analysed using a SOB point-of-care biomarker panel (troponin I, myoglobin, CK-MB, D-dimer, and BNP at the time when patient presented with SOB within 15 minutes of patient’s visit to the ED. Thirty-day follow-up for HF, ACS and PE was performed.

The following cut off were used for determining a positive biomarker:

1. myoglobin > 107 ng/mL,
2. CK-MB > 4.3 ng/mL,
3. troponin I > 0.40 ng/mL,
4. D-dimer > 500 ng/mL, and
5. BNP > 100 ng/mL.

CTCA, CTPA and 2D Echo were taken as the Gold Standard for the diagnosis of ACS, HF and PE.

Results/Conclusions

SALIENT FINDINGS

ACS:
P<0.001
Sensitivity=81.2%
Specificity=90.6%
PPV=78%
NPV=92.2%
Accuracy=87.8%

HF:
P<0.001
Sensitivity=69.1%
Specificity=66.4%
PPV=50.7%
NPV=81.1%
Accuracy=67.3%

Conclusion We conclude that there is significant correlation between SOB point-of-care biomarker panel diagnosis and final diagnosis.

In patients presenting with SOB, one of the three clinical conditions identified by the SOB point-of-care biomarker panel will lead to earlier diagnosis and initiation of specific management.

RCEM moderated

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THE EFFECT OF AFFECT: WHAT WE TEACH OUR LEARNERS ABOUT THE ROLE OF PATIENT INDUCED EMOTION IN CLINICAL REASONING IN THE ED AND WHY?

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Aims/Objectives/Background Few empirical studies explore the contribution of non-clinical factors to perceptions of patient difficulty in EM. Fewer have investigated what students placed in EDs learn about ‘difficult’ patients or what, if anything, clinicians teach about the topic. We looked to address this. Considering these questions is imperative: patients perceived as frustrating report lower satisfaction with their clinical encounter, experience worse health outcomes and seem to be at risk of medical error secondary to faulty clinical reasoning.

Methods/Design With ethical approval, we undertook three interrelated, qualitative studies to conduct a case study of the undergraduate EM module delivered at Edinburgh University. In the first two, focus groups were used as the method of data collection; five clinician (n=23) and four medical student (n=21) groups were facilitated. In the third, semi-structured interviews with clinicians (n=12) were conducted. All groups/interviews were audio-recorded and transcribed. The data were analysed inductively using reflexive thematic analysis.

Results/Conclusions Frequent attendance, demands, pre-existing relationships and unrealistic expectations contributed to perceived patient difficulty. These were modified by personal and circumstantial factors. Although rarely told, students were aware who these ‘difficult’ patients were through observing behaviours. Critically, clinicians and students alike believed