

pregnancy complication and often results in vaginal bleeding. There is a paucity of evidence informing the ED management of hemodynamically unstable patients with EPL. EM residency training for this situation typically focuses on medical management. However, for unstable patients hemorrhaging as a result of EPL, the American College of Gynecology recommends prompt surgical evacuation of the uterus as definitive management. This procedure is called manual uterine aspiration. EM physicians do not routinely receive formal training in MUA despite its potential utility in the ED, particularly in settings without in-house gynecology consultants.

Educational Objectives: Our goal was to implement a curriculum to teach EM learners how to identify and procedurally manage hemorrhage from EPL using MUA.

Curricular Design: Rooted in the mastery learning model, this curriculum sought to use simulation to teach EM learners the indications, contraindications, and steps for performing MUA as an ED treatment for hemorrhage from EPL. A two-part simulation session was designed for a group of EM learners. Part one consisted of a lecture and video demonstration showing a competent instructor performing MUA. Part two consisted of hands-on deliberate practice with procedural simulation models at three different stations. Learners were supervised at each station by a trained gynecologist, who used checklists to ensure that all steps of the procedure were performed.

Impact/Effectiveness: The MUA curriculum was evaluated using a post-workshop survey. 100% of participants reported increased confidence in their ability to identify indications for ED MUA and cases that would be deemed higher risk for ED MUA. All reported increased comfort in performing steps necessary for ED MUA. To our knowledge, this was the first time MUA was taught to EM learners using simulation.

25 Medical Humanities: A Novel Residency Curriculum

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Background: The medical humanities have a long-recognized role in strengthening resilience, empathy, communication, critical thinking, and observation while reducing burnout in physician training. However, few medical institutions incorporate humanities teaching into their residents' curricula, and the block structure of emergency medicine residency makes established curricula difficult to implement.

Design: Our humanities electives are designed for two-week blocks and focus on autonomy, relatedness, and competence. Elective offerings include Introduction to the Medical Humanities and subspecialized electives in literature, theatre, fine arts, climate and health, philosophy, and film. Through self-directed learning, residents read, listen to, watch, and observe a curated medical humanities selection. Residents follow and interpret prompts, submit a reflection journal, and produce an independent project at the completion of the elective. Participants then evaluate the electives on a 5-point Likert scale. Impact: Since the initial course offering in 2020, 23 of our residents have taken a medical humanities elective. Deliverables included narratives, poetry, visual art, a novel, videos, music, a cookbook, and the creation of further electives. On post-intervention survey, participants reported the electives met their professional needs (4.88/5), empowered them to change their practice (4.72/5), enhanced their practice (4.8/5), reduced burnout (4.93/5) and provided them with a clear plan for new skill implementation (4.64/5).

Impact: Our course has filled a significant gap related to enhancing the physician experience and building fundamental skills through the medical humanities. This curriculum is

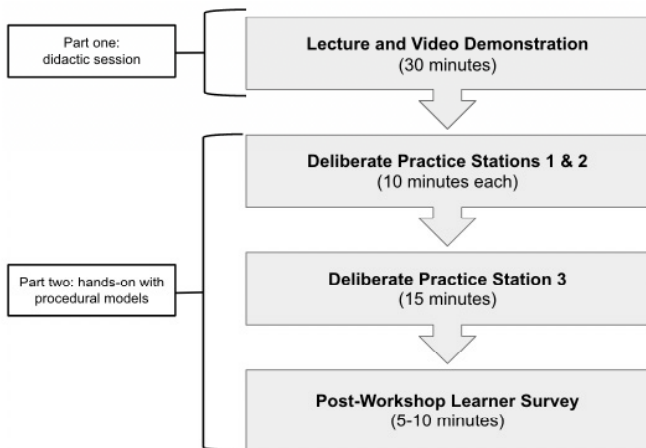


Figure.

Table 1. Postintervention survey item mean responses with 95% CI.

Question	M (95% CI)
This medical humanities elective met my current professional needs.	4.88 (4.71 to 5.05)
Upon completion of this elective, I feel empowered to implement specific changes or strategies that will enhance my professional practice and competence.	4.72 (4.51 to 4.93)
The content of this elective served to enhance my professional practice and competence.	4.8 (4.60 to 5.00)
It is clear to me how I would implement the desired learning outcomes (changes or new strategies) in my practice, if given the chance.	4.64 (4.39 to 4.89)
Reduced Burnout	4.93 (4.80 to 5.06)



Image 1. Deliverable examples from the Fine Arts and Medicine electives.

generalizable to other residency programs and the self-directed format is engaging and mobile. Emergency medicine residency programs should consider offering electives in the medical humanities to improve empathy, communication, observation, and decrease burnout in their residents.

26 Multimodal Rural Emergency Medicine Curriculum: Preparing Residents for Rural Practice

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Background: Rural regions face EM physician shortages. Most training programs are located in cities and lack rural clinical experiences, didactics, and mentorship to excite and prepare residents for rural EM practice. There is limited data on optimal training methods to prepare residents for rural practice.

Educational Objectives: 1) Provide a multimodal rural EM curriculum that prepares trainees to work in rural EDs. 2) Evaluate our program quantitatively and qualitatively to assess the opportunities and limitations of rural training.

Curricular Design: Our rural EM faculty working group, with extensive experience in rural practice, developed this curriculum based on 2 years of weekly case review from 2 rural critical access hospitals (CAHs). This 3-year program features clinical rotations, lectures, and simulation training. Rotations take place at rural CAHs and remote indigenous hospitals. Lectures and simulation focus on skills required in resource-limited solo practice, such as ventilator management, critical medication mixing, obstetric emergencies, patient transfer logistics, leveraging telemedicine, and prolonged critical care when transport is unavailable.

Impact: During each resident's elective, quantitative data on patient volume, acuity, and procedures is collected; each rotation concludes with a qualitative evaluation of new skills,

unique experiences, and limitations. Our rural EM curriculum has proven successful over the first 2 years. Quantitatively, residents see patient acuity and procedures similar to academic center rotations but gain unique skills from the challenges of a rural environment. Qualitatively, 7 of 7 residents gained new skills and confidence, with 86% choosing a rural practice. We plan to expand our program, share didactic content with other residencies, and open additional rural clinical experiences to trainees nationwide, with the goal of bridging the gap between urban training programs and rural emergency care needs.

27 Multiple Casualty Simulation Scenario Secondary to Natural Disaster at a Music Festival

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Introduction: Communication plays a significant role in medicine, especially in the emergency department. Using simulation will teach learners how to actively listen, delegate roles, and effectively engage with the entire team despite the continuous distractions. This simulation adds innovative value as the elected team leader is blindfolded and therefore must rely solely on team member communication to effectively triage, manage, consult, and appropriately determine the patient's disposition.

Objective: To assess the effectiveness of team communication towards triage, assessment, and management of multiple trauma patients during a mass casualty simulation (MCI) and develop confidence for future real-life applications.

Curricular Design: Learners will begin in a group and should assign roles amongst themselves to manage a critical pediatric patient during a shift in the emergency department. During a simulated earthquake, the team leader is affected by dust and is blindfolded for the rest of the scenario. Three patients will arrive with various traumatic injuries from a nearby music festival. The team will need to quickly assess, stabilize, treat, and disposition these patients appropriately for immediate surgical intervention. During the debrief, the blindfolded team leader should be asked to explain their understanding of each patient's clinical course which can be compared to the non-blindfolded team members in order to determine the accuracy of communication between the team during the MCI. To assess the utility of this project, a pre and post questionnaire to evaluate their knowledge, confidence, and engagement was obtained.

Effectiveness: Table 1 shows the post-tests had significantly higher knowledge scores than the pre-test, $t(48) = 4.64, p < 0.05$. Image 1 demonstrates there was a significantly greater confidence in their ability to handle an MCI in the post than the pre-test, Mann-Whitney $U = 227, p < 0.05$.