faculty (46) and administrators such as Chairs (7), Vice Chairs (8) and Research Directors (7) also responded. 21 responded “other”, of which the majority were Clerkship Directors (9). Likert responses are reported in Table One. 214 (97.14%) stated that the loss of protected time would impact their ability to perform their jobs. Table 2 summarizes the 94 open-ended responses. Negative impact to stated core ACGME values such as the educational environment, scholarly output, resident evaluation/remediation, and the patient care environment were all noted.

Conclusions: The self-reported anticipated impact by EM faculty concerning the ACGME changes to the CPR appear mostly negative. The overwhelming majority of respondents anticipate a very strong negative impact from these changes on their job satisfaction, their personal well-being, and the experiences of their residents in training. Particularly concerning are their reported potential for negative impact on their ability to perform their academic duties for their residents and their unwillingness to continue their current positions considering these changes.

Table 1. Self-reported impact of Accreditation Council for Graduate Medical Education Common Program requirement changes.

<table>
<thead>
<tr>
<th>Question Anchor</th>
<th>No Impact, Will Continue</th>
<th>Minimal Impact</th>
<th>Job Throttled</th>
<th>Max Negative Impact on Future</th>
<th>Weighted Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job Satisfaction</td>
<td>6.5%</td>
<td>1.6%</td>
<td>1.8%</td>
<td>12.8%</td>
<td>17.5%</td>
</tr>
<tr>
<td>Personal Well-Being</td>
<td>1.5%</td>
<td>2.1%</td>
<td>2.6%</td>
<td>25.3%</td>
<td>33.9%</td>
</tr>
<tr>
<td>Negative Impact on Training</td>
<td>6.5%</td>
<td>1%</td>
<td>2%</td>
<td>22%</td>
<td>33%</td>
</tr>
<tr>
<td>Likelihood to Continue</td>
<td>2.4%</td>
<td>1.6%</td>
<td>2.7%</td>
<td>10.8%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Table 2. Qualitative analysis and selected responses.

**Table 2**: Qualitative Analysis and Selected Responses

- **Top 10 Qualitative Themes in Order of Frequency**
  - Negative impact on the educational program, including lectures, simulation, ultrasound, mentoring/coaching.
  - Institutional focus on “mandatory minimum” will result in increased clinical responsibility leaving no time to perform faculty responsibilities.
  - Negative impact on faculty wellness. This includes statements about the impact of shift work (ie: “on call”).
  - Negative impact on the recruitment and retention of academic faculty.
  - Negative impact on the future of the specialty.
  - Negative impact on research and scholarly output.
  - Negative impact on patient care and administrative (medical direction) oversight of the clinical environment.
  - Negative impact on the ability to evaluate and remediate residents.
  - Negative impact on medical students.
  - No impact

- **Selected Responses**
  - “The ACGME is in the business of guaranteeing educational experience and patient safety. This makes no sense to me.”
  - “This is the faculty equivalent of Service vs. Education.”
  - “Education is a Professional Commitment. This takes time.”
  - “We perform high acuity shift work. This ultimately impacts our ability to educate as such.”
  - “A similar argument is how the care maximum hours a resident can work is 80 hours average but EM has a maximum of 60 hours.”
  - “It appears that the ACGME is asking to perform all these tasks (generate lectures, quality improvement, remediation, interviews, CCC) as volunteers.”
  - “More and more of the education of EM residents must come from times when we are not directly assigned to clinical duties.”
  - “Education takes time. If there is no time, is there potential for education?”
  - “This would be a climate change that will make the academic emergency physician extinct.”
  - “Yes I would quit. But I am confident they could find a schtick to fill in for a while.”

CCC, clinical competency committee.

3. Do Personality Characteristics Vary by Gender in Emergency Medicine Residents?

Jordan J, Maculatis M, Linden J, Schneider J, Hem H, Marshall J, Wills C, Friedman A, Yarris L / UCLA, Ronald Reagan UCLA Medical Center, Los Angeles, California; Kantar Health, New York, New York; Boston University School of Medicine, Boston, Massachusetts; Alameda Health System - Highland Hospital, Oakland, California; Maimonides Medical Center, Brooklyn, New York; J3Personica, Eatontown, New Jersey; Oregon Health and Science University, Portland, Oregon

**Background:** Understanding and assessing trainee personality characteristics may be helpful to medical educators and program leadership in a variety of applications, including specialty advising, residency selection, faculty selection, mentoring, coaching, and remediation.

**Objectives:** This study aimed to understand gender differences in personality characteristics of emergency medicine (EM) residents.

**Methods:** In this cross-sectional study, a convenience sample of residents (N=140) at five EM residency programs in the United States (U.S.) completed three personality assessments: the Hogan Personality Inventory (HPI) – describing usual tendencies, the Hogan Development Survey (HDS) – describing tendencies under stress or fatigue, and the Motives Values and Preferences Inventory (MVPI) – describing motivators. Independent-samples t-tests were performed to examine differences between male and female EM residents across programs. To evaluate the magnitude of sex differences, standardized effect sizes (Cohen’s d) were estimated, using the thresholds reflecting small (d≤.20), medium (d=.50), and large (d≥.80) mean differences.

**Results:** One hundred forty (100%), 124 (88.6%), and 121 (86.4%) residents completed the HPI, HDS, and MVPI respectively. T-test results comparing male and female EM residents on all personality measures are displayed in Table 1. For the HPI, male EM residents scored significantly higher than females in Inquisitiveness (M=67.6 vs. M=47.7, p=.001) and Sociability (M=67.2 vs. M=49.9, p=.004). In contrast, female residents scored significantly higher than males on Prudence (M=48.3 vs. M=32.5, p=.03). Effect size estimates, which ranged from d=.55 to d=.88, indicated that sex differences on these three measures were moderate to large in magnitude. No sex differences were found for the remaining four HPI scales or on any of the HDS and MVPI scales.

**Conclusions:** Our findings suggest that, while male and female EM residents scored similarly on most personality traits, stress tendencies and motives, male residents may be more likely to engage in strategic thinking and to be socially proactive, whereas female residents may have a greater tendency to be organized and dependable.
**4 Speaker Training Pilot Program for Women in Health Care Decreases Fear of Public Speaking**

Wolfe J, Deutsch A, Poronsky K, Hoadley D / Baystate Medical Center, Springfield, Massachusetts

**Background:** Effective and engaging public speaking is a skill that facilitates academic advancement in healthcare by increasing name recognition as a source expert and creating networking and collaborating opportunities. Studies suggest that female speakers are under-represented in academic settings and face unique challenges in developing speaking skills. To address this problem, our institution’s resource group “Women Advancing and Achieving in Medicine” piloted a women’s speaker training program.

**Objectives:** This study aims to assess feasibility, value to participants, and effectiveness in encouraging public speaking.

**Methods:** Participants were nominated by department chairs to attend a 6-month program created in collaboration with Speaker Sisterhood, a network of speaking clubs for women. Sessions included didactics, speaking exercises and immediate group feedback, culminating in a final videotaped speech by each participant. Participants completed a before and after validated survey “Personal Report of Communication Apprehension” (PRCA_24). Qualitative reported value to participants was documented in their final videotaped session. Non-parametric Wilcoxon Ranks Signed tests were run in conjunction with descriptive statistics using SPSS software.

**Results:** 28 participants registered for the program, 57.7% being attending physicians and the remainder trainees or advanced practitioners. Over 70% of participants reported professional advancement as motivation to attend. 16 completed the pre and post-survey PRCA-24. Post-program scores (55.5, IQR 53.75-63.25) were statistically significantly lower than pre-program scores (65, IQR 58.75-66.5).

**Conclusions:** This pilot women’s speaker training program resulted in decreased apprehension around public speaking among our participants. Participants reported the program gave them in increased comfort in teaching that may lead to career advancement.

**5 When Less is More: A Novel Strategy for Improving Resident Evaluations**

MacVane C, Perron A / Maine Medical Center; Tufts University School of Medicine, Portland, Maine

**Background:** Residency programs from all specialties, including Emergency Medicine (EM) frequently have difficulty obtaining a sufficient amount of meaningful feedback

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**Table 1. Sex Differences in Personality Scale Scores.**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean HDS Mean SD HPI Mean SD MVPI Mean t d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjustment</td>
<td>38.89 31.41 33.29 27.85 .77** .19</td>
</tr>
<tr>
<td>Ambition</td>
<td>27.46 26.22 23.10 22.65 .73** .18</td>
</tr>
<tr>
<td>Inquisitiveness</td>
<td>67.57 22.91 47.68 22.77 3.58** .88</td>
</tr>
<tr>
<td>Interpersonal Sensitivity</td>
<td>57.78 32.74 58.58 33.30 .10 .02</td>
</tr>
<tr>
<td>Learning Approach</td>
<td>51.57 29.18 54.58 23.90 .45 .11</td>
</tr>
<tr>
<td>Prudence</td>
<td>32.54 26.31 48.32 32.02 -2.23** .55</td>
</tr>
<tr>
<td>Sociability</td>
<td>67.24 33.38 49.87 25.16 2.95** .73</td>
</tr>
</tbody>
</table>

HDS, Hogan Development Survey; HPI, Hogan Performance Inventory; MVPI, Motives, Values, Preferences Inventory. ns=34 to 37 males; ns=25 to 31 females. Scores on each measure could range from 0-100%. Degrees of freedom are shown in parentheses.