Table 1. Sex Differences in Personality Scale Scores.

Scale	Mean	SD	Mean	SD	t	d
		HPI Scale				
Adjustment	38.89	31.41	33.29	27.85	$.77_{(66)}$	.19
Ambition	27.46	26.22	23.10	22.65	$.73_{(66)}$	.18
Inquisitiveness	67.57	22.91	47.68	22.77	$3.58_{(66)}$**	.88
Interpersonal Sensitivity	57.78	32.74	58.58	33.30	$-.10_{(66)}$	.02
Learning Approach	51.57	29.18	54.58	25.90	$-.45_{(66)}$	.11
Prudence	32.54	26.31	48.32	32.02	$-2.23_{(66)}$*	.55
Sociability	67.24	23.38	49.87	25.16	$2.95_{(66)}$**	.73
		HDS Scale				
Excitable	58.80	26.66	53.20	30.73	$.75_{(58)}$	.20
Skeptical	64.34	26.56	61.92	22.25	$.37_{(58)}$	.10
Cautious	67.63	28.21	72.24	29.02	$-.62_{(58)}$	.16
Reserved	60.43	28.71	57.28	30.29	$.41_{(58)}$	.11
Leisurely	61.74	28.52	68.60	24.92	$-.97_{(58)}$	.25
Bold	40.74	30.98	47.12	33.69	$-.76_{(58)}$	.20
Mischievous	53.23	31.11	50.04	34.23	$.38_{(58)}$	.10
Colorful	53.97	30.28	45.08	25.69	$1.19_{(58)}$	.31
Imaginative	56.80	27.89	44.40	31.78	$1.60_{(58)}$	.42
Diligent	55.11	33.20	53.92	27.66	$.15_{(58)}$	.04
Dutiful	62.74	26.42	57.56	32.01	$.69_{(58)}$	.18
		MVPI Scale				
Aesthetics	67.41	27.17	59.80	28.99	$1.03_{(57)}$	.27
Affiliation	55.94	30.47	57.52	30.37	$-.20_{(57)}$	.05
Altruistic	75.97	21.32	74.56	19.03	$.26_{(57)}$	.07
Commercial	29.53	28.02	28.56	21.47	$.14_{(57)}$	.04
Hedonistic	73.38	26.18	75.84	26.65	$-.35_{(57)}$	.09
Power	47.32	26.25	52.68	27.18	$-.76_{(57)}$	.20
Recognition	44.00	31.84	48.72	28.99	$-.58_{(57)}$	.15
Scientific	83.74	17.78	82.20	19.41	$.32_{(57)}$	.08
Security	47.62	27.36	38.12	25.27	$1.36_{(57)}$	.36
Tradition	33.18	25.86	23.72	21.47	$1.49_{(57)}$	.39

HDS, Hogan Development Survey; *HPI*, Hogan Performance Inventory; *MVPI*, Motives, Values, Preferences Inventory. ns=34 to 37 males; ns=25 to 31 females. Scores on each measure could range from 0-100%. Degrees of freedom are shown in parentheses.

4 Speaker Training Pilot Program for Women in Health Care Decreases Fear of Public Speaking

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Background: Effective and engaging public speaking is a skill that facilitates academic advancement in healthcare by increasing name recognition as a source expert and creating networking and collaborating opportunities. Studies suggest that female speakers are under-represented in academic settings and face unique challenges in developing speaking skills. To address this problem, our institution's resource group "Women Advancing and Achieving in Medicine" piloted a women's speaker training program.

Objectives: This study aims to assess feasibility, value to participants, and effectiveness in encouraging public speaking.

Methods: Participants were nominated by department chairs to attend a 6-month program created in collaboration with Speaker Sisterhood, a network of speaking clubs for women. Sessions included didactics, speaking exercises and immediate group feedback, culminating in a final videotaped speech by each participant. Participants completed a before and after validated survey "Personal Report of Communication Apprehension" (PRCA_24). Qualitative reported value to participants was documented in their final videotaped session. Non-parametric Wilcoxon Ranks Signed tests were run in conjunction with descriptive statistics using SPSS software.

Results: 28 participants registered for the program, 57.7 % being attending physicians and the remainder trainees or advanced practitioners. Over 70% of participants reported professional advancement as motivation to attend. 16 completed the pre and post-survey PRCA-24. Post-program scores (55.5, IQR 53.75-63.25) were statistically significantly lower than pre-program scores (65, IQR 58.75-66.5).

Conclusions: This pilot women's speaker training program resulted in decreased apprehension around public speaking among our participants. Participants reported the program gave them in increased comfort in teaching that may lead to career advancement.

5 When Less is More: A Novel Strategy for Improving Resident Evaluations

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Background: Residency programs from all specialties, including Emergency Medicine (EM) frequently have difficulty obtaining a sufficient amount of meaningful feedback

on residents. This burden increased with the adoption of the ACGME Milestones in 2013, when EM programs were tasked with obtaining data on 23 Milestones for each resident. With persistently low evaluation numbers we decided to implement a new strategy to improve feedback received.

Objectives: We sought to determine whether asking faculty to complete less evaluations per month would paradoxically result in increased quality and quantity of resident evaluations we received.

Methods: Historically in our program, we asked each faculty member to evaluate all the residents rotating through the Emergency Department each month (approximately 15 residents per month). Starting in July 2016, we asked each faculty member to provide meaningful feedback on only 3 residents per month. Completion of 36 evaluations at the end of the academic year was tallied and tied to faculty compensation.

Results: In the academic year before the intervention we received 469 evaluations on 24 residents, for an average of 19.5 evaluations per resident. Post-intervention we received 1019 evaluations on 26 residents, for an average of 39.2 evaluations per resident. Pre-intervention no faculty completed the targeted number of evaluations. Post-intervention, 59.4% of faculty completed the expected number of evaluations.

Conclusions: Giving EM faculty physicians a clear, achievable metric for the number of evaluations they are expected to complete can result in a significantly increased number of evaluations. This effect is seen even with a low target such as demonstrated in our study. The strategy we used could easily be translated to other residency programs and specialties.

6 Examining the Relationship Between the AAMC Standardized Video Interview and Step 2 Cs Subscores

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Background: The Association of American Medical Colleges (AAMC) Structured Video Interview (SVI) is an assessment tool designed to measure interpersonal and communication skills and professionalism, two competencies identified by the Accreditation Council for Graduate Medical Education (ACGME) as critical when considering information about residency applicants. Step 2 CS of the USMLE is designed to assess the applicant's patient centered skills including communication. As both the SVI and CS attempt to measure related competencies, demonstrating that the SVI positively relates to the relevant subscore of the Step 2 CS will bolster the validity case for the SVI as a valuable tool for residency selection and contribute to the nomological network for residency selection tools in emergency medicine.

Objectives: The goal of the study is to examine the relationship between scores on the SVI and subscores for the Step 2 CS Exam. We expect SVI will have the strongest relation to the CIS (Communication and Interpersonal Skills) subscore, and the weakest relation to the SEP (Standardized English proficiency) subscore.

Methods: This is an observational retrospective study of existing data for 2201 residency applicants in 2017 who had both valid Step 2 CS subscores and SVI scores. We obtained data for the full population of 2017 residency applicants with both scores and examined Pearson correlations between each of the three subscores and SVI total score.

Results: SVI total score and Step 2 CS subscores exhibited sufficient variance for prediction. SVI was correlated at r = .16 with Step 2 CIS score, r = .13 with Step 2 Integrated Clinical Encounter (ICE) score, and r = .10 with Step 2 SEP score.

Conclusions: There is a small positive correlation between the SVI and each Step 2 subscore. As hypothesized, the strongest relation is between the Step 2 CIS score and SVI, and the weakest relation is between the Step 2 SEP score and SVI. Although these correlations are small, they are in line with reported correlations in the employment and educational literature for personality and non-cognitive competencies, which are generally more difficult to assess. Further research should examine the predictive validity of selection tools for emergency medicine with additional outcome variables.

7 Graded Responsibility Among Emergency Medicine Residency Programs

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Background: The ACGME requires all residency programs to provide increasing autonomy as residents progress through training, known as graded responsibility. However, there is little guidance on how to implement graded responsibility in practice and a paucity of literature on how it is currently implemented among emergency medicine residency programs.

Objectives: We sought to elucidate which domains of practice are subject to graded responsibility among EM residency programs and what factors are used to determine a resident's progression within each domain. We hypothesized that postgraduate year is the most commonly applied factor in determining graded responsibility.

Methods: A 23-question web-based survey was created, assessed for response process validity, and distributed by