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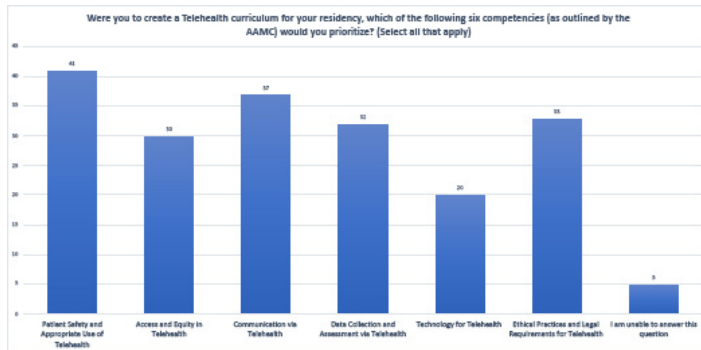
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low response rate, based on the near uniformity of data, we suspect there is validity to these findings. Time constraints impede integration of Telehealth into residency curricula. There is a demand for resources on ethical practices and legal requirements and patient safety and appropriate use of Telehealth, highlighting areas for future development.



41 Relationship between Gender Identity and Underrepresented-In-Medicine Identity on Emergency Medicine Resident Feedback

Nickolas Srica, Ryan Coughlin, Jessica Bod, Alina Tsyrlunik, Dylan Devlin, David Della-Giustina, Katja Goldflam, Katarzyna Gore, Michael Gottlieb

Introduction Effective delivery of feedback is critical to enhancing learning, clinical performance, and professional growth among residents. However, disparities may exist in how feedback is given to different learner groups.

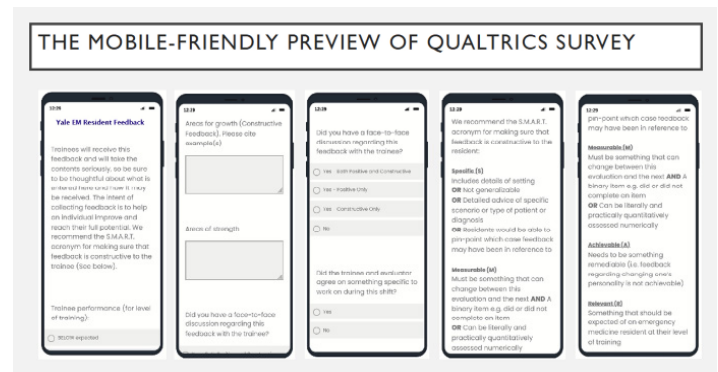
Objectives: To determine if resident gender or underrepresented-in medicine (UiM) identity influenced the likelihood of receiving feedback.

Methods: This was a retrospective study of feedback delivery at an academic, four-year, emergency medicine residency program over a 28-month period in New Haven, CT. All resident physicians in the EM program were eligible for inclusion. Generalized estimating equation models were performed to assess the odds of receiving feedback, feedback delivery, feedback content, or use of deliberate practice with respect to resident and assessor gender identity and UiM identity, or resident-assessor gender identity or UiM identity concordance.

Results: The data set contained 3,480 consecutive feedback entries from interactions between 127 unique residents and 102 unique assessors during the study period. Resident gender identity (OR 0.96; 95%CI 0.84-1.11) and UiM identity (OR 1.02; 95%CI 0.81-1.27) were not associated with differences in receiving written feedback. Analysis among those who received face-to-face feedback revealed no significant differences in feedback delivery method by gender (OR 1.13; 95%CI 0.83-1.52) or UiM

identity (OR 1.40; 95%CI 0.97-2.02). There were no significant differences in the use of deliberate practice (gender OR 0.94; 95%CI 0.81-1.09 and UiM OR 1.009; 95%CI 0.77-1.33). Neither faculty-resident gender concordance (OR 0.95; 95%CI 0.83-1.08) nor faculty-resident UiM concordance (OR 1.07; 95%CI 0.92-1.24) were significantly associated with receiving written feedback.

Conclusions: In this single-center, retrospective study, there were no significant differences in the odds of receiving feedback, feedback delivery, self-reported feedback content, or use of deliberate practice with respect to resident gender identity and resident UiM identity, or resident-faculty gender or UiM concordance. Further research with larger, multi-site datasets is needed to draw more definitive conclusions regarding disparities in these areas on a larger scale and to further assess the quality of the feedback being delivered.



42 A Low-Fidelity, Active Learning Approach to Resuscitation Leadership Education

Damia Michael Sobin, Peter Prescott, Brett Todd, Danielle Turner-Lawrence

Introduction: Effective resuscitation leadership is crucial in improving the quality of resuscitation efforts and patient outcomes. Despite its importance, formal curricula for cultivating resuscitation leadership skills are lacking. Existing published resuscitation leadership training programs predominantly rely on high-fidelity simulations, while low-fidelity options remain underrepresented in the literature.

Educational Objectives: This curriculum aimed to improve resident resuscitation leadership knowledge and skills using active learning techniques. We utilized the Leadership Behavior Description Questionnaire (LBDQ) as learning objectives.

Curricular Design: We designed a three-part guided discussion series employing active learning techniques to cover and review the learning objectives. The sessions utilized a flipped-classroom model, with learners engaged in self-directed learning before participating in case-based