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38 Interprofessional Gender Bias During Emergency Medicine Residency Training

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Introduction: Gender disparities continue to persist within medicine. Adverse effects of gender bias are well documented, including among trainees in Emergency Medicine (EM). Recent studies demonstrate significant differences in the evaluation of female and male trainees with respect to milestone achievement during residency. This may be attributable to unconscious gender bias among educators. The extent to which gender-based discrimination occurs in the context of interprofessional interactions is not well understood. Of particular interest is extent to which this occurs between resident physicians and nurses.

Objective: This study aims to explore and understand perceptions and experiences of bias in the context of interprofessional relationships between Emergency Medicine residents and Emergency Department nurses.

Methods: We explored the way gender shapes interprofessional interactions in our EDs through structured interviews and focus groups with EM residents and ED nurses at our two main institutions. An additional component of this study is ongoing, and includes a survey administered to all EM trainees and nurses working in the EDs at Brigham and Women's and Massachusetts General Hospitals.

Results: Several key themes emerged from interviews and focus groups with female and male nurses and residents. Nearly all participants identified gender as an important factor in interprofessional working relationships in the ED. However, the degree to which gender influenced relationships differed between professions and genders. Table 1 illustrates the codes developed from analysis of qualitative data, as well as representative examples. Table 2 includes representative quotes.

Conclusions: Gender continues to play a significant role in shaping interprofessional interactions, including between trainees and nurses in the ED. Gender bias contributes to dissatisfaction in the workplace, the effects of which are felt by both male and female nurses and resident physicians.

Table 1. Codebook from qualitative interviews and focus groups.

Code	Examples
Differences in male vs female residents' interactions w/nurses	Nurses push back against female residents' orders Nurses offer help to male residents, but not females Nurses preferentially ask the male doctor (resident) about the plan instead of female resident or attending Men place orders and don't have to talk to nurses, whereas female residents place orders then go talk to nurses - otherwise plan won't get enacted Male residents talk down to nurses
Forming relationships	Social capital (example: nurses excited over male resident's baby, when a male resident brings cookies it's easier to curry favor with nurses than when a female resident brings food Intentionality about developing relationships – more recognition of need to maintain relationships among females
Difference between practice environments	More questioning of female residents at one facility than another
Change in relationships over time	Difference from intern year to senior year - stronger relationships and more dialogue over time
Allyship	Interviewee offers thoughts about how to be an ally to female residents
Conversations about gender bias with colleagues	Hesitance to discuss bias with male colleagues and superiors [female participants] Unsure how to best support/advocate for female colleagues [male participants]
Mechanisms for reporting gender bias	Safety reporting: seen as ineffective to solving issues of gender bias Discussion with leadership about gender bias felt to be ineffective
Suggestions for change	Decreasing salary gap at attending level Increased opportunities for communication between nurses and residents to foster shared understanding

Table 2. Representative quotes from study participants.

"The friendliness factor varies... I think men get a lot more leeway to try to be 'friends' with the nurses. And it doesn't damage their professional reputation." "Exactly. I think that it's because they can be friends, but in moments of leadership they can still be looked at as leaders, whereas **I think a lot of times the nurses don't necessarily see the women as leaders. They'll see them as peers.** Everything is a discussion and a conversation. Versus men are deferred to more. It's like, 'Oh of course. You're telling me to do this so even if I kind of question it I'm still going to do it,' because there's more trust in what the man is saying, what he's telling them to do." *-Female resident physicians*
"I think that male residents' orders are questioned less, their competence is questioned less." *-Male resident physician*
"Sometimes female residents, when they first start, try to assert themselves more because they're generally taken less serious by the male attendings or male residents, so I think that usually they start a little more hot-headed and then reel it in a little bit." *-Female nurse*
"[Male nurses] get taken more seriously and they're not questioned as much about things that they say or feel... If they said something or suggested something it was taken as the end-all be-all, and they weren't given as much of an argument.." *-Female nurse*
"I often struggle with what my role should be...as a cis gender white male...It's hard for me to know how to be an ally and support racial or ethnic minorities balanced with not wanting to strain the professional relationships you have with others as well." *-Male resident physician*

39 Lower-third SLOEs: Does Gender Make a Difference in Match Outcomes?

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Background: The Standardized Letter of Evaluation (SLOE) is consistently ranked as the most influential application component. Although recent literature has demonstrated superior performance from females compared to male counterparts on global assessment (GA) SLOE rankings, no prior work has studied gender influence amongst applicants with lower-third rankings and ultimate match outcome.

Objective: The purpose of this study was to determine whether gender influences the likelihood of not matching in those applicants receiving a SLOE with a lower-third GA. Our hypothesis was that females with a lower-third GA have a higher risk of not matching.

Methods: We conducted a retrospective cohort study evaluating Liaison Committee on Medical Education (LCME) applicants to a single EM residency program during the 2018 and 2019 match cycles. GA SLOE rankings and gender were extracted and correlated to the National Resident Matching Program (NRMP) data for each applicant. Comparative analyses were conducted between gender and SLOE groupings in order to obtain an odds ratio (OR) of gender and match outcomes.

Results: A total of 2,017 SLOEs were reviewed from 798 applicants. Overall, 716 applicants (90%) successfully matched into EM. A total of 277 (35%) applicants had at least one lower-third GA ranking. For all applicants, having at least one lower-third was associated with a significant risk of not matching (OR .20, 95% CI, 0.12-0.34). Of the 277, 85 of them (31%) were female and 192 (69%) were male. Of the applicants with a lower-third GA, 15 females (17%) and 39 males (20%) failed to match into EM. Gender was not associated with a significantly increased risk of not matching (OR 1.18, 95% CI, 0.61-2.21).

Conclusions: Female applicants receive a lower-third GA less frequently than male applicants. Although having a lower-third GA increases the risk of not matching in EM for all applicants, there appears to be no specific gender influence on match outcome

40 Manifestations of Second Victim Syndrome at an Academic Emergency Department

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Background: Second Victim Syndrome (SVS) describes the suffering of caregivers involved in an adverse patient event. While ED providers are at high risk, relatively little work has been done to assess the prevalence of SVS amongst ED providers. Understanding the prevalence of SVS may be particularly important at academic institutions, where learners are at risk, may have limited skills in dealing with SVS, and may model behavior after affected faculty.

Objective: We sought to examine the incidence of second victim symptoms amongst our providers.Describe the prevalence and types of Second Victim Syndrome experiences and symptoms amongst MDs (attending, fellow, and resident) and advanced practice providers at an academic Emergency Department.

Methods: Physicians (attending, fellow, resident) and advanced practice providers (APPs) in the University of Wisconsin Department of Emergency Medicine were anonymously surveyed with two validated instruments, the Secondary Traumatic Stress Scale (STSS) and Second Victim Experience and Support Tool (SVEST).

Results: Survey response rate was 50.5% (52/103). Providers universally endorsed one or more symptom of SVS. From the STSS, most common symptoms included “easily annoyed” (87.5%), followed by “trouble concentrating” (83.3%) and “thinking about work when not intending to” (81.3%), while “avoiding people, places, or things that reminded me of my work” (29.2%) was least common. The SVEST similarly demonstrated ubiquitous symptoms with a similarly broad range of endorsements. 42.86% reported considering leaving their job and 38.1% considering taking a position outside of patient care. 4.88% reported taking time off and 11.9% taking a mental health day. 2.38% reported accessing support resources in the past 6 months.

Conclusion: Our results indicate symptoms of Second Victim Syndrome are prevalent in our department. Those affected infrequently access support resources. Reported rates of symptoms must be considered significant, particularly in the context of high burnout rates and non-clinical, academic stressors. These results point to the need for increased recognition of and support for SVS.

41 Massage Out Burnout

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Background: Physician wellness leads to better patient care. However, many interventions offered to improve wellness take time and time is not something residents have much of. Massage therapy in the workplace is easily accessible and gives the doctor a chance to be taken care of: a momentary break from the role of caretaker. One study showed incorporating a 10 minute chair massage into nurses’ shifts helped decrease their perception of stress moreso than a “coffee break”, while another recognized the relation to patient care and provided massages to hematologists to help “recharge their batteries” and optimize the care they provided. Yet another study showed that massages provided during spa therapy for people of varying occupations improved symptoms of burnout.

Objective: We hope to demonstrate that massage therapy decreases burnout levels for emergency medicine resident physicians.

Methods: Our study employs a prospective cohort design. 47 EM residents at one program will participate over a 6-month period from October 2019 to April 2020. They will receive massage therapy via a massage chair while on shift. We will examine burnout using the Copenhagen Burnout Inventory (CBI). Residents will complete an initial baseline CBI survey, a repeat survey at the end of the initial 3-month massage period, and again at the end of the latter 3-month period of no massages.