

BOARD OF DIRECTORS REPORT F TO THE 2006 CONGRESS OF DELEGATES

CRITICAL CHALLENGES FOR FAMILY MEDICINE: DELIVERING EMERGENCY MEDICAL CARE – “EQUIPPING FAMILY PHYSICIANS FOR THE 21ST CENTURY”

EXECUTIVE SUMMARY

(1) Family physicians are an essential part of the emergency medicine safety net, and without this contribution, large areas of the country would be without adequate emergency medical care. 40% of family physicians provide emergency medical services, and many family physicians have made lifelong careers in emergency medicine.¹ The Future of Family Medicine Project (FFM) envisions a transformation of the United States health care system, in partnership with other organizations, including emergency medicine. One of the critical challenges in equipping family physicians for the 21st century is re-defining our role in providing emergency care.

(2) Historically and internationally, family medicine and emergency medicine have much in common. Both specialties have broad scopes of practice that are unrestricted by age, gender or organ system. In rural areas of the United States, family physicians are uniquely well suited to provide emergency care. Many international programs in emergency medicine are based on a primary care foundation such as family medicine.

(3) Family physicians are trained to provide emergency medical care through residency and post residency education, but have often been viewed by residency trained emergency physicians as competitors, rather than colleagues. The success of emergency medicine as a specialty has perpetuated this bias against family physicians, but several recent events may help to change this. The approval of joint training programs between the ABEM and the ACFM may provide areas of cooperation, and the recently released IOM report on the Future of Emergency Care suggests a model that is compatible with the integrative approach described in the Future of Family Medicine. The integrity of the emergency medical safety net requires family physicians.

PREFACE

(4) Marcus Welby captured the imaginations of many Americans in the 1970's and popularized the family physician as a compassionate role model. In the same way, recent television programs like 911, ER, and Trauma: Life in the ER reveal that the new medical hero in the public's eye is the “ER doc”. These programs glamorize the practice of emergency medicine, and project this image across the globe³. Although physicians may object to many of the stereotypes that are portrayed in the media, they serve as an example of the evolution of our public image. Emergency medicine is a challenging field with a unique body of knowledge, but it has many similarities with family medicine and it has important historical connections. Although most family physicians do not claim to be “ER docs”, this is still an important part of scope of practice, and in much of the world, emergency medicine and family medicine are educationally and developmentally intertwined.

INTRODUCTION

Equipping Family Physicians for Emergency Care in the 21st Century

(5) As family medicine strives to implement the transformative changes that are fundamental to reforming the specialty and the US health care system as a whole, our role in providing emergency care needs to be clarified. The Future of Family Medicine Report² calls for a New Model of care that is

grounded in timeless values of personalized, patient-centered care coupled with the application of new technologies and systems⁴. This New Model emphasizes our core values and our potential for improving the health care of our nation, but does not specifically address the important role that family physicians have in providing emergency care.

(6) The changes that are recommended in this New Model of family medicine emphasize an integrative, general approach to health care. This core value needs to be applied to the provision of emergency care in the United States, and the implication of this for the future of family medicine needs to be reconsidered. Additionally, the development of international emergency medicine holds specific implications relative to how this integrative and generalist approach should apply to emergency care by family physicians in the United States, particularly in rural areas where workforce issues are problematic.

BACKGROUND

(7) Family physicians can provide high quality, cost-effective care for all patients in different clinical settings^{5, 6}. Although many family physicians currently provide emergency care in a variety of settings, their abilities have been questioned by some within the emergency medicine professional societies and organizations. This bias against family physicians is ironic, since family and emergency medicine practitioners are the only generalists routinely seeing patients regardless of age, gender, or organ system⁷. Compounding this problem is the fact that many are excluded from certain administrative and clinical appointments^{9, 10} due to ABMS certification in family medicine rather than in emergency medicine.

HISTORY

The Emergency “Room” becomes the Emergency “Department”

(8) The birth of emergency medicine arose partly from the need for better trained physicians who could treat critically ill or multiple trauma patients¹². In 1979, Emergency Medicine was sanctioned by the American Board of Medical Specialties (ABMS) as the twenty-third medical specialty. Family physicians were among those who championed the cause, and thousands of physicians with family medicine backgrounds accessed the ABMS Emergency Medicine board exam during the 1980’s via its “grandfathering” provisions. Initially, family physicians were actively involved in the advancement of emergency medicine. Several charter members of ACEP were family physicians with a strong interest in moving the specialty forward. American Board of Family Practice (ABFP) members were also involved in the developmental phase of ABEM with the founding ABFP executive director serving on the board of the ABEM for several years¹⁵.

(9) Family medicine has contributed significantly to the well being of the rural emergency health care system. The majority of after hours and weekend coverage in rural communities has always been provided by family physicians. Residency trained American Board of Emergency Medicine (ABEM) certified physicians do not often settle in these under-served areas¹³ or, if they do agree to come, it is difficult to retain them for any length of time¹⁴.

(10) In 1976, the year that the American Board of Emergency Medicine was first incorporated, dialogue between the leaders of family medicine and emergency medicine “envisioned extensive cooperative efforts in our training programs, ... post-graduate efforts, ... legislative efforts, and residency preparation, acceptable to both family practice and to emergency medicine, which would allow us to certify that these physicians entering rural practice are indeed well prepared to practice in both of these specialty areas.”¹⁷ In 1993, the ABFP explored a combined training program leading to double board certification. This was rejected by ABEM members even though collaborative projects had been developed between ABEM and the American Boards of Pediatrics and Internal Medicine¹⁶.

(11) After more than 30 years of competition between the specialties of family medicine and emergency medicine in the United States, joint training programs have finally been approved by the ABEM and the ABFM in 2006^{1,9,10}.

PROFESSIONAL RECOGNITION AND SUPPORT

Outside the House of Emergency Medicine

(12) The American Academy of Family Physicians (AAFP) has supported its members who practice emergency medicine. In 1995, the AAFP developed a policy that stated, “Family physicians, through their training and experience, are qualified to provide emergency care services. Privileges to practice in the emergency department should be based on the individual physician’s documented training and/or experience, demonstrated abilities, and current competence.”²¹ Additionally, the AAFP published a set of core curricular guidelines on acute and emergency care for residents in family medicine residency programs.

(13) In 2006, the AAFP proposed a policy to be addressed by the 2006 Congress of Delegates²² on emergency medicine that could be the standard of care for credentialing and workforce issues, since it parallels the recommendations from the IOM Report, and provides a foundation for re-defining our role in emergency care in the 21st century.

Recommendation:

(14) *The Board of Directors approved the new policy statement on “Emergency Medicine” to read as follows:*

*(Language to be deleted is indicated by ~~strikethrough~~;
new language is noted with **bold double underlined**)*

Emergency Medicine

The provision of emergency medical care is an essential public service in the United States. Providing comprehensive emergency medical services to a diverse population requires a cooperative relationship among a variety of health professionals.

The most important objective of the physician must be the provision of the highest quality of care. Quality patient care requires that all providers should practice within their degree of ability as determined by training, experience and current competence.

Family physicians are trained in the breadth of medical care, and as such are qualified to provide emergency care in a variety of settings. In rural and remote settings, family physicians are particularly qualified to provide emergency care.

Emergency department credentialing should be based on training, experience and current competence. Combined residency programs in family medicine and emergency medicine, or additional training, such as fellowships in emergency medicine or additional course work, may be of added benefit.

CERTIFICATION AND CREDENTIALING

(15) Central to the issue of family physicians practicing emergency medicine are fundamental concerns over competency, job security, and certification. Many family physicians have made careers in emergency medicine, and in rural areas family physicians will always be the primary providers of emergency care. At the same time, the criteria for staffing emergency departments have emphasized board certification over actual physician performance.^{1, 23, 24} Specialty-neutral credentialing is not the norm in most hospital organizations. If better standards are not developed for evaluating emergency department practitioner applicants, the practice of emergency medicine by family physicians could be jeopardized.

(16) The recently released Institute of Medicine Report²⁵ concludes with recommendations that the “Department of Health and Human Services...partner with professional organizations (to) develop national standards for core competencies... (in emergency and trauma care) ... using an evidence based, multi-disciplinary process.” If enacted, these changes would be an important expansion from the restrictive credentialing that emergency medicine has previously promoted.

(17) Limited access to the ABEM examination through closure of the “grandfather” practice track created significant controversy in emergency medicine during the first few decades.^{27, 28} The ABEM exam was first offered in 1980.²⁹ From 1980 to 1988, there were two ways for physicians to qualify for the examination. One could either complete a residency in emergency medicine, or satisfy the requirements of a “practice track” pathway. The prerequisites of this option were 7,000 hours and 60 months of emergency department practice experience, with a specified number of CME credits in emergency medicine.

(18) In 1988, this alternative pathway was terminated, sparking considerable controversy and dissension. Some felt that this closure was arbitrary and premature. Others felt this action was inevitable, and adequate notification had been provided in the medical literature.

(19) The controversy surrounding certification and competency is linked to the process of how physicians are certified and by which organization. The medical profession has a closely regulated structure for conferring certification to those seeking specialty recognition.^{30, 31} The ABMS has granted specialty status to twenty-four allopathic specialties since 1933. The AOA began in 1897 with the development of Osteopathic Medicine and offers its own specialty exam: the American Osteopathic Board of Emergency Medicine (AOBEM).

(20) The ABMS and its subsidiary boards, which include the ABFM and the ABEM, set the standards for many certification processes and their acceptance by organized medicine and many institutions. In 1994, a committee of the American Board of Medical Specialties developed a proposal to revise the process of board certification. The Committee on Certification, Sub-certification, and Recertification (COCERT) recognized certification as a dynamic process, which “should permit movement of qualified individuals across specialties and sub-specialties.” They recognized that the boards should continue to establish standards and educational and/or practice requirements for admission to the examinations³⁴.” Physicians with knowledge, training, and/or experience in a given area deserve access to the examinations³⁵. In the end, the language from COCERT was viewed by many as too broad in its scope, particularly with regard to “experience” being listed as one factor in determining access to the examination.

(21) COCERT’s failed proposal left in place the certification barriers that still effectually exclude many family physicians from the practice of emergency medicine. This “specialty driven” model of emergency medicine fails to recognize the important role that family physicians have in providing emergency care, and was recently the basis for a national media campaign by the American College of

Emergency Physicians (ACEP) promoting ABEM board certification as the only standard for emergency physician quality verification.

(22) The “National Report Card on the State of Emergency Medicine” was released by ACEP in early 2006, and referred to itself as a “wake-up call” for policymakers. Purporting to report each state’s support for their emergency care systems, the Report Card used a series of measuring criteria to rank each state in four areas: access to emergency care, quality/patient safety, public health/safety, and medical liability.³⁶

(23) While the Report Card called for many worthwhile actions and goals, such as liability reforms, increased use of immunizations for the elderly, improved usage rates of seat belts, increasing numbers of trauma centers, etc., it also placed significant emphasis on the number of emergency physicians certified by ABEM in each state. A poor grade was given to any state that had a percentage of ABEM-certified emergency physicians deemed to be below a designated threshold, and importantly for family medicine, it ignored the thousands of career emergency physicians practicing in thousands of emergency departments in this country without the opportunity to have “grandfathered” into the ABEM exam. The family medicine physicians engaged in the full-time practice of emergency medicine were not mentioned, nor were they entered into any calculation regarding access to emergency care, quality of emergency care, patient safety, or liability issues.

(24) Credentialing issues have been detrimental to the emergency medicine workforce, since many competent emergency physicians have been arbitrarily excluded by restrictive policies. Although the success of emergency medicine as an academic discipline has improved the quality of care, it has led to a “hiring bias” against family physicians and other primary care trained emergency physicians. Even today, there remains a geographically determined shortage of board certified emergency medicine physicians, and family physicians have not been recognized for their role in providing quality emergency department care. Institutional support for family physicians who practice emergency medicine has gradually waned in the last decade, as emergency department directors and hospital administrators are affected by the “specialty driven” policies that emergency medicine has successfully promoted.

INTERNATIONAL EMERGENCY MEDICINE

(25) As emergency medicine has matured as a specialty in the United States, it has brought recognition and academic strength to a field that was previously considered to be the domain of moonlighters. 25 years ago, when the American Board of Medical Specialties recognized emergency medicine as a “primary specialty”, it opened the door for acknowledgement that there is a unique body of knowledge in emergency medicine.³⁷ Prior to this, emergency medicine was defined by location (the emergency “room”), rather than being defined by a body of knowledge and the skills necessary to practice this specialty.

(26) The literature on international emergency medicine is replete with examples of how family medicine and other primary care specialties can provide a foundation for emergency medicine training and development. Internationally, family medicine training is recognized as providing the requisite skills that are easily enhanced through focused clinical training (fellowships) in emergency medicine. In Anglophone countries such as the United Kingdom and Australia, emergency medicine is a subspecialty with close associations with the disciplines that provide access to this supplemental training. The title of a recent article in the National Medical Journal of India speaks for itself: Developing Emergency Medicine through Primary Care.³⁸ Canadian physicians can either complete a one year emergency medicine fellowship after family practice residency that leads to a recognized certification process (CCFP-EM), or can train in a 4-5 year program intended to train “specialists” (FRCPCs).³⁹

NEW STANDARDS

IOM Report Endorses Family Physicians in EM

(27) The recent release of the Institute of Medicine report entitled “The Future of Emergency Care in the United States Health System” describes the condition of emergency medicine in our nation and gives it a poor prognosis unless dramatic changes occur. It describes in detail the developments in the last few decades, but also describes a system that is fragmented and inconsistent in the level of quality that it provides. In addition to focusing on issues such as overcrowding, poor coordination among emergency medical systems, shortage of on-call specialists and lack of disaster preparedness, the report addresses in detail the “The Emergency Care Workforce” and rural emergency medicine.

(28) Comprehensive in scope and astute in analysis and prescription, the IOM Report stands as a challenge to the current paradigms espoused by many health care experts in emergency medicine. The report concludes with recommendations that point the way to “coordinated, regionalized and accountable” solutions that will require change in a number of the ways that emergency care is structured in the United States. These include more collaborative efforts between specialties, and core curricula for all physicians involved in emergency care. The essential role of family physicians in rural areas is described in detail, and the need for improved cooperation with academic emergency medicine is emphasized. Family physicians are described as part of the “essential component of the ED workforce at many hospitals, especially smaller facilities in suburban and rural settings. Although they are certifiably ABFM rather than ABEM, they demonstrate a high level of competency in emergency care through a combination of residency and post-residency education, directed skills training, and on the job experience.

WORKFORCE STATISTICS

Access Across America

(29) The ACEP Workforce Studies of 1997 and 1999 estimated that there were 32,000 emergency physicians, and that 38 percent of these physicians were neither board certified nor residency trained in emergency medicine. 84 percent of these non-EM certified physicians had completed a residency in another specialty, with the largest percentage being family medicine trained (32 percent).^{41, 42}

(30) Currently, there are more than 1000 emergency medicine graduates each year, and more than 135 emergency medicine residency programs.⁴³ Growth in emergency medicine has exceeded growth in most specialties overall, but for several more decades, the workforce is likely to be dependent on emergency physicians who trained in other specialties.⁴⁴

(31) Some emergency medicine leaders feel that the major problem is no longer a workforce shortage, but a mal-distribution of residency-trained emergency physicians.¹³ This is certainly consistent with the data, since most emergency medicine training programs are in urban areas.

(32) In rural areas, family physicians provide the overwhelming majority of emergency care.⁴⁵ Out of 4,919 US community Hospitals in the United States, 2200 were rural hospitals reporting emergency visits (AHA 2001). The average rural emergency room census was 9500 visits (AHA 2001). According to the Graduate Medical Exam National Advisory Counsel report on the Number of Persons Needed To Support Specific Physician Specialties, 18,000 people would be required to support one emergency medicine residency trained physician. This explains in part why EM trained physicians tend not to settle or work in rural areas, and why many hospitals rely on local family physicians for emergency department coverage.

(33) Compared to the 21,000 family physicians that live and work in rural America, only a fraction of this number of emergency physicians practice in rural areas. According to the Robert Graham center only 3323 emergency medicine trained physicians practice in Non-Metropolitan service areas, and the number of residency trained emergency physicians who practice in rural areas is less than 2000 physicians. Between 1997 and 2002, the percentage of residency trained emergency physicians practicing in rural areas decreased from 15 % to 12 %, even as the percentage of medical students entering EM training programs steadily increased. It should be noted that 50 million people or one fifth of the population of the United States reside within Non metropolitan Service Area counties.

Family physicians are uniquely qualified to provide emergency medical services in rural communities.

(34) Family physicians provide most of the emergency medical care in rural communities, since they live and work within these communities. One-fourth of family physicians practice in communities of less than 10,000 people, while one-fourth of the U.S. population lives in such communities. The IOM Report on emergency medicine addresses the essential role that family physicians have in providing rural emergency care, as well as the challenges, but may not adequately address the strengths that family medicine brings to rural issues.

(35) Rural communities have emergency rooms with fewer patients, lower overall revenue and often cannot afford a full time EM trained physician. Rural Hospital ERs report an average census of 9500 visits which is roughly half what is necessary to support an EM trained physician. Because of their broad scope of practice including procedural and obstetrical skills, family physicians have other sources of revenue, and can staff low volume EDs far more cost effectively. This can make the critical difference as to whether a community can afford emergency care.

(36) Using community physicians in the emergency room allows greater physician staffing in the hospital and in the community, thus increasing hospital revenue and community safety. A well trained Family physician can generate additional revenues by performing diagnostic procedures, or⁴⁷ obstetrical services⁴⁸. Family physicians can evaluate patients in the ED, admit patients to the hospital, and follow them to discharge as the attending physician, which is necessary for hospitals with small medical staffs. Family physicians are trained to operate independently in communities without sub-specialist physicians, and rapid transfer of critical patients is often impossible.

(37) Small communities often have strong ties with their local family physicians, and desire to see them when presenting to the emergency room. Access to health care in rural communities depends on numbers of primary care provider.⁵⁰ Patient satisfaction for medical services in rural communities is greater than in urban or suburban communities, and the outcomes are equivalent or better.⁵¹ In rural communities, confidence in medical care is directly related to length of relationship between the provider and the patient⁵², and family physicians in rural areas care for their patients from the cradle to the grave, during chronic illness and acute, life-threatening events. Emergency care is an integral part of this relationship.

EMERGENCY MEDICINE TRAINING

A Matter of Perspective

(38) Some may wonder why the American Board of Family Medicine (ABFM) hasn't supported the establishment of emergency medicine as the basis for a Certificate of Added Qualifications (CAQ). According to the rules of the American Boards of Medical Specialties (ABMS), primary certifying boards are prohibited from establishing subspecialties or CAQs in clinical domains where another major specialty already exists. Thus, since an American Board of Emergency Medicine (ABEM) is currently in existence, the ABFM cannot establish a CAQ in emergency medicine.

(39) Joint training guidelines for combined residency programs in family medicine and emergency medicine have recently been announced.⁵⁸ This is the outcome of efforts initiated more than 15 years ago when residency directors noted the substantial overlap in curriculum between the two specialties and medical students began inquiring why internal medicine and pediatrics had combined programs with emergency medicine, but family medicine did not. The joint training guidelines describe an integrated five-year curriculum with equal emphasis on the two disciplines. Resident physicians enrolled in such programs will benefit from the opportunity to train in the intense environment of advanced-level trauma centers, while at the same time reaping the educational advantages of continuous and comprehensive patient care in a family medicine center.

(40) The contribution and impact of these programs on the workforce remains to be determined, but their development promises to improve academic cooperation. They are unlikely to solve many of the issues facing rural areas, because the length of the training programs may exacerbate the problem of recruiting these graduates to isolated areas. Even if most graduates become academicians, as do those who complete joint ABEM-ABIM (Internal Medicine) programs, they highlight the similarities instead of the differences between EM and FM.

Within Family Medicine Residencies

(41) The 2006 edition of the Program Requirements for the Accreditation of Residencies in Family Medicine demonstrates increased attention to emergency care training within family medicine residencies.⁵⁹ For example, the required curricular time has been increased requirements for advanced life support have been clarified, procedures for both medical and trauma emergencies are specified, and the minimum experience with critical care patients have been defined.

(42) Notwithstanding the changes in family medicine residency requirements, trainees in family medicine who plan to practice predominantly in an emergent care setting may need to further expand their clinical training. This would include additional skills in emergency procedures and trauma care⁵⁶, and more familiarity with the rapid, algorithmic approach that typifies advanced resuscitations.⁶⁰

Fellowships Enhancing the Core Curriculum

(43) Fellowships in emergency medicine developed in the 1990's for family physicians and other primary care physicians in response to the need for additional training in emergency medicine in academic centers.

(44) One year fellowships [family medicine – emergency medicine] have been established as a logical extension of accredited family medicine residencies in West Virginia, North Carolina, Arkansas, Tennessee, Texas, and other states.⁶² These have been successfully used as pathway to credentialing in community hospitals and academic settings, or as a needed enhancement of acute care skills prior to frontier medicine, rural practice, or international missions. The advantages of these fellowships have been their flexibility and financial feasibility. Generally they can be self funded due to the high need for workforce in rural areas, and the fact that the learners are residency graduated physicians.⁶³ These fellowships have successfully modeled the rural reality of simultaneously staffing the office, the ER, and the hospital, and provide access to enhanced training for graduates of family medicine residencies who plan to practice in rural areas.

Training Considerations for Rural and Remote Settings

(45) In the emergency departments of rural and remote communities, the vast majority of patients presenting for care will be there as a result of minor injuries or exacerbations of chronic illnesses. In these areas, the ideal physician is a “generalist with expertise in emergency medicine.”⁶⁴ The training environment for most of today’s emergency medicine residencies is one where specialty consultants and advanced technology are readily available to the emergency physician to assist in the assessment and care of their patients. Most rural and remote emergency departments lack those kinds of resources, and physicians caring for patients in those settings must depend upon their own best clinical skills and judgment to a greater degree than in the typical urban center. For this reason, it may be arguable that the training breadth of the family physician is better suited to the care of most emergency patients in rural and remote settings than the typical emergency medicine residency graduate.

(46) A unique program has been recently developed for those family physicians who periodically face the challenge of providing “first hour” emergency care in rural areas. The Minnesota Chapter of the AAFP has created an innovative Comprehensive Advanced Life Support Course (CALS course).⁵⁷ The curriculum includes teaching material from all the major advanced life support programs, and both family medicine and emergency medicine leaders are involved in its development. This project promises to strengthen the preparation of family physicians and other physicians and health care providers who currently practice in rural areas, and who need additional training in emergency medicine.

(47) The success of this course could lead to a similar program for all rural physicians who provide emergency stabilization, and serves as a model for collaborative approaches between emergency medicine and family medicine. A team approach involving all EMS providers is integral to the program, and life-saving procedural skills and a core body of knowledge in emergency medicine are basic components of the curriculum. More such focused collaborative projects are necessary, and are part of the mandate delivered by the IOM report.

RESEARCH AGENDA

(48) The research agenda for family physicians should be collaborative, and practice-based with a focus on how family medicine can have an impact in such varied emergency environments as urban, rural and remote areas. Practice-based research networks (PBRNs) are designed to address such questions through the integration of research and everyday practice. The AAFP National Research Network includes more than 300 FPs in 45 states with integration of an electronic medical record system. Collaboration with Pediatric PBRNs and with emergency medicine research groups can allow for expanded research into new areas such as the economic impact of family physicians in emergency medicine, quality of care and efficient utilization of emergency resources, especially in rural areas.

(49) Family physicians that practice full time emergency medicine, whether in academic settings or community hospitals, are part of the emergency medicine infrastructure. Institutions and physicians involved in this aspect of emergency medicine should be aware of the recommendations of the Institute of Medicine for emergency care research, since it “ involves many disciplines and cross-cutting themes.”⁶⁵ As academic cooperation increases between the specialties on the residency training level, family physician educators and graduates of joint training programs will be involved in these areas of research including resuscitation science, injury prevention, and epidemiology. Many of these areas are included in family medicine curricula, and evidence based research for acute care is a strength of 21st century family medicine.

(50) A small database of research already exists on the unique aspects of emergency care that is provided by family physicians, but more data is needed to enhance the science of family medicine in this area. Many hospitals and communities are in financial distress, and additional research in rural and critical access hospitals on the cost effectiveness and quality of care of family physicians is needed.

Other issues needing investigation and study include rural emergency care delivery, provision of “first hour” emergency care in family physician offices, trauma care in remote areas, and procedural skills. One successful example of this kind of project demonstrated that family medicine graduates providing care in Colorado emergency departments felt that they were adequately trained in emergency medicine, but would benefit from more exposure to trauma training and enhanced contact with EMS personnel.

AN EXPANDED SCOPE

Wilderness Medicine

(51) Family physicians have been actively involved in the practice and development of wilderness medicine. The broad diversity of training that is part of family medicine residency programs is easily adapted to the low-tech requirements of emergency care in remote areas.

(52) The initial Wilderness Medical Society membership included family physicians and other specialists. Family physicians have flourished within the specialty and this organized body has been a strong educational support for family physicians that practice in rural/remote areas. Through this, they have encouraged the development of this unique discipline that integrates many aspects of emergency medicine and family medicine, as evidenced by such topics as high-altitude medicine, search and rescue, tropical and desert emergencies, emerging infections, and space exploration.⁷⁷ This field is built on cooperation between the two specialties and individual physicians who share a love of outdoor adventure and innovation, and should be a model for other areas of collaboration.

Urgent Care

(53) Many physicians with either family medicine or emergency medicine training practice “urgent care.”

Disaster Medicine

(54) The flexibility and depth of family medicine can be recognized in such areas as disaster preparedness and bioterrorism planning, which are a key part of the IOM’s recent recommendations for emergency care in the United States.⁴⁰ Given the potential for all types of disasters and the need for early recognition and immediate response, family physicians are essential to disaster medicine’s success, in both the clinical and the administrative setting. Family physicians represent a critical asset in natural or man-made disasters as exemplified by their involvement in the response to the Anthrax attack in the DC-Metropolitan area, the SARS epidemic in Toronto, the international crisis that developed from the Tokyo subway chemical incident, and most recently the growing Avian flu outbreak abroad. Through research and clinical practice, family physicians have been intimately involved in the development and improvement in surveillance techniques that led to the recognition of these developing global crises. FPs have developed systems of collection and analysis with state and local health departments on injury incidence, disease trends and bioterrorism community threats. In addition, family medicine leaders are actively involved in disaster preparedness planning at all stages, from leadership positions to first responders. FPs may be the first health professionals to identify diagnostic clues that are crucial in early infectious disease outbreaks in order to generate a quick, efficient public response.

(55) FP educational leaders have been involved in disaster training, including different methods such as distance learning, field exercises, drills and written material distribution. Family physicians both at the national and state levels have made a concerted effort to include disaster management and intervention as part of established professional curricula, continuing medical education and certificate programs. They

also serve on hospital/EMS and other emergency board and committees to assist in developing strong interagency response networks, which will be critical in a live scenario. When a disaster takes place, it is most likely family physicians will be involved at some level, either directly on the front-lines of recognition, or interagency communication of critical information, transport, regionally or nationally.

(56) Disaster management in rural areas has not been as focused as it has been in urban environments. However, the threat of terrorism may be great in rural areas because of the remote locations of the most likely targets of terrorism, such as nuclear power plants, chemical facilities, and Air Force missile launch stations. Rural areas are faced with many problems in disaster preparedness including limited resources and staff, surge capacity problems within small hospitals and lack of equipment. However, family physicians in rural areas have learned to adapt and creatively overcome significant barriers that already exist in the rural health care system. This un-recognized expertise needs to be strengthened through integrated urban networks/communication systems in order to improve the national response to the next true catastrophic event. The Institute of Medicine report clearly identifies the need for improved disaster training for all physicians, and the critical need for improve disaster preparedness in rural areas. Family physicians are key to this process.

CONCLUSION

Critical Challenges

Providing comprehensive emergency medical services to a diverse population requires a cooperative relationship among a variety of health professionals.

(57) Delivering quality, comprehensive emergency care requires that emergency medical care and workforce issues be based on “best practices” models that include all necessary and contributing specialties and disciplines. In the 21st century, competition should be replaced with cooperation built around joint training programs between ABEM and ABFM, as well as new policies which recognize and support the critical role of family physicians in emergency medicine in the U.S.

The most important objective of the physician must be the provision of the highest quality of care. Quality patient care requires that all providers should practice within their degree of ability as determined by training, experience and current competence.

(58) The AMA, AAFP and most medical specialties have adopted the policy that medical practice privileges be based on “training, experience and demonstrated competence,” not arbitrary specialty. The IOM report emphasizes that high quality, efficient, and reliable patient care can best be achieved through integrative approaches. Core competencies in emergency medicine should be evidenced based and multi-disciplinary.

Family physicians are trained in the breadth of medical care, and as such are qualified to provide emergency care in a variety of settings. In rural and remote settings, family physicians are particularly qualified to provide emergency care.

(59) Family medicine training equips physicians to provide urgent and emergent care to patients, with an appreciation for the full scope of longitudinal and continuing care. Whether in the hospital-based emergency department, the rural office practice, or in remote sparsely-settled terrain, family physicians draw from the wealth of all the medical and surgical specialties when managing emergency patients. In rural areas, these unique skills combined with strengths such as availability and cost effectiveness make family medicine the foundation of rural emergency care.

Emergency department credentialing should be based on training, experience and current competence. Combined residency programs in family medicine and emergency medicine, or additional training, such as fellowships in emergency medicine or additional course work, may be of added benefit.

(60) Improving emergency care in the 21st century will require a “multi-pronged strategy that includes improving efficiency and a coordinated, regionalized, accountable system” (IOM report). Practicing family physicians need to be integrated into this process. Joint training programs are another way to begin this cooperative approach, as are fellowships in emergency medicine (i.e., the Canadian model).

Supplement #1

(61) The Canadian system may provide a helpful model for the United States, since residency trained emergency physicians provide academic leadership to the specialty, but family physicians are recognized for their essential role in providing emergency care.^{78, 79} The College of Family Physicians in Canada (CFPC) offers a special competency certification in emergency medicine to qualified family physicians through either a two-year residency program, or a practice tract eligible pathway.⁸⁰ All candidates must pass a rigorous “special competency” exam in the specialty. The Royal College of Physicians and Surgeons certifies residents who complete a four- or five-year program in emergency medicine. The first qualifying exam was offered in 1983, and grandfather eligibility through a practice track existed through 1987 (Royal College of Physicians and Surgeons of Canada, 1988). During this period a significant number of physicians became double boarded in Family and Emergency Medicine. Interestingly, just as in the United States, consideration for a conjoint certification by both Colleges occurred, but no agreement could be reached concerning the details of the training program.⁸¹ Both organizations, however, have continued to collaborate on clinical practice and quality of care issues.

(62) The College of Family Physicians of Canada supports cross training in emergency medicine for family physicians, and there is greater acceptance of this within the medical community. (Physicians and Surgeons of Canada, 1994) Many of these specialists have chosen high level administrative positions. The Canadian Association of Emergency Physicians (CAEP) has also developed an abbreviated core CME program, which is similar to an intensive several month rotation. It is province specific, and is not universally available in Canada. It is a refresher course for those family physicians interested in improving their emergency medical skills. The instructors are from both the College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada (RCPSC). The one-year post-graduate emergency medicine training program is also organized and directed by certified physicians from both disciplines.⁸² These collaborative efforts provide a model for cooperation that should be considered by medical associations and certifying boards in the United States.

Supplement #2

(63) Rodney WM, et al. have posted their curriculum proposal [www.psot.com; subsection on the Association for Rural Family and Emergency Medicine. These fellowships are likely to maintain a market advantage since they produce the same outcome in four total years as compared to the ABFM-ABEM proposal which requires five years. The joint training programs have an inherent academic legitimacy that ACEP and ABEM will accept. The fellowship programs are consistent with the AAFP position that: “Combined residency programs in family medicine and emergency medicine, or additional training, such as fellowships in emergency medicine or additional course work, may be of added benefit.” This is an idea whose strength has been maintained despite opposition from ACEP. John Peter Smith Hospital has reported a very successful first year with its program which opened in 2005.⁸¹

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