with comfort, perceived realism, or perceived usefulness after microaggression-focused simulation scenarios. We hypothesized no group differences.

Methods: We conducted a prospective observational study of residents at a New York area EM residency program (PGY 1-5) from November 2023-March 2024. Thirty-six residents participated in two microaggression-focused simulation scenarios followed by structured debriefings. Participants completed an anonymous post-simulation survey assessing comfort, realism, and usefulness using a five-point Likert scale. Descriptive statistics characterized the sample; median and interquartile range described age. Frequencies and proportions summarized perceptions. For interpretability, agreement items were collapsed into a dichotomous variable combining strongly agree and agree versus all other responses. Proportions of dichotomized responses were compared across demographic groups using Chi-square or Wilcoxon rank sum tests, where appropriate.

Results: Thirty-six residents completed the survey. Most were female (63.6%), White (60.1%), and PGY3 (33.3%). Nearly all reported witnessing or experiencing workplace bias (94.4%). All responses were strongly agree, agree, or neutral. Comfort, realism, and usefulness did not differ by gender, race, or training level (all $p>0.05$). Prior bias experience was not analyzed due to small subgroup size.

Conclusions: A simulation based microaggressions curriculum appeared psychologically safe, realistic, and useful across groups. Similar perceptions suggest simulation may support equitable skill development for handling bias in clinical settings. Findings support integrating microaggression-focused simulation into residency curricula. Limitations include small sample size, single-program design, convenience sampling, and possible response bias.

26 The Certifying Exam Is Coming - Are We Ready? A Faculty Communications Needs Assessment

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Background: In 2026, ABEM will introduce the new Certifying Exam (CE), replacing the Oral Exam. The CE format will assess communication skills, including conducting difficult conversations, managing conflict, and using patient-centered communication (PCC). Preparing residents for the CE requires faculty who are confident in performing, teaching, and assessing these competencies.

Objectives: We assessed faculty confidence in performing communication tasks prioritized on the CE, comfort teaching these skills, and perceptions of PGY-3 residents' skill in these domains. We hypothesized that faculty would indicate greater confidence in their own communication skills than those of the residents, as well as poor confidence in teaching these skills.

Methods: We developed a cross-sectional survey using a 5-point Likert scale (1 = not confident, 5 = very confident) and open-ended questions. After piloting, we sent the anonymous survey to all 117 faculty from our 3-year EM program, collecting responses from March to April 2025.

Results: The survey response rate was 60% (70/117). Faculty reported high confidence in conducting difficult conversations and using PCC, with ≥80% selecting 4 or 5. Confidence was slightly lower for managing conflict, with only 75% selecting 4 or 5. However, faculty felt that residents needed improvement in these skills. Ten percent of faculty felt residents could operate independently in difficult conversations, 5.7% in conflict management, and 7.1% in PCC. Faculty also reported low confidence teaching these skills and providing feedback. Preferred faculty development topics included feedback, de-escalation techniques, difficult patients/families, conflict with consultants or colleagues, and real-time coaching.

Conclusions: Faculty felt confident performing communication skills prioritized by the CE but identified gaps in resident skills and their own ability to teach these competencies. This highlights potential targets for curricular and faculty development.

27 Developing a Peer Support Training Curriculum for Senior Emergency Medicine Residents: Insights from a Qualitative Analysis

Kirlos Haroun, McKenzie Warshel, Kathryn Lorenz, Linda Regan, Kathryn Ritter

Background: Burnout and secondary traumatic stress are common among EM residents, contributing to emotional exhaustion, reduced psychological safety, and diminished clinical engagement. Most peer support programs target faculty or interprofessional staff, leaving limited resident-focused training or curricular integration in graduate medical education.

Objectives: To evaluate the feasibility, cultural impact, and perceived effectiveness of embedding a structured peer support training program into required residency conference time for senior EM residents.

Methods: This qualitative study took place in Fall 2024 at an urban academic EM residency. Twelve PGY-4 residents were invited to a 90-minute conference-based peer support session teaching seven core response principles; six (50%) attended. Ninety days later, six residents participated in a voluntary focus group utilizing a semi-structured interview guide. Transcripts underwent inductive thematic analysis with double-coding, memoing, and coder triangulation.

Results: Residents reported increased confidence

initiating emotionally focused conversations but variable success applying skills learned during clinical work. Five themes emerged: (1) balancing emotional support with supervisory responsibilities; (2) wide variability in frequency and depth of support interactions; (3) communication and culture shifts wins, including more structured debriefing; (4) bolsters for program implementation such as a desire for booster sessions, faculty modeling, and clearer escalation pathways and (5) barriers to peer support, including time constraints, fatigue, skill decay, and limited awareness of trained supporters.

Conclusions: A brief peer support curriculum embedded in conference time was feasible and perceived to strengthen emotional leadership among senior EM residents. Reported improvements in communication practices and wellness culture support broader integration of resident-centered peer support training into GME, though findings are limited by single-site design and voluntary participation in the qualitative focus group analysis.

Table 1: Categorized Thematic Analysis From Participant Semi-Structured Interviews

Theme	Theme Definition	Representative Quote(s)
1. Balance Between Emotional Support and Supervision	Residents struggled to balance emotional support with supervisory roles, particularly in high-stress moments.	"How can I be a mentor on shift but also provide critique and growth? … Maybe I caused the emotional tension – this can happen. How do I handle this?"
2. Variable Frequency and Depth of Peer Support	Peer support interactions varied in frequency and depth, influenced by individual style, time, and supportee needs.	"With the bigger check-ins … there is a weird feeling around the time commitment. But afterwards there is a sense of fulfillment."
3. Communication and Culture Shift Wins	The program influenced both communication habits and cultural norms, emphasizing frequent emotional labeling, listening without fixing, and structured debriefing.	"The point isn't to take over the story … but more so letting others talk about their feelings." "I feel like more peer support improved the culture of wellness. Further formalizing it, would only be better."
4. Bolsters for Program Implementation	Participants recommended structural supports like follow-ups, formalization, and more visible resources to sustain the program.	"I feel as though proactively pursuing these skills and this program could be valuable in our high stress specialty." "Can we teach the attendings these skills?"
5. Barriers to Peer Support	Time, emotional capacity, skill decay, and lack of peer awareness limited consistent peer support engagement.	"I sometimes do not know if I can be emotionally stable for them … Is that a great place for vulnerability when I'm distracted?"

28 Trends in Rank Order Preferences of Emergency Medicine Residency Applicants by Applicant Type, 2020 - 2025

Christian Keenan, Matthew Klein, Brian Clyne

Background: Emergency medicine (EM) experienced a sharp decline in total applications in 2022 and 2023 according to National Residency Matching Program (NRMP) data.1,-4. While the number of EM applicants rebounded in 2024 and 2025, their rank order list preferences suggest changes in applicant behavior. While US allopathic (US MD) seniors have long comprised the majority of matched EM applicants, the proportion of osteopathic (DO) and international medical graduates (IMG's) matching into EM has increased significantly in recent years5,6. To our knowledge, there is limited data to describe rank order list position preferences for EM among different types of applicants.

Objectives: To identify trends in EM applicant behavior using NRMP Main Residency Match data, on rank order list preference for different applicant types (US MD, US DO, US-IMG, and non-US IMG) from 2020 to 2025.

Methods: This retrospective analysis utilized NRMP Match results for EM applicants from 2020 to 20257. Four applicant types were included:: US MD seniors, US DO seniors, US IMG's seniors, and non-US IMG's seniors. The NRMP reports rank order list categories as "only choice," "first choice," and "not first choice." We compiled data for each combination of applicant type and rank order list category. The percentage of each applicant type, out of the total number of EM applicants, was calculated. The percentage of applicant type for each rank order preference was calculated.

Figure 1. The percentage of applicants that ranked EM as "not first choice" based on their medical training from 2020 to 2025.

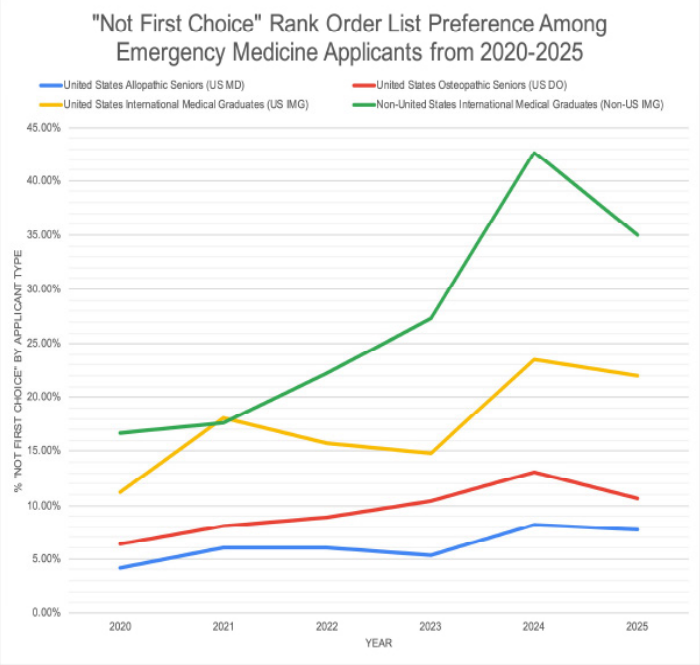

Table 1. The rank order preference rates for United States allopathic (US MD) seniors, United States osteopathic (US DO) seniors, United States international medical graduate (US IMG) applicants, and non-United States international medical graduate (non-US IMG) applicants for 2020 - 2025.

Applicant Type	Year	Total EM Applicants	US MD Senior Applicants		Only Choice		First Choice		Not First Choice	
			#	% EM Applicants	#	% US MD Senior	#	% US MD Senior	#	% US MD Senior
US MD Senior	2025	3,753	1,514	40.3%	1,318	87.1%	78	5.2%	118	7.8%
	2024	3,574	1,386	38.8%	1,218	87.9%	54	3.9%	114	8.2%
	2023	2,765	1,337	48.4%	1,194	89.3%	72	5.4%	71	5.3%
	2022	3,081	1,695	55.0%	1,470	86.7%	124	7.3%	101	6.0%
	2021	3,734	2,081	55.7%	1,816	87.3%	140	6.7%	125	6.0%
	2020	3,323	1,935	58.2%	1,685	87.1%	168	8.7%	82	4.2%
US DO Senior	2025	3,753	1,231	32.8%	1,009	82.0%	91	7.4%	131	10.6%
	2024	3,574	1,171	32.8%	908	77.5%	110	9.4%	153	13.1%
	2023	2,765	799	28.9%	641	80.2%	75	9.4%	83	10.4%
	2022	3,081	850	27.6%	630	74.1%	144	16.9%	76	8.9%
	2021	3,734	1,013	27.1%	756	74.6%	175	17.3%	82	8.1%
	2020	3,323	863	26.0%	641	74.3%	167	19.4%	55	6.4%
US IMG	2025	3,753	469	12.5%	281	59.9%	85	18.1%	103	22.0%
	2024	3,574	486	13.6%	276	56.8%	96	19.8%	114	23.5%
	2023	2,765	366	13.2%	210	57.4%	102	27.9%	54	14.8%
	2022	3,081	255	8.3%	113	44.3%	102	40.0%	40	15.7%
	2021	3,734	304	8.1%	135	44.4%	114	37.5%	55	18.1%
	2020	3,323	304	9.1%	124	40.8%	146	48.0%	34	11.2%
Non-US IMG	2025	3,753	337	9.0%	132	39.2%	87	25.8%	118	35.0%
	2024	3,574	349	9.8%	125	35.8%	75	21.5%	149	42.7%
	2023	2,765	121	4.4%	54	44.6%	34	28.1%	33	27.3%
	2022	3,081	81	2.6%	34	42.0%	29	35.8%	18	22.2%
	2021	3,734	102	2.7%	31	30.4%	53	52.0%	18	17.6%
	2020	3,323	78	2.3%	24	30.8%	41	52.6%	13	16.7%