

Results: 117 patients participated in this study. Pre- and post AAI pictographic faces [c1] scale results showed an average improvement of 1.2. Before AAI, patients most commonly reported feeling pain, anxiety, tiredness, sadness, boredom, weakness, and a desire to go home. Immediately after the AAI, they most commonly reported feeling happiness, relaxation, better, calmness, and good. Observers noted positive participant and family changes during the AAI, including tone of voice, body language, facial expression (e.g., smiling), and openness. Patients often made efforts to make physical contact for the majority of the visit, often despite pain and immobility. There was also frequent sharing of stories about patients' pets, which seemed to serve as a comfort within the emergency department environment. **Conclusion:** Animal-assisted interventions with a therapy dog team in an emergency department is a 'pawsitive' addition to the patient experience. An important next step is to measure whether the positive impact continued post visit.

Keywords: animal-assisted interventions, therapy dog, emergency department

P022

Physician reporting of medically unfit drivers: barriers and incentives

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Introduction: Most medically unfit drivers are not reported to licensing authorities. In BC, physicians are only obligated to report unfit drivers who continue to drive after being warned to stop. This study investigates barriers to and incentives for physician reporting of medically unfit drivers. **Methods:** We used an online survey to study physician-reported barriers to reporting medically unfit drivers and their idea of incentives that would improve reporting. Email invitations to participate in the survey were sent to all physicians in BC through *DoctorsofBC* and to all emergency physicians (EPs) in the UBC Department of Emergency Medicine. **Results:** We received responses from 242 physicians (47% EPs, 40% GPs, 13% others). The most common barrier to reporting was not knowing which unfit drivers continue to drive (79% of respondents). Other barriers included lack of time (51%), lack of knowledge of the process, guidelines, or legal requirement for reporting (51%, 50%, 45% respectively), fearing loss of rapport with patients (48%), pressure from patients not to report (34%), lack of remuneration (27%), and pressure from family members not to report (25%). EPs were significantly less likely than other physicians to cite loss of rapport, pressure from patients, or pressure from family as barriers, but more likely to cite not being aware of drivers who continue to drive after being warned, lack of knowledge (regarding legal requirements to report, guidelines for determining fitness, and the reporting process), and lack of time. Factors that would increase reporting unfit drivers included better understanding of criteria for fitness to drive (70%), more information regarding how to report (67%), more information on when to report (65%), and compensation (43%). Free text comments from respondents identified other barriers/incentives. Reporting might be simplified by telephone hotlines or allowing physician designates to report. Physicians feared legal liability and suggested the need for better medico-legal protection. Loss of patient rapport might be minimized by public education. Failure of response from licensing authorities to a report (long wait times, lack of feedback to physician) was seen as a barrier to reporting. **Conclusion:** We identified barriers to physician reporting of medically unfit drivers and incentives that might increase reporting. This information could inform programs aiming to improve reporting of unfit drivers.

Keywords: driver fitness, motor vehicle crashes

P023

Emergency department data provides a realistic count of pedestrian injuries

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Introduction: Walking as a form of active transportation is promoted by health professions and environmentalists alike. While the health benefits are indisputable, active transportation is not without risk. Pedestrians are vulnerable road users who often suffer serious injuries especially when involved with collisions with motor-vehicles. While pedestrian injuries involving motor-vehicles are captured in road trauma surveillance systems based on police crash reports, non-collision injuries in this population may be caused by poorly designed infrastructure but are seldom counted as road trauma. This gap hinders road improvement efforts aiming to increase safety for all road users. This study aims to address this knowledge gap. Our objective is to study the profile and circumstances of injuries in pedestrians presenting to ED.

Methods: This was a cross-sectional historical chart review study. All injured patients attending our ED are electronically flagged according to mechanism of injury. We reviewed the medical charts of all ED visits flagged as "Pedestrian" or "Fall" to identify all injured pedestrians (defined in this study as anyone walking on a public roadway or getting on/off public transportation). All pedestrian injuries occurred in 2015 were included for chart review. **Results:** In 2015, a total of 6192 ED presentations were flagged as pedestrian (n = 436) or fall (n = 5756), and 1108 of these met our inclusion criteria. Of these, 181 (16%) were admitted to hospital. Older pedestrians (≥ 70 yrs) had a higher hospital admission rate (78/303; 27%) compared to younger ones (<70 yrs: 103/805; 13%). Collision with motor vehicles (MVCs) resulted in only 25% of pedestrian injuries while fall (or tripping) accounted for about 72%. MVC related injuries were more common in younger pedestrians (29% vs 13%) whereas fall related injuries occurred more in older pedestrians (85% vs 67%). The most commonly sustained injuries among the fallers were abrasions followed by fractures. **Conclusion:** Police crash reports (which capture only MVC related pedestrian injuries) or hospital admission data (which miss those who are treated and released from ED) do not capture all cases of pedestrian injury. ED visit data provides a more realistic count of pedestrian injuries. More pedestrian injuries are caused by falls than by MVCs and policymakers should pay more attention to fall prevention strategies for older pedestrians outside their home environment.

Keywords: pedestrian, road trauma

P024

Physician reporting of medically unfit drivers: knowledge, attitudes, and practice

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Introduction: Medical conditions that impair perception, cognition or motor skills may make people unfit to drive. Reporting unfit drivers to licensing authorities is seen by many as a public health obligation. This study investigates physician knowledge, attitudes and practice around the management of medically unfit drivers. **Methods:** We used an online survey to explore physician knowledge of fitness to drive issues and their attitudes and practice with regard to counselling and reporting unfit drivers. Email invitations to participate in the survey were sent to all physicians in BC through *DoctorsofBC* and to all emergency physicians (EPs) in the UBC Department of Emergency Medicine.

Results: We received responses from 242 physicians (47% EPs, 40% GPs, 13% others). The majority (78%) reported little/no knowledge on determining driver fitness and 94% had little/no training around guidelines, reporting, and laws involving fitness to drive. Most (88%) agreed that physicians should be obligated to advise medically unfit patients not to drive, and 74% reported that they often warn patients not to drive. The majority of physicians also chart their opinion of patients' fitness to drive (67% do so more than twice per year). Most respondents (70%) indicated that it is "always appropriate" to report *definitely* unfit drivers whereas only 25% indicated that it is "always appropriate" to report *potentially* unfit drivers. However, in practice physicians see far more unfit drivers than they report to licensing authority: 67% of physicians encounter *definitely* unfit drivers more than twice per year but only 19% report *definitely* unfit drivers more than twice per year and 34% never report *definitely* unfit drivers. Compared to other physicians, EPs reported less knowledge and training about criteria for determining fitness to drive, were more likely to feel that reporting unfit drivers was not their responsibility, and were less likely to report unfit drivers to licensing authorities. **Conclusion:** Our findings indicate a need for more education and information resources to help physicians, particularly EPs, identify and manage medically unfit drivers. Although most physicians warn unfit drivers not to drive and document this in medical records, many medically unfit drivers are not reported to licensing authorities, a potential public health problem that should be further investigated.

Keywords: driver fitness, motor vehicle crashes

P025

The Dunning-Kruger effect in medical education: double trouble for the learner in difficulty

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Introduction: It is difficult for learners to perform accurate self-assessments. This difficulty may be exaggerated in unskilled learners, a phenomenon termed the Dunning-Kruger Effect (Dunning & Kruger, 1999). Learners with the least amount of knowledge or skill may paradoxically be more likely to evaluate themselves favorably compared with their peers. This phenomenon is particularly relevant in medicine where we rely on self-directed learning not only in many of our undergraduate and postgraduate programs, but in guiding the pursuit of continuing medical education. The objectives of this study are to 1) determine whether the Dunning-Kruger Effect is present in medical education settings, 2) to determine the quality of studies in this area, and 3) to determine how this effect, if present, could influence approaches to the learner in difficulty. **Methods:** This is a review of the literature. PubMed databases were searched for all relevant articles. Included studies reported self-assessment of medical trainees or staff and comparison with an external rating. Studies were identified using select keywords and MeSH terms. Only studies published in English were included. No publication date limits were adopted. The Medical Education Research Study Quality Instrument (MERSQI) was used to assess study quality. Both authors independently abstracted data and rated study quality. **Results:** Eighty-six articles were identified in the PubMed search. On abstract review, 45 studies were found to meet criteria for further full article review. Studies were variable in setting and approach to self and external assessment. Criteria were not met for pooled analyses/meta-analysis. Results are presented as a summary of findings with special consideration of findings based on level of training (undergraduate, postgraduate, staff clinician). **Conclusion:** This review summarizes the current literature on the Dunning-Kruger Effect in medical education and provides an assessment of the quality of studies

in this area to date. The potential relevance of the Dunning-Kruger Effect in medical education is discussed as are implications for interventions to support the learner in difficulty. Additional study in this area is indicated, in particular given the significant upcoming changes to postgraduate medical education in Canada in the era of Competence By Design (CBD).

Keywords: self-assessment, Dunning-Kruger, education

P026

Need for training in medical education: staff emergency physician perspectives

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Introduction: Emergency medicine physicians in our urban/suburban area have a range of training in medical education; some have no formal training in medical education, whereas others have completed Master's level training in adult education. Not all staff have a university appointment; of those who are affiliated with our university, 87 have appointments through the Department of Medicine, 21 through the Department of Pediatrics, and 117 through the Department of Family Medicine. Emergency physicians in our area are a diverse group of physicians in terms of both formal training in adult education and in the variety of settings in which we work. The purpose of this study was to gauge interest in formal training in adult education among emergency medicine physicians. **Methods:** With research ethics board approval, we created and sent a 10-item electronic questionnaire to emergency medicine staff in our area. The questionnaire included items on demographics, experience in emergency medicine, additional post-graduate training, current teaching activities and interest in short (30-60 minute) adult education sessions. **Results:** Of a potential 360 active emergency physicians in our area, 120 responded to the questionnaire (33.3%), representing 12 area hospitals. Nearly half of respondents had been in practice over 10 years (48.44%). Respondents were mainly FRCP (50%) or CCFP-EM (47.50%) trained. 33.3% of respondents had masters degrees, of which 15% were MEd. Most physicians were involved in teaching medical students (98.33%), FRCP residents (80%) and family medicine residents (88.3%), though many were also teaching off-service residents, and allied health professionals. More than half of respondents (60%) were interested in attending short sessions to improve their skills as adult educators. The topics of most interest were feedback and evaluation, time-efficient teaching, the learner in difficulty, case-based teaching and bedside teaching. **Conclusion:** Emergency physicians in our area have a wide variety of experience and training in medical education. They are involved in teaching learners from a range of training levels and backgrounds. Physicians who responded to our survey expressed an interest in additional formal teaching on adult education topics geared toward emergency medicine.

Keywords: education

P027

Nursing duties and accreditation standards and their impacts: the nursing perspective

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Introduction: With ongoing medical advances and an increase in elderly and complex patients presenting to the Emergency Department