the "likelihood to recommend" and "cleanliness" questions, respectively; 54.4% of patients reported waiting less than 15 minutes to see a physician. Patients in the intervention group had significantly higher mean scores on the validated post-visit survey compared to controls on questions regarding "likelihood to recommend" (4.21, confidence interval [CI] 4.03-4.38 vs 3.82, CI, 3.61-4.02, p = 0.01), overall rating (4.16, CI 4.00-4.33 vs 3.87, CI 3.68-4.06, p = 0.04), waiting time for provider (4.11, CI, 3.92-4.31 vs 3.81, CI 3.61-4.00, p = 0.01), and department cleanliness (4.09, CI, 3.91-4.27 vs 3.80, CI, 3.62-3.98, p = 0.02) (Table1).

Conclusion: An ED-oriented patient liaison program allowed for real-time feedback and opportunities for immediate service recovery, resulting in increased patient satisfaction ratings across multiple indicators.

Table 1. Patient experience ratings and 95% confidence intervals for patients encountered by patient navigators vs case-matched controls.

	Control	Intervention	p-value
"Likelihood to recommend"	3.82 (3.61-4.02)	4.21 (4.03-4.38)	0.010*
Overall	3.87 (3.68-4.06)	4.16 (4.00-4.33)	0.039*
Wait time	3.81 (3.61-4.00)	4.11 (3.92-4.31)	0.012*
Cleanliness	3.80 (3.62-3.98)	4.09 (3.91-4.27)	0.016*

22 "Secure-Preserve-Fight" or "Run-Hide-Fight": Expectations of an Emergency Department Patient Population During an Active Assailant Event

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Objective: We sought to assess the opinions of a general emergency department (ED) patient-family population regarding healthcare providers' life-saving responsibilities during an active assailant event (the traditional "Run-Hide-Fight" paradigm [provider-centric] vs the novel "Secure-Preserve-Fight" [vulnerable patient-centric]) paradigm.

Design and Method: This institutional review board-approved study presented a scenario-based questionnaire to a convenience sample of ED patients and their retinues. Demographic information included prior military service, formal active-shooter training, and prior violent victimization. The randomly selected subjects evaluated four typical patient scenarios of varying severity within which an emergency physician/nurse was in immediate proximity. They were provided four responses addressing their expectations regarding the healthcare provider's actions: provider-centric (namely, "Run-Hide-Fight), or patient-centric (that is, Secure-Preserve-Fight). The frequency of each response was the primary outcome. We employed a non-parametric binomial test as well as SPSS (IBM, Chicago, IL)

Conclusion: For this particular ED population, a significant majority supported the patient-centric "Secure-Preserve-Fight" paradigm over the more provider-centric "Run-Hide-Fight" option. This lay public perspective should spur healthcare staff and administration to reconsider their current active shooter plans and possibly modify them to be consistent with "Secure-Preserve-Fight," especially when dealing with the vulnerable patient.

23 Burnout in Resident Physicians: Correlation with Mistreatment and Workplace Violence

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Background: Research studies show a high burnout level among physicians. Research also shows that mistreatment of medical trainees and workplace violence have potentially long-term, negative effects on the individual. This study examines the correlation between resident burnout and the self-reported incidence of mistreatment and workplace violence.

Methods: Each year, the University of Kansas Medical Center Graduate Medical Education Wellness Subcommittee administers a wellness survey to all 560 residents and fellows. The 71-question electronic survey was originally developed at Stanford University Medical Center. We obtained institutional review board approval for this study..

Results: Of 560 residents and fellows from various specialties who received the survey, 393 completed it (70% response rate); the responses included 147 from female residents (37%) and 246 from males (63%). We found that 20.4% of all resident surveys had responses indicative of burnout. Of the 16 emergency medicine (EM) residents who completed the survey, we found a 37.5% burnout rate. Overall, 35 residents reported being publicly humiliated, and they had a significantly higher burnout rate than those who did not (62.9% vs 16.9%; p value = <0.0001). We also found the following: 55 residents reported being publicly embarrassed, and they had a higher burnout rate than those who did not (52.6% vs 15.5%; p value = <0.0001); 23 residents reported being subjected to offensive sexist