where demand for CL/P is increasing. We describe a strategy that may be used to improve global outreach for patients, providers, and international organizations such as Operation Smile. By enhancing our understanding of patient demand based on relative search interest by country and subregion, global health organizations can better direct their efforts in providing care to those populations that express a high interest in cleft care but may not have the provision to provide this care.

9. Representation Matters: Disparities in Imaging in Plastic and Reconstructive Surgery Education Materials

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Background: Racial disparities permeate our healthcare system. One known contributor is implicit bias among healthcare professionals. Lack of representation among images used in medical education materials, a well documented phenomenon, contributes to such bias. Because plastic surgery relies heavily on patient images it is highly susceptible to incorporating and perpetuating racial implicit bias. This study aims to assess visual representation of patient diversity in the American Society of Plastic Surgery (ASPS) Resident Education Curriculum (REC).

Methods: Color photos, graphics, and videos featured in the “Course Materials” (excluding articles) for each module in the REC curriculum were categorized using the Fitzpatrick scale (I-II, III-IV, or V-VI) by a team of six reviewers. Proportional data and average number ± standard deviation of photos and graphics for each category were reported. Significant difference between images and graphics categorized as Fitzpatrick I-II and Fitzpatrick V-VI (P<0.001). Significance was maintained despite excluding benign and malignant skin chapters (P<0.001).

Results: An average of 1861 photographs and 237 graphics were assessed with 82% (1518± 25.11) of photos and 97% (231± 24.45) of graphics categorized as Fitzpatrick I-II, 12% of photos (220±9.57) and 2% (5± 2) as Fitzpatrick III-IV, and 7% (124± 2.64) of photos and 1% (2± 0.31) of graphics as Fitzpatrick V-VI. A one-way ANOVA with a Tukey’s post-test demonstrates a statistical difference between images and graphics categorized as Fitzpatrick I-II and Fitzpatrick V-VI (P<0.001). Significance was maintained despite excluding benign and malignant skin chapters (P<0.001).

Conclusion: Our data reveals an opportunity to improve racial representation in resident education. When 76% of patients in the US are white and 13% are Black, our findings demonstrate both an unequal and unrepresentative distribution of photos of non-white patients. This is furthered by the vast overrepresentation of fairer skin tones in included graphics, which are not limited by patient presentation. The discussion of implicit bias is incomplete if it does not also consider ways such biases are perpetuated (e.g. images). Residency is a formative time in a surgeon’s career and exposure to an accurate reflection of our diverse patient population is imperative.

10. Do Plastic Surgery Residents Get Sued? An Analysis of Malpractice Lawsuits

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Background: Residents may be implicated in malpractice lawsuits. Our study aims to examine medical malpractice lawsuits involving plastic surgery trainees.

Methods: Using the LexisNexis legal database, jury verdicts and settlements from all appellate state and federal cases between February 1988 and 2020 were queried, and a non-representative sample of over 300 cases was compiled, each of which were manually reviewed by 2 authors (A.G. and S.J.).

Results: During a 30-year period, 22 malpractice cases involving plastic surgery trainees were identified. Of these cases, 15 (68.2%) involved claims in which a trainee was directly named as a defendant. A total of 18 (81.8%) cases were due to procedural-related adverse outcomes, while 4 (18.2%) cases were associated with clinical or diagnostic-related adverse outcomes. Of the procedure-related cases, 5 (27.8%) occurred when the trainee was the lead surgeon.
Allegations raised by plaintiffs included lack of informed consent of procedure complications (12, 54.5%), procedural error (11, 50%), inexperience of the trainee (8, 36.4%), incorrect diagnosis or treatment (5, 22.7%), a delay in evaluation (3 cases, 13.6%), lack of informed consent of resident being involved (3, 13.6%), lack of follow-up care (3, 13.6%), and prolonged operative time (1, 4.5%). The median time from injury to lawsuit resolution was 3.5 years (interquartile range [IQR], 3-5 years). Verdicts were ruled in favor of the defense in 9 (40.9%) cases and for the plaintiff in 6 (27.3%) cases. A settlement was made in 7 (31.8%) cases. The median payout for plaintiff-won cases was $5,100,000 (IQR $1,530,000-$17,500,000), and the median settlement was $2,500,000 (IQR $262,500-$4,410,000).

Conclusion: Procedural error, improper informed consent, improper trainee supervision, and resident inexperience were the most common allegations proposed by patients in cases involving plastic surgery trainees. These factors can lead to an enduring financial and psychological burden early on in a physician's career, as well as poor health outcomes. Highlighting these issues during medical education may decrease physician malpractice risk, lower the incidence of burnout, and ultimately improve patient satisfaction and outcomes.

11. A Novel Interdisciplinary Educational Model for Traumatic Laceration Repair in Surgical Training Programs

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Background: Laceration repair is a critical component of general surgery. Most general surgery residency programs, however, allocate minimal time for laceration repair training and education. We present a collaborative and practical educational intervention in which general surgery postgraduate year-one (PGY-1) residents receive laceration repair training by senior plastic surgery residents in a manner integrated into routine patient care.

Methods: Study participants were PGY-1 general surgery residents at a single institution. The control group (2018-2019) did not receive any additional laceration repair training. The experimental group (2019-2020) underwent a didactic session led by plastic surgery senior residents, after which all clinical laceration repairs that required consultation of the plastic surgery service were performed by the general surgery PGY-1 resident under the guidance of the plastic surgery senior resident. Both groups completed an end-of-year confidence survey, basic knowledge test, and practical examination; the experimental group additionally completed these at start-of-year.

Results: The control group consisted of seven residents, and the experimental group consisted of 16 residents. The experimental group performed significantly better on both components of the end-of-year practical exam compared to the control group, (p<0.005 and p=0.025), and as compared to its start-of-year results (p<0.005 and p<0.005). No significant difference was found in confidence or basic knowledge.

Conclusion: Residents demonstrated an improvement in practical laceration repair following this simple intervention. The intervention is collaborative, simple to implement without the use of additional resources, is compatible with routine patient care, and is likely to be a valuable teaching role for plastic surgery residents.

12. WITHDRAWN.

13. Cross-Institutional Virtual Mock Oral Exam - A New Paradigm?

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Background: Mock oral examinations (MOEs) are shown to be valuable in preparation for national board oral exams. While traditionally these exams have been in-person, improved technological advances have supported exploring virtual alternatives. Additionally, the COVID-19 pandemic has further necessitated virtual learning. Without the constraints of physical logistical coordination, we hypothesized that the virtual platform would improve and expand the MOE experience to include collaborative institutions while still approximating a board examination environment.

Methods: 16 senior plastic surgery residents and 14 attending faculty from three separate plastic surgery training programs