsibilities, and your professional experience. After you learn to say “yes,” you have to learn to say “no.” Only then will your academic career be both successful *and* sustainable.

You will know when your plate starts to feel full. *Before* it overflows, practice saying, “Wow, that sounds like a wonderful opportunity. I wish I could say yes. I really don’t have the *bandwidth* right now to give that all the attention it deserves. Thank you so much for considering me.” I am not joking: say it *exactly* that way, and repeat if necessary. Your family will thank you for it! ●