scholarly tracks within emergency medicine residency programs.

Methods: We conducted a retrospective survey of emergency medicine residency programs with medical education fellowships, as identified through the Council of Residency Directors in Emergency Medicine (CORD) Community of Practice directory. Program leaders received a REDCap-based questionnaire examining scholarly track structure. The survey was open from May to July 2025, during which follow-up reminder emails were sent every two weeks. Data analysis was completed using R.

Results: Responses were received from 39 programs (39/48, 81.3%), with 26 programs (26/39, 66.7%) reporting scholarly tracks, and 23 reporting a medical education track (23/39, 59.0%). . Residents are required to remain in a single track in 42.3% of programs (11/26), while 46.2% (12/26) allows residents to participate in multiple tracks. Of those that responded, the most common meeting frequency was quarterly (8/20), followed by monthly (7/20), bi-monthly (3/20) and semi-annually (2/20). Over half of the education tracks were led by the medical education fellowship director (11/20, 55%), with fellows (3/20, 15%) assistant/associated programs directors (2/20, 10%), and residency program director (1/20, 5%) leading the others. Only 15% (3/20) report FTE buy-down for faculty leading the track, ranging from <0.1 FTE support to 0.2–0.3 FTE.

Conclusion: MedEd tracks differ in structure, logistics, and leadership across EM residency programs. Understanding implementation and leadership for these tracks can help to guide the development of tracks at other institutions as well as improve current tracks.

42 Building Future Educators in Emergency Medicine: A Study of Medical Education Scholarly Track Curriculum

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Background: Scholarly tracks are increasingly integrated into residency training across specialties, including emergency medicine (EM), offering structured opportunities for academic development. While prior studies have examined their impact on career choice and practice settings, detailed characterization of their content and resident requirements remains limited. This study focuses on medical education tracks within EM.

Objectives: Our aim was to determine the essential components and resident requirements of medical education scholarly tracks in EM.

Methods: A retrospective survey targeted all EM programs with medical education fellowships listed on the Council of Residency Directors in EM Community of Practice website. A REDCap questionnaire assessing track content and resident requirements was distributed to fellowship directors from May to July 2025, with biweekly reminders. Topics were based on Core Content for Education Scholarship Fellowships in Emergency Medicine by Yaris et al. Data were analyzed using R.

Results: Responses were obtained from 39 of 48 programs (81.3%). Of these, 23 programs reported having a medical education scholarly track (58.9%). Over 65% included teaching methods, feedback, learning theories, bedside procedural skills, and curriculum design and evaluation (Table 1). Eleven programs required a scholarly project (47.8%): seven required a local/institutional presentation and four required a regional/national presentation (Table 2). Eight programs required an educational presentation (34.8%), most commonly a large-group didactic (4/8, 50%) (Table 2).

Conclusion: This survey highlights key content areas for inclusion in scholarly tracks and suggests curricula can be tailored to time available with residents, ensuring flexibility while maintaining essential components. Nearly half require a scholarly project, providing structured pathways for academic development. Findings may not generalize to all EM programs, as only those with fellowships were surveyed.

Yarris, L. M., Coates, W. C., Lin, M., Lind, K., Jordan, J., Clarke, S., Guth, T. A., Santen, S. A., & Hamstra, S. J. (n.d.). A Suggested Core Content for Education Scholarship Fellowships in Emergency Medicine. Academic Emergency Medicine, 19(12), 1425–1433. https://doi.org/10.1111/acem.12032

Content Area	Frequency (n = 23)	Percentage	Rank
Teaching methods (large group, small group, simulation)	19	82.61	1
Providing effective feedback	17	73.91	2
Learning theories	16	69.57	3
Bedside teaching and teaching procedural skills	15	65.22	4
Curriculum design and evaluation	15	65.22	4
Mentorship training	13	56.52	6
Simulation education and case development	12	52.17	7
Critical appraisal of literature	11	47.83	8
Development of CV and/or educator's portfolio	11	47.83	8
Creating career goals	11	47.83	8
Microteaching strategies	10	43.48	11
Simulation techniques and applications	10	43.48	11
Administration topics	8	34.78	13
Research methods	8	34.78	13
Effective remediation and managing difficult learners	5	21.74	15
Program evaluation	4	17.39	16
ACGME requirements	3	13.04	17
Proper peer review techniques	3	13.04	17

Table 1: Content Topics Included in Medical Education Scholarly Track Curriculum (n=23).

	Frequency	Percentage
Track Requirement (n=23)		
Complete a Scholarly project	11	47.83
Lead Education Presentation	8	34.78
Presentation Location (n=11)		
Present at a local/institutional research meeting	7	63.64
Present at a regional/national research meeting	4	36.36
Type of Education Presentation (n=8)		
Large Group Didactic	4	50.00
Small Group Didactic	2	25.00
Simulation	1	12.50
Clinical/Bedside Teaching	1	12.50

Table 2. Requirements for Residents Participating in Medical Education Scholarly Tracks

43 Evaluating Operational Impacts of On-Shift Morning Report in the Emergency Department

Steffen Simerlink, Andrew Golden

Background: EM residency education often relies on didactics outside of clinical care, with limited structured teaching during shifts due to concerns about effects on ED operations. Morning report, a brief daily didactic session, is widely used in other specialties but less common in EM. We implemented a daily fifteen-minute morning report during clinical shifts to provide focused education. Its operational impact is not well described.

Objectives: The objective of this study is to evaluate the impact of morning report on ED throughput metrics. We hypothesized no significant operational changes after implementation of structured daily teaching.

Methods: This retrospective observational cohort study was conducted in a high-volume, urban academic ED. Morning report occurred daily at 0930 and was faculty-facilitated. ED encounters from six months before (pre) and six months after (post) implementation were utilized, comparing patients arriving during morning report and those arriving 0700-1100 outside of morning report. Outcomes included arrival-to-provider time, ED length of stay (LOS), provider-to-disposition time, time to analgesia, and ED mortality, with subgroup analysis by ESI level.

Results: 11,765 visits were analyzed (pre n=5,835; post n=5,930). Overall LOS was similar (480.7 vs. 492.1 min, p=0.37) and provider-to-disposition time was unchanged (311.3 vs. 303.7 min, p=0.72). Arrival-to-provider time increased slightly (38.0 vs. 44.3 min, p<0.001). Time to analgesia showed no significant overall difference (240.9 vs. 288.1 min, p=0.06). Among ESI-3 patients, LOS (541.0 vs. 693.4 min, p<0.001) and time to analgesia (264.5 vs. 406.7 min, p<0.001) increased. ED mortality did not change.

Conclusions: Morning report was implemented without major effects on ED throughput; however, there were significant trends by patient acuity, with greater impacts among ESI-3 patients. These differences highlight the need to consider patient level impacts when integrating structured educational activities into clinical shifts.

44 Does Chief Residency Impair In-Service Training Exam Performance or Reduce First-Attempt Board Pass Rates?

Brian Walsh, Fred Fiesseler

Background: Chief residency is a prestigious leadership position in medical training programs, often involving increased administrative, teaching, and clinical responsibilities. Concerns exist that these duties may detract from personal study time, potentially impairing performance on in-service training exams (ITE) and reducing first-attempt pass rates on the ABEM Qualifying Board Exam. This study investigates whether serving as a chief resident is associated with diminished ITE score improvements or lower board pass rates compared to non-chief residents.

Methods: We conducted a retrospective cohort analysis of 85 internal medicine residents from a single program over multiple years. Data included raw and percentile ITE scores for postgraduate years 1, 2, and 3, along with score changes (deltas) between years, and first-attempt board pass status. Residents were categorized as chief residents (n=20) or non-chief residents (n=65). Descriptive statistics (means ± standard deviations) were calculated for scores and deltas. Independent t-tests compared continuous variables between groups, and chi-square test assessed differences in pass rates. Statistical significance was set at $p<0.05$.

Results: Baseline PGY1 raw ITE scores were similar between chief and non-chief residents (70.85 ± 6.48 vs. 70.82 ± 7.14, p=0.98). PGY2 scores (75.85 ± 6.88 vs. 76.82 ± 6.09, p=0.55) and PGY3 scores (79.45 ± 6.25 vs. 79.68 ± 6.47, p=0.89) also showed no significant differences. Score improvements from PGY1 to PGY2 were comparable in raw scores (delta: 5.0 vs. 6.0, p=0.54). From PGY2 to PGY3, raw deltas (3.6 vs. 2.86, p=0.62) and percentile deltas (3.5% vs. -1.31%, p=0.48) likewise did not differ significantly. First-attempt board pass rates were 6.2% higher for non-chiefs, but this result was non-significant (chi-squared=0.10, p=0.75), indicating no association with chief status.

Conclusions: Chief residency does not appear to impair ITE performance or reduce first-attempt pass rates on the ABEM Qualifying Exam. Chiefs maintained equivalent scores and improvements despite added responsibilities, suggesting that leadership roles may not compromise academic outcomes. These findings support encouraging high-performing residents to pursue chief positions without fear of negative impacts on certification.