

the “likelihood to recommend” and “cleanliness” questions, respectively; 54.4% of patients reported waiting less than 15 minutes to see a physician. Patients in the intervention group had significantly higher mean scores on the validated post-visit survey compared to controls on questions regarding “likelihood to recommend” (4.21, confidence interval [CI] 4.03-4.38 vs 3.82, CI, 3.61-4.02, $p = 0.01$), overall rating (4.16, CI 4.00-4.33 vs 3.87, CI 3.68-4.06, $p = 0.04$), waiting time for provider (4.11, CI, 3.92-4.31 vs 3.81, CI 3.61-4.00, $p = 0.01$), and department cleanliness (4.09, CI, 3.91-4.27 vs 3.80, CI, 3.62-3.98, $p = 0.02$) (Table 1).

Conclusion: An ED-oriented patient liaison program allowed for real-time feedback and opportunities for immediate service recovery, resulting in increased patient satisfaction ratings across multiple indicators.

Table 1. Patient experience ratings and 95% confidence intervals for patients encountered by patient navigators vs case-matched controls.

	Control	Intervention	p-value
“Likelihood to recommend”	3.82 (3.61-4.02)	4.21 (4.03-4.38)	0.010*
Overall	3.87 (3.68-4.06)	4.16 (4.00-4.33)	0.039*
Wait time	3.81 (3.61-4.00)	4.11 (3.92-4.31)	0.012*
Cleanliness	3.80 (3.62-3.98)	4.09 (3.91-4.27)	0.016*

22 “Secure-Preserve-Fight” or “Run-Hide-Fight”: Expectations of an Emergency Department Patient Population During an Active Assailant Event

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Objective: We sought to assess the opinions of a general emergency department (ED) patient-family population regarding healthcare providers’ life-saving responsibilities during an active assailant event (the traditional “Run-Hide-Fight” paradigm [provider-centric] vs the novel “Secure-Preserve-Fight” [vulnerable patient-centric]) paradigm.

Design and Method: This institutional review board-approved study presented a scenario-based questionnaire to a convenience sample of ED patients and their retinues. Demographic information included prior military service, formal active-shooter training,

and prior violent victimization. The randomly selected subjects evaluated four typical patient scenarios of varying severity within which an emergency physician/nurse was in immediate proximity. They were provided four responses addressing their expectations regarding the healthcare provider’s actions: provider-centric (namely, “Run-Hide-Fight”), or patient-centric (that is, Secure-Preserve-Fight). The frequency of each response was the primary outcome. We employed a non-parametric binomial test as well as SPSS (IBM, Chicago, IL)

Conclusion: For this particular ED population, a significant majority supported the patient-centric “Secure-Preserve-Fight” paradigm over the more provider-centric “Run-Hide-Fight” option. This lay public perspective should spur healthcare staff and administration to reconsider their current active shooter plans and possibly modify them to be consistent with “Secure-Preserve-Fight,” especially when dealing with the vulnerable patient.

23 Burnout in Resident Physicians: Correlation with Mistreatment and Workplace Violence

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Background: Research studies show a high burnout level among physicians. Research also shows that mistreatment of medical trainees and workplace violence have potentially long-term, negative effects on the individual. This study examines the correlation between resident burnout and the self-reported incidence of mistreatment and workplace violence.

Methods: Each year, the University of Kansas Medical Center Graduate Medical Education Wellness Subcommittee administers a wellness survey to all 560 residents and fellows. The 71-question electronic survey was originally developed at Stanford University Medical Center. We obtained institutional review board approval for this study.

Results: Of 560 residents and fellows from various specialties who received the survey, 393 completed it (70% response rate); the responses included 147 from female residents (37%) and 246 from males (63%). We found that 20.4% of all resident surveys had responses indicative of burnout. Of the 16 emergency medicine (EM) residents who completed the survey, we found a 37.5% burnout rate. Overall, 35 residents reported being publicly humiliated, and they had a significantly higher burnout rate than those who did not (62.9% vs 16.9%; p value = <0.0001). We also found the following: 55 residents reported being publicly embarrassed, and they had a higher burnout rate than those who did not (52.6% vs 15.5%; p value = <0.0001); 23 residents reported being subjected to offensive sexist

remarks/names, and they too suffered higher burnout (47.8% vs 19.6%; p value = 0.0015). Finally, 89 residents reporting being verbally threatened at work in the prior year, and they had a higher burnout rate than those who had not been threatened (42% vs 14%; p value = <0.0001).

Summary: Our wellness survey confirms prior studies showing a high rate of burnout among resident physicians

and among EM residents specifically. Our survey also confirmed an increased burnout rate associated with mistreatment and workplace violence. EM faculty should keep in mind the significant impact of embarrassment, humiliation, and sexism when interacting with residents who already work in a stressful environment in which there is a high risk of workplace violence.