

be attributable to other causes.

Conclusions: Allowing RIs to self-schedule ED shifts led to marked increases in wellness in this pilot study.

56 The Role of the Medical Student in the Emergency Department

Grant Gauthier, Haley Krachman, Cameron Whitacre, Lan Segura, Jessica Sauve-Syed, E. Page Bridges

Background: Currently, more than half of medical schools require an EM clerkship, and this number continues to grow. The wide variety of patients and disease presentations provides an excellent learning environment and students the opportunity to function as part of the medical care team. Despite this, there is scarce literature on the role of the student.

Objectives: The goal of this study is to document the utilization of medical students in a typical ED shift. As this study was conducted following the 2018 change by CMS allowing student documentation in the official medical record, we anticipate a significant portion of time will be spent in the EMR.

Methods: The study was conducted using an observational prospective design. In total, 6 students on their third-year core clerkship and 13 students on their acting internship (AI) were observed at an urban level 1 trauma center. Observers classified medical student activities as shown in table 1 and table 2. Analysis was performed using basic inferential statistics.

Results: Overall, nearly 40% of time was spent on computer-based activities including non-bedside clinical work and documentation, while less than 30% of time was spent on direct patient care. Compared to AIs, M3 students spent a significantly larger amount of time waiting and shadowing (p-values 0.04 and <0.01, respectively). AIs spent a significantly larger amount of time on non-bedside clinical care and documentation (p-values <0.01 and 0.03, respectively).

Table 1.

Category	Total Minutes Spent (percent)
Awaiting patient	808 (9.00)
Clinical (bedside)	1793 (19.98)
Clinical (non-bedside)	1952 (21.75)
Documentation	1531 (17.06)
Education	678 (7.55)
Personal	557 (6.21)
Procedures	401 (4.47)
Shadowing/Observing	964 (10.74)
Other Patient Care	228 (2.54)
Other	64 (0.71)

Conclusions: Similar to physicians, students spend the largest portion of time on computer-based activities. This may reflect the 2018 change by CMS allowing student documentation in the medical record. The amount of time spent by third year medical students in activities such as waiting and shadowing likely reflects the decreased level of experience and perceived ability by the attending physician. Future studies will analyze activities deemed most useful by students and faculty.

Table 2.

Category	Average minutes (percent) per shift		Difference (P value)
	M3	Acting Intern	
Awaiting patient	75 (15.91)	27.5 (5.82)	47.5 (0.04)
Clinical (bedside)	79.2 (16.80)	101.4 (21.44)	22.21 (0.12)
Clinical (non-bedside)	70.5 (14.96)	117.6 (24.87)	47.11 (<0.01)
Documentation	50.3 (10.68)	94.5 (19.99)	44.20 (0.03)
Education	37.7 (7.99)	34.8 (7.35)	2.90 (0.41)
Personal	28.3 (6.01)	29.8 (6.29)	1.43 (0.50)
Procedures	37.5 (7.96)	13.5 (2.86)	23.96 (0.12)
Shadowing/Observing	81 (17.19)	36.8 (7.77)	44.23 (<0.01)
Other Patient Care	9.3 (1.98)	13.2 (2.80)	3.90 (0.20)
Other	2.5 (0.53)	3.77 (0.80)	1.27 (0.26)

57 The Status of Pediatric Critical Care (PCC) Experience in Emergency Medicine (EM) Residency Training Programs

Elaine Josephson, Muhammad Waseem, Hina Asad, Masood Shariff

Background: PCC experience is an Accreditation Council for Graduate Medical Education (ACGME) requirement for EM programs.

Objective: With limited number of PCC centers, most tertiary care-based, EM programs, especially in Affiliated (AFF) or Community (COM) settings would experience challenges to obtain PCC experience. We explored accessibility of acquiring PCC rotations for EM Residents in United States (US) and Puerto Rico (PR).

Methods: Web link utilizing SurveyMonkey platform for data capture was emailed to ACGME accredited EM programs (n=264) in US and PR. We stratified program type (practice setting, length of training, institution type) and access to PCC rotation for EM residents (Pediatric (PED) ICU (PICU), Neonatal ICU (NICU), PED Surgical ICU (PSICU), PED Neurosurgical ICU (PNeuroICU)). Comparison made by the regions, Northeast (NE), South, Midwest (MW), and West, as well as institution (Urban/Suburban/Rural) and practice (Academic (ACA)/COM) setting.

Results: 153 EM programs completed survey with 75% reporting a 3-year curriculum. The majority were urban (61%); ACA practice comprised 53% and COM 39%. Overall, programs answered “very easy” (39%)

and “moderately easy” (20%) to arrange PCC rotations. Regions finding it “moderately difficult” were NE (26%) and MW (24%). ACA and COM programs had no difference in obtaining PCC rotations, however, COM programs scheduled PICU rotations at AFF and non-AFF centers (73%) compared to ACA with PICU at their primary institute. (61%) ($p < 0.001$). Rotations in NICU (21%), PSICU (13%) and PNeuroICU (1%) were less common. Accessibility noted if ICU was outside the primary institute, 42% COM programs reported difficult and 35% by ACA programs ($p=NS$).

Conclusion: A PCC unit in the Primary or AFF hospital is the most achievable option. Overall, EM programs reported no deficit in fulfilling the PCC rotation. Reexamination is needed as more hospitals consolidate with specific PED Tertiary centers available only to their own rotators.

58 Thriving in Emergency Medicine Residency

Kevin Hanley, Jillian Mongelluzzo

Background: It has been shown that the burnout rate for emergency medicine providers is among the highest seen in healthcare. While resilience and grit have been studied as protective against burnout, the ability to thrive may be a more useful target. Thriving has previously been defined as a combination of vitality—having energy available and feeling “alive”—and learning—acquiring and applying valuable knowledge. Thriving has been found to be dependent on several categories, one of which is unit contextual features (UCFs). UCFs are factors such as challenge or hindrance stressors, autonomy, and trust.

Objectives: This study is being done to determine if Emergency Medicine residents are thriving, and what UCFs are contributing to their ability or inability to thrive during residency.

Methods: We administered a mixed-methods survey developed from previously validated surveys regarding the UCFs and overall thriving to emergency medicine residents at one four-year emergency medicine residency training program in March of 2022.

Results: We received 38 responses (out of 58 residents) with 8-11 respondents per PGY level. Overall thriving score for all residents was 3.2/5. First-year residents had a score of 3.5/5 while 2nd-4th years each had a score of 3.1/5. Social support was the UCF that most contributed to thriving while hindrance stressors, challenge stressors, and autonomy negatively affected the residents’ thriving.

Conclusions: We found ideal targets for interventions from the survey, with qualitative responses that can help guide those interventions to increase thriving. Other residencies could similarly use this survey to identify targets

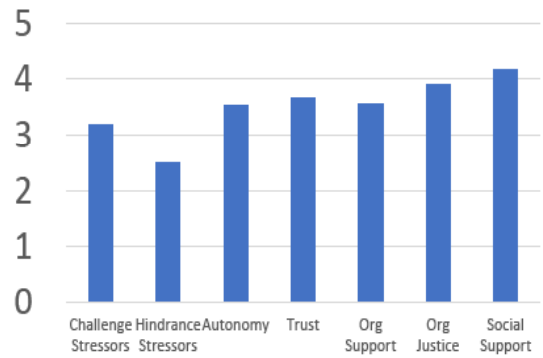


Figure. Unit contextual features.

Table.

Unit Contextual Feature	Sample of Responses		
Hindrance Stressors	Feeling like I'm working in a broken system, feeling like patients are rotating through without making much of a difference for any of them	Boarding, difficulties in connecting people to follow up, decrease in number of available social services (particularly shelter beds) during COVID	Lack of care or support for unhoused patients and people suffering from addiction because this represents a huge portion of our patients that I feel like I can barely help
Autonomy	I have had fantastic Attendings that let me make all of my decisions, which allows me to learn the most. I have had other Attendings that have basically treated me like a scribe; they have seen my very stable patients before me and ordered their own labs/imaging before I can even present them.	Attendings (and trauma surgeons) sometimes immediately take over (sometimes rightfully so), but often we learn best by having to talk through the decisions instead of having someone run the code behind your back	
Social Support (positive effect on thriving)	attendings that advocate for your learning, but also sympathize with the amount of shifts you work per month (ie empathy towards your situation)	The times when I can truly feel that I have learned and grown, times when I have brought people joy or made their day better	community, being able to share with others that I'm not thriving or that I am, hearing about the experiences of others, the idea that One day I'll be working less and will be able to have a more balanced life.

for intervention. Responses highlighted hindrance stressors present in the ED that would be ideal targets for intervention, while targeting social support may not have as much of an impact. The study was limited due to administration once during the year as time during the academic year may affect the level of thriving.

59 Traditional Bedside Versus Digital Point-of-Care Ultrasound Education

Michael Sobin, Steven Johnson, Amit Bahl

Background: While standard point-of-care ultrasound