

Objectives: The first nationwide survey of EM program directors showed that resident attrition is a complex and multifactorial entity. This survey study serves as the starting point for understanding attrition in EM. Our primary objectives are to quantify resident attrition in EM training programs and the reasons behind it from a PD perspective. Our secondary objectives are to describe demographic characteristics of residents undergoing attrition, personal factors associated with attrition, and the avenues of resident replacement.

Methods: We conducted a national survey study of all EM PDs during the 2018-2019 interview season. PDs were asked to identify all residents who left their program prior to completion within the last four academic years (2015-2016 to 2018-2019), provide relevant demographic information, and select perceived reasons for attrition. Frequencies, percentages, proportions, and 95% confidence intervals were obtained for relevant program- and resident-specific demographics. Fisher’s Exact tests were performed to compare reasons for attrition between age groups.

Results: A total of 118 of 217 PDs who received our recruitment email completed the questionnaire (response rate of 54%). During the four-year study period, 39 of the 118 programs (33%) experienced at least one resident attrition. A total of 52 residents underwent attrition. Residents undergoing attrition were more likely to be early in training. Gender was not associated with attrition. Older residents were more likely to leave due to perceived academic challenges. The most common perceived reason for attrition was to switch specialties. Resident replacement was successful in 42% of cases.

Conclusions: Nearly one-third of residencies were affected by resident attrition. Although arguably predictive of attrition in other fields, gender was not associated with attrition in our sample.

Table 1. Characteristics of residents undergoing attrition (n=52).

PGY* status in 2018-2019		n	%
	PGY-1	10	19.23
	PGY-2	15	28.85
	PGY-3	19	36.54
	PGY-4	8	15.38
Completed years at your program			
	Less than 1 year	13	25.00
	1 year	32	61.54
	2 years	7	13.46
Gender			
	Male	36	69.23
	Female	16	30.77
Estimated age			
	<26	6	11.54
	26-30	28	53.85
	31-35	9	17.31
	36-40	6	11.54
	>40	3	5.77
Under-represented minority in medicine			
	Yes	9	17.31
	No	42	80.77
	Unsure	1	1.92
Marriage status			
	Married	21	40.38
	Unmarried	27	51.92
	Unsure	4	7.69
Children before starting residency			
	Yes	10	19.23
	No	38	73.08
	Unsure	3	5.77
	Missing	1	1.92
New child or became pregnant during residency			
	Yes	6	11.54
	No	42	80.77
	Unsure	3	5.77
	Missing	1	1.92
Medical school education			
	MD** from US/Canada allopathic medical school	36	69.23
	DO*** from US/Canada osteopathic medical school	15	28.85
	International medical graduate	1	1.92
Trained in part or completed residency in another specialty before applying to EM****			
	Yes	6	11.54
	No	45	86.54
	Missing	1	1.92
Final rank list position			
	Top 10%	5	9.62
	Top 1/3	16	30.77
	Middle 1/3	19	36.54
	Lower 1/3	4	7.69
	Unknown	8	15.38
Ties to geographic area			
	Grew up in the area	6	11.54
	College/medical school, worked in area	7	13.46
	Has family living in area	3	5.77
	No ties to the area	29	55.77
	Unknown	6	11.54
	Missing	1	1.92

*PGY = Post-Graduate Year
 **MD = Doctor of Medicine
 ***DO = Doctor of Osteopathic Medicine
 ****EM = Emergency Medicine

4 A Novel and Well-Received Way to Track Resident Procedures

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Background: Tracking of ACGME-required procedure is fraught with issues. Resident progress was often only analyzed during semi-annually evaluations and residents had a propensity to fall behind. Objective: We sought to create a better way to track residents’ procedures in order to ensure they were keeping up-to-date. We then assessed whether the residents found it beneficial and motivating and whether they were offended by others seeing their progress.

Objective: To evaluate a novel way to track residents’ progress in documenting procedures

Methods: A spreadsheet was developed in Google Sheets. It contains the names of all the residents, the 15 required

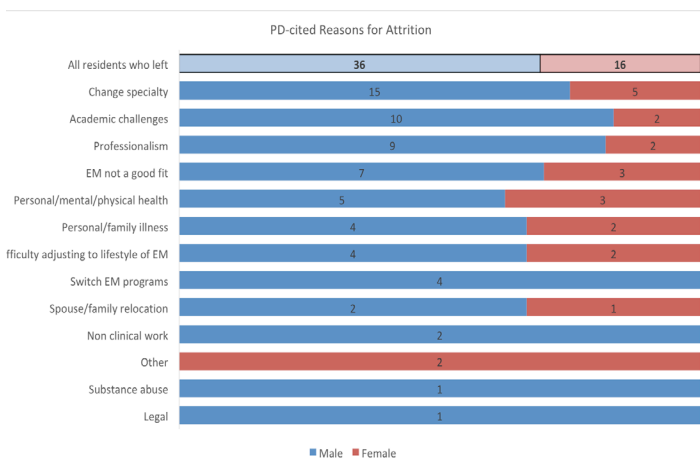


Figure 1. Perceived reasons for attrition, by gender.

procedures, and the minimum threshold for competence of each. The expected number of procedures for each resident for that time in their training was calculated. We termed the expected number the “PACE Score.” Residents received the entire programs’ PACE scores monthly. For two years, residents were surveyed about the PACE Score using an online questionnaire with a 5-point Likert scale (1=bad to 5=good). Average ratings and differences (D) were calculated with 95% confidence intervals (CI).

Results: 45 residents (15 in each PGY) completed the PACE score survey. Overall, the residents found it moderately beneficial (average 3.4, CI: 3.1, 3.7) and moderately motivating (average 3.3, CI: 3.0, 3.7), while not being offensive (average 3.9, CI: 3.6, 4.2). PGY-3s found the PACE score significantly more beneficial than PGY-1s (4.1 vs 3.3, D 0.8, CI: 0.1, 1.5) and PGY-2s (4.1 vs. 2.9, D 1.2, CI: 0.4, 2.0). PGY-3s also found the PACE Score more motivating than PGY-1s (4.0 vs. 3.2, D 0.8, CI: 0.5, 1.5) and PGY-2s (4.0, 2.8, D 1.2, CI: 0.5, 1.9). While no PGY level was offended by sharing the PACE scores (range 3.5-4.5), PGY-3s found it significantly less offensive than PGY-1s (4.5 vs 3.5, D 0.9, CI: 0.2, 1.6).

Conclusion: Overall, residents are very satisfied with the PACE score. The residents found the PACE score beneficial, motivating, and not offensive. PGY3 residents were particularly happy with process.

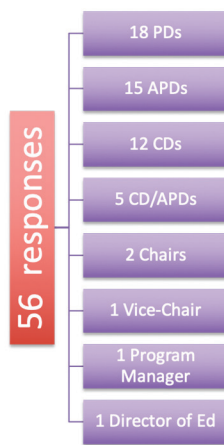


Image 1.

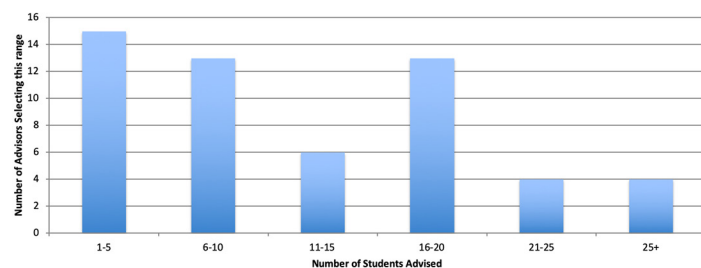


Image 2. Number of Students Advised.

5 A Wide Range of Sizes: Advisors’ Approaches to Standardized Video Interview Preparation

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Background: The Standardized Video Interview (SVI) was introduced by the AAMC and piloted by Emergency Medicine Residency programs. As a novel residency application component, we suspected advisors’ recommended methods and resources for student preparation might vary and sought to identify those practices. The recently announced withdrawal of support by our specialty for participation in the SVI may be interpreted in the context of these data.

Objectives: At the conclusion of this activity, the learner will have an increased understanding and demonstrate insight into the practices used within the CORD community to advise students on preparation for the Standardized Video Interview, and evaluate potential impact on medical students. We sought to gain insight into SVI preparation methods

Methods: After IRB approval, we surveyed emergency medicine educators through the CORD listserv with 56 programs responding. Incomplete responses were excluded from the data analysis.

Results: The 56 respondents comprised mainly of PDs, APDs and CDs (Image 1). The number of students advised varied greatly (Image 2). Advice was commonly generated from personal experience and interpretation of national organization guidelines. An assortment of resources were allocated to the effort, represented by responses as varied as “none--advise students not to worry about it,” to two advisors who reported using a commercial interview-prep service. It was common for applicants to be offered space (23/56, 41%) or technical support (27/56, 48%). The time committed to student advising ranged from zero to 20 hours. Associated costs attributed to preparation varied, including faculty time and/or resources, with values estimated to be up to \$10,000. Most (31/56, 55%) advisors felt that time spent preparing students for the SVI was just right, with the second-most common response (15/56, 27%) being “not sure.”

Conclusions: For this novel, un-tested, and high stakes assessment, the number and types of resources and costs used for preparation varied greatly. The heterogeneity of responses may, although our survey did not directly address this, have been associated with a lack of clarity on the goals, assessment rubric and attributes assessed by the SVI.