Emergency Medicine and Critical Care Medicine: Have the Stars (Finally) Aligned?

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SEE RELATED ARTICLE, P. 217.

In this issue of Annals, Huang and coauthors, a multidisciplinary group of leaders in the fields of critical care medicine and emergency medicine, strongly advocate for increased educational cross-fertilization between these 2 disciplines. Specifically, they call on the American Board of Medical Specialties (ABMS) to permit emergency medicine graduates who complete accredited critical care fellowships access to critical care medicine subboard certification.

Huang’s paper has been simultaneously published in Critical Care Medicine and has been endorsed by specialty organizations from both disciplines.

Their arguments are persuasive ones. They cite literature that demonstrates improved clinical outcomes and cost savings through increased use of trained intensivists in ICUs. The statistics are staggering: an estimated 53,000 lives and $5.4 billion saved annually with this staffing pattern. Such a magical (and unusual) combination of improved quality at lower cost is the Holy Grail of public policymakers. Not surprisingly, numerous organizations, such as the Leapfrog Group, have jumped on the bandwagon, urging substantially increased staffing of ICUs by trained intensivists.

Facing this demand for an increased intensivist workforce, the unfortunate reality is that the supply of intensivists is woefully inadequate, and the Graduated Medical Education pipeline minting new ones is similarly lacking.

Like most such complex problems, this one will be best solved with multiple solutions. However, one obvious piece of the puzzle is to open access to critical care fellowship training and board certification to emergency medicine residency graduates.

Interestingly, the Leapfrog Group has already acknowledged this rather obvious conclusion and explicitly includes emergency medicine–certified and critical care fellowship–trained (but not critical care–certified) physicians within their definition of acceptable intensivists.

There seems to be little logical rationale to limit critical care fellowship training and board certification to graduates of internal medicine, anesthesia, general surgery, and pediatric residencies. Unlike some other subspecialties, critical care medicine has always been a multidisciplinary field. Indeed, critical care medicine has as much or more in common with emergency medicine as with these other specialties. As Huang et al point out, emergency medicine residency curricula are Residency Review Committee program requirements—mandated to include at least 2 months of critical care. In fact, they often contain considerably more (mine contains 6 months).

Huang et al outline some of the history of the American Board of Emergency Medicine’s (ABEM’s) attempts to gain access to the critical care subboard at the ABMS level. These attempts have persisted, in one form or another, for more than 2 decades. Only 1 small toehold was gained, with the 1999 approval of joint internal medicine/emergency medicine/critical care residency programs, a 6-year track leading to triple board certification. However, it seems unlikely that many medical students will opt for such a daunting residency prospect. And to date, only 1 such program has been established. It is therefore unlikely that this programmatic model (an attempted compromise to a vexing conflict) will provide any meaningful answer to the workforce shortage.

Despite this one toehold, the ultimate objective of access to the critical care subboard examination has persistently eluded emergency medicine’s efforts. Finally, after decades of tilting at this windmill, ABEM threw in the towel in 2004, and ceased—at least for the foreseeable future—its efforts at the ABMS level.

As a long-time emergency medicine educator, I have no doubt that interest in critical care training exists for many emergency medicine residency graduates. Throughout the years, dozens of emergency medicine residents have independently approached me about the possibility of pursuing critical care medicine fellowship training. I’ve patiently explained the history of the quandary, noting that although it is possible that they could gain acceptance into such a fellowship, there is no current possibility that they could become critical care board-certified, at least through ABMS. After considering the situation, not one person has pursued the option.

This differs from the marketplace for other types of post-emergency medicine residency fellowship training, in which interest at times appears tepid and many fellowship slots go unfilled. In contrast, expressed interest among my own trainees runs about 10:1 in favor of critical care.

However, lack of access to critical care board certification remains the key stumbling block. Residents rightly worry that...
they may not be eligible for hospital privileging or may assume second-class status compared with other fellowship-trained and critical care board-certified colleagues. They realize that in this day and age, board certification is a critical key to their future professional success.

Other, less tangible considerations also come into play. Over the years, I’ve noted an apparent (although perhaps stereotypical) similarity in personality characteristics between emergency physicians and intensivists. They seem to share the tendencies of decisiveness, action-orientation and “work hard, play hard” (admittedly, some colleagues in other specialties have characterized it differently).

Another factor is the expectation of shift work. Critical care coverage is rapidly evolving into an in-house, day in/day out specialty, a trend seen in other areas of medicine, as well, such as anesthesia, obstetrics, trauma, and radiology. However, these changes may be at odds with preexisting career expectations. Indeed, I highly doubt that many physicians of my generation who entered radiology expected to be pulling midnight shifts.

In contrast, physicians entering emergency medicine realize from the very outset that full-time coverage, including nights, weekends, and holidays, is part of their professional career. This may be Darwinian selection or merely the establishment of realistic expectations. Regardless, it dovetails nicely with the expected future lifestyle of intensivists.

An unknown is what practice models these proposed emergency medicine–critical care graduates might adopt. It is possible that some would enter full-time critical care practice without an emergency medicine component. It is possible that others would revert to full-time emergency medicine practice without a critical care component. However, perhaps most likely would be part-time practice in both specialties. Given the shift-work nature of emergency medicine (and, increasingly, critical care medicine), such a shared practice might fit together nicely, as it currently does for many emergency medicine–internal medicine graduates who have combined emergency medicine–hospitalist practices.

Another facet noted by Huang et al. deserves strong additional emphasis. A critical piece of this puzzle is a relaxation of the federal government’s GME institutional funding caps. These caps severely limit the development and expansion of residency and fellowship training positions and inhibit the ability of our entire GME system to flexibly respond to the changing needs of society. Medical teaching institutions and their oversight agencies have never been terribly nimble, and these governmental restrictions inhibit their responsiveness even more. It will do us little good to increase the supply of trainees wishing to enter critical care training if the fellowship spots aren’t there for them.

In conclusion, we face the following scenario:

- Evidence exists that increased intensivist staffing saves substantial lives and dollars.
- In response, there is substantial public pressure to increase intensivist staffing.

- Existing critical care training models are inadequate to meet these staffing needs.
- Thus, the critical care training pipeline must be substantially expanded.
- Existing parent specialties enter an inadequate number of trainees into that pipeline.
- Therefore, other sources of trainees must be found.
- Emergency medicine has had a longstanding interest in providing such trainees at the organizational and individual level.

This certainly sounds like a win-win situation to me. Will these developments spark serious reconsideration by the ABMS and its member boards? Have these stars finally aligned? I certainly hope so.

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REFERENCES

DIAGNOSIS:

_Erythema migrans_ in Tennessee. This rash resembles _erythema migrans_; however, recently, reports of a new disease entity known as southern tick-associated rash illness have emerged.\(^1\) As with our patient, cases of southern tick-associated rash illness are associated with an erythema migrans rash that is clinically indiscernible from the rash observed in Lyme disease. Recent literature suggests that a new spirochete, _Borrelia lonestari_, may be responsible for the clinical phenomena observed in southern tick-associated rash illness.\(^2\) Furthermore, it is believed that the Lone Star tick (_Amblyomma americanum_) is the probable vector for the disease.\(^3,4\) Based on a review of available literature and the lack of confirmed laboratory evidence of Lyme disease in our region, the authors hypothesize that the rash observed in this patient was likely a case of southern tick-associated rash illness.

REFERENCES