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Curricular Design: A virtual workshop was designed for third-year students at the end of core clerkships. The session began with a didactic session to review HSS concepts and the uncertainty frameworks. Students then engaged in small group learning through a time-lapsed, unfolding case of a patient navigating his care. Several challenge points were built in that introduced a differing clinical uncertainty. Students were prompted to apply HSS tools and strategies to navigate dilemmas, as well as apply a framework to make sense of and classify the uncertainty in order to select a problem-solving strategy. The session ended with a debriefing.

Impact: The session was conducted with 128 students, of which 111 completed the evaluation (87%). Most (101/111, 89%) found the session useful in preparing them to problem-solve during uncertainty. Students applied an array of strategies integrating HSS knowledge (e.g. patient advocacy, patient-centered communication, interprofessional collaboration, social determinants, transitions of care, and shared-decision making). Our case also successfully highlighted the complexities of care for persons living with disabilities.

61 Not Everyone Can Be a Chief

Sameer Desai, Linda Katirji

Background: In 2015 our program adopted a new chief resident model of having all final year residents have a “chief” role. Multiple other programs had already adopted this. “Chiefs” are meant to be leaders, have direct influence in the program, & serve as liaisons with other department chiefs. Common jobs include assisting in conference scheduling, clinical scheduling, & recruitment.

Objectives: Prior to 2015, our program had 3 chief residents a year. They were chosen using a vote within the program, with ultimate decision made by the residency leadership. Many other residents were interested, and often qualified, but ultimately not chosen. In 2015 we adopted all-chief model with the goal of giving each PGY3 a leadership opportunity & a tangible product as they transition to fellowship or new job.

Curricular Design: Residents were allowed to pick their position, with some influence by residency leadership. Residents were also encouraged to “think outside the box” and create new roles which aligned with their personal interests or career goals. Examples included Medical Director Chief, U/S chief, and Wellness Chief.

Impact/Effectiveness: We quickly learned that some residents thrived when given responsibility & others did not. Some that were barely able to fulfill residency requirements & could not manage more responsibility. There was clear disparity in effort. When we started this, all residents’ total shifts/month was decreased equally. This created some controversy when workload, as well as work ethic, was not equal. We altered details, requirements, & expectations every year in attempts to correct the failures. Ultimately, we feel all chief model was a failure. This year (2022-23) we reverted to a traditional chief model, allowing only those the residency leadership felt could manage chief responsibilities have a role. We only chose 6 residents out of 12, creating some healthy competition. Those not doing a chief role did not get a shift reduction.

62 Orthopedic Taboo: A Break from Traditional Image Review

Damian Lai, Brent Becker, Amber Billet

Background: Recognition of specific fracture patterns and determination of appropriate management are vital skills in emergency medicine (EM). EM residents have traditionally been taught through a review of radiographic images in lecture format; however, gamification facilitates experiential learning, incorporates team-building and promotes wellness. The classic board game Taboo provides a format well suited to strengthening memorization, improving pattern recognition and engaging both clue-givers and team members as active learners. We adapted this game as the basis for a novel educational activity: Orthopedic Taboo.

Education Objectives: 1) Increase EM resident medical knowledge of specific orthopedic fractures and management. 2) Enhance resident team building and wellness.

Curricular Design: Randomly ordered radiographic images of classic fracture patterns involving the spine, pelvis and extremities were organized in a slide presentation. Residents were split into teams of 3-5 participants. The classroom was set up such that only one chair in each group faced the screen. The resident facing the screen (clue-giver) described each Taboo word/image (fracture pattern) using medical terminology so the other blinded team members could correctly guess the fracture. If unsuccessful after 30 seconds, an additional hint slide was revealed. After all groups had identified the fracture, the management was jointly discussed, including reduction and splinting techniques. A point was awarded to the team that identified each fracture the fastest and the team with the highest cumulative point total won the game. The total time for this educational activity was 30 minutes.

Impact/Effectiveness: Orthopedic Taboo was incorporated into didactics with positive resident feedback, particularly early in the academic year. It enhances team building and wellness. These sessions are conducted for 30 minutes every 1-2 months to enhance spaced repetition.