Graduate Training in Emergency Medicine

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In the late 1980s, the American Board of Emergency Medicine (ABEM) closed the practice track for certification. This left thousands of career emergency physicians (EP's) who originally trained in other specialties, and who often held leadership and academic positions, vulnerable to pressure from competitors holding board certification in emergency medicine. For most of the history of emergency medicine (EM), the majority of EP's have not been residency trained and until recently were not board certified. The infusion of graduates from EM residencies amounts to only about 1,000 per year into a pool estimated at about 30,000 FTE's. The attrition rate is not well established but may be as much as 5-10% yearly. Many physicians also move in and out of EM practice situations while many may include acute or minor care, "fast track," industrial/occupational, sports, correctional, and institutional medicine and clinics as well as function in administrative and academic situations.

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Into this climate the American Association of Physician Specialists (AAPS) and others introduced methods by which the career EP's without EM boards could demonstrate capability in their field. Since the early 1990's this organization has stepped forward with a mechanism for certifying EP's via the Board of Certification in Emergency Medicine (BCEM).

There are now three pathways to this designation. First is the completion of an EM residency training program. The second is completion of a residency in family practice, internal medicine, pediatrics, general surgery, or anesthesiology plus five years of full-time EM practice. The last is completion of a graduate training program of 12-24 months (plus sufficient practice time to comprise a full 24 months). Any of these allow the candidate to sit for a written board exam to be followed by an oral examination to complete the process.

Graduate training programs (GTP's) in EM were not part of the original qualifications for the BCEM exam, although EM training programs existed before BCEM and before the GTP pathway, in places such as North Carolina, New York, Iowa, West Virginia, and Indiana. It wasn't until recently that programs were credentialed by AAPS for the express purpose of allowing candidates to qualify for the exam. Programs currently operating include the University of Tennessee-Memphis and the University of Tennessee-Knoxville; two other programs have been recently approved to operate at the University of Tennessee-Jackson and John Peter Smith Hospital in Fort Worth, Texas.

It is unlikely that graduates from non-EM residencies who develop a desire to do full-time EM will be allowed to go back to join an EM residency training program. This is due to the graduate medical education funding model, which does not allow Medicare funding to be

used more than once for post-graduate training by an individual. In other words, if an individual goes through an internal medicine program (three years) that person's eligibility is used up and no more training funds will be awarded for participation in any additional GME programs. Only a few EM residencies have enough endowments to forego Medicare dollars, which provide the majority of program funding for residents, faculty, and support.

The practice track continues to exist and is not expected to sunset. This requires a graduate of one of the previously mentioned specialties who has decided to pursue EM as a career to spend five full years at the craft before applying under the practice track pathway option. All diplomates must re-certify every seven years.

The GTP is based on the model established by the Residency Review Committee. A suitable site with appropriate institutional support is selected. A program director and staff are designated, curriculum follows broad based core competency guidelines as described by the American College of Emergency Physicians and funding (non GME) is procured. The application itself can be used as a guideline for setting up a program, it must be completed and sent to AAPS along with an application fee (download from aapsga.org). GTP's allow interested parties who already have suitable broad-based talents from their residency training to add the specific knowledge and skills necessary for EM without the burden and risk of on the job training via the practice pathway and can be completed in less time. Physician stress and liability are reduced by working under the tutelage of faculty proctoring while quality assurance measures and standards of practice are more dependably adhered to.

Much of the emergency care available in rural and underserved areas is delivered by primary care physicians, especially family physicians who fill patient needs in the office, hospital, nursing home, and ED. Many of these people are essentially dual trained in family practice and emergency medicine, the two most broadly based specialties. GTP applicants from family practice interested in GTP's have primarily been from states with rural needs and large underserved populations without ready access to sub-specialists and tertiary care. Linkage between family practice and emergency medicine are extensive and practical due to the ability of both programs to train practitioners in patient care unrestricted by age, sex, or organ system.

Summary

In view of several great needs, GTP's in EM are considered important in planning management of the crisis in emergency medicine. Emergency department visits ever increase while department closures have cut the number of facilities over 20 percent during the past two decades. Managed care organizations and liability risk issues put pressure on the primary care practitioners to send patients with urgent and/or unexpected problems to the ED. Emergency department's are stuffed with patients, creating long waits secondary to hospital bed shortages. Ambulance diversions are rampant. Staffing in the ED is still primarily by non-residency trained EP's and the flow from EM programs is not likely to provide sufficient manpower for another 15-20 years. Practitioners are currently available and interested in demonstrating expertise in emergency medicine via BCEM credentialing. It is likely that non-residency trained practitioners will be needed until most of us "boomers" are retired, and it is our belief that ED staffing will be improved by the arrival of appropriately changed GTP graduates who will be able to supplement the EM work force and deliver quality care.