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Virtual Standardized Direct Observation Tool (v-SDOT)

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shifting simulation online. It is unknown if online simulation software, such as Full Code, represents an appropriate tool for simulation-based training.

Objective: We aim to assess Full Code, a commercial virtual simulation program, as an objective assessment of medical student performance in an EM Clerkship and Sub-Internship (Sub-I).

Design: Third-year (MS-3s) and fourth-year medical students (MS-4s) completed Full Code assessments during their EM clerkships and Sub-I during the pandemic. Full Code is a virtual simulation offered by Minerva Medical (<https://full-code.com/>). Our institution purchased a 1-year software license. Students had access to >100 virtual cases and participated in faculty-facilitated practice session, in lieu of in-person simulation. Students completed 3 Full Code cases as part of their clerkship grade, each of which aligned with course objectives. The grade for cases was calculated using Full Code's internal scoring system and counted for 15% of the overall course grade.

Impact: On review of 120 MS-3 and 24 MS-4 students, the average final scores were 81.99% and 81.37%, respectively. For MS-4 students, there was no statistical difference between average score on the Full Code assessment and other assessments (departmental clerkship exam, shift evaluations). For MS-3 students, average score on the Full Code assessment was statistically higher than other forms of assessment (EM NBME Subject Exam, shift evaluations). Full Code represents a feasible alternative to simulation experiences in EM student courses. Next steps will evaluate the Full Code scoring system to determine if assessing for only critical actions represents a reliable proxy for student knowledge and performance, and evaluating whether the number of practice cases completed correlates with exam performance.

59 Virtual Simulation-Based Workshop for Addressing Patient Discrimination Against Trainees

Kimberly Sokol, MD, MS, MACM; Lauren Bacon, MD

Learning Objectives:

- 1.State 4 communication strategies medical trainees can use when faced with patient discrimination.
- 2.Apply those 4 communication strategies to actual patient scenarios.
- 3.State the resources available to employees at their hospital when faced with discriminatory patients.

Abstract:

Introduction: Incidents of patient discrimination towards medical residents can present intense challenges for them as they go through their training. There is, however, little guidance provided to resident physicians when faced with these challenges. In an effort to address this, we instituted

a virtual simulation-based workshop to help trainees better navigate such encounters as they occur in the moment.

Educational Objectives:

- 1.State 4 communication strategies medical trainees can use when faced with patient discrimination.
- 2.Apply those 4 communication strategies to actual patient scenarios.
- 3.State the resources available to employees at their hospital when faced with discriminatory patients.

Curricular Design: We created a workshop to address discrimination towards medical trainees. It was a single 2-hour session that involved resident physicians from several specialties including emergency medicine, core faculty members, and program coordinators. Learners went through two virtual simulation scenarios depicting discrimination against trainees. In between the scenarios, the learners underwent a lecture in which they learned 4 different communication strategies to help them more effectively manage the discrimination. The second scenario was therefore used to help the learners put their knowledge into practice. Pre- and post-session questionnaires were distributed to evaluate the workshop in terms of learning and satisfaction.

Impact/Effectiveness: The workshop was effective in teaching strategies for managing patient discrimination in real time. Attendees expressed the desire for us to create similar workshops to include discrimination by attending physicians and advised the broader incorporation of hospital personnel; we are currently working on these. While prevention of these situations would be the ultimate goal, in the meantime, we can at least place our attention on giving our residents the tools to better manage these situations.

60 Virtual Standardized Direct Observation Tool (v-SDOT)

Amber Billet, MD; Robert Clontz, MD; Hieger Michelle, DO

Learning Objectives:

1. For attending physicians to complete a virtual SDOT instead of an in-person SDOT.
2. To provide emergency medicine residents real time feedback at the completion of the v-SDOT.

Abstract:

Introduction/Background: Resident feedback is an ACGME common program requirement. Feedback serves to help identify a resident's strengths and areas for improvement. It also aids residency leadership in identifying those individuals who may need extra educational assistance. One of the most common ways residency programs evaluate residents is through a standardized direct observation tool (SDOT). Traditionally, these individual resident SDOTs are completed by attending physicians in person. During the covid-19 pandemic, virtual video-based SDOTs (v-SDOT) were performed.

Curricular design: At a community academic emergency medicine residency program, with approximately 86,000 visits per year, two board certified emergency medicine attending physicians performed v-SDOTs on ten EM-2 and EM-3 residents. These v-SDOTs were performed by utilizing a video conferencing software program (Zoom) installed on a portal electronic tablet. The average total v-SDOT duration was 2 hours.

Impact/Effectiveness: The innovation for a v-SDOT was implemented for the first time during the covid-19 pandemic from June 1, 2020 to November 1, 2020. The v-SDOT enabled residents to receive feedback without requiring attending physicians to be physically present in the department. This decreased the attending's possible covid-19 exposure and

helped to conserve personal protective equipment.

Based on resident survey results, 2 preferred v-SDOTs compared to live, 3 preferred live compared to virtual, 2 had no preference and 3 did not reply. Residents felt that both virtual and live SDOTs were equally distracting. Utilizing v-SDOTs has the advantage of attending physicians being able to complete these remotely. There was a perceived advantage that the residents may be less likely to ask the attending for advice in the v-SDOT format, making it a more realistic patient encounter.

Potential limitations of v-SDOTs include poor internet connectivity, tablet limitations such as attending field of view and microphone clarity/range, and the resident not carrying the tablet with them for the entire observation period.