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Objectives: To describe an innovative process using AI-driven tools to generate, refine, and validate clinical and communication scenarios for the ABEM Certifying Exam.

Methods: We designed a pilot framework integrating large language models (LLMs) with expert review. AI was tasked to create case prompts aligned with ABEM's EM Model and Knowledge, Skills, and Abilities (KSAs), incorporating undifferentiated presentations, prioritization challenges, and difficult conversations. Generated cases were iteratively refined through faculty feedback for accuracy, cultural sensitivity, and alignment with scoring rubrics. Scenarios were tested for variability, clarity, and adaptability for standardized patient scripts and simulation environments (Supplement 1).

Innovation: AI enables rapid generation of diverse, evidence-based cases that mirror real-world complexity. Features include dynamic branching logic for evolving patient conditions, embedded communication challenges, and customizable difficulty levels. This approach supports scalability, reduces cognitive load for case developers, and allows continuous updates as exam content evolves. Integration with simulation platforms and standardized patient

Across Performance Script: Difficult Conversation Scenario

Character: Sarah White, 30-year-old female

Context and Background: You are Sarah White, the devoted daughter of George White, a healthy and active 65-year-old. He was brought to the Emergency Department about 2 hours ago with chest pain. You've only been informed that he experienced chest discomfort and was taken to the hospital. You have a strong emotional bond with your father and are currently anxious, hopeful, and deeply worried.

Physician Enters the Room:

- **Physical cues:** Stand up slightly, anxious posture, wringing hands gently, eyes searching physician's face.
- **Tone:** Urgent but hopeful.
- **Line:** "Yes, I'm Sarah. Please, how is my dad? What's happening?"

Upon Receiving Clear and Empathetic News of Your Father's Death:

- **Initial shock:** Freeze momentarily, eyes widen, breath quickens.
 - **Tone:** Trembling, disbelief.
 - **Lines:** "No, that can't be right. Please, check again. There's been a mistake."
- **Seeking Information:** Lean forward slightly, voice urgent and distressed, tears forming.
 - "How could this happen so quickly? Was he in pain?"
 - "Was someone with him? Did anyone help him right away? Did he ask about me?"
- **Emotional Breakdown:** Allow yourself to visibly and audibly become emotional, breaking into tears, voice cracking.
 - "I don't understand! He was always so careful with his health. We had plans... He was my everything."
 - "How am I supposed to accept this? I just spoke to him."
- **Next Steps:** Attempt to compose yourself slightly but remain overwhelmed, searching physician's face for comfort.
 - "I need to see him. Can I go to him now?"
 - "What am I supposed to do now? Who should I call first? Please guide me."

If Physician's Explanation is Unclear:

- **Show confusion mixed with desperation:**
 - "Is there something else I need to know right now?"
 - "Are there papers to sign, or anything immediate I need to handle?"

Alternate Responses Based on Physician's Approach:

Lacking Empathy or Cold:

- **Physical cues:** Draw back slightly, defensive posture, voice hurt and raw.
- **Lines:**

- "How can you speak about him like that? He was my father—he deserves better!"
- "He might be just another patient to you, but he's my dad. Show some compassion!"

Condescending Manner:

- **Physical cues:** Stand straighter, assertive posture, maintain firm eye contact.
- **Lines:**
 - "I'm grieving, not ignorant. Don't speak down to me."
 - "I'm here for answers, not to be treated like a child."

Excessive Medical Jargon:

- **Physical cues:** Lean forward, confused, shaking head slightly, voice pleading.
- **Lines:**
 - "Please stop—I don't understand these medical terms. Can you explain clearly?"
 - "None of that makes sense right now. Just plainly tell me what happened to my father."

Acting Tips:

- Transition naturally from initial hopefulness to shock, disbelief, grief, and desperation.
- Allow your emotional state to evolve authentically based on physician's tone and clarity.
- Maintain emotional authenticity and vulnerability throughout, enhancing realism and challenging the physician's empathy and communication skills.
- Use physicality and facial expressions deliberately to convey your internal emotional turmoil clearly and convincingly.

training enhances realism and standardization.

Conclusions: By accelerating scenario development under expert oversight and enhancing realism, this approach strengthens exam validity and fairness while reducing resource demands. Future evaluation will examine scenario quality, scoring consistency, and candidate experience during pilot testing.

3 Bridging the Practical Teaching Gap: A Needs-Based Faculty Development Curriculum in Emergency Medicine

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Introduction: Academic Emergency Medicine (EM) faculty are expected to function as effective educators regardless of formal educational roles or training. However, practical teaching skills are rarely emphasized in traditional faculty development. A needs assessment of our academic EM faculty revealed significant discomfort and limited formal training in these areas. As expectations for inclusive, learner-centered clinical environments increase, a structured, practical, and accessible faculty development model is needed to address these gaps and strengthen day-to-day teaching practices.

Educational Objectives: Our primary educational goal is to provide continuing education on practical teaching topics to academic faculty. At the completion of our curriculum, our faculty should be able to (1) describe best practices regarding bedside teaching and procedural supervision, (2) model essential education leadership skills, and (3) develop and utilize a community of practice of likeminded academic emergency medicine educators.

Curriculum Design: Our curriculum design utilizes Kern's conceptual framework. Our targeted needs assessment included

a survey completed by our academic faculty group serving to identify areas of discomfort. This informed our individual session goals and objectives. Our educational strategy integrates a monthly, needs-based faculty development series embedded within resident conference time. Each one-hour session, led by Education Division faculty, includes an open discussion of challenges, a 20-minute review of best practices based on relevant frameworks or literature, and think-pair-share exercises focused on translating concepts into clinical teaching practice. Curriculum evaluation is conducted through post-session surveys with questions related to effectiveness of the curriculum and barriers to implementation.

Impact: To date, 89% of faculty participants reported the sessions as effective, citing peer discussion and practical frameworks as key strengths. Scheduling conflicts were identified as the primary limitation, prompting exploration of alternative timing and potential asynchronous options. Our future plans include expanding content to address teaching medical students and incorporating objective measures of teaching behavior change.

4 Food for Thought: A Recipe for Cooking up Useful Faculty Feedback

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Introduction: Feedback is a critical component of continued professional development. However, the ability to generate actionable, resident-to-attending feedback is a common challenge. On one hand, residents are concerned that specific feedback can abate anonymity. On another, individual feedback does not provide a collective consensus and risks being dismissed as one's unique perspective. We sought to create a setting in which residents provide feedback as a collective to uphold anonymity and facilitate discussion of faculty strengths and areas for growth. While literature can be found on the importance of attending-to-resident feedback, far less has been published on improving resident-to-attending feedback.

Objective: Enhance faculty development by creating an anonymous mechanism to provide consensus faculty feedback

Curricular Design: Residents met bi-monthly to formally evaluate faculty on a series of categories derived from the ACGME Clinician Educator Milestones including professionalism in the learning environment, learner assessment ability, feedback generation and delivery, and overall culture of well-being. Divided into three groups, residents were tasked to generate specific comments as a unified voice. Each cycle, deidentified feedback was shared and discussed with the program director (PD) for incorporation in the department's annual review process.

Impact/Effectiveness: The feedback from this process, alongside individual feedback methods (unchanged from prior years), received a dramatically positive faculty response.

As documented on our ACGME Faculty survey of "Faculty member satisfied with process for evaluation as educators," our score went from a Program Mean 3.7/5 to 4.8/5, with a corresponding rise in %Program Compliance from 60% to 100%. Teaching pearls/methods appreciated by residents were also shared at monthly faculty meetings to promote faculty development. This feedback format can be broadly implemented to enhance faculty development.

5 Advancing Health Equity Through Hybrid Emergency Medicine Education in Phnom Penh, Cambodia

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Introduction: Emergency Medicine (EM) is not yet a recognized specialty in Cambodia, and recent assessments highlight major gaps in emergency care capacity. At a private medical university in Phnom Penh, we piloted a short "Introduction to EM" course for senior medical students using a hybrid virtual and in-person model to expand access to foundational resuscitation concepts.

Background: Hospitals in Cambodia have limited emergency care capacity at this time and few opportunities for structured EM training, with education identified as a key gap. To help address this, we contacted local deans to gauge interest in exposing students to emergency assessment frameworks and essential resuscitation skills. Local leadership supported logistics and in-person activities. This pilot aimed to introduce core EM concepts and demonstrate how structured EM education could complement existing training.

Educational Objectives: Introduce EM principles; emphasize recognition of high-risk diagnoses and early critical actions; provide hands-on skills practice; and model a hybrid approach to expand access to specialty education.

Curricular Design: 29 virtual sessions were conducted over 10 weeks used case-based discussions focused on early recognition of life-threatening conditions. A 3-day in-person practicum followed, during which students rotated through procedural skills, simulation, and clinical encounters reinforcing communication, rapid assessment, and foundational resuscitation techniques. This course was conducted in English, the school's language of instruction.

Impact/Effectiveness: This pilot demonstrated the feasibility of hybrid EM education to bridge geographic distance and resource limitations and expand access to specialty content not readily available locally. Further development will require a deeper needs assessment to understand the existing curriculum, identify priority gaps, and determine how an EM course can best integrate with current pathways. This early effort may support broader growth in emergency care education and capacity building in Cambodia.