

and were modified or eliminated. After refinement, S-CVI/Ave values for most checklists and global rating scales approached or exceeded 0.80, indicating stronger content validity

Table 1: Expert Ratings, Item-Level Content Validity Index (I-CVI), and Scale-Level Content Validity Index (S-CVI) from Round 1 Review of Four Assessment Tools: (1) UVC Task-Specific Checklist, (2) OSATS-UVC, (3) Lumbar Puncture Task-Specific Checklist, and (4) OSATS-Neonatal LP. Items rated "relevant" or "quite relevant" were scored 1; items rated "somewhat relevant" or "not relevant" were scored 0. NA = No answer.

TASK-SPECIFIC CHECKLIST-UVC								
Item	Expert #						I-CVI	
	1	2	3	4	5	6		
1	Creates and maintains a sterile field	1	1	0	1	1	1	0.83
2	Ties umbilical tape around the base of the umbilicus	1	1	1	1	1	1	1
3	Selects appropriate sized catheter based on patient's weight	1	0	1	1	1	1	0.83
4	Grasps umbilical cord with forceps and cuts cord perpendicularly with #10 or #11 blade scalpel to expose umbilical vasculature	1	1	1	0	1	1	0.83
5	Correctly identifies the umbilical vein	0	1	1	1	1	1	0.83
6	Inserts catheter into umbilical vein, to appropriate depth, which is when blood freely flows through the catheter, but no more than 5 cm	0	1	1	0	1	1	0.67
7	Applies an appropriate method to secure the umbilical line (transparent dressing, sutures, or H-tape method)	1	1	0	1	1	1	0.83
8	Would you allow this individual to perform an UVC unsupervised and independently on your next patient? Yes or no?	1	0	1	1	1	1	0.83
S-CVI/Ave								0.83
OSATS-UVC								
1	Instrument Handling	1	0	1	1	1	1	0.83
2	Respect for tissue	0	0	0	0	1	1	0.33
3	Time & Motion	0	0	1	1	1	0	0.5
4	Knowledge of specific procedure	0	1	1	1	1	1	0.83
5	Competency Evaluation	0	0	1	1	1	1	0.67
S-CVI/Ave								0.63

TASK-SPECIFIC CHECKLIST LUMBAR PUNCTURE								
0	New Scoring System (1,2,3)	1	1	1	1	1	1	1
1	Plans Insertion Site	1	1	1	1	1	1	1
2	Preparation	1	1	1	1	1	1	1
3	Cleanses	1	1	1	1	1	1	1
4	Maintains sterility	1	1	0	1	1	1	0.83
5	Instructs holder	1	1	1	1	1	1	1
6	Inserts Needle	1	1	1	1	1	1	1
7	Advances needle	NA	1	1	1	1	1	1
8	Makes corrections	1	1	1	1	1	1	1
9	Acquires fluid	1	1	1	1	1	0	0.83
10	Removes needle	0	1	1	1	1	1	0.83
11	Discards Sharps	1	1	1	1	1	1	1
12	Competency evaluation	1	0	1	1	1	1	0.83
S-CVI/Ave								0.95
OSATS-NEO LP								
1	Instrument Handling	1	1	1	1	1	1	1
2	Tissue Handling	1	1	1	1	1	0	0.83
3	Time & Motion	1	1	1	1	1	1	1
4	Knowledge of Procedure	1	1	1	1	1	1	1
5	Decision-Making and Adaptability	1	1	1	1	1	1	1
6	Competency Evaluation	1	1	1	1	1	1	1
S-CVI/Ave								0.97

evidence. Some individual items remained below threshold, but overall scale-level metrics improved.

Conclusions: CVI methodology offered a systematic approach for refining simulation-based assessment tools for neonatal LP and UVC. The resulting instruments demonstrate improved content validity and may strengthen evaluation practices in procedural training. Limitations include the small expert sample and absence of further validation evidence.

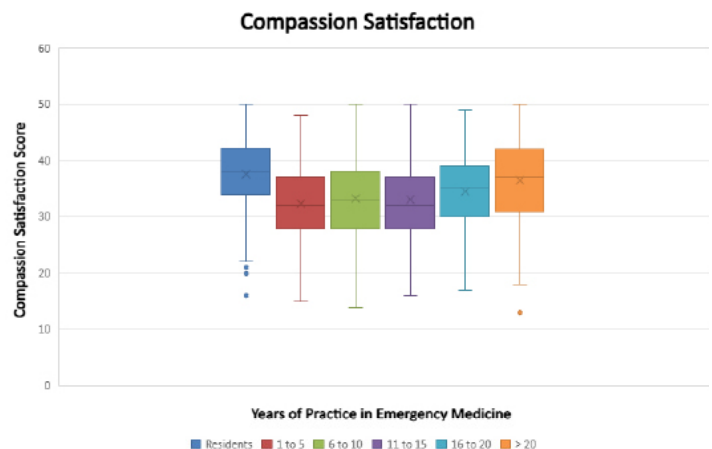
50 Compassion Satisfaction, Burnout, and Secondary Traumatic Stress Across Career Stages in Emergency Medicine Physicians

Tuan Vo, Rebecca Jeanmonod, Donald Jeanmonod

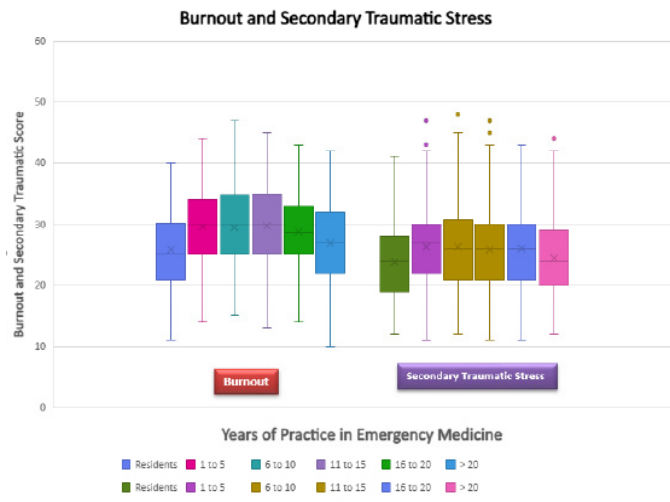
Background: Emergency physicians (EPs) work in high-pressure environments where compassion satisfaction (CS) can coexist with burnout (BO) and secondary traumatic stress (STS), the key components of compassion fatigue. This study evaluates CS, BO, and STS across career stages and examines differences between trainees and attendings.

Methods: A cross-sectional survey using the validated Professional Quality of Life (ProQOL) tool was distributed anonymously to practicing and training EPs in the United States. Demographics were collected. Chi-Square and Kruskal-Wallis tests were used, with significance set at $p < 0.05$.

Results: A total of 1,170 EPs participated: 503 male (42.99%), 658 female (56.24%), and 9 identifying as other (0.77%). Respondents included 166 residents (14%), 192 EPs within 5 years post-graduation (16%), 240 with 6–10 years (21%), 240 with 11–15 years (21%), 144 with 16–20 years (12%), and 188 with >20 years (16%). Significant differences across career stages were found for CS ($p = 1.99E-15$), BO ($p = 6.73E-11$), and STS ($p = 9.0E-4$). CS demonstrated a U-shaped trend—highest among residents and >20-year EPs, with lower levels in mid-career. BO and STS followed inverted U-shaped trends, peaking in mid-career and lowest among trainees and late-career EPs.



Discussion: Mid-career EPs appear most vulnerable to burnout and STS, potentially due to cumulative system pressures, increasing administrative responsibilities, evolving leadership roles, job transitions, and expanding clinical and non-clinical duties. In contrast, higher CS among residents and late-career EPs may reflect strong training environments, structured support systems, the development of long-term coping strategies, and more stable, established practice settings. These patterns suggest that the career stage plays a significant role in EP well-being. Targeted, career-specific wellness strategies—particularly those aimed at supporting mid-career physicians—may help mitigate burnout and enhance compassion satisfaction across the professional lifespan.



51 Embedded Palliative Care in the Emergency Department Enhances Resident Confidence and Competency

Aarsh Shah, Jacqueline Nicholas, Rahul Nayar, Tracey Piparo, Paul Peng, Jonathan Briganti, Erick Ferreras

Background: Early initiation of palliative care (PC) in the emergency department (ED) has been shown to improve patient-centered outcomes. However, barriers exist among emergency medicine residents, including limited education in PC and decreased confidence in serious illness symptom management and goals of care (GOC) discussions. No research has examined how an embedded-PC clinician providing on-site clinical guidance influences emergency medicine residents’ primary PC competencies.

Objectives: Evaluate residents’ PC knowledge, clinical competency in symptom management, and GOC discussions during exposure to an ED-embedded palliative care physician associate (PCPA).

Methods: Observational, qualitative study at an urban academic ED from January 1, 2025, to October 1, 2025, where a PCPA (intervention) was present during business hours. Residents

completed post-intervention surveys at 3 months and 9 months, assessing PC understanding and confidence with symptom management and GOC discussions. The nonparametric Wilcoxon signed-rank test was used to compare the two related groups.

Results: A total of 23 and 19 residents completed surveys at 3 and 9 months, respectively. After 9 months, statistically significant improvements were found across all three domains: PC knowledge ($p = 0.013$), self-reported comfort with pain and symptom management ($p = 0.035$), and GOC conversation confidence ($p < 0.001$) (Figure).

Conclusions: Integrating PCPA exposure into resident training significantly improved residents’ knowledge of PC and self-reported confidence in managing acute palliative symptoms and leading GOC discussions. This aligns with ACGME core competencies and addresses known educational gaps in resident training. Formalised PC integration should be considered as a necessary curriculum component to enhance patient-centred, compassionate care.

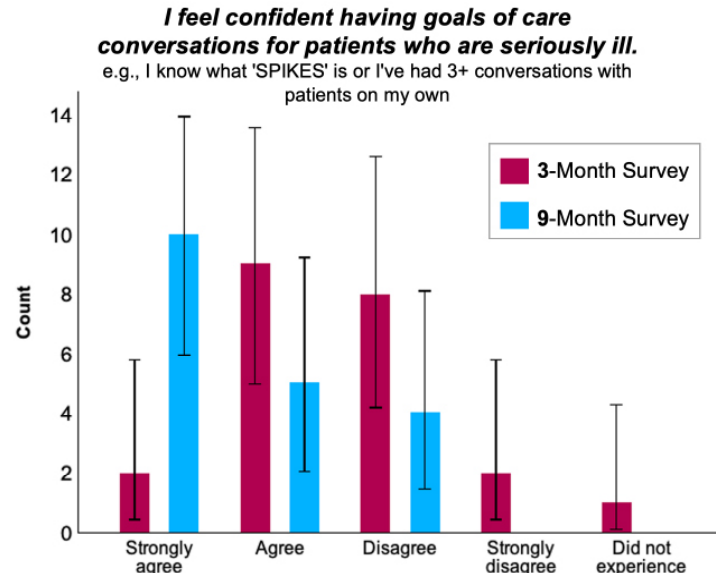


Figure. Confidence of residents to have GOC conversations at 3 months and 9 months

52 Training Gaps in Emergency Medicine Procedural Complication Management

Noah Huff, Manasa Jaishankar, Enola Okonkwo, Nicole Rettig, Rebecca Lipscomb, Steven Garay-Morales, Rahul Mhaskar, Shreya Narayanan, Jordan Beau

Background: Procedural complications are an inevitable part of EM practice, yet training in technical execution, risk communication, and psychosocial support is variable and understudied. Understanding formal and informal training’s impact on EM resident preparedness is critical for patient safety and clinician well-being.