University of Alberta with acute AFF were enrolled. Following informed consent, each patient completed a survey administered by a trained researcher, administrative ED information (e.g., ED times) was collected from the ED information system, a chart review on treatments was conducted and patients were contacted for follow-up at 7 days via telephone. Descriptive (median and interquartile range {IQR} and proportions) and simple (Wilcoxon-Mann-Whitney, chi-square, z-proportion) statistics are presented for continuous and dichotomous outcomes. **Results:** Overall, 217 patients were enrolled; the median age was 64 years (IQR: 55, 73) and 39% were female. Males presenting to the ED with AFF were 10 years younger than females ($p < 0.001$); however, females weighed significantly less (median weight 69 vs. 95 kg; $p < 0.001$), consumed less alcohol (12 vs. 60 drinks/year; $p < 0.001$) and were less likely to be ex-smokers ($p = 0.022$) than men with AFF. Women arrived by Emergency Medical Services (EMS) ($p = 0.037$), experienced palpitations ($p = 0.042$), and reported a history of hypertension ($p = 0.022$) more frequently than men. Females were more often prescribed oral anticoagulants before ($p = 0.041$) and after ($p = 0.011$) the ED visit, and females with a history of AFF were less likely to present without anticoagulant/antiplatelet therapy ($p = 0.015$). Overall, both sexes had similar attempts at cardioversion (59.4% vs. 61.3%) and hospitalizations (12.5% vs. 8.6%), respectively. If initial chemical cardioversion failed, females were more likely to receive subsequent electrical cardioversion (60.0% vs. 26.7%, $p = 0.036$) than men. **Conclusion:** Overall, both women and men present frequently to the ED with AFF. Compared to men with AFF, women present with symptoms 10 years later, have different risk factors, experience more severe symptoms and use EMS more commonly; however, outcomes were similar. Unexplained sex-based variations in-ED and post-ED management are evident and these differences warrant further scrutiny.
Keywords: atrial fibrillation, anticoagulation, sex differences

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Burnout among emergency physicians working at a large tertiary center in London, Ontario

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Introduction: Emergency medicine (EM) is known to be a high-stress specialty. Work related stress and burnout have been reported to negatively impact physician-patient interactions, collaboration and ultimately overall physician mental and physical health. We sought to assess the rates of burnout among emergency physicians working at a single large Canadian tertiary care center and to identify higher risk groups. We hypothesized burnout rates to be uniformly high. **Methods:** We conducted a local cross-sectional study to assess burnout among adult and pediatric emergency physicians, fellows and residents at London Health Sciences Centre (LHSC). A total of 118 participants were invited to complete an anonymous online survey encompassing demographics, the validated MBI tool (Maslach Burnout Inventory) with additional questions aimed at identifying determinants of emergency physician burnout at LHSC. Each respondents three MBI scale scores for Emotional Exhaustion, Depersonalization and Personal Accomplishment were recorded with a possible range of 0-6. Descriptive statistics were calculated and relationships between risk factors (age, gender, years of practice, marital status, and credentials) and burnout scores were examined using t-tests, one-way ANOVAs, and/or regression analyses where appropriate. **Results:** To date the survey had a 50% (59/118) response rate. Of the 59 respondents 24 (40%) were female, the mean (SD) age was 40.6 years (10.5) and years of practice ranged from 1 to 35, with a mean of 13. Survey results indicated a high degree of burnout among LHSC EM physicians with a mean (SD) Emotional Exhaustion Score of 2.9 (1.3) and Depersonalization score of 2.4 (1.3), indicating that physicians felt burnt out from work between once a day to once a week. Inversely, the protective variable of Personal Accomplishment, with a score of 4.7 (0.9), indicated daily to weekly feelings of accomplishment. Female physicians (independent samples t-test, $p = 0.003$) and those having fewer years of practice (linear regression, $R2 = 0.188$, $p = 0.04$) were identified to have higher burnout. We did not identify any factors associated with Personal Accomplishment. **Conclusion:** Consistent with previous literature, LHSC emergency physicians were shown to be at risk for moderate to severe burnout. High risk groups identified included gender (female) and fewer years of practice. We did not identify any factors to be protective. Despite this, LHSC emergency physicians showed a high degree of personal accomplishment. While all physicians experience burnout, targeted interventions to newer female staff could have the highest benefit.
Keywords: wellness, burnout, emergency medicine consultant

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FLO on flow: front line ownership of emergency department, hospital, and health system patient flow a novel approach to ED overcrowding (Part 1)

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Introduction: Hospital access block, often called Emergency Department (ED) overcrowding when it manifests there, is an important public health issue and seemingly intractable problem in our evolving Health Care system. The multiple, dynamic, and inter-dependent factors influencing its cause (and potential solutions) may best fit a complex adaptive systems analysis and approach. One technique described in similar contexts is Front Line Ownership (FLO) based on the theoretical framework of positive deviance. The aim of this study is to discover where pragmatic bottom-up insights and adaptive work-arounds can be elicited, described, iterated, and potentially implemented at a broader scale to catalyze systems change, in service of improving patient flow. **Methods:** This is a qualitative study which identified, convened, and surveyed stakeholders representing three components of the system. Purposive sampling was used to gather a full range of perspectives from three groups: 1) patients and or families, 2) front-line providers, and 3) management/leaders. Interviews were recorded and transcribed by a third party, then each transcription was coded independently by two investigators (at least one of which was the PI). Informed consent was obtained from all participants and each was offered the opportunity to review the transcription to ensure accuracy. A framework analysis was used to synthesize, reflect upon, and interpret the data from multiple perspectives using a structured, iterative approach. **Results:** In part 1 of this study, three broad over-lapping themes emerged from the analysis as being areas of opportunity for reducing hospital access block. They are: 1) Boundary Conditions (the historical, organizational cultural, psychological, economic, and other contexts influencing system performance), 2) Systems Integration (how well the parts interface with each other relate to the whole), and 3) Operations management (the more technical aspects of patient flow). When these three broad themes are cross-analyzed with a more conventional input-throughput-output approach, previously under-emphasized avenues for improvement may become apparent. **Conclusion:** A front-line ownership analysis of ED overcrowding is feasible. There are adaptive behaviors by some front-line individuals at each "level" of perspective that have been identified

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