

Electronic Residency Application Service (ERAS) application cycle the SVI pilot was administered to applicants applying to Emergency Medicine residency programs.

Objectives: This survey aims to assess Emergency Medicine residency applicant attitudes towards the Standardized Video Interview.

Methods: A survey was developed and piloted at an urban ACGME-approved emergency medicine residency. This survey was subsequently distributed to residency candidates at the conclusion of their interview day. Respondents were asked a series of questions regarding their demographic data and thoughts regarding the added value of the SVI to their ERAS application. Participation was optional and responses were anonymous. This is an interim analysis of completed surveys.

Results: A total of 80 candidates completed the survey representing a 100% response rate. 58% were male, 38% were female, and 4% did not respond. Candidates were 58.7% Caucasian, 15% Asian, 12.5% African American and Hispanic respectively. SVI scores ranged from 6-26. 46.25% (n=33) of respondents felt their score was worse than they expected and 25% (n=20) stated they were aware of how they would be scored. Only 7.5% (n=6) felt the SVI added information about their knowledge of professional behaviors and 11.25% (n=9) felt that it added information about their interpersonal and communication skills that was not available elsewhere on their application. Only 3% of survey respondents felt the SVI should remain a portion of the ERAS application.

Conclusions: Candidates overall were not aware of how the SVI was scored and approximately half had scores that were worse than expected. Overall, most respondents felt the SVI was not an accurate representation of their interpersonal and communication skills or their knowledge of professional behaviors. The vast majority do not think it should remain a part of the ERAS application.

7 Are ACGME Duty Hour Restrictions Associated with Improved Academic Performance?

Kiefer C, Shaver E, Sharon M, Davis S, West Virginia University School of Medicine, Morgantown, West Virginia

Background: The ACGME duty hours were implemented with the anticipation that restricting clinical hours would lead to improved patient safety and medical knowledge. Although several studies have evaluated the impact of decreased clinical duty upon patient safety and wellness, little previous work in Emergency Medicine (EM) has assessed the impact of restricted duty hours upon medical knowledge. No prior study has evaluated performance on the

in training examination (ITE) to assess medical knowledge longitudinally during training.

Objectives: This study evaluated the impact of restricted clinical duty hours on academic performance and medical knowledge as measured by ITE score. We hypothesized that increased time available for studying would improve performance on the ITE.

Methods: We conducted a retrospective, observational study where ITE scores from a single EM residency were analyzed during 3 distinct time periods: program inception to the first duty hours restrictions 1994-2003 ('baseline'), and the periods following each reduction in duty hours: 2004-2011, and 2012-present. Resident performance on the ITE was tabulated and compared across study periods. Differences in average ITE scores between the 3 periods were analyzed using the Kruskal-Wallis test with Dunn's test used to assess significant differences in post hoc means while controlling the overall error rate.

Results: Overall, 425 ITE scores were available for analysis over the 3 study periods. A significant increase in test performance ($p < 0.01$) was observed between the baseline and both duty hour restriction time periods (71.26%; 76.02%; and 75.24%, respectively). No significant difference ($p > 0.05$) in performance was observed between the two duty hour restriction periods.

Conclusions: Resident performance, as measured by ITE score, improved during the period following the initial duty hours restrictions (2004-2011) compared to performance prior to duty hour implementation (1994-2003). There was no improvement in ITE performance associated with the further restrictions in 2011. Limitations to this study include the fact that it was conducted at a single site which may limit the generalizability of the findings, and did not include data on the actual amount of time residents engaged in studying during the study periods.

8 Are Standardized Video Interview Scores Predictive of Interview Performance?

Willis J, Surlis T, Silverberg M, Kendall S, LoCascio H, Gernsheimer J, Schechter J, Regan A, Smith T /SUNY Downstate, Brooklyn, New York

Background: The Standardized Video Interview (SVI) was developed by the AAMC to be used in ERAS applications for residency. The goal for the SVI is to aid program directors to identify applicants who do not perform well on other objective markers and increase the chance of an interview. The SVI tests interpersonal communication and professionalism which are factors evaluated in an interview. There is controversy whether the SVI score is valuable to the application and how it should be used. One proposed use of the SVI is to predict how an applicant will interview.

Objectives: The objective is to determine if SVI scores predict how an applicant performs in an interview. We believe that the SVI score will correlate with interview scores.

Methods: Traditionally, at SUNY Downstate interviewees are scored based on their objective data (USMLE, Dean’s Letter, LORs) as well as an interview evaluation (IE) which reflects their performance at the interview. This application season all interviewers have been blinded to the SVI score and was not used in applicant selection. Applicants were interviewed by 5 faculty and the median of the IE’s were used. Retrospectively, the SVI score is compared to the IE by a third party. This third party did not participate in interviewing and used de-identified data. The SVI and IE scores were converted to percentages and ranked to standardize the data. The null hypothesis that there is no statistically significant correlation was tested. A Spearman Rank Correlation Test with an alpha = 0.05 and 2-tails was used.

Results: 57 applicants were interviewed thus far in the 2017-18 season. The demographics at this time are similar with 30 male and 27 female. The medical school is skewed because 23 are from SUNY Downstate due to initial home interview days. The results of the analysis produced an r squared of 0.2 showing poor correlation and a p value of 0.175.

Conclusions: The p value fails to reject the null hypothesis and shows the scores are not statistically correlated. Therefore in this early data the SVI is testing something different than the interview performance. This is a small sample and with more data there may be more correlation. We did not account for other factors the SVI predicts such as performance in residency or prediction of match success. As Emergency Medicine is the first speciality to use these scores more research needs to occur to determine their value.

9 Career Outcomes of Graduates of EM/IM and EM/IM/CC Residency Programs

Scott N, Rodos A, Coletti C, Martin D, Carter C, Tyo C, /Hennepin County Medical Center, Minneapolis, MN; University of Illinois at Chicago, Chicago, Illinois; Christiana Care Health System, Newark, Delaware; The Ohio State University, Columbus, Ohio; University of Maryland, Baltimore, Maryland; University of Illinois at Chicago, Chicago, Illinois

Background: The most recent effort examining the career outcomes of graduates of Emergency Medicine / Internal Medicine (EM/IM) residency programs was published 9 years ago. Previous literature lacks a detailed description of the clinical practice of EM/IM graduates. Outcomes for Emergency Medicine / Internal Medicine / Critical Care (EM/IM/CC) graduates have never been described. A current understanding is important for medical students, residents, program leadership, and institutions supporting these programs.

Objectives: The objective of this study is to provide an updated and detailed description of the career outcomes of EM/IM and EM/IM/CC graduates, including current clinical practice, frequency of fellowship training, practice setting, board certification status in EM and IM, and satisfaction with training.

Methods: This study is a cross-sectional survey. Select questions from previous studies were utilized. Content validity evidence was established by expert review and response process validity was established by use of pilot participants. All graduates from EM/IM and EM/IM/CC training programs through 2017 were eligible. Statistics are descriptive. The study was approved by the institutional review board at Hennepin County Medical Center.

Results: 158 EM/IM and 24 EM/IM/CC graduates responded, constituting a response rate of 63% for graduates with available contact information. 12 training sites are represented. 34% of EM/IM graduates entered fellowships, of which critical care and pulmonary/critical care were most frequently chosen. After training, 70% entered academic positions. 95% plan to continue board certification in EM;

Table 1. Current clinical practice of EM/IM and EM/IM/CC graduates.

	Training Program	
	EM/IM	EM/IM/CC
EM practice only	74 (54%)	4 (17%)
IM practice only	15 (11%)	4 (17%)
Ambulatory	3	0
Inpatient	0	0
Ambulatory + Inpt	1	0
Intensive care unit	11	4
EM + IM practice	47 (35%)	15 (65%)
EM + Ambulatory	9	0
EM + Inpatient	23	1
EM + Ambulatory + Inpt	3	0
EM + Intensive care unit	12	14

This table describes the current clinical practice of graduates of Emergency Medicine/Internal Medicine (EM/IM) and Emergency Medicine / Internal Medicine / Critical Care (EM/IM/CC) training programs. Ambulatory and inpatient care include subspecialty care in these settings.

86% plan to continue in IM. Table 1 describes current clinical practice. 87% report being “extremely satisfied” with their residency training. 90% feel that obtaining a position with both IM and EM clinical practice required “somewhat” or “much more” effort than a position with either one alone.

Conclusions: Graduates report high rates of satisfaction with their training. Fellowship training in critical care and academic practice are frequently chosen. EM-only and practice in both EM and IM is common. Most EM/IM/CC graduates practice in