21 Emergency Medicine Program Leadership Preferences For In Person Versus Virtual Residency Interviews

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Learning Objectives: Assess EM residency program leadership preferences/concerns for the 2021-22 residency interview cycle.

Background: The Coalition for Physician Accountability recommended 2021-2022 residency interviews be held virtually. Studies assessing EM program leadership preferences for virtual versus in person interviews have been limited.

Objective: Assess EM residency program leadership preferences/concerns for the 2021-2022 residency interview cycle.

Methods: Via CORD's Program Director and Faculty Community, EM program leadership were asked to complete a 10 question survey, which included likert, multiple choice, and open response questions. There were 73 responses (86.3% PDs, 12.3% APDs, 2.7% CDs, Vice Chair of Education 1.4%). Descriptive and summary statistics were used.

Results: When asked comfort level with formats for 2021-2022, respondents felt most comfortable (agree or strongly agree) with virtual interviews only (64.4%), followed by virtual interviews with all applicants with optional in person second looks (57.5%), in person interviews only (50.7%), and offering both in person and virtual formats with applicants choosing the format they prefer (29.1%). When asked which one format they prefer, 37% preferred virtual interviews with all applicants with optional in person second looks, followed by 26% virtual interviews only, 20.5% offering both in person and virtual formats with applicants choosing which format they prefer, and 16.4% preferred in person interviews only (Figure 1). There was concern for bias if students are given a choice between in person and virtual interviews (Figure 2). In the open response, a novel idea suggested second looks for students after programs have submitted their rank list, yet before students submit their lists.

Conclusions: A majority of EM program leaders feel comfortable with virtual interviews only for the 2021-2022 cycle. The largest percentage prefer virtual interviews with all applicants, with optional in person second looks. As a follow up, we plan to survey current interns who interviewed in 2020-2021.

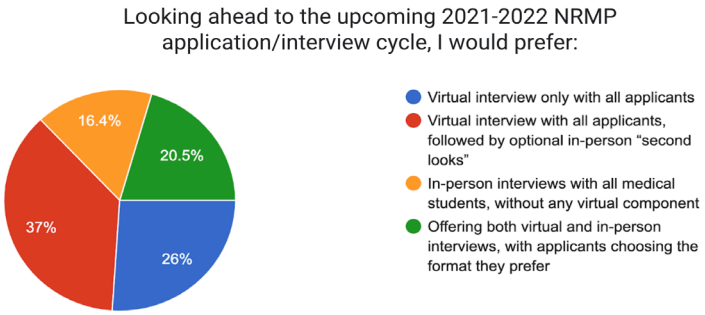

Figure 1. Program leadership top preference for the 2021-2022 application/interview cycle.

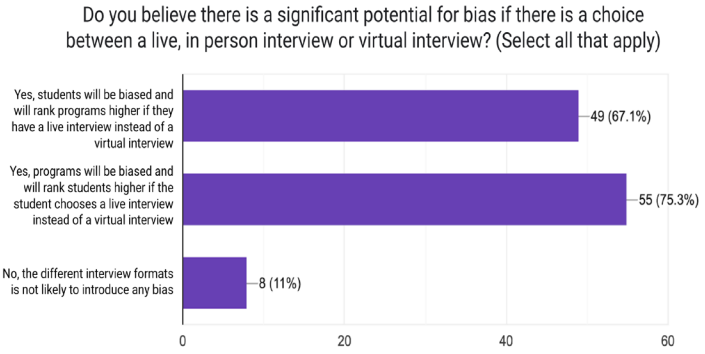

Figure 2. Progam leadership concer for bias with choice of in-person and virtual interviews.

22 Medical Student Perceptions of the Virtual Interview Process for Emergency Medicine Residency Application

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Learning Objectives: Investigate medical student perceptions of the virtual interview process.

Background: In the setting of the Covid-19 pandemic, emergency medicine (EM) residency programs engaged an unprecedented transition to virtual interviews. The use of virtual interviews and their impact on medical students had not been previously studied in the published literature.

Objectives: We aimed to investigate medical student perceptions of the virtual interview process.

Methods: We conducted a cross-sectional survey-based study of EM applicants who interviewed at our community teaching hospital during the 2020-21 season. The survey was sent electronically to all interviewees following Match Day, excluding applicants who had completed a clinical rotation

in our department. The survey consisted of 8 Likert scale questions assessing specific components of the interview and overall impressions of the virtual interview format.

Results: A total of 113 surveys were distributed with 34 (30%) interviewees completing the survey. Overall, respondents were 32.4% Female and the mean number of virtual interviews attended was 15.3 (SD = 4.8). Responses to questions regarding overall impression and specific components of the virtual interview are reported in Table 1. Regarding how the nationwide transition to a virtual interview process affected their match, 32% responded negatively, 41% responded neutral, 26% responded positively. Most interviewees (71.9%) agreed that virtual interviews should be offered as part of the traditional residency interview cycle.

Conclusion: Medical students felt that our virtual interview process benefited their experience overall. While the nationwide transition is not thought to have benefitted their match, students feel that virtual interviews should be offered as an option moving forwards. The study was limited by small sample size and single-center setting.

Table 1. Responses to survey questions regarding the virtual interview process.

Survey Questions	Likert Scale (%)					Mean Score (SD)
	1. Strongly Disagree	2. Somewhat Disagree	3. Neutral	4. Somewhat Agree	5. Strongly Agree	
Pre-interview Resident Meet & Greet: Provided a good "feel" for the program culture	0 (0.0)	3 (10.0)	2 (6.7)	17 (56.7)	8 (26.7)	4.00 (0.87)
Virtual Department Tour: Provides a visual representation of the ED	1 (3.2)	1 (3.2)	2 (6.5)	10 (32.3)	17 (54.8)	4.32 (0.98)
Program Brochure: Provided adequate information	0 (0.0)	0 (0.0)	2 (6.3)	14 (43.8)	16 (50.0)	4.44 (0.62)
Interview Day Format: Allowed me to get to know the program and present myself	0 (0.0)	1 (3.1)	4 (12.5)	9 (28.1)	18 (56.3)	4.38 (0.83)
Social Media: Helped familiarize with residency culture	0 (0.0)	2 (9.5)	5 (23.8	8 (38.1)	6 (28.6)	3.86 (0.96)
Overall Impression: Provided opportunity to familiarize myself with program and present myself as candidate	0 (0.0)	1 (3.1)	2 (6.3)	13 (40.6)	16 (50.0)	4.38 (0.75)

23 Self-Assessment of Preparedness: Incoming Emergency Medicine Interns in the Era of COVID-19

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Learning Objectives: The purpose of this study was to assess the preparedness of the incoming emergency medicine intern (EM-1) resident class in light of changes to clinical rotations incurred by COVID-19. This feedback was given to programs to alter orientation programs and address knowledge gaps.

Background: The COVID-19 pandemic resulted in modification, limitation or cancellation of rotations that affected the clinical experience of graduating fourth-year medical students (MS4).

Objective: The purpose of this study was to assess the preparedness of the incoming emergency medicine intern (EM-1) resident class in light of changes to clinical rotations incurred by COVID-19.

Methods: We conducted a prospective, survey-based assessment of MS4 matriculating into 7 geographically distinct US EM residency programs in July 2021. The anonymous survey collected data on respondent demographics, rotations, procedures performed, and subjective comfort level with clinical scenarios. Each respondent was assigned a procedural index score (PS) and a clinical comfort index score (CCS), defined as the total sums of reported procedure counts and the quantitative Likert values for each clinical scenario, respectively. Spearman's rank order coefficient was used to assess correlation between the index scores (PS, CCS) and educational variables.

Results: A total of 63 respondents returned completed surveys. The median numbers of EM rotations, virtual rotations and ED encounters were 2 (IQR 2-2), 3 (IQR 1-4,) and 100 (IQR 55-100), respectively. MS4 rotations were "somewhat" or "moderately" limited due to COVID-19 for 82.5% of respondents and "somewhat" or "moderately" suspended in 73.0%. Calculation of index scores yielded a median PS=35 (IQR 30-39) and CCS=30 (IQR 27-32). PS was significantly positively correlated with the number of EM rotations (r=0.395) p=0.001), and ED patient encounters (r=0.369, p=0.006).

Conclusion: Based on self-reported data, changes to MS4 rotations did not significantly impact the procedural exposure or clinical comfort level of incoming EM-1 residents. Procedural experience, but not overall clinical comfort level, was positively correlated with the number of EM rotations and patient encounters completed.

Table 1. Reported number of procedures performed.

Procedure/Skill	Number of Procedure Performed (%)				
	0	1-2	3-5	6-10	>10
Abscess incision/drainage	6 (9.5)	29 (46.0)	18 (28.6)	6 (9.5)	4 (6.3)
Cardioversion	26 (0.0)	25 (39.7)	6 (9.5)	2 (3.2)	4 (6.3)
Central venous catheter	35 (55.6)	13 (20.6)	11 (17.5)	4 (6.3)	0 (0.0)
Chest x-ray intepretation	0 (0.0)	1 (1.6)	3 (4.8)	19 (30.2)	40 (63.5)
EKG interpretation	0 (0.0)	3 (4.8)	5 (7.9)	13 (20.6)	42 (66.7)
Endotracheal intubation	16 (25.4)	14 (22.2)	9 (14.3)	12 (19.0)	12 (19.0)
Laceration repair	1 (1.6)	7 (11.1)	16 (25.4)	16 (25.4)	23 (36.5)
Lumbar puncture	28 (44.4)	28 (44.4)	5 (7.9)	2 (3.2)	0 (0.0)
Pediatric evaluations	1 (1.6)	3 (4.8)	9 (14.3)	9 (14.3)	41 (65.1)
Pelvic examination	0 (0.0)	8 (12.7)	29 (46.0)	15 (23.8)	11 (17.5)
Peripheral IV	18 (28.6)	20 (31.7)	8 (12.7)	10 (15.9)	7 (11.1)
Psychiatric evaluations	2 (3.2)	3 (4.8)	13 (20.6)	11 (17.5)	34 (54.0)
Simulation (EM)	4 (6.3)	12 (19.0)	17 (27.0)	16 (25.4)	14 (22.2)
Slit lamp examination	31 (49.2)	19 (30.2)	6 (9.5)	3 (4.8)	4 (6.3)
Splint placement	18 (28.6)	21 (33.3)	15 (23.8)	5 (7.9)	4 (6.3)
Ultrasound (point of care)	3 (4.8)	4 (6.3)	14 (22.2)	11 (17.5)	31 (49.2)