Schulich MEDICINE & DENTISTRY

Children's Hospital
London Health Sciences Centre

Western

# Paediatric Insider

## CONTINUING MEDICAL EDUCATION ANNUAL REPORT 2018

# Table of Contents



# CME Contributors

**DIRECTOR OF THE CME**
Dr. Rahul Ojha - Academic Paediatrician

**CME COMMITTEE MEMBERS**
Dr. Dirk Bock - Academic Paediatrician
Ms. Kristine Fraser - Paediatric Nurse Consultant MNCYN
Dr. Anna Gunz - Paediatric Intensivist
Ms. Vanessa Jones - CME Coordinator
Dr. Doreen Matsui - Clinical Pharmacology
Dr. Asuri N. Prasad - Paediatric Neurology
Dr. Janice Tijssen - Paediatric Intensivist
Dr. Tamara Van Hooren - Academic Paediatrican
Dr. Jamie Wickett - Family Medicine

**Regional Representatives:**
Dr. Manju Rajguru - Paediatrican, Cambridge
Dr. Harleen Bhandal - Paediatrician, Sarnia
Dr. Ram Gobburu - Paediatrician, Stratford
Dr. Nadine Mitchell - Paediatrician, Stratford
Dr. Justin Jagger - Paediatrician, Thunder Bay

**ANNUAL REPORT CONTRIBUTORS**
Dr. Rahul Ojha - Writer/Editor
Ms. Vanessa Jones - Writer/Editor/Designer

Dr. John Yoo - Paediatric Interim Chair/Chief
Dr. Dhandapani Ashok - Grand Rounds Chair
Dr. Amrita Sarpal - Ethics Rounds Chair/Writer
Dr. Gurinder Sangha - Paediatric Simulation
Dr. Guido Filler - Article Contributor
Dr. Simon Levin - Article Contributor
Dr. Rajkamal Lalli - Article Contributor
Dr. Rod Lim - Article Contributor
Dr. Amrita Sarpal - Article Contributor
Ms. Renee Vachon - Contributor
Ms. Patty Smith - Manager
Ms. Jody Andody - Administrative Assistant

# Chair/Chief's Message

Welcome to the 2018 Continuing Medical Education (CME) Annual Report. This year was one of change and growth for the Department of Paediatrics. It is my pleasure to acknowledge the hard work and dedication of the Division in preparing and presenting different CME activities locally, nationally and internationally. I am proud of the commitment of our department in providing educational days to the community.

While children's health care, technology and medical practices continue to evolve, CME is essential to providing the best medical care, innovation and treatment for our patients. By committing to CME we are committing to our children's future.

John Yoo, MD, FRCS(C), FACS
Acting Chair/Chief
Department of Paediatrics
Schulich Medicine & Dentistry, Western University
London Health Sciences Centre

# Director's Message

With all the technological advancements, ongoing research and updated medical information, continuing medical education (CME) is an essential part of any medical professionals' career. Paediatric CME has been determined to grow, expand and provide engaging educational opportunities internally and to Southwestern Ontario's medical community.

With medicine forever changing it is important for medical staff to stay up-to-date, expand their knowledge and grow, this is why CME is so detrimental to medical professionals continued success.

Rahul Ojha, MBBS, DCH, MD, FRACP
Assistant Professor,
Department of Paediatrics
Schulich School of Medicine & Dentistry, Western University
Children's Hospital, London Health Sciences Centre





# Conferences in Focus

## Children's Hospital Paediatric Update Conference

In its third year, the Children's Hospital Paediatric Update Conference has become a two-day event with a pre-conference simulation workshop. The pre-conference simulation workshop allowed participants to practise their procedural skills in addition to learning crisis resources management skills in a safe simulated environment. The conference continues to grow and expand each year. This year there was an additional session - Meet the Expert panel. This conference is dedicated to enhancing paediatric knowledge amongst health care professionals. Some interesting topics covered this year were street drugs, paediatric emergencies, patient transport in addition to common paediatric respiratory and infectious diseases.

## Paediatric Emergency Medicine Refresher Course

The Paediatric Emergency Medicine Refresher course provides the opportunity for health care professionals to learn about the current standard of care for paediatric emergency medicine. This year's conference focused on adolescents and covered a wide range of topics like mental health, conversion disorders, syncopal episodes, resurgence of infections, adolescent acute care and many more.

## Genetics in your Practice

The Genetics in your Practice day is a biennial event, which provides health care professionals the opportunity to learn about the relevant topics in genetics, to recognize the physical features which should prompt a genetic referral and to recognize the red flags in the family history that could suggest a genetic disorder.

## Canadian Paediatric Emergency Medicine Review Course

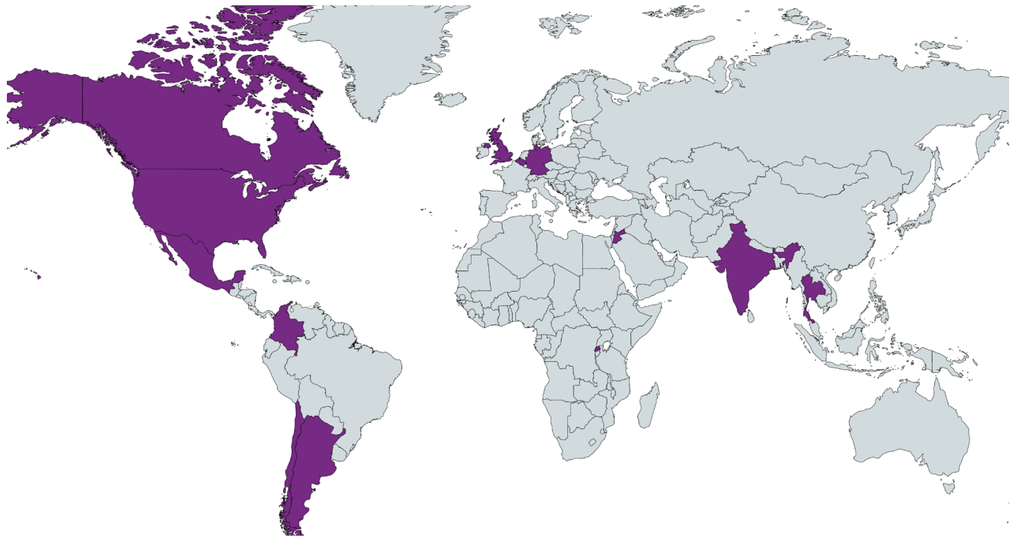
The Canadian Paediatric Emergency Medicine Review course is a national, annual course offering attendees from across Canada the opportunity to update their knowledge regarding core paediatric emergency medicine topics. This year's attendees travelled to Mont-Tremblant, Quebec, for a two-day comprehensive course that focused on case-based interactive learning. The course also provided the opportunity for participants to review literature, learn strategies to improve bedside ultrasound and update knowledge on procedural sedation, common hematological, cardiac, surgical, neurological and behavioral emergencies.

## Drug Therapy Day

The 40th annual Drug Therapy Day Conference was presented in 2018. The Conference covers all stages across the lifespan of common drug therapy. Attendees were able to learn about a wide variety of drug therapies with a special focus on renal disease.

More than 465 Attendees
More than 65 speakers
5 different conferences

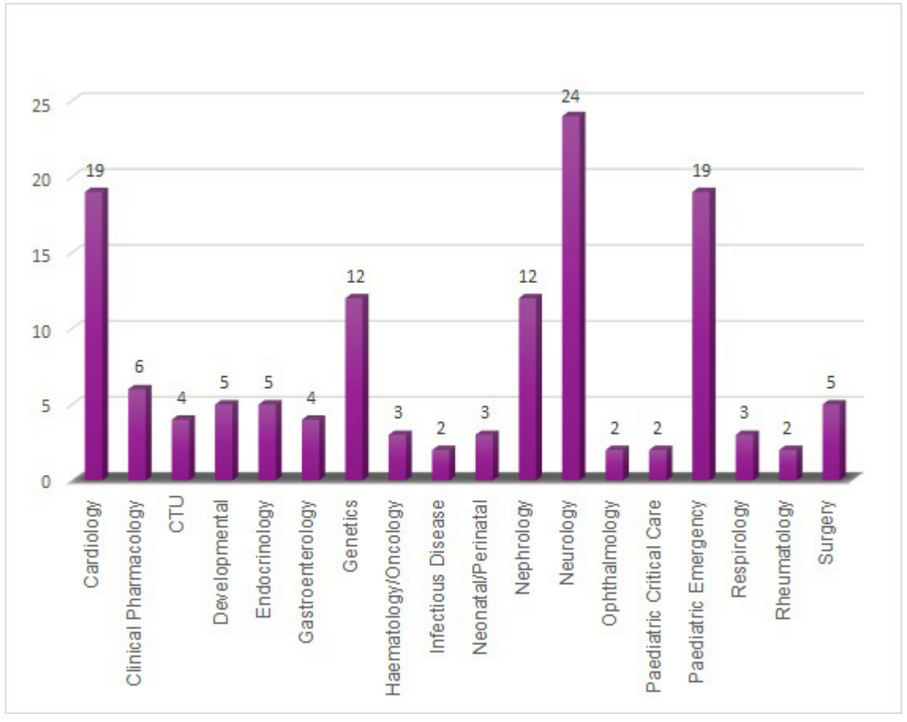
# International Impact



## Where in the World?

The Department of Paediatrics has provided more than 130 continuing medical education (CME) presentations in 13 different countries around the world. From Canada and the United States, to Mexico, Colombia, Chile, Argentina, United Kingdom, Germany, Belgium, Jordan, Rwanda, India and Thailand.

The presentations have ranged in topics from teaching medical students in Rwanda, to providing neurological updates in India, to providing a Kawasaki Disease update in Jordan and providing a keynote address in Colombia and everything in between. Members from most divisions in Paediatrics have provided CME lectures locally, nationally or internationally. The activities ranged from a small in-house grand rounds presentations to large conference keynote speakers.




## Breakdown by Division

The Department of Paediatrics is comprised of nineteen different divisions. Each division is invited to submit their continuing medical education activities each year. Annually, the Department increases its offerings. In the first year of this report for 2015/2016, the Department delivered 105 presentations, in 2017 there were 114 and in 2018 it increased to 132 presentations.

# CME Strategic Goals

## Five Year Plan - Completed in Three Years

Looking back to 2015, there was no formal paediatric continuing medical education; there hadn't been a conference in many years; grand rounds were not provided to the community; paediatric ethics rounds did not exist, the website had very little information and there was no formal outreach education provided. Fast forward to 2018, the Department's CME program has achieved all five strategic goals. It has become a leader in education, provided excellent Program planning and delivery, foster collaboration within hospital and with regional partners, ensures CME Program sustainability and we are integrating technology to improve education and information.

### Program Planning and Delivery

***Goal: Have regular assessment of delivered CME content and include unmet needs into the program***

This has been achieved by receiving annual CME feedback, developing a curriculum for the Paediatric Update Conference, Paediatri Regional Outreach Program Lecture Series, Simulation Events and through regular planned meetings. The feedback that participants provide help to shape the topics for the conference next year, for simulation cases and for upcoming topics for the PROP lecture series. By listening to the feedback we are able to tailor the education that is provided.

### Foster Collaboration within Hospital and Regional Partners

***Goal : Supporting educational development in the region***

The Paediatric CME committee now has regional partners who sit on the committee from Cambridge, Sarnia, Stratford and Thunder Bay. The CME has partnered with the Maternal Newborn Child Youth Network to help provide education to the community. Finally, the CME has started PROP which provides education to Centre's around the region through simulation days at the host's facility and by providing the PROP lecture series via Ontario Telemedicine Network to many different hospitals.

### CME program sustainability

***Goal: Ensure operation is sustainable***

It is important for Paediatric CME to be sustainable and grow. The CME has a self-sustainable budget. The Paediatric Update conference has now become a two-day conference with a one-conference day and a pre-conference simulation day. CME has provided more simulation workshops to the community and are starting the PROP lecture series shortly.



### Leadership in Education

***Goal : Organize regional paediatric conference annually***

The Paediatric Update Conference is now a two day conference which covered a wide variety of paediatric topics, with more than 40 different speakers and more than 430 attendees in three years. The attendees have come from across Southwestern Ontario, and as far away as Thunder Bay, Manitoba and Detroit.

***Goal : Develop curriculum for outreach education program***

For every program that the CME offers a very detailed curriculum is created. To create the curriculum a needs assessment survey is done, regional partners are contacted, literature is reviewed and experts are contacted. We use this information to generate topics and precise objectives to meet the communities needs. With the new upcoming PROP Lecture Series, a in-depth curriculum is being generated to ensure the CME is helping to meet the needs of the 18 centres who have expressed interest in the program.

***Goal : Supporting faculty education and development***

The Paediatric CME hosts a weekly grand rounds sessions. These sessions help to promote the research that the faculty is doing, as well as provide educational activities to the Department. The Grand Rounds Committee also helps to bring in external speakers to enhance learning. Grand rounds are also now available on Ontario Telemedicine Network to provide education to community. The CME program also provides Ethics Rounds to the Department. In 2018, these Rounds have increased to five times a year, with the addition of a Mental Health Ethics Round.

### Integrating technology to improve education & information

***Goal : Utilize technology to improve program visibility***

The CME now regularly uses technology to promote events by using flyers/brochures to advertise events. Grand rounds are now presented on OTN so the community can engage.

***Goal : Develop informative, easily navigable CME website***

The CME has added some much needed information to the Schulich Medicine & Dentistry Paediatric website.

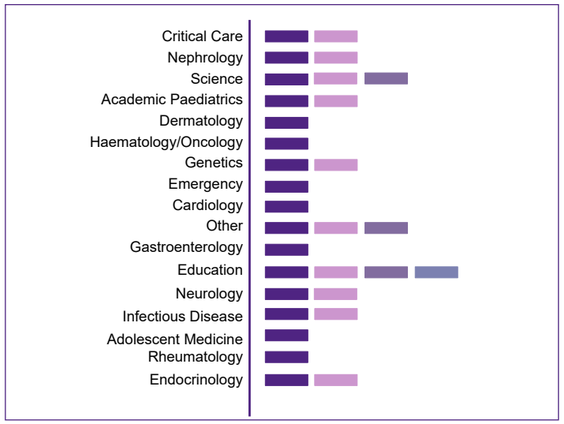
# Educational Activities

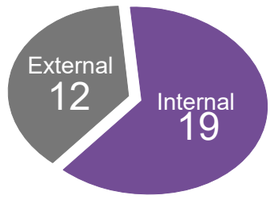
## Spotlight on the Education Activities for Continuing Medical Education

### Grand Rounds

Paediatric Grand Rounds lectures take place weekly during the academic calendar year. The Rounds are designed to discuss and evaluate cutting edge topics relevant to contemporary paediatric practice. Grand Rounds is a forum for information exchange and to display excellence in paediatric research and education.

# Of Grand Rounds Speakers by Division




In 2018, there were 31 grand rounds presentations consisting of 19 internal speakers and 12 external speakers. A wide variety of topics were presented at grand rounds by local and international guest speakers. Topics included Paediatric Sleep Disorders, Transport Medicine, Eye Manifestations, Adolescent Medicine, Physical Wellness and much more. There were also an additional 26 Special Grand Rounds in 2018. These Rounds are accredited by the Royal College as a Category 1 Continuing Professional Development activity.

### Ethics Rounds

In 2018, the Department of Paediatrics Ethics Rounds increased to five times a year. Before 2018, Paediatric Ethics Rounds were only happening four times a year. These rounds are designed to encourage a rich, interactive discussion focusing on the ethical principles in question through discussion of a clinical case or case composite. It is a forum for information exchange and learning for all. The lectures are presented by faculty and trainees of the Department of Paediatrics at the Children's Hospital.

Dr. Dhandapani Ashok
Grand Rounds Chair

Dr. Amrita Sarpal
Ethics Rounds Chair

### Paediatric Regional Outreach Program (PROP)

In 2018, the Continuing Medical Education Committee worked in conjunction with the Paediatric Simulation Centre and the Maternal Newborn Child and Youth Network to launch the Paediatric Regional Outreach Program (PROP).

PROP provides specific learning opportunities for physicians and other health care professionals in the region. We are proud to share the expertise of physicians and educators in providing an OTN lecture series and outreach simulation days. The overall goal is to share our collective knowledge base with our regional partners.

There are two parts to the PROP. The first part is a Paediatric Simulation Day where the team will travel to different hospital around the region and provide opportunities to develop hands on skills in form of simulation workshop in their own space. This adds more realism to the simulation as participants are working with people they may be on shift in a familiar space.

In 2018, the PROP team began to plan the second part of the program. It will be an educational online lecture series that will provide high quality evidence based knowledge, skills, and inter-professional learning opportunities for Physicians and other health care providers in the region.

### Certified Courses (PALS, APLS, NRP)

Certified courses provided on regular basis

# Side-stepping the silo from day one

Dr. Rajkamal Lalli, MD, Resident

To work in paediatrics is to be a collaborator at heart. It's long been known by those who care for children that to maintain and advance their continued health both inside and outside hospitals and clinics, effective team work is needed between physicians, residents, families, allied health professionals and above all patients.

A central mission of the Continuing Medical Education program is to continue to foster regional collaboration as we strive to provide the best possible care to patients from Southwestern Ontario and beyond. In a catchment area as large as this and with more than 80% of Canadian paediatricians working in communities of 100 000 people or more, this represents a worthy goal to ensure timely and quality care can be provided to children closer to home.

The Canadian Paediatric Society also recognizes that with increasingly complex and chronic health conditions affecting our patients, the traditional silo approach to medicine is fundamentally unable to meet their unique health care needs. It is therefore encouraging that Schulich School of Medicine & Dentistry's paediatric residency program has a focus on the role of a physician as collaborator and strives to develop strong relationship building skills in its residents from day one, which will prepare us to best serve the many disparate communities across Southwestern Ontario and Canada we will disperse to upon graduation in our often dual role as consultants and primary care physicians.

This can be seen in the updated social paediatrics curriculum, which connects residents with known public health advocates in the London community. Building on their years of experience as social workers, nurse practitioners and mental health liaisons, residents such as Drs. Kelcie Lahey and Frances Yeung are tackling ATV legislation in Ontario, while Drs. Subhrata Verma and Mong Tieng are engaging patient advocacy groups to smooth parents' transition into the NICU environment.

Our simulation program, taking place in a dedicated paediatric facility and beginning in the first week of residency, lets residents of different levels in training and different specialties to draw and learn from each others experiences and practise effective communication skills. Similarly, regular hospital-wide mock codes further extend this practise and allows for the development of a collaborative relationship within a multidisciplinary team.

As residency curriculums continue to evolve in order to adapt to changing population needs and a focus on patient-centred care, the discipline of paediatrics will hopefully remain a leader in training its residents as effective team workers, in recognition of the fact that the needs of our patients are best served in a multidisciplinary practice.





# Preventing burnout, Increase Wellness

Dr. Rod Lim, MD, FRCPC, Associate Professor, Paediatric Emergency

In the past, physicians have often been taught to soldier on, by the motto "Physician heal thy self." As system pressures have increased, there has been a greater realization of the terrible personal and professional effects of physician wellness.

Physician health and wellness has been identified as a key issue for all physicians, their patients, and health systems by the media, by professional organizations and by hospital systems.

A recent survey by the Canadian Medical Association in 2018 showed that one in four doctors were suffering burnout. In high risk specialties, rates have been reported as high as eight in 10. Burnout is defined as a long-term stress reaction characterized by depersonalization, including cynical or negative attitudes toward patients, emotional exhaustion, a feeling of decreased personal achievement and a lack of empathy for patients. Burnout is directly linked to lower patient satisfaction, decreased care quality, higher medical error rates, higher staff turnover, physician drug alcohol and drug abuse and increased thoughts of suicidality. For this reason, the realization that this is a system issue or an occupational hazard has been made, and many different groups have attempted to address the issue.

Many models have been developed to attempt to show the complex interplay of factors that effect physician wellness. One model by Patty Purpur de Vries describes three reciprocal domains that influence each other. They are: personal resilience; the culture of wellness that exists within the physician practice environment; and the efficiency of practice. Since they affect each other, no area can be evaluated in isolation. Due to this complexity as well, the solutions do not lie within individuals, groups, hospitals or government but to all of them in combination. No sustained improvements will be achieved without systematic deliberate actions that address the reciprocal domains.

The American Medical Association advises a 5 step program for MD Wellness. **Step 1** involves Creating a framework. This involves finding a group or team who can serve as champions to begin systematic local change. They can evaluate the current vs. desired state and enroll support of leadership. **Step 2** involves designing a program. In the spirit of continuous quality improvement, programs designed to tackle the most pressing needs of the group should be designed, implemented and evaluated. The programs need to address the three reciprocal domains. Special attention to efficiency of practice is important; as depriving willing MD's of feeling like their daily efforts have positive impact will cause "moral injury" and hasten a decline in wellness.

**Step 3** involves fostering wellness at an individual level. Ensuring supports are available, and evaluating different realms of wellness are critical. These areas can include: nutrition; fitness; emotional health; preventative care; financial health; and mindset/behavioural adaptability. On an individual level, examining oneself for signs of emotional exhaustion, depersonalization or lack of perceived job impact is a start. Talking with trusted mentors, family and colleagues will give a broader picture of signs that may be hidden.

**Step 4** involves empowering faculty to confront burnout and have the tools and resources to do so effectively. If one does not address the culture of wellness at an institution, it will be hard to move the needle of wellness in any direction. The final step, **Step 5** involves developing the systems and processes to develop sustainability. Without sustained effort, any progress is sure to be lost.

Although the scope and prevalence of the problem is daunting, the increased attention on physician wellness at many levels is encouraging that sustainable, systematic solutions can be found. As always, if individual doctors feel at risk, it is important to enlist the support of organizations such as the Ontario Medical Association or Canadian Medical Association to help support our mental health.

# Reflections: Being Program Director Since Time Began

Dr. Simon Levin, MD, FRCPC, Professor, Paediatric Neurology

I have been Paediatric Program Director in each of the last three decades. As my colleague said the last time, “third time’s a charm!” It is, of course, enormously satisfying to be asked to lead the Departmental educational program.

These are very personal, anecdotal observations about the challenges, struggles and successes leading a program which grew from a small program of 10 residents to a medium-large program of 40 residents.

What’s changed and what hasn’t changed?
The parents of patients have changed. They have significantly more information, sometimes not correct and often taken out of context but you must be prepared to listen, hear and educate without prejudice or defensiveness.

> “Medicine is an apprenticeship best served at the bedside”

On the other hand, the parents have not changed. They are still overwhelmingly devoted to caring for their children, wanting the best care for them and needing clear, understandable explanations about what is wrong, how it will be fixed and what the prognosis is.

The residents have changed from being predominantly male residents to predominantly female. It is not a surprise that there are implicit and explicit biases to be dealt with. Previously, most residents became subspecialists, now most are becoming general paediatricians. Irrespective of gender, they want appropriate communication and impersonal critical evaluation. Comments can only be given in the context of CanMEDS roles and should never stray into personal attributes or speculation about character. Residents are also less certain, less independent and more demanding about educational needs being provided. I see it in their approach to the Standardized Assessment of a Clinical Encounter Report exam and the level of anxiety in preparation for the Royal College Fellowship.

On the other hand, the residents have not changed. They are the same idealistic, committed, ambitious, intelligent, capable young people physicians in training have always been.

The Royal College has changed with ever increasing demands for formal teaching and demonstration and documentation that training requirements have been met. For teachers, competency-based medical education will create greater demands. In my first iteration as Program Director in the early 90s, my clinical secretary managed the program without any support. We now have 1.5 full time highly competent administrative staff. The volume of organization and paper generated would make NASA shudder.

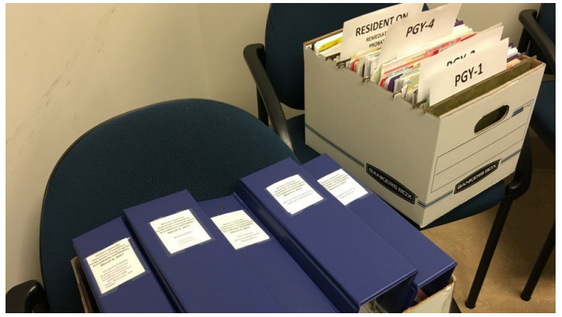



Figure 1. Documentation for RCPS External Review

The societal climate has changed which has led to a change in the way we practice and teach our residents to practice. We refer to subspecialists more, do more unnecessary investigations and overtreat. As someone who has been sued (just once) and has given expert medicolegal opinions many times, I can say that we have nothing to fear from the legal system. Judges are fully alive to the possibility of mistakes occurring and will support physicians as long as they have been thorough and logical in their assessments. As teachers, we need to assert and model our behaviour as clinicians who will not surrender to the vagaries of lawyers and administrators. The bedside is our and our patients’ domain and we should not surrender it to others.

The electronic milieu has overwhelmingly changed. Electronic medical records, immediate access in and outside the hospital to patient data including imaging, conducting clinical assessments by videoconferencing, obtaining advice from colleagues half a world away and Dr. Google have transformed the way we practice. It is also transforming the way we teach with online lectures, podcasts and interactive teaching modules. We will need to teach our residents to manage these changes.

As teachers, what do we need to do better? How do we cope with this brave new world of medicine?

Most importantly, we need to remember that it is still about the patient and family. No amount of electronic wizardry will replace smart history-taking, directed examination and above all, synthesis of information. These principles must remain the holy grail of the clinician. We need to recreate a mantra of the importance of clinical skill over the technology of investigation. As teachers, faculty need to become more engaged.

Mindful communication using the right words delivered in a considered manner is especially important for all health care professionals and is best taught by example. Medicine is an apprenticeship best served at the bedside. Proper clinical teaching is time-consuming. But the reward comes when you are called at two in the morning about a case and when you ask if you need to come in the resident says, “No, I’m OK, I’ve got this!”

# Changing Lives through Organ and Tissue Donation

Dr. Amrita Sarpal, MD, FRCPC, Associate Professor, Paediatric Critical Care

It's a warm summer's day when a routine trip to the grocery store ends in tragedy. Physicians, nursing and other staff covering Trauma, Critical Care Trauma (CCTC), Paediatric Critical Care Unit (PCCU), Obstetrics and Neonatal Intensive Care Unit (NICU) receive word of an awful crash – an experience that many will never forget. Years later they reflect on their experience and involvement in Danah's story.

**NICU**

Rhiannon was born at 34 weeks via emergency caesarian section, flat and lifeless. Resuscitative measures were instituted. She developed severe multi-organ damage secondary to asphyxiation. Despite aggressive life saving measures she died seven days later following withdrawal of life sustaining measures. Years later, staff members of the NICU continue to express deep sadness about the tragedy recognizing that it could have happened to anyone. As one staff member commented, "(it) hit home quite a bit – (as) everyone could relate. It was a freak accident and it could have involved me." Knowing there is never enough time to say goodbye, staff did their best to support the family and to ease their pain and suffering as they said goodbye to their daughter Rhiannon. Years later, some wonder if their actions or words of support served some purpose and what more could they have said or done.

**PCCU**

"We knew when (Addison) came in that she wasn't going to live." As one staff member reflects on the tragedy, she recalls mom entering the PCCU to say goodbye to her daughter Addison. She recalls assisting and supporting mom, to reach up and hold Addison's hand as she herself was severely injured. After saying goodbye, Danah and Addison's father agreed to organ donation, and thus Addison's treatment shifted toward maintaining homeostasis in the hopes of maximizing organ recovery. "Nursing for organs is a challenging job – in the moment you are doing your job, and it's only afterward that it really hits you." Simultaneously, in a PCCU bed nearby, lay Addison's younger sister, Miah. Danah remembers seeing Miah while she was intubated and sedated, covered in lacerations and bruises with numerous fractures and severe internal injuries. She had a broken back and arm. Danah shares, "It's impossible to adequately describe how I felt while witnessing my two young children in such a state. It was agonizing." With time, Miah left the PCCU and continued her recovery. Danah and Miah's recovery has been a physical, psychological and emotional journey and will in some capacity be ongoing as they come to terms with "the Accident" and its impact upon them and their family.

Years later, as difficult as it is, staff shared the importance of asking about organ donation. As one nurse noted, "It is never a good time or easy to ask the donation questions, but it is right to ask." Through donation some good can perhaps be realized in the midst of such grief and sorrow.

**Danah's story**

Danah shares, "in a mere moment everything changed. My future (was) stripped of promise and I've lost the pleasure of planning life to come as I've learned in the hardest way possible that nothing is guaranteed. What I want everyone to understand is that my loss is compounded. I didn't just lose Addison and Rhiannon, I lost generations. I lost my future. I lost grandchildren. I lost my sense of security. I lost my sense of self. This is my life-sentence. The guilt that I survived and my daughters didn't haunt me. I am forced to live with the pain from 'The Accident' and the grief from the loss of my daughters forever."

Despite her overwhelming grief and loss, Danah and her husband made the difficult decision without hesitation to donate Addison's organs, and had they had the opportunity they would have done the same for Rhiannon. Danah shares she has always been supportive or organ donation, and only later did she realize how much the decision to donate would impact her grief.

"A few months had passed when we learned of the lives Addison saved. Her heart went to a little girl, her bowels and liver to a little boy, and her kidneys to two separate adults. It takes a while to appreciate, but once the realization hits, and for me it was the fact that my daughter gave 4 people a second chance at life, it makes the blow of loss and tragedy a little less hard. Donation has helped me to see the light while in a very dark place and has led me to a new passion in life."

Despite the tragic circumstances, despite the heart break, asking individuals and families to consider organ donation is of the utmost importance. Danah's grief remains overwhelming at times, but knowing that Addison's life lives on in others provides her with inner peace that she died with a purpose, making her loss a little easier to cope with.

"Without the organ donor, there is no story, no hope, no transplant. But when there is an organ donor, life springs from death, sorrow turns to hope and a terrible loss becomes a gift."

"...my daughter gave 4 people a second change at life, it makes the blow of loss and tragedy a little less hard."

# Behaviours for Being a Successful Scholar by Choice

Dr. Guido Filler MD, PhD, FRCPC, Professor, Paediatric Nephrology

When I embarked on my post-doc at Great Ormond Street Hospital in London, England, I met Professor Martin Barratt, then Dean of Medicine at University College of London. I was extremely privileged to have him as a supervisor. He gave me three stretch goals for a wholesome academic career that included become a department chair; be a journal editor; and publish 300 papers in PubMed. Also, incorporating being well recognized by frequent invitations to international meetings.

I have accomplished these (deputy editor of Pediatric Transplantation), and I have finished writing my first book entitled “Becoming a Successful Scholar – A Practical Guide to Academic Achievement in the Medical Professions”. It will be published by Springer and I hope to get the galley proof early in June. I am pleased to share a few pearls from this book:

What is not written is never known: You may be the world’s best doctor, but if it is not communicated, it does not exist. So why should you choose against communicating your teachable moments?

Evidence for treatment exists only for a fraction of conditions and diseases we have to treat. We have an obligation to close the knowledge gaps and to generate new knowledge.
A journey of a thousand miles begins with a single step. Do one step at a time and plan out your work.
Make your daily goals so that your mind perceives at least 70% likelihood for success. If the project is too large, you will not succeed. Break them up into manageable pieces and follow your schedule. Find your pace and work on your projects every day. This is also the most important strategy to avoid procrastination.
Do not exhaust your resources. Make pilot projects, start with small expendable projects. It is important to conduct low risk pilot projects to validate your hypothesis and use that as a foundation as a means towards the larger research application or project.
Build reserves, which could be cash or other resources. These buffers are there to prepare for unexpected events and bad luck before they happen.
Consider three types of risks, namely death line risks, asymmetric risks and uncontrollable risks. For your promotion and tenure, you have requirements, and you should budget for these with a healthy buffer because something always will come up. For asymmetric risks, you have to calculate your risk when taking a gamble so that the risks taken help progress your career rather than being detrimental to it.

> “Collaborate, collaborate, collaborate. Use reciprocity. You will immediately double your productivity.”

You will inevitably run into problems. You are not alone if you get completely stuck on a project and feel defeated. But then what? When faced with the possibility of a dead-end and a floundering goal, zoom out. You need to change the lens you use to view your situation. It is easy to become too focused on the minuscule details of a project, but this can severely hamper your ability to strategically assess possible pathways to your goals. If you are too zoomed in, especially when dealing with unexpected situations, it is easy to become frustrated and overlook solutions that are obvious if you simply zoom out. Successful scholars can use a wider-angle lens to assess how they should be reacting in certain situations. By zooming out, you are able to remain self-aware of changing circumstances, allowing you to be prepared to tackle unexpected problems. The book provides you with a few examples.

- Ask for advice. Consider Einstein’s famous quote: "We cannot solve our problems with the same thinking we used when we created them." Get an outside perspective. You have more resources available to you than you think. Ask senior faculty members.

- Stay in what Steven Covey calls Quadrant 2, namely important but not urgent. Spend no time in urgent but totally unimportant areas such as social media or certain emails. Be proactive and anticipate issues so that you can spend less time on urgent and important matters.

- Develop a growth mindset. Instead of thinking, “I’m not good at this,” try thinking “what am I missing?”. Instead of giving up, try thinking “I should try a different strategy”. Instead of stating “It is good enough,” ask yourself “is this the best work I can do?”. Instead of saying “I can’t make this any better”, consider saying “I can always improve”. Instead of saying “this is too hard”, tell yourself “it will take some time”. Think as follows: “When I am frustrated, I persevere.” “When I fail, I learn. My effort and my attitude determine everything.”

- Collaborate, collaborate, collaborate. Use reciprocity. You will immediately double your productivity.

- Perseverance is the quality of continuing with something even though it is difficult. Don’t give up when a paper is finally written and gets rejected because you aimed at a journal with a high impact factor. While there is considerable pressure placed on dissemination of your teachable moments, the overall rate of published full articles is usually only about 25%. This rate may even be as low as 6% in some journals. Don’t take any shortcuts and just resubmit to another journal. Take the advice in the decision letter not lightly. Peer review is free expert assessment designed to improve your work. Address all of the concerns and revise the manuscript accordingly before you submit to another journal. Otherwise your odds for having the paper rejected again will increase and the likelihood that your important findings will never get published just increases. Get into the state of mind of acceptance and hope quickly. Read what the reviewers wrote without emotions and consider its merit rather than dismissing their comments. Make an itemized list of every point, similar to what you would do when you are asked to revise a paper. Then systematically work yourself through every single point, with repeating the statement, an answer or rebuttal to each point, and suggested changes to the manuscript. I do this regardless whether a manuscript was asked to be revised or whether it was rejected. Don’t dismiss what was raised. Usually, reviewers’ views reflect the main-stream reasoning and you may not get beyond them if you ignore this. Rather, consider each point with respect and modesty. Word your rebuttal of a contentious point with calm and reason and try to use maximum clarity in your response. It will help you to see with clarity how you can overcome the biases or preconceptions, especially when you break with a paradigm.

Finally, choose successful mentors. We have great talent in the department and need to harvest it.

Schulich MEDICINE & DENTISTRY

Children's Hospital
London Health Sciences Centre

Western

**Paediatrics**
Schulich School of Medicine & Dentistry,
Western University
800 Commissioners Road East
London, Ontario
Rm. B1-169B
t: 519.685.8500 ext. 77566
www.schulich.uwo.ca/paediatrics