Education for Non-Emergency Medicine Residency Trained Physicians

EM Workforce Section Workgroup on Non-EMRT Education

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Purpose:

This paper serves to delineate the expectations and educational process a non-emergency medicine residency trained physician should complete in order to ensure proficiency in their practice of emergency medicine.

Principles:

1. Emergency Medicine Residency is the best means to prepare for a career in emergency medicine.

2. The Model of Clinical Practice in Emergency Medicine put forth by the Core Content Task Force defines the core curriculum for all physicians providing emergency medical care, including non-EM residency trained physicians.

3. Acceptable methods of providing additional education to non-EM residency trained physicians include the following:

   a. Focused Educational/Patient Care Program under Direct Supervision
   b. Didactic Education
   c. Focused Procedural Skills Course

4. A process should exist to complete competency focused testing of non-EM residency trained physicians on their knowledge and procedural skills and this focused testing should be developed, and approved, if not administered, by ACEP or an organization designated this task by the ACEP Board. Successful completion of any such test should not be deemed equivalent to successful passing of the certification examination offered through ABEM or AOBEM.

5. Those non-EM residency trained physicians who successfully complete such a course of education should be considered for recognition by the American College of Emergency Physicians including Affiliate/Associate Membership if, and when, the Council authorizes such an Affiliate/Associate Membership program.
The **Current State** can be outlined as follows:

**The College:**

ACEP is a member organization that exists to support the highest quality of emergency medical care and to serve as advocates for patients, its members and the specialty of emergency medicine.

**Membership:**

Membership in the college is available to physician emergency specialists who meet one of the following requirements:

1. Satisfactory completion of an emergency medicine residency program accredited by the Accreditation Council on Graduate Medical Education (ACGME).
2. Satisfactory completion of an emergency medicine subspecialty-training program accredited by ACGME.
3. Satisfactory completion of an emergency medicine residency training program accredited by the American Osteopathic Association (AOA).
4. Satisfactory completion of an emergency medicine residency program approved by an ACEP-recognized accrediting body in a foreign country.
5. Certification by an emergency medicine certifying body recognized by ACEP. Or
6. Eligible for active or international membership in the College at any time prior to the close of business December 31, 1999.

**Workforce:**

Based on Dr. Camargo’s work (Assessment of Emergency Physician Workforce Needs in the United States, 2005, *Academic Emergency Medicine, 2008;* 15:1317-1320, Society for Academic Emergency Medicine) in the best scenario (no current emergency physicians retiring or dying), EDs will not be fully staffed with emergency medicine trained physicians until 2019 or beyond. **In practical terms, the goal of full staffing by emergency medicine residency trained physicians will not be met, with current resident production levels.** Because of insufficient numbers of EMRT physicians, and as a solution to the current insufficient number of EMRT physician, many emergency departments must use non-EMRT physicians to meet the staffing needs of their hospital and community. The skill and knowledge possessed by these physicians is variable. Some practice at a very highly skilled level. Others do not. It is in the interest of public safety that these physicians have access to and obtain further education for ongoing development and maintenance of emergency medicine skills and knowledge. This is a responsibility of the College, as the leading organization for emergency medicine. Education for non-EMRT physicians should not be construed as an alternate path to the
practice of EM, and focused testing should not be deemed equivalent to certification through ABEM or AOBEM, as the best preparation for a career in emergency medicine is the completion of an EM residency. Nonetheless, such education should be recognized as consistent with ACEP’s foregoing and fundamental goal “to support the highest quality of emergency medical care” and would embrace all who provide emergency care. Furthermore, it acknowledges and recognizes that such providers are a part of the overall emergency medicine workforce and will continue to serve as a means to supplement the EMRT workforce until a sufficient EMRT workforce is available.

Although theIdeal Stateis an emergency residency trained physician staffing every position in every hospital, a method should exist to address the Gap between the current state and this ideal and we propose the following:

1. Develop or adopt the specifics of the methods of education acceptable to the ACEP BOD.

2. Develop or adopt a test/process to assess the skill and knowledge of non-EMRT that is acceptable to the ACEP BOD.

3. That physicians who have completed such a course of education in a time frame acceptable to the ACEP BOD, should be offered Affiliate/Associate Membership in the College.

This educational process could be used as a guideline and aide for those ED medical directors in assessing physicians and making recommendations to the hospital’s credentialing body as called for in the ACEP Policy on Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine. It is also consistent with the ACEP philosophy that those applying for privileges should be eligible for ACEP membership. This policy states:

“A qualified emergency physician is defined as one who possesses emergency medicine training or sufficient experience in emergency medicine to evaluate and manage all patients who seek emergency care. ACEP believes that the ED medical director should be responsible for assessing and making recommendations to the hospital’s credentialing body related to the qualifications of emergency physicians with respect to the clinical privileges granted to them. At a minimum, those applying for privileges as emergency physicians should be eligible for ACEP membership. Board certification by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine is an excellent but not the sole benchmark for decisions regarding an individual’s ability to practice emergency medicine. Other qualifications may include objective measurement of care provided; sufficient experience; prior training; and evidence of continuing medical education.”
This proposal is based on the assumption that ACEP intends to embrace a central role in the care delivery system within the practice of Emergency Medicine, by maintaining a level of competency and proficiency of all those who practice within the profession. The proposal also assumes that ACEP wishes to increase its influence within the profession, one way, by increasing its number of members who practice Emergency Medicine.

**APPENDIX A:**

**Examples of Differences between Residency Programs in EM, IM and FP**

ACGME establishes criteria utilized by general and specialty residency programs. The criteria utilized in the accreditation process focus on direct patient care hours as well as didactic requirements. Representative examples of the major training backgrounds of those physicians, and the number of months per rotation, are found in the following:

<table>
<thead>
<tr>
<th></th>
<th>Emergency</th>
<th>Pediatric ED</th>
<th>Internal Medicine</th>
<th>OB/GYN</th>
<th>Radiology</th>
<th>Anesthesia</th>
<th>Cardiology</th>
<th>Medical ICU</th>
<th>Trauma</th>
<th>Surgical ICU</th>
<th>Pediatric ICU</th>
<th>Neurosurgical ICU</th>
<th>EMS</th>
<th>Elective</th>
<th>CCU</th>
<th>Ambulatory Care</th>
<th>General Surgery</th>
<th>Family Medicine</th>
<th>Geriatrics</th>
<th>Pediatrics</th>
<th>Community Medicine</th>
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<td>EM South Carolina*</td>
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<td>IM Duke University</td>
<td>2  9.5  1  1  3.5</td>
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<td>FP Nevada**</td>
<td>2  7  3  1  1</td>
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* Emergency Medicine RRC specifies that pediatric exposure be established at 4 months and some of those months can occur in the ED if the number of pediatric case exposure meets the standard. Similarly there is an exposure standard for critical care cases, which can occur in multiple settings.

** Family Medicine RRC requests 1-2 months pediatric ED exposure, 1 month cardiology, 1 month pediatric ICU which could occur in the pediatric nursery, 6 months of surgery, one month of which should occur within a surgical ICU.

One obvious difference between an emergency medicine training program and a primary care training program is the total number of required months spent within an emergency department and an intensive care setting, which intuitively address the quantity and quality of critical care situations within those focus areas, utilized in the educational experience and preparing physicians to work independently in an acute care setting. Some of those critical months and experiences may be addressed during the direct patient care months in internal medicine, ICU, CCU and surgery, and elective rotations found within the primary care residency programs.
APPENDIX B:

Suggested Methods of Providing Additional Education to Non-EMRT Physicians

These recommendations are considered the minimum required and can be supplemented by direct training experiences and in some cases may be replaced by a direct training experience.

1. Focused Educational Program under Supervision:
   
   A. The practitioner completes 7000 hours and 60 months of practicing or teaching emergency medicine

   This will address the gap recognized in the number of emergency medicine direct patient care hours that is seen between the primary care residency training programs and emergency medicine training programs, allowing for educational opportunities.

   B. Annual FPPE/OPPE completed by the Director of the Emergency Department

   This Focused Professional Practice Review will serve as a tool to be utilized as an objective measurement of performance, as well as a perceptual data tool.

   Evaluation methods may include one or more of the following: chart review (concurrent and retrospective), monitoring clinical practice patterns, direct observation, external peer review, discussion with other individuals involved in the care of each patient, an evaluation of the physician’s ability to work harmoniously with others, interpersonal skills with peers, nursing staff, ancillary personnel, and hospital administration.

   Each department may determine the terms of the evaluation for its members. Procedures crossing specialty lines will have uniform evaluation requirements. The minimum number of cases reviewed shall not be altered without the approval of the credentialing committee.

2. Didactic Education:
   
   A. Completion of and maintaining certification in ATLS, PALS, ACLS.

   This will serve as one avenue to judge didactic knowledge in the respective acute care processes.

   B. Completion of a Review of Adult and Pediatric Emergency Medicine.
This will serve as one avenue to didactic knowledge in the respective acute care process for those who have not completed clinical rotations in adult and pediatric medicine (in conjunction with a focused Educational Program under Supervision).

Documentation of training may substitute: minimum 2 months of pediatric emergency medicine direct patient care experience.

C. Completion of annual LLSA.

This will serve as a continuous CME update.

3. Focused Procedural Skills Course:

Any procedural skills required outside of the core competencies, and utilized as an adjunct during the evaluation and intervention phases of emergent care (Can be coupled with a Focused Educational Program under Supervision).