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

Title

Gender-Coded Language in Recruitment Materials Influences Student Choices during Application to Summer Externships and Residencies

Permalink

https://escholarship.org/uc/item/6kk061gs

Journal

Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health, 26(3.1)

ISSN

1936-900X

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Publication Date

2025-06-21

DOI

10.5811/westjem.48736

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Care (SEPC) and Thanatophobia scales (TS). The SEPC is a 23-item survey that measures efficacy in communication, management, and teamwork, while the TS has 7 items that assess attitudes towards palliative care.

Results: Seventeen residents completed the pre-intervention survey out of a body of 54. Five of these residents completed a follow-up (29.4%). All training years were represented: 35.3% PGY1, 47.1% PGY2, 17.6% PGY3. The majority were female (64.7%), white (94.1%), and non-Hispanic (82.4%). Mean pre-intervention SEPC and TS were 51.2 (SEM = 3.1) and 24.5 (SEM = 2.7) respectively. Neither SEPC (p = 0.342) nor TS (p = 0.770) differed across PGY year. Among those who completed both a pre- and post-survey, initial SEPC scores (x = 54.4, SEM = 3.9) improved after the training event (x = 79.3, SEM = 4.3); (p = 0.002) (Figure 2). There was no significant difference in TS scores (x pre = 27.6, SEM = 4.1; x post = 23.2, SEM = 2.7); (p = 0.450).

Conclusion: Resident preparedness for palliative care in the ED is suboptimal. These data suggest that residents are unlikely to passively absorb palliative principles during their training. However, improving self-efficacy in this discipline appears to be trainable, so long as there is a dedicated effort and emphasis on its curricular importance.

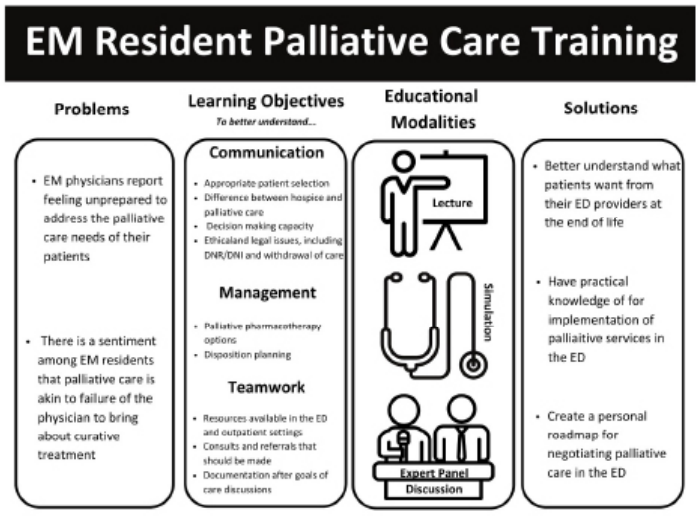

Figure 1. Schematic of EM resident palliative care training event.

36 Physician-Patient Communication in Emergency Medicine Resident vs Attending Physicians

Katarzyna Gore, Callan Coghlan, Danielle Raslan, Aylin Ornelas Loredo, Dustin Brown, Galeta Clayton, Gary Peksa, Michael Gottlieb

Introduction: Patients provide feedback on attending physicians through surveys, whereas residents usually do not have the same opportunity. Feedback residents receive is often based on secondhand accounts.

Objective: We aimed to evaluate resident and attending physicians' communication with patients using the Communication Assessment Tool (CAT). We hypothesized that attending physicians would score higher on individual survey questions.

Methods: We conducted a single center prospective observational study at a tertiary care Emergency Department (ED). After being treated in the ED, patients completed a survey on both resident and attending physicians independently. If no ED resident was caring for the patient, only the attending was evaluated. Off-service residents were excluded. Only English speaking patients were included. A mixed-effects model was used to compare attending and resident data, accounting for participant-level random effects. Open ended questions were graded as positive, negative, or neutral.

Results: 36 residents and 49 attendings were eligible for assessment. Between May and July 2024, we gathered responses from 144 participants. In the 90 resident surveys and 144 attending surveys, responses were predominantly positive, with "Very Good" making up 87.2% of responses for residents and 89.5% of responses for attendings. Open-ended feedback was positive or neutral, highlighting physician strengths or focusing on unrelated patient conditions. Results comparing residents and attendings on

Table 1. Results of Communication Assessment Tool (CAT) Questions in Residents vs Attendings.

CAT question	Resident mean (SD)	Attending mean (SD)	Difference (95% CI)	p-value
Greeted me in a way that made me feel comfortable	3.85 (0.05)	3.88 (0.03)	-0.03 (-0.13, 0.07)	0.52
Treated me with respect	3.89 (0.03)	3.90 (0.03)	-0.01 (-0.10, 0.07)	0.77
Showed interest in my ideas about my health	3.84 (0.05)	3.87 (0.04)	-0.03 (-0.13, 0.08)	0.6
Understood my main health concerns	3.86 (0.05)	3.88 (0.04)	-0.02 (-0.12, 0.08)	0.65
Paid attention to me (looked at me, listened carefully)	4.10 (0.04)	4.12 (0.04)	-0.02 (-0.11, 0.07)	0.68
Let me talk without interruptions	3.75 (0.06)	3.77 (0.05)	-0.02 (-0.15, 0.10)	0.71
Gave me as much information as I wanted	3.92 (0.03)	3.95 (0.03)	-0.03 (-0.12, 0.07)	0.5
Talked in terms I could understand	3.88 (0.04)	3.91 (0.03)	-0.03 (-0.13, 0.07)	0.59
Checked to make sure I understood everything	3.72 (0.05)	3.75 (0.05)	-0.03 (-0.14, 0.08)	0.66
Encouraged me to ask questions	4.00 (0.03)	4.03 (0.03)	-0.03 (-0.10, 0.05)	0.45
Involved me in decisions as much as I wanted	4.05 (0.03)	4.08 (0.03)	-0.03 (-0.10, 0.05)	0.42
Discussed next steps including any follow up plans	4.02 (0.04)	4.04 (0.03)	-0.02 (-0.11, 0.06)	0.71
Showed care and concern	3.80 (0.05)	3.82 (0.05)	-0.02 (-0.14, 0.10)	0.75
Spent the right amount of time with me	3.70 (0.06)	3.72 (0.05)	-0.02 (-0.16, 0.11)	0.78

each discrete survey question showed p-values from 0.42 to 0.77, indicating no significant difference between groups.

Conclusion: The CAT survey administered to ED patients generally reported positive resident and attending assessments. This suggests that current tools may not effectively differentiate between the communication skills of physicians, highlighting the need for a more discerning method to evaluate resident communication.

37 Gender-Coded Language in Recruitment Materials Influences Student Choices during Application to Summer Externships and Residencies

Chloe Jeanmonod, Adriana Facchiano, Genevieve Schmitt, Christopher DeFeo, Marykate Decker, Jonathan Pester

Introduction: Research in technology and finance has shown that gender-coding in advertisements impacts the gender make-up of the applicant pool. We have previously shown that emergency medicine physician job recruitment materials are frequently masculine-coded. We sought to determine whether gender-coded language in pre-medical summer programs and residency recruitment materials influence pre-medical and medical student choice during the application process.

Methods: Generic advertisements (not for specific specialties) for summer programs and residency programs were generated using artificial intelligence, and modified to include gender-coded language as per Gaucher's prior research on gender-coded words, creating highly masculine-coded and highly feminine-coded ads. Premedical and medical students were recruited to complete anonymous web-based surveys. College students were recruited via email to 200 college programs chosen at random, with emails sent to the coordinators for their medical professional interest groups. Medical students were recruited via email to 200 medical schools chosen at random, with emails sent to the dean of students and to the director of diversity, equity, and inclusion, if the school had such a position. Students were also recruited on shift at the primary study site via QR codes hung prominently in the emergency department. Choices between male-identifying and female-identifying students were compared using chi square. The study was reviewed by the IRB and found to be exempt.

Results: Two hundred seven students have been recruited to date. Of these, 64 identify as male, 142 identify as female, and one identifies as non-binary. The non-binary student was excluded from further analysis. 67.6% of female students would choose to apply to feminine-coded programs over masculine-coded programs. 53% of male students would also choose to apply to feminine-coded programs over masculine-coded programs, although female students showed a statistically significant preference (p=0.03).

Conclusion: Gender-coding in recruitment materials for students may influence the gender make-up of the recruitment pool.

38 Calculating Work Relative Value Units for EM Residents: Another Piece of the Productivity Puzzle

Susan Owens

Introduction: In EM, efficiency and productivity are key to success in clinical practice. The current measure for productivity in clinical practice is relative value unit (RVU) generation, a topic lacking direct instruction at the residency level. At the University of Kentucky (UK) patients per hour is the efficiency metric used to evaluate residents, which does not reflect how productivity is measured in clinical practice. The work component of the RVU (wRVU), a numerical value that represents the medically necessary work performed and documented in a patient encounter, could be a more holistic measurement of resident productivity and efficiency. At UK there is no direct mechanism to obtain resident wRVUs despite senior resident requests for this information.

Educational Objective: Develop a process to determine resident wRVUs

Project Design: At UK the billing department assigns wRVUs to the last EM attending to sign a provider note in the encounter but they receive no data regarding residents. I developed a process to connect the resident data from the electronic medical record (EMR) to the data provided by the billing department. I generated a list of all ED encounters in January 2024 (8,000 charts) then removed encounters completed by non-EM residents. I manually assigned a billing resident to each encounter (5,500 charts) and worked with a relative cycle manager to generate total wRVUs, wRVUs per billable encounter, and wRVU per hour for each resident in addition to coding curves for each class (Image 1, Table 1). There is no reasonable way to parse out individual procedure wRVUs for the residents; the assigned billing resident was awarded all wRVUs for the encounter. This project consumed 75 hours.

Impact/Effectiveness: The data from this project was confidentially shared during a monthly faculty meeting and with residency leadership. The data provided a reasonable approximation of wRVUs generated by the residents and anecdotally was received well by the residents, particularly senior residents entering community practice. This project also allowed for review of thousands of resident notes which generated a conference didactic series on documentation and informed major changes to the EM provider note template.