



Figure 2. Perceived helpfulness of four possible future advising resources for emergency medicine residency applicants. (n= 182-189)

31 Teaching Medical Students Emergency Medicine Focused Oral Presentations Skills

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Background: Medical students often receive generalized training in oral presentations, but lack preparation for Emergency Medicine (EM)-specific presentations, which differ in length, focus, and structure. Previous research suggests that students require further instruction on EM-focused oral presentations.

Objectives: In our pilot study, we assessed the need for further research and training of EM-bound medical students in EM-specific oral presentations, and evaluated the efficacy of components of a multimodal curriculum.

Methods: Fourth-year EM-bound students from 9 different medical schools rotating in August 2017 were voluntarily enrolled. Students (n=13) anonymously completed a pre-instruction survey on prior training for oral presentations, both general and specific to EM, and their feeling of preparedness for EM presentations. Students then completed a self-paced, multimodal curriculum from existing sources during a four-week rotation (Figure 1). At the end of the rotation, students filled out unmatched surveys to rate their sense of preparedness and the effectiveness of each component of the curriculum. Data were analyzed using t-test for statistical significance for preparedness and ANOVA for curriculum components.

Results: Based on self-reported findings, 77% of students had previous education in oral presentations, however less than half (31%) reported receiving EM-specific training. On pre-intervention surveys, students had an average of 5.92/10 when asked how prepared they felt presenting in an EM format, regardless of whether

or not they had received EM-specific oral presentation preparation (p=0.90). Students surveyed after curriculum completion felt significantly more prepared presenting an EM case, with an average 8.18/10 (p<.05). Two students were lost to follow-up. There was no significant difference in the effectiveness between each of the components of the curriculum (F(4,48) = 0.16, p= 0.96).

Conclusions: Our study suggests that current didactic methods for EM-focused oral presentations are ineffective. After completing a multimodal curriculum, students felt more prepared for EM-focused presentations. There remains a need for development of a standardized and focused multimodal model for educating fourth-year EM-bound medical students on oral presentation skills specific to EM.

Modality	Author	Year	Title
Primary literature	Davenport <i>et al.</i>	2008	The 3-Minute Emergency Medicine Medical Student Presentation: A Variation on a Theme
Supplemental outline	Davenport <i>et al.</i>	2008	Oral Presentations in Emergency Medicine
Video	CDEM/EMRA	2015	Patient Presentations in Emergency Medicine
Podcast	EMBasic: Steve Carroll, MD	2012	How to Give a Good ED Patient Presentation
Podcast notes	EMBasic: Steve Carroll, MD	2012	How to Give a Good ED Patient Presentation

1. Davenport, Chip *et al.* "The 3-Minute Emergency Medicine Medical Student Presentation: A Variation on a Theme." *Academic Emergency Medicine*, vol. 15, no. 7, 2008, pp. 683-687
2. EMRA Education Committee/CDEM. "Patient Presentations in Emergency Medicine." 2015. <https://www.emra.org/students/education/patient-presentations/>
3. Carroll, Steve. "How to Give a Good ED Patient Presentation." EMBasic. 2012. <http://embasic.org/how-to-give-a-good-ed-patient-presentation/>

Figure 1. Multimodal didactic curriculum components.

32 The Patient Experience Curriculum: Increasing Medical Student Awareness of Patient Centered Care

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Background: Patient centered care (PCC) has been shown to increase patient satisfaction and outcomes. Despite this, few medical schools offer curriculum dedicated to improving student attitudes of PCC. Creating a module focused on teaching learners about PCC may raise awareness of the topic.

Objectives: This study will analyze how learners' attitudes towards PCC change after implementing a dedicated PCC curriculum. We hypothesize that upon completing this curriculum, learners will have better attitudes towards PCC.

Methods: This is a prospective observational study that analyzes how learners' attitude towards PCC change throughout this curriculum. A previously validated PCC scoring tool, the Patient-Practitioner Orientation Scale (PPOS), was administered to the learners at the beginning and end of the module. It grades an individual's attitude towards the doctor-patient relationship, and also examines it along two dimensions termed sharing and caring. Surveys

were anonymized upon completion. Done at a Level 1 trauma center, this study looked at 40 MS-3 students (20 male, 20 female) in the Emergency Medicine clerkship from 7/1/17-12/1/17. This module included an intro session, a standardized patient encounter/debriefing, a 4 hour patient shadowing shift, and a debriefing session. Data was collected using pre and post-module PPOS surveys.

Results: A T-test prepared sample analysis was performed. The mean (SD) pre and post PPOS scores were 75.6 (7.9) and 75.0 (7.9). There was no significant change in learners' overall attitudes towards PCC nor either of the sharing or caring subcategories.

Conclusions: We determined that implementing a 3-week curriculum dedicated to PCC does not appear to impact a learner's attitude towards PCC. There were some limitations to this study. First, this study was limited by a small number of participants. There were also 3 learners whose pre-PPOS to post-PPOS changes were outliers by over 2 standard deviations. This, combined with a low number, may have skewed the results. Despite lacking statistical significance, learners stated that this curriculum was beneficial during the debriefing. They thought this would be more impactful if it was done in both the pre-clinical and clinical years of medical school. Further studies done in both settings can see if it leads to significant changes in attitudes towards PCC.

Table. Paired sample test

		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower				Upper
Pair 1	PreTotal - PostTotal	.0650	5.3501	.8459	-1.8461	1.7761	.077	39	.938
Pair 2	PreShare - PostShare	.5100	3.5743	.5682	-.6331	1.6531	.902	39	.372
Pair 3	PreCare - PostCare	-.4450	3.4778	.5499	-1.5573	.6673	-.809	39	.423

33 The Standardized Video Interview: How Well Does the SVI Score Correlate With Traditional Interview Performance?

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Background: An on-line Standardized Video Interview (SVI) was piloted by all applicants to emergency medicine

(EM) residency programs in this academic cycle. The proposed goal of the SVI is to highlight applicants' professionalism and interpersonal communication skills. It is unclear if this simulated interview (as they were not actually having a conversation with another person) format is a fair representation of an applicant's interview skills.

Objectives: To determine if the SVI score correlates with an actual in-person interview score.

Methods: Six ACGME-approved EM residency programs are participating in this prospective, observational multi-center study. Data is from interviews conducted through Nov 25, 2017. Common demographic data (gender, age, USMLE score, SVI score, etc) were obtained through an ERAS export function before interviews began. During each interview day, one interviewer (who does not participate in applicant selection) was blinded to the applicants' applications. A convenience sample of applicants was enrolled based on random assignment to the blinded Interviewer. The interviewer was asked to rate each interview on a 1-5 scale that was developed a priori. The scale was deemed to have face validity based on review by multiple residency program directors involved in the study. In addition to standard statistical methods, a linear regression was performed.

Results: 100 interviews were performed that had an SVI score and an in-person interview score. 3 were excluded because of prior knowledge of the applicant. Of the 97 interviews, there were 91 unique applicants. When an applicant was interviewed at more than 1 program, a mean in-person interview score was generated. SVI scores ranged from 13-28 with a mean of 19.9. Linear regression of SVI score against in-person interview score demonstrated no relationship (p=0.98). When separating SVI scores into low, middle and high scores, there was no correlation with interview score (p=0.33).

Conclusions: Preliminary data suggest there is no correlation between the simulated standardized video interview score and the in-person interview score. We will have substantially more data at the time of poster presentation at CORD.

Comparison of SVI sub-group with in-person interview score

SVI Sub-group	Mean interview score	p
12-17	3.75	0.33
18-23	3.41	
24-30	3.73	

SVI, standardized video interview.