

Table 1. 157 US EM CDs (44% response rate).

Gender	Age/Inequity	Formal education	Checkup year	ED rotation type	Long-term plans
<ul style="list-style-type: none"> •55 female (35%) •98 male (62%) •4 no answer (3%) 	<ul style="list-style-type: none"> •Mean years since residency graduation: 10.9 (+/- 7.13 1 SD) •Mean years as EM CD: 5.53 (+/- 4.46SD) 	<ul style="list-style-type: none"> •30 (19%) with Masters degree •22 (14%) completed Med-ed/um fellowship •16 (10%) completed other fellowship •10 (6%) obtained a formal teaching certificate •7 (4%) with PhD 	<ul style="list-style-type: none"> •78 (50%) supervise only •8 (5%) medical students •71 (45%) supervise both 2nd and 4th year medical students •7 (5%) supervise only 3rd year medical students 	<ul style="list-style-type: none"> •103 (66%) University hospitals •79 (50%) Community hospitals •40 (26%) County hospitals •10 (6%) Rural hospitals •5 (3%) VA hospitals •60 (38%) include multiple sites 	<ul style="list-style-type: none"> •56 (36%) plan to change or add academic roles: •27 (17%) Assistant/Associate dean •18 (11%) AFD or PD •14 (9%) National leadership position •11 (7%) Reserve of medical school course •11 (7%) Vice chair or education •9 (6%) Clinical director/Administrative leadership •6 (4%) Direct additional EM or SOM courses •5 (3%) Departmental chair •1 (1%) Researcher

Table 2. EM CD long-term plans.

In how many years do you plan to change or add roles?			For how many more years do you plan to act as a CD?		
# of years	# CDs	% of all survey respondents	# of years	# CDs	% of survey respondents
0	5	3.2	0	13	8.3
1	14	8.9	1	15	9.6
2	12	7.6	2	24	15.4
3	7	4.5	3	17	10.9
4	1	.6	4	5	3.2
5	12	7.6	5	55	35.3
6	1	.6	6	1	.6
8	1	.6	8	2	1.3
10	1	.6	10	16	10.3
Total	53	33.8	12	1	.6
			15	4	2.6
			18	1	.6
			20	1	.6
			25	1	.6
			Total	156	100.0

Median 2 (IQR 4)
Mean 2.7 +/- SD 2.145

Median 2 (IQR 4)
Mean 2.45 +/- 2.025

32 Characteristics of Residency Applicants Choosing Virtual versus In Person Interviews

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Background: The COVID pandemic changed the way in which residency interviews are conducted with many programs now utilizing virtual interviews. There appears to be demand for in person or hybrid interviews, but it is not clear what factors may affect this choice and whether this may cause an inherent bias in the interview process.

Objectives: We sought to determine the applicant characteristics that were associated with choosing in person (IP) versus virtual (V) interviews over the past two application cycles.

Methods: This case control study was conducted at a single PGY1-3 EM program with 54 residents. For the past two application cycles, applicants were offered a choice between IP or V interviews. We compared applicant characteristics including gender, self-reported race, preference signal status, proximity of medical school and hometown, and USMLE scores to evaluate for differences between the two groups. Rotating students were excluded from the analysis as they were asked to pick virtual interviews.

Results: 331 applicants were included in analysis with 241 (72.8%) choosing V and 90 (27.2%) choosing IP

interviews. Compared to V interviewers, IP were equally likely to be male (57.8%IP v 53.1%V), more likely to have given a preference signal (32.2% v 12.8%; OR=3.2(95%CI 1.8-5.6)), more likely to attend medical school in state (22.2% v 9.5%; OR=2.7(95%CI 1.4-5.1)), more likely to have their hometown in state (17.7% v 9.5% OR=2.0 (95%CI 1.1-4.0)), and less likely to be Black (4.4% v 7.1%). There was no difference amongst applicants who report race as white, Hispanic, or Asian. Mean USMLE Step 2 (V 251 vs. IP 250) scores were equal between groups.

Conclusions: There was no difference between test scores and gender amongst applicants who chose to interview IP compared to V. There were differences in race, proximity, and preference signals. This information can be useful for programs for future interview planning and for reducing bias when making their rank list.

33 Emergency Medicine Residency Website Wellness Pages

Alexandra Sappington, Brian Milman

Background: Resident wellness is a critical part of resident training. The COVID-19 pandemic impacted the way medical students seek residency positions. In 2020, ACGME advocated for virtual interviews. Most EM interviews in 2023 remain virtual. The virtual format for residency interviews will likely persist, causing medical students to rely heavily on the websites of prospective programs. Eliminating the in-person evaluation of perceived wellness amongst residents will require programs to be transparent about resident wellness on websites.

Objectives: To quantify the number of emergency medicine programs with wellness pages on their websites and identify themes portrayed on those pages.

Methods: We analyzed wellness pages from Emergency Medicine websites based on the 2022 NRMP program list. Wellness statements were coded by two authors independently through an inductive process. Codes were revised iteratively until consensus was achieved. Codes were organized into themes.

Results: 278 (100%) emergency medicine residency websites were identified. 57 (20.5%) had a wellness page, 45 (16.2%) linked to an institutional page that discussed wellness, 169 (60.8%) discussed wellness themes on their website, but did not have a dedicated page, and 69 (24.8%) had no direct mention of wellness anywhere on their website. Based on the programs that had a wellness page, the themes identified include community involvement, growth and development, nutrition and health, psychological well-being, social and relaxation activities, wellness culture and environment, wellness curriculum, wellness structure and resources, and work-life integration.

Subthemes appear in Table 1.

Conclusion: Most emergency medicine programs do not have a wellness page on their website. Of the programs that do, important themes are discussed that help applicants identify programs that align with their values.

Table 1. Themes and subthemes identified on EM residency wellness pages and percent of pages that discussed each subtheme.

Community Involvement		Social and Relaxation Activities	
14.3% National involvement		83.9% Social events	
12.5% Community service		28.6% Local amenities	
7.1% Advocacy		23.2% Relaxation	
Growth and Development		Wellness Culture and Environment	
30.4% Professional development		41.1% Culture	
30.4% Finance		12.5% Definition	
28.6% Mentorship		3.6% Harassment	
16.1% Professional satisfaction		3.6% Lack of professional fulfillment	
10.7% Coaching		3.6% Legal concerns	
7.1% Contract negotiations			
3.6% Leadership skill development		Wellness Curriculum	
3.6% Personal development		51.8% Didactics	
1.8% Achievement		7.1% Scholarship	
1.8% Empathy			
Nutrition and Health		Wellness Structure and Resources	
55.4% Physical health		53.6% Institutional structure	
48.2% Food		42.9% Resident wellness committee	
16.1% Spiritual health		32.1% Resources	
		23.2% Counseling services	
		17.9% Medical health services	
		8.9% ACGME requirements	
Psychological Well-being		Work-Life Integration	
57.1% Mental health		39.3% Work-life balance	
50.0% Burnout		16.1% Family and childcare	
41.1% Resilience and coping		12.5% Schedule	
33.9% Stress		10.7% Efficiency	
30.4% Peer support			
19.6% Depression/suicide			
16.1% Destructive habits			
14.3% Self-monitoring			
3.6% Imposter syndrome			

34 Contemporary Views and Practices on GME Dizziness and HINTS Exam Curricula: A National Survey of Emergency Medicine Residency Program Directors

Mary McLean, Justin Stowens, Ryan Barnicle, Negar Shah, Kaushal Shah

Background: Neurologists and neurology sub-specialists utilize the HINTS exam to rule out posterior stroke, but its diagnostic utility is controversial when used by emergency physicians. Educators lack consensus on best practices for teaching this skill to emergency medicine residents.

Objectives: We aimed to characterize emergency medicine’s HINTS educational practices and to develop a formal needs assessment.

Methods: In this cross-sectional study, a survey was emailed to residency directors, the focuses of which included HINTS education perceptions, practices, resources, and needs. Likert scales, frequency distributions, and descriptive statistics were used.

Results: Of 250 possible programs, 201 (80.4%) responded

and consented. Of active respondents, 148 (77%) believed the HINTS exam is valuable to teach, 125 (65%) reported HINTS conference sessions, and 148 (77%) reported clinical bedside teaching by faculty. Residency graduates were perceived as more comfortable and confident than faculty. Both parties were perceived as more comfortable than they were competent. Most-effective teaching modalities were clinical bedside teaching, online videos, and simulation (see Figure 1). Teaching struggles included head impulse training, test of skew training, and exam application to correct patients. Teaching barriers were faculty lacking expertise, concern for HINTS reproducibility, and lack of simulation models (see Figure 2). Program directors would dedicate a mean of 2.0 hr/yr (standard deviation 1.3 hr/yr) to implementing a standardized HINTS/dizziness curriculum.

Conclusions: This needs assessment can guide development of a formal, standardized curriculum focusing on residency directors’ cited HINTS exam educational struggles, barriers, resources, and perceptions of effective teaching modalities. Limitations include likely non-response bias (49 residency programs did not open or consent to the survey, and no survey item was “required” except consent).

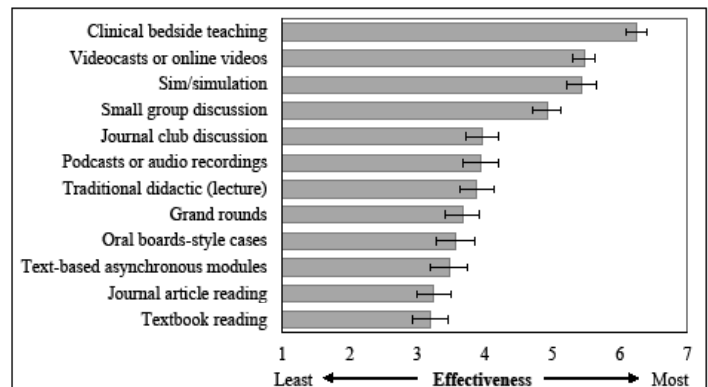


Figure 1. Ranking of educational modalities for teaching the HINTS examination, from most (top) to least (bottom) effective. Effectiveness is based on mean Likert scale ratings and error bars represent the 95% confidence interval of the mean.

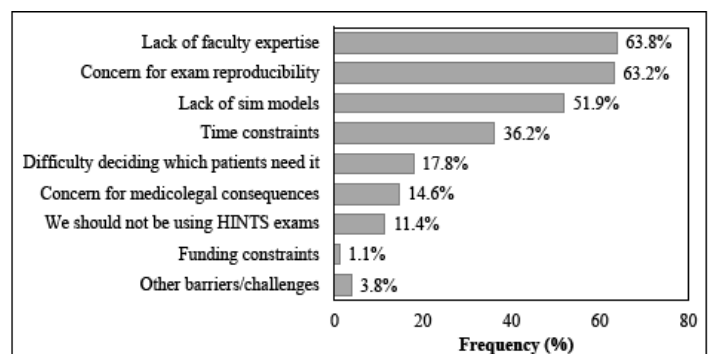


Figure 2. Frequency of residency program director-reported barriers to teaching HINTS examination.