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Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health

Title

Comparing the Standardized Letter of Evaluation (SLOE) 2.0 with SLOE for Non-residency-based EM Physicians

Permalink

<https://escholarship.org/uc/item/8r77j7fq>

Journal

Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health, 25(3.1)

ISSN

1936-900X

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Publication Date

2024-03-24

DOI

10.5811/westjem.20396

Supplemental Material

<https://escholarship.org/uc/item/8r77j7fq#supplemental>

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for men/women and URiM/non-URiM students.

Methods: This was a multi-institution cross-sectional study with 5 EM programs. We analyzed SLOE 2.0 data from the 2022-2023 application cycle of EM applicants who applied to one of the included EM programs. Exclusion criteria are displayed in Table 1. Part A of the SLOE 2.0 was converted to a quantitative 3-point scale, C1 to a 4-point scale, and C3 to a 5-point scale. We evaluated mean and standard deviations (SD) for the scores for men/women and compared them using a t-test. We also did this for the URiM/non-URiM SLOEs. After Bonferroni correction, p=0.0036 signified statistical significance.

Results: 3689 total SLOEs were analyzed from 1775 total applicants. 1709 SLOEs were from women. 1956 SLOEs were from men. 24 SLOEs were excluded because the applicant identified as “other.” We also analyzed 691 SLOEs from URiM students and 2963 from non-URiM students. 35 were excluded because they did not answer that demographic question. Table 2 includes the mean and SD for men/women students, as well as URiM/non-URiM students. P-values are included.

Table 1. Exclusion criteria for SLOEs.

Exclusion Criteria
Duplicate SLOEs between the 5 included institutions
SLOE not written by a faculty group or other qualified person
SLOE written by someone who wrote <5 SLOEs the prior year
SLOE with incomplete data
Subspecialty SLOE or OSLOEs

SLOE, Standardized Letter of Evaluation
OSLOE, Off-service Standardized Letter of Evaluation

Conclusions: Our data showed that women applicants had statistically higher mean scores for most of the SLOE 2.0 questions. Non-URiM students had statistically higher scores compared to URiM students for some of the questions. The clinical significance of these findings needs to be explored further. While we explore this data further, it is important for residency programs to be aware of these differences in the SLOE 2.0.

Table 2. Mean and standard deviation for each SLOE 2.0 question based on gender and race for EM applicants.

	Women	Men	P-Value	URiM	Non-URiM	P-Value
Question	Mean (SD)	Mean (SD)		Mean (SD)	Mean (SD)	
A1 Ability to perform a focused history and physical exam (1-3)	2.76 (0.45)	2.71 (0.48)	0.0012	2.89 (0.49)	2.74 (0.46)	0.0111
A2 Ability to generate a differential diagnosis (1-3)	2.54 (0.54)	2.50 (0.55)	0.0009	2.48 (0.57)	2.55 (0.54)	0.0024
A3 Ability to formulate a plan(1-3)	2.48 (0.56)	2.40 (0.56)	0.0001	2.38 (0.56)	2.46 (0.56)	0.0007
A4 Ability to perform common ED procedure (1-3)	2.38 (0.80)	2.38 (0.78)	1.0000	2.35 (0.80)	2.39 (0.80)	0.2345
A5 Ability to recognize and manage basic emergent situations (1-3)	2.81 (0.53)	2.55 (0.55)	0.0008	2.51 (0.55)	2.59 (0.54)	0.0088
B1 Compassion, sensitivity, and respect towards patients and team members (1-5)	4.40 (0.69)	4.25 (0.75)	0.0001	4.16 (0.73)	4.31 (0.72)	0.1012
B2 Receptivity to feedback and ability to incorporate feedback (1-5)	4.31 (0.72)	4.23 (0.77)	0.0012	4.26 (0.70)	4.27 (0.74)	0.7466
B3 Dependability, responsibility, initiative, and work ethic (1-5)	4.41 (0.73)	4.30 (0.77)	0.0001	4.26 (0.81)	4.37 (0.74)	0.0006
B4 Punctuality, attendance, and preparation for duty (1-5)	4.39 (0.73)	4.30 (0.77)	0.0003	4.27 (0.81)	4.36 (0.74)	0.0047
B5 Timeliness and responsiveness in completing administrative tasks (1-5)	4.30 (0.75)	4.21 (0.81)	0.0005	4.13 (0.83)	4.28 (0.77)	0.0001
B6 Interpersonal and communication skills with patients and family members. (1-5)	4.40 (0.68)	4.24 (0.75)	0.0001	4.34 (0.72)	4.31 (0.72)	0.3241
B7 Interpersonal and communication skills with faculty, residents and healthcare professionals. (1-5)	4.35 (0.70)	4.20 (0.82)	0.0001	4.25 (0.80)	4.27 (0.80)	0.5540
C1 Anticipated Guidance (1-4)	3.24 (0.72)	3.14 (0.72)	0.0001	3.09 (0.76)	3.21 (0.72)	0.0001
C3 Rank List (0-4)	2.81 (0.90)	2.62 (0.90)	0.0001	2.82 (0.95)	2.73 (0.90)	0.0042

SD, standard deviation
URiM, underrepresented in medicine

11 Comparing the Standardized Letter of Evaluation (SLOE) 2.0 with SLOE for Non-residency-based EM Physicians

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Introduction: For emergency medicine (EM) programs the Standardized Letter of Evaluation (SLOE) provides vital data. The SLOE 2.0 and “SLOE for non-residency-based EM physicians (SNEP)” are relatively new. It is unknown if SNEPs have differences in their scoring from the SLOE 2.0. This could impact SLOE interpretation and rank list positions

for EM programs.

Objective: The objective was to explore if there are differences in scores between the SLOE 2.0 and SNEP.

Methods: From the 2022-2023 application cycle data, we performed a multi-institution, retrospective, cross-section study looking at all 4 week EM rotation SLOEs that were submitted to one of the 5 EM programs that were part of the study. Duplicate applicants were eliminated by cross referencing Association of American Medical Colleges numbers among the 5 programs. Exclusions for the SLOEs were: not written by a faculty group of other qualified person, letter writers wrote <5 SLOEs last year, incomplete data, or subspecialty or OSLOE. Since Part A and C1 provided qualitative data, they were converted to a 3-point scale and a 4-point scale to get quantitative data. We calculated mean scores from the SLOE 2.0 and compared them with mean scores from the SNEPs using a t-test. “Anticipated position on the rank list” was not included since SNEPs do not have that question. We applied a Bonferroni correction, resulting in a p=0.00384 for statistical significance.

Results: 1775 applicants (3690 individual SLOEs) were studied. 3520 (95.29%) were SLOE 2.0s; 170 (4.60%) were SNEPs. The means, standard deviations, and p-values for SLOEs and SNEPs are provided in Table 1.

Table 1. Mean and standard deviation for each standardized letter of evaluation (SLOE) 2.0 and SLOE for non-residency based EM Physicians (SNEP) questions.

	SLOE	SNEP	P-value
Question	Mean (SD)	Mean (SD)	
A1 Ability to perform a focused history and physical exam (1-3)	2.73 (0.47)	2.91 (0.38)	0.0001
A2 Ability to generate a differential diagnosis (1-3)	2.53 (0.55)	2.64 (0.53)	0.0108
A3 Ability to formulate a plan(1-3)	2.44 (0.56)	2.52 (0.54)	0.0685
A4 Ability to perform common ED procedure (1-3)	2.38 (0.80)	2.38 (0.76)	1.0000
A5 Ability to recognize and manage basic emergent situations (1-3)	2.58 (0.54)	2.65 (0.53)	0.0986
B1 Compassion, sensitivity, and respect towards patients and team members (1-5)	4.31 (0.72)	4.50 (0.87)	0.0001
B2 Receptivity to feedback and ability to incorporate feedback (1-5)	4.20 (0.75)	4.40 (0.84)	0.0001
B3 Dependability, responsibility, initiative, and work ethic (1-5)	4.34 (0.76)	4.63 (0.81)	0.0001
B4 Punctuality, attendance, and preparation for duty (1-5)	4.33 (0.76)	4.60 (0.80)	0.0001
B5 Timeliness and responsiveness in completing administrative tasks (1-5)	4.25 (0.78)	4.40 (0.71)	0.0152
B6 Interpersonal and communication skills with patients and family members. (1-5)	4.31 (0.72)	4.54 (0.85)	0.0001
B7 Interpersonal and communication skills with faculty, residents and healthcare professionals. (1-5)	4.20 (0.80)	4.51 (0.86)	0.0001
C1 Anticipated Guidance (1-4)	3.17 (0.73)	3.42 (0.88)	0.0001

SD, standard deviation

Conclusion: The results show that when comparing SLOE 2.0s to SNEPs, most of the questions showed statistically significant higher mean scores on the SNEPs. EM programs who use data from the SNEPs need to be aware of these inherent differences in scores. Further analysis should look at reasons for and implications of these differences.

12 Does Offering CME Credit Increase Emergency Medicine Faculty Attendance at Weekly Resident Conference?

Justine McKittrick, Ralph Ward, Lindsey Jennings, Kathryn Koval

Aim: Prior studies demonstrated that offering continuing medical education (CME) credits increased faculty attendance at resident lectures. The Medical University of South Carolina (MUSC) Emergency Department increased the amount of CME offered to faculty attending resident conference with the hopes of improving attendance.

Objectives: The purpose of this study is to analyze the effect of increasing CME credit hours offered at resident conference on faculty attendance. It is anticipated there will be a positive correlation between faculty attendance with the amount of CME offered.

Methods: This study was a retrospective analysis of the attendance rates of faculty at resident conference at MUSC between July 2021 to June 2022 (year 1: 2 hours of CME offered monthly) and July 2022 to June 2023 (year 2: 3 hours of CME offered monthly) An interrupted time series analysis was used to determine if the intervention led to an immediate and longer-term change in attendance hours per day. Chi-square analysis was used to compare attendance between years.

Results: In year 1, total hours attended per training day for CME and non-CME sessions had similar baseline rates and both rates were gradually decreasing over time. In year 2, CME attendance appeared to jump initially and then gradually dropped to return to the non-CME attendance rate, while total attendance hours per day was flat over time. The large variation in attendance between weeks resulted in no statistically significant values. Total hours of faculty attendance increased between year 1 and year 2 from 533 to 589, and the percentage of attendees at CME training increased from 24.4% to 35.1% (p<0.0001). Much of this increase appeared to occur early in year 2, after which attendance patterns gradually reverted to their earlier values.

Conclusions: Increased CME did not appear to be correlated with a long-term shift in faculty attendance. One major study limitation was incomplete logging of attendance.