

of pinpoint pupils, initial oxygen saturation, initial Glasgow Coma Score (GCS), respiratory rate, or time on scene. Both patient groups were managed similarly with respect to route of naloxone administration and the use of a bag valve mask. All patients who were intubated were in the no confirmed history group ($n=5$; $p=0.003$). Post naloxone there were no differences in last recorded vital signs except the no confirmed history group was less likely to achieve a GCS 10 (57% versus 89%; $p<0.001$). The overall post-naloxone development of agitation (9%) was moderate while the need for physical/chemical restraint (2%) was low with no differences between groups. All patients were transported to the hospital. **Conclusion:** A substantial proportion of patients who received naloxone did not have a confirmed history of an opioid overdose. These patients closely resembled those with a confirmed history with respect to demographics and physical characteristics. The primary difference was a lower proportion of patients with no confirmed history who achieved a post naloxone GCS 10. Despite a moderate development of post naloxone agitation, paramedics were able to manage most of these patients without the use of physical/chemical restraints.

Keywords: emergency medical services, opioid overdose, naloxone

P015

Staff skills: a procedural skills curriculum for emergency medicine attending physicians in Calgary

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Introduction: Emergency medicine attending physicians perform many essential procedures but some infrequently. Skill proficiency and familiarity declines over time. We intended to identify skills where colleagues felt deficient and create an opportunity to demonstrate and practice in a safe environment. **Methods:** Sessions began from a review of ultrasound guided central line and pacemaker insertion. Other procedures have been added as a result of critical incidents, needs assessments by attending physicians, acquisition of new technology/equipment and expert consensus. An evaluation and needs assessment is performed after each session to adjust curricula. **Results:** Since 2011, we have held 2-3 skill sessions per year at the Advanced Trauma Surgical Skills Laboratory at the University of Calgary. Sessions are taught by attending emergency physicians, employ task trainers, simulators, animal and human cadaveric models, ultrasound, and procedural equipment stocked in our local hospitals. We are able to accommodate ~30 participants per session for 3 hours of rotating 7-8 participants through various stations. Every session has been fully attended with a wait list. Physicians register by email with preference given to new participants and those identified during clinical practice review of requiring remediation. Costs of sessions are covered by voluntary contribution to an emergency department physician support fund. Procedures practiced have included airway (basic, adjuncts, bronchoscopy, video laryngoscopy, surgical airway, chest tube), vascular access (ultrasound guided central venous insertion, transvenous pacemaker insertion, nerve blocks, IO insertion), surgical skills (thoracotomy, chest tube, canthotomy, surgical airway) and other percutaneous procedures (paracentesis, thoracentesis, nerve block, lumbar puncture). High fidelity skills videos were created to augment the sessions, available on the department website. Four point scale evaluations from our most recent session yielded 100% excellent rating for overall workshop and relevance to practice. The 6 facilitators performance received 100% excellent or good ratings. **Conclusion:** We have developed a fun, nonthreatening opportunity for attending physicians to practice infrequent but important ED procedures. The sessions are well received, well

attended, foster collegiality, confidence and competence in performance of infrequent ED skills. Our model could be generalized to other centres.

Keywords: innovations in emergency medicine education, procedural skills, attending physician

P016

Junior and senior clinician educators rank key medical education articles differently depending on topic

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Introduction: Medical education includes a diverse range of topics and disciplines. For junior clinician educators, it may be difficult to get a grasp of pertinent literature. Our study aims to retrospectively identify whether senior clinician educators (SCEs) and junior clinician educators (JCEs) differ in their selection of what they perceive as key medical education articles. **Methods:** As a part of the Academic Life in Emergency Medicine (ALiEM) Faculty Incubator program, we developed a series of primer articles for JCEs over the preceding year, designed to enhance their educational growth by identifying and discussing key articles within specific medical education arenas. Each set of articles within the primer series were selected based on data collected from JCEs and SCEs, who ranked the specific articles with respect to their perceived relevancy to the JCEs. ANOVA analysis was performed for each of the nine primer series to determine whether there was a statistically significant difference between senior and junior CE ratings of articles.

Results: 216 total articles were evaluated within the nine different primer topics. Through a multilevel regression analysis of the data, no statistically significant difference was found between the rankings of papers by SCEs and JCEs (95% CI: -0.27, 0.40). However, a subgroup analysis of the data found that 3 of the 9 primers showed statistically significant divergence based on seniority ($p<0.05$). **Conclusion:** Based on this data, involvement of JCEs in the consensus-building process was important in identifying divergence in views between JCEs and SCEs in one-third of cases. To our knowledge, no other group have compared whether junior and senior clinical educators may have divergent opinions about the relevance of medical education literature. Our findings suggest that it may be important to involve JCEs in selecting articles that are worthwhile for their learning, since SCEs may not fully understand their needs.

Keywords: innovations in emergency medicine education, mismatch between junior and senior clinical educator priorities

P017

When the rules hit the road: how emergency physicians make decisions in the era of the clinical decision rules

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Introduction: The diagnostic process is wrought with potential sources of error. Psychologists seek to coach physicians to refine their cognition. Researchers try to create cognitive scaffolds to guide decision-making. Physicians however, are caught in middle between their own daily cognitive processes and these external theories that might influence their behaviour. Few attempts have been made to understand how experienced clinicians integrate guidelines or clinical decision rules (CDRs) into their decision-making. We sought to explore experienced clinicians decision-making via a simulated exercise, to develop a model of how physicians integrate CDRs into their diagnostic thinking. **Methods:** From July 2015-March 2016, 16 practicing emergency physicians (EPs)