

the topics is as follows: diagnostic errors/misdiagnosis 83% (95%CI 74-90), QA 88% (95% CI 81-95), malpractice and risk management 78% (95% CI 68-87), resident requirement to participate on departmental QA committee 90% (95% CI 84-96). There was no statistical difference in prevalence of formal education by program length. 52% (95% CI 42-63) of programs offer less than four hours per year of QA education. 62% (95% CI 51-72) of programs offer less than four hours per year of education on risk management. Of programs that offer a formal curriculum on diagnostic errors, the following modalities of teaching were reported: morbidity and mortality conference 94% (95% CI 88-99), lecture 74% (95% CI 62-84), small group discussions 44% (95% CI 32-56), simulation 41% (95% CI 28-54) and web-based modules 22% (95% CI 12-32).

Conclusions: The majority of programs include formal didactics on diagnostic errors, QA, and malpractice but there are few dedicated hours for these specific topics. A limitation of this study is the response rate. Given the growing focus on error reduction and QA in the clinical setting, an expanded and standardized approach to education on these topics may be beneficial in EM training programs.

48 Resident Reactions to Unannounced Standardized Patients in the ED

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Background: Communication and professionalism has a significant impact on patient outcomes and satisfaction and are also two of six ACGME defined core competencies, but evaluation in medical education is a challenge. The USMLE Step 2 CS is necessary for graduation in LCME accredited medical schools and uses standardized patients to evaluate these core competencies in medical students, but is limited by artificial environments and the Hawthorne effect. In the business world, these confounders are eliminated by the use of “mystery shoppers.” The equivalent in medical education is the unannounced standardized patient (USP). In our residency program, videotaped USP encounters are currently used to assess empathy and interpersonal communication skills of EM1s. However, ethical considerations and resident reaction to the use of USPs in resident education is unknown.

Objectives: To determine overall resident reaction regarding the use of USP encounters in medical education.

Methods: This was a cross sectional survey of EM residents (N=46) at an urban community academic center with 120,000 patient visits per year. Residents signed consent to participate in a study using USPs. After initiation of the program, residents were asked to fill out an anonymous survey containing twelve questions regarding the use of USPs in the ED.

Results: A total of 39/46 (85%) EM residents completed the survey (23 males, 16 females; 14 EM1s, 10 EM2s, and 15 EM3s). Almost half (43%) of EM1s admitted to feeling

pressured by peers and/or faculty to participate in the training. In addition, 8 (21%) of all residents surveyed were concerned that USP interactions in the ED would affect their reputation within the residency. The survey also revealed that 17 (44%) residents felt there was educational value to a USP encounters, 17 (44%) were indifferent, and 5 (12%) saw no educational value. Only 5 (12%) residents surveyed did not believe compassion and/or empathy could be taught to EM residents.

Conclusions: While many residents believed there was educational value in the use of USPs, some were concerned that their reputations within the residency would be affected. Clearly defining educational goals may help mitigate ethical concerns such as how the data will be used.

49 Retrospective Study to Explore the Potential Benefit of an ECMO Protocol in Our Emergency Department

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Background: Cardiac arrest is common condition treated in the Emergency Department (ED). Treatment options for this condition remain limited with poor survival rates despite multiple revisions made to advanced algorithms at our disposal. Most cardiac arrest patients are initially treated outside of a hospital setting, yet survival rates for these patients have remained at 8% for the past 30 years. However reports of survival to discharge after initiation of Extracorporeal Membrane Oxygenation (ECMO) range from 21-34%. Thus ECMO may have a role in improving survival rates for this patient population if initiated in the ED.

Objectives: Our institution sees a substantial number of cardiac arrests, as a result, we sought to explore the need for ECMO as a useful modality in cardiovascular rescue. The goal of this investigation was to establish a rationale for initiating a protocol for emergent provision of ECMO in our ED.

Methods: Three investigators conducted a retrospective cohort study of ED patients who had expired in the ED between January, 2003 and December, 2013. Electronic ED records were selected using a query of inclusion criteria consisting of patients ages 15 - 65, a diagnosis of cardiac arrest, and a disposition of “expired”. The data were analyzed to determine the number of eligible patients by then using exclusion criteria comprised of signs of prolonged down time, severely impaired functional status or chronic illness, initial presentation of asystole, total arrest time over 60 minutes, and traumatic arrest.

Results: Our query identified 467 total patients in the specified time period that met inclusion criteria. A patient was considered eligible for ECMO if no exclusion criteria were met. A total of 80 patients out of the 467 (17.1%) were found to be eligible for ECMO. Patients meeting one or more