

Results: 18 of 24 core faculty (75%) and 23 of 26 (88%) residents completed the survey. Residents rated their initial competence higher in every category than did the faculty (mean difference 20.9%, 95% CI 4.6-43.3%). The greatest discrepancy was for Observation and Reassessment (PC6) with 90.5% of residents rating themselves competent compared to faculty estimating that only 47.2% are competent at the start of internship. (P<0.0001). The most concordant results occurred for milestones where both faculty and residents gave lower overall ratings (PC3, PC5, PC9, PC11, PC12, PC14), which included predominantly procedural and pharmacology-based milestones.

Conclusions: EM Residents rate high self-perceived mastery of level 1 EM milestones at the start of residency, and significant discrepancies were identified between residents and faculty in perceived milestone competency. These discrepancies in perceived mastery are likely multifactorial, but may guide future development of educational interventions for incoming EM residents.

31 Faculty and Resident Perception of Mastery of Level One Emergency Medicine Milestones

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Background: Residency programs are in an era of accreditation that pressures them to evaluate their curricula and faculty with metrics that demonstrate their effectiveness. This demand can overwhelm residents with surveys, forms, and checklists, and the validity of such evaluations should be suspect, given the high volumes that are being requested. While the reliability of performance evaluation reports has been studied in the literature, the effect of when and how these evaluations are administered on the quality of data gathered is not well understood.

Objectives: The aim of this study was to evaluate

Table 1. Intern competency in level 1 milestones as assessed by faculty and residents.

| Milestone | Level 1 Description | Faculty Mean | Resident Mean | Mean Difference (95% CI) | P-value |
|---|---|--------------|---------------|--------------------------|---------|
| PC1 Emergency Stabilization | Recognizes abnormal vital signs. | 73.6 | 95.2 | 21.7 (7.1-36.3) | 0.0048 |
| PC2 Focused H&P | Performs a reliable, comprehensive history and physical exam. | 56.9 | 90.5 | 33.6 (15.8-51.4) | 0.0005 |
| | Communicates a reliable, comprehensive history and physical exam | 50.4 | 85.7 | 35.3 (14.0-56.5) | 0.0018 |
| PC3 Diagnostic Studies | Determines the necessity of diagnostic studies. | 43.4 | 52.4 | 8.9 (-19.4 – 37.3) | 0.5256 |
| PC4 Diagnosis | Constructs a list of potential diagnoses based on chief complaint and initial assessment. | 52.2 | 85.7 | 33.5 (13.1-53.8) | 0.002 |
| PC5 Pharmacotherapy | Knows the different classifications of pharmacologic agents and their mechanism of action. | 46 | 52.4 | 6.4 (-21-34.4) | 0.647 |
| | Consistently asks patient for drug allergies. | 47.7 | 57.1 | 9.5 (-18.6-37.6) | 0.4985 |
| PC6 Observation and Reassessment | Recognizes the need for patient re-evaluation. | 47.2 | 90.5 | 43.3 (24.8-61.8) | 0.0001 |
| PC7 Disposition | Describes basic resources available for care of the emergency department patient. | 55.1 | 66.7 | 11.6 (-15.0-38.2) | 0.3821 |
| PC8 Task-switching | Manages a single patient amidst distractions | 65.8 | 85.7 | 19.9 (-1.7-41.5) | 0.0703 |
| PC9 General Approach to Procedures | Identifies pertinent anatomy and physiology for a specific procedure | 60.9 | 66.7 | 5.8 (-19.9-31.5) | 0.6517 |
| | Uses appropriate Universal Precautions. | 66.3 | 85.7 | 19.4 (-3.2-42.0) | 0.0906 |
| PC10 Airway Management | Describes upper airway anatomy | 56.9 | 81 | 24.1 (10.0-47.1) | 0.0414 |
| | Performs basic airway maneuvers or adjuncts (jaw thrust/chin lift, oral airway/nasopharyngeal airway) and ventilates/oxygenates patient using BVM. | 58.3 | 90.5 | 32.2 (12.2-52.2) | 0.0024 |
| PC11 Anesthesia, Pain Management | Discusses with the patient indications, contraindications and possible complications of local anesthesia. | 43.3 | 52.4 | 9.1 (-18.2-36.4) | 0.5031 |
| | Performs local anesthesia using appropriate doses of local anesthetic and appropriate technique to provide skin to sub-dermal anesthesia for procedures. | 56.9 | 81 | 24.1 (0.2-48.0) | 0.0482 |
| PC12 Ultrasound | Describes the indications for emergency ultrasound. | 52.5 | 57.1 | 4.6 (-21.8-31.1) | 0.724 |
| PC13 Wound Management | Prepares a simple wound for suturing (identifying appropriate sutures material, anesthetizing wound and irrigate) | 65.1 | 90.5 | 25.4 (5.9-44.9) | 0.0122 |
| | Demonstrates sterile technique. | 66.2 | 90.5 | 24.3 (4.9-43.8) | 0.0157 |
| | Places simple interrupted suture. | 74.1 | 95.2 | 21.1 (6.2-36.1) | 0.0069 |
| PC14 Vascular Access | Performs a venipuncture. | 43.9 | 61.9 | 18.0 (-9.2-45.2) | 0.1874 |
| | Places a peripheral intravenous line. | 33.5 | 61.9 | 28.4 (1.6-55.2) | 0.0386 |
| | Performs an arterial puncture. | 35.4 | 47.6 | 12.2 (-15.0-39.4) | 0.3682 |
| SBP1 Patient Safety | Adheres to standards for maintenance of safe working environment. | 64.1 | 90.5 | 26.4 (5.7-47.1) | 0.0139 |
| | Describes medical errors and adverse events. | 52.8 | 80 | 27.2 (3.5-51.0) | 0.0258 |
| SBP2 Systems-based Management | Describes members of ED team (nurses, technicians, security) | 70.8 | 81 | 10.1 (-13.1-33.4) | 0.3833 |
| SBP3 Technology | Uses the Electronic Health Record (EHR) to order tests, medications and document notes and responds to alerts. | 68.1 | 85.7 | 17.6 (-3.8-39.0) | 0.1033 |
| | Reviews medication for patients. | 41.7 | 66.7 | 24.9 (-1.2-51.1) | 0.0607 |
| PBL1 Practice-based Performance Improvement | Describes basic principles of evidence-based medicine | 51.8 | 71.4 | 19.7 (-5.6-44.9) | 0.1238 |
| PROF1 Professional Values | Demonstrates behavior that conveys caring, honesty, genuine interest and tolerance when interacting with a diverse population of patients and families. | 74.4 | 100 | 25.6 (14.6-36.7) | 0.0001 |
| PROF2 Accountability | Demonstrates basic professional responsibilities such as timely reporting for duty, appropriate dress/grooming, rested and ready to work, delivery of patient care as a functional physician. | 83.1 | 95.2 | 12.2 (-0.5-24.8) | 0.0584 |
| | Maintains patient confidentiality. | 84.1 | 100 | 15.9 (10.0-21.9) | 0.0001 |
| | Uses social media ethically and responsibly. | 77.1 | 100 | 22.9 (15.7-30.0) | 0.0001 |
| ICS1 Patient Centered Communication | Establishes rapport with and demonstrates empathy toward patients and their families. | 74.3 | 100 | 25.7 (19.6-31.8) | 0.0001 |
| | Listens effectively to patients and their families. | 67.2 | 95.2 | 28.0 (25.3-40.3) | 0.0001 |
| ICS2 Team Management | Participates as a member of the patient care team. | 77.8 | 95.2 | 17.5 (4.0-30.9) | 0.0125 |

the timeliness of completion and variation of response by residents being asked to provide mid-year evaluations for EM faculty members.

Methods: 33 EM residents were randomized into 2 groups and asked to complete voluntary anonymous evaluations that assessed faculty members' interpersonal and communication skills, medical knowledge, practice based learning, and systems based practice on a scale from 1(unsatisfactory) to 5 (Superior). Group A received all 27 faculty evaluations at one time while Group B received 5 faculty evaluations each week on the day of conference for a period of 6 weeks.

Results: The response rate for the Group A was 19.7% and 47.8% for Group B at 90 days with an overall response rate at only 33% for all faculty evaluations. The time to completion at the 90 day mark was 34.6 days for Group A and 19.6 days for Group B. The overall faculty evaluation mean score was 4.5 (Excellent {4}/Superior {5}) with 4.6 for Group A and 4.4 for the Group B.

Conclusions: Understanding the effect of the timing of requests for evaluation may allow programs to increase the number and quality of faculty evaluations.

Our findings suggest that it is beneficial to offer fewer surveys over a longer period of time to increase voluntary response rates. Trends of greater score variation were noted in Group B, but none with statistical significance.

This study has provided evidence that decreasing the number of evaluations requested at one time is will likely improve response rates and decrease form fatigue. Further investigation into the timing of requests is warranted, including number of requests, deadline for completion and length of individual evaluations.

Figure 1.

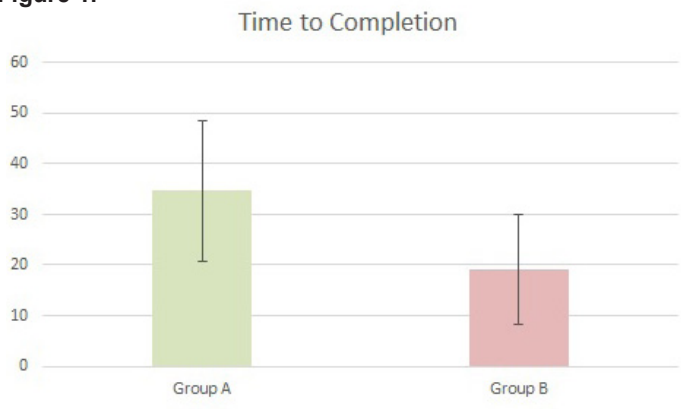
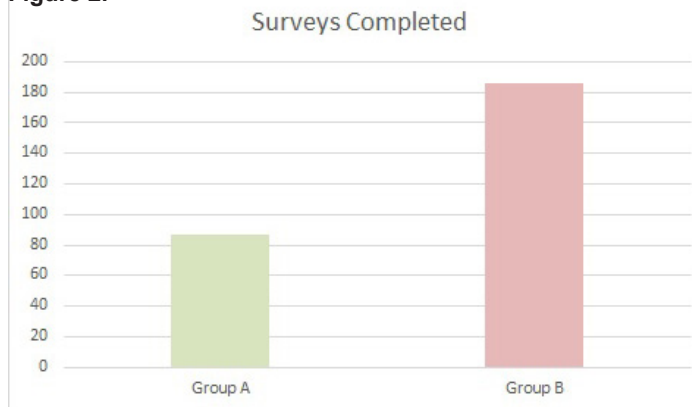


Figure 2.



32 Going with the ED Flow: Teaching and Learning Rapid Task Prioritization

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Background: Rapid task prioritization is a critical skill in the emergency department. Regularly, emergency physicians are asked to concurrently manage multiple patients at once at any given point in their shifts, and often have to make time-sensitive decisions around the priorities across multiple patients. The art and science of teaching the critical skill of task prioritization is not well described in the literature.

Objectives: In this study we sought to identify the strategies used and barriers faced by faculty members when teaching of task prioritization in the Emergency Department.

Methods: DESIGN - We conducted a qualitative study with semi-structured, critical incident interviews aimed at better what teaching and learning strategies that are employed by faculty and residents to facilitate the acquisition of emergency department (ED) management and prioritization skills. SETTING - We conducted this study at multiple teaching hospitals associated with a major Canadian academic institution. PARTICIPANTS - Both experienced physicians (nominated via a peer-nomination technique) and junior residents (postgraduate year 1 or 2) were interviewed in an effort to triangulate the experiences around teaching and learning the skill of task prioritization.

Results: Twenty physicians (10 faculty members, 10 junior residents) participated in this study. There were three main themes that emerged from our interviews in our participant's descriptions of how they taught or learned the skill of task prioritization: 1) Formal didactic teaching; 2) Observation; 3) In Situ instruction (i.e. on-the-job teaching, informal coaching in the ED). Only one teaching strategy was named by a single participant (i.e. formal teaching around the Canadian Triage Acuity Score). The bulk of teaching and learning strategies were more akin to coaching. They tended to be found within the In Situ category (Collaborative Problem Solving; Information Conversation with Staff [i.e. Think Aloud, "running the board", walk-around rounds]). A