

The Emergency Medicine Chief Resident Survival Guide

Review by Jennie Buchanan, MD

How to Report Statistics in Medicine

Review by David L. Schrager, MD, MPH

0196-0644/\$-see front matter

Copyright © 2007 by the American College of Emergency Physicians.

The Emergency Medicine Chief Resident Survival Guide

Arbaleaz C, Babu K, Martin J, et al
EMRA 2006

96 pages, \$19.95-Member; \$34.95-Non-Member
ISBN 019-900190

I am almost halfway through my chief year and wish “*The Emergency Medicine Chief Resident Survival Guide*” had been given to me prior to my tenure. It is a pleasure to review such a concisely written and applicable guide. The authors present a fair picture of the chief resident position. When I finished the guide, I realized that all residents should read this, not just chiefs.

This guide is approximately 81 pages and segmented into 9 chapters with goals at the end of each section. An appendix, which contains examples of memos to send to residents, augments the end of the book. The guide also lists contact information on national conferences, meetings, and scheduling programs. Chapters take a reader through the 100 first days of being a chief and end with life post residency. The middle content examines the chief as a leader, clinician, educator, administrator, and ends with “the complete chief.”

A few poignant points worth mentioning in the guide include the extensive review of the first 100 days of chief residency, the most challenging and stressful time for a new chief. Recommendations include the importance of a candid meeting with former chiefs and chiefs from other specialties. Probably the most simple but important piece of advice is to save all e-mails regarding chief issues; anecdotally, this has helped me on multiple occasions. A central e-mail address is also another recommendation worth implementing as it keeps the line of communication clear between residents and chiefs. However, the most important recommendation in this guide is also touched upon in this chapter: maintaining a united front with your co-chiefs, who are your backbone and are to be honored, cherished, confided in and respected.

I highly recommend this guide for future, current, and former chiefs. It is an honest and fair portrayal of the challenges that we all face as a chief resident both good and bad. It is a quick read; however, the perspective and helpful hints will serve you well throughout the chief year.

Jennie Buchanan, MD
Denver Health
Denver, CO

doi:10.1016/j.annemergmed.2006.11.034

How to Report Statistics in Medicine

Lang TA, Secic M
American College of Physicians, 2006
488 pages, \$54.95
ISBN 19305-13690

Want to see anarchy? Put researchers and statisticians in a room and ask them to write guidelines on how to conduct and analyze research. Given the surfeit of strongly held beliefs and the abundance of controversial topics, you can be sure that nothing useful will emerge. Not surprisingly then, I approached “*How to Report Statistics in Medicine: Annotated Guidelines for Authors, Editors and Reviewers Ed. 2*” with some skepticism. How could anyone write on this subject without making the guidelines so specific that readers would be too busy arguing about them to follow them or so vague that they were useless?

The genius of this book is that Lang and Secic, by focusing on the reporting of research, can offer sensible advice about what the medical literature should look like without passing judgment on contentious issues about the conduct of research. Much like the mentor who teaches his trainee to write the paper before embarking on the research, Lang and Secic teach much about statistics and research methodology by beginning at the end. The approach is so successful that one could use this book as the text for an introductory statistics/epidemiology/research methodology course for medical students. Anyone involved in the conduct or evaluation of medical research should own this book, read this book, and refer to it frequently. It may not sound like a page-turner, but those with an interest in this field will find it a remarkably easy read filled with rewarding insights and recommendations.

The first 12 chapters focus on the reporting of statistics, everything from means and medians to ANCOVA models. For each statistical model the authors provide a step-by-step inventory of the material that should be presented. Mr. Lang is a writer and reporter and it is therefore not surprising that the

book stresses the importance of telling the “who, what, where, why, and how” of what was done. Good reporting is good reporting, regardless of the subject matter. Although the emphasis of Part I is descriptive and frequentist statistics, it is balanced by a chapter on the reporting of Bayesian statistics.

Parts II and III of the book provide recommendations for specific types of papers: randomized trials, prospective studies, case-control studies, surveys, meta-analyses, cost-effectiveness analyses, decision analyses, and practice guidelines. While these chapters draw heavily on existing reporting guidelines such as CONSORT, they address many topics not covered by existing guidelines and provide additional material justifying all of the recommendations that are made.

In Part IV of the book the authors consider Tables, Charts, and Graphs. These topics were not considered in the first edition. The chapters are a superb addition to the book and should be mandatory reading for anyone using these devices to present data. A glossary of statistical terms, an excellent primer on the difference between statistical significance and clinical

importance, and a number of useful technical appendices round out the text.

Over the past 15 years I have reviewed the methods and statistics of 1,500 manuscripts submitted to *Annals of Emergency Medicine*. I fantasize about how much shorter my reviews could have been had authors heeded this book when constructing their papers. I hope that authors will do so in the future. I know that I will be liberally citing this book in my reviews.

In summary, this is an outstanding work that makes a huge contribution to field. It is well organized with coded headers that inform readers of the purpose of each entry. I could quibble with a few of the recommendations in the text but that would be an unnecessary distraction from my main message. Read this book, your papers will be better for it.

David L. Schrager, MD, MPH
University of California, Los Angeles
Los Angeles, CA

doi:10.1016/j.annemergmed.2006.11.033

IMAGES IN EMERGENCY MEDICINE

(continued from p. 823)

DIAGNOSIS:

Chlamydia conjunctivitis. Chlamydia conjunctivitis infects roughly 50% of infants born vaginally to mothers infected with chlamydia and has been identified as the most common infectious cause of neonatal conjunctivitis. The incubation period is 5 to 14 days. Infants usually present with hyperemic conjunctiva, mucopurulent discharge, pseudomembrane formation, swollen eyelids, and chemosis. Diagnosis is made with Giemsa staining, which identifies intracytoplasmic inclusion bodies from the epithelial cells of the conjunctiva. Tissue culture, direct fluorescent antibody, polymerase chain reaction, or enzyme immunoassay is an alternative for diagnosis.

Topical therapy alone is insufficient, though hospitalization is not required. Erythromycin is adequate systemic therapy to treat ocular and other potential systemic infections. Neonates born to mothers with untreated chlamydia during delivery should be treated for 14 days. Because the efficacy of systemic erythromycin therapy is approximately 80%, a second course sometimes is required.