resources available to manage these issues, and ultimately the confidence to pass this education on to their patients.

71 What's Wrong with Me, Doc? Applying A Curriculum for Communicating Diagnostic Uncertainty in The Emergency Medicine Clerkship

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Background: Diagnostic uncertainty is ubiquitous in emergency medicine (EM). Training to prepare students to communicate uncertainty with emergency department (ED) patients is limited in UME. Previous work has integrated the Uncertainty Communication Checklist (UCC) in EM resident education. Implementation in the EM clerkship has not yet been examined. We developed a curricular intervention that implements uncertainty training into the EM clerkship for third-year medical students.

Objectives: Students will be able to describe diagnostic uncertainty and its impact on patients and provider, explain the UCC during patient conversations, practice using checklist during simulated encounters, and apply the checklist to patient conversations on shift.

Curricular Design: At our institution, students complete a required 3-week EM clerkship. Students were first tasked with completing prework in the form of an Articulate Rise module on communicating diagnostic uncertainty. An additional didactic session was included in the clerkship orientation. Students then engaged in peer role play, as either patient or physician during a simulated case of discharging a patient with an uncertain diagnosis. The session ended with a debriefing. While in the department, we assessed students' performance in applying each aspect of the checklist while communicating diagnostic uncertainty with patients through a standardized direct observation tool.

Impact: As students grapple with diagnostic uncertainty during their EM clerkship for the first time, the clerkship itself may serve as an ideal time to implement training on navigating these conversations. The breadth of patient encounters in the ED allows for deliberate practice of this skill. The UCC was successfully implemented into our clerkship. Initial data shows that students perform well and complete most elements of the checklist (83%). We plan to continue with implementation, data collection, and dissemination of this innovation.

72 Sub-internship Simulation Curriculum to Enhance Medical Student Preparedness for Practice

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Background: Simulation and procedure work-shops in Emergency Medicine (EM) training aid in the development of procedural competence, recognition of disease processes, and help address a lack of clinical experience to better prepare medical students for residency training. We developed a simulation curriculum for our senior medical student EM rotation incorporating procedural practice and exposure to high acuity clinical scenarios.

Objective: Develop an EM clerkship curriculum focused on teaching common procedures and exposure to high acuity clinical scenarios via simulated cases appropriate for fourth year medical students.

Methods: All the residents at a three-year EM program were surveyed using an anonymous questionnaire in Google Forms. Resident wellness was assessed using the Depression, Anxiety and Stress Scale (DASS), a validated psychometric scale that is used across multiple industries. Using a 5-point Likert scale, residents were also asked how often they feel like they are the victim of microaggressions: 1: never or almost never to 5: very frequently. The term "microaggressions" was not defined, allowing residents to determine what they feel it to be. Pearson product moment correlation between the two variables was calculated and statistical significance to $p<0.05$ was determined.

Results: 20 out of 27 residents responded to the questionnaire. Seven residents scored for at least mild depression (three severe), nine residents scored for at least mild anxiety (five severe), and 11 residents scored for at least mild stress (one severe). The average rating on the frequency of being the victim of microaggressions was 2.2 (95%CI: 1.6, 2.7), suggesting residents infrequently felt victimized by microaggressions. The Pearson correlation between Depression and the frequency of microaggressions is $r=0.56$ ($p=0.01$), between Anxiety and microaggressions is $r=0.41$ ($p=0.07$, NS), and between Stress and microaggressions is $r=0.63$ ($p=0.004$)

Conclusion: This study suggests there is a correlation between depression/stress and a residents' perception of being victimized by microaggressions. It is unclear whether being the victim of microaggression leads to more depression/stress or if residents with more depression/stress view comments as being more insulting. Certainly, this subject merits further study.