

## Emergency medicine training

Editor's note: Two different educational tracks can lead to emergency medicine specialization in Canada: the 5-year emergency specialist program of the Royal College of Physicians and Surgeons, and certification from the College of Family Physicians. We asked two experts in emergency medicine to comment on the relative merits of these training paths. Ivan P. Steiner's perspective follows this comment by James Ducharme.

# Preparing emergency physicians for the future

**James Ducharme**

β See related article page 1549

Where is emergency medicine headed? Budget constraints leading to decreased acute care bed availability have affected all of medicine, but emergency medicine most of all. Forced to cope with increasing numbers of admitted patients, emergency departments suffer from a lack of acute care beds. Bed shortages create stressful working conditions and oblige emergency physicians to increase their scope of practice. Patients who in the past would have been quickly transferred to wards receive longer-term care in the emergency department. Many patients are held overnight or under observation rather than being put through the futile exercise of requesting a (brief) admission. Patients who require intensive care are often held in the emergency department for many hours. Consequently, emergency physicians are required to improve their critical care skills. Because failure to improve such skills will result in suboptimal outcomes for these patients, residency training has to address this change in emergency department practice.

Emergency department overcrowding is an issue in rural sites as well, owing to fewer local resources, and delays in patient transfers to overburdened tertiary care centres. How can we expect rural physicians — the foundation of primary emergency care in Canada — to manage acutely ill, unstable patients for longer periods of time?

When we add the problem of an aging physician population to the problem of an increase in critical care demands and the associated increase in stress, we can predict an exodus of general practitioners from emergency medicine. Family physicians who hope to incorporate emergency care into their practice will have to consider adding more emergency and intensive care rotations to their training.

There is a power vacuum in emergency medicine. Although we supply an adequate number of specialists to many areas, we need more leaders with long-term vision and planning ability. As a group, we are stumbling forward as health care changes dramatically around us. Although there are many successful directors who are improving care

at many sites, there are not nearly enough, and very few have administrative training. We need more leaders in our specialty to establish national standards, to identify and solve workforce issues and to plan emergency medicine for this century. We have yet to establish a structure that provides time to work on these issues: almost all contributions toward improving emergency medicine are provided by physicians on a voluntary basis, adding to their already lengthy lists of tasks.

Emergency specialists from the Royal College of Physicians and Surgeons of Canada (RCPSC) will remain a minority among physicians providing emergency care. Expertise is required in several nonclinical areas, such as administration, teaching, research, pre-hospital care and toxicology. A 5-year program is necessary to provide training beyond the primary clinical domain. The RCPSC program in emergency medicine must respond to that need and encourage even further training after residency. A 5-year residency is not required to produce a good emergency clinician, but it is required if we hope to prepare physicians for nonclinical roles. The primary reason the RCPSC program was lengthened by a year more than a decade ago was to allow a fellowship-type year to encourage nonclinical expertise.

In a time when we have an inadequate number of physicians, it does not make sense to restrict clinical positions to RCPSC graduates only, as is the practice in many centres. Most clinical positions in major centres can and should be filled by physicians with emergency medicine certification from the College of Family Physicians of Canada (CCFP-EM). The 2 programs complement each other very well: the clinical scope of the CCFP-EM program and the academic scope of the RCPSC program are both desperately required in emergency medicine in Canada.

Students considering emergency medicine as a career should understand why the programs are different, and that these 2 options will have different implications for their future career path. With such limited residency po-

sitions available, it makes little sense to have a resident train in an RCPSC program for 5 years only to enter a purely clinical practice. This needs to be made clear to medical students before and during residency interviews. Most CCFP-EM residents should expect to enter a practice that is focused primarily on patient care, but which may also accommodate interests such as clinical or didactic teaching.

For emergency medicine to fulfill its role in coming years, we need to prepare residents for the emergency department as it now exists and how it is expected to evolve — not how we wish it could be. We will not be working in emergency departments where admitted patients move immediately to ward beds.

Family medicine, the CCFP-EM program and the

RCPSC fellowship each provide training that leads to satisfying, but different, emergency medicine careers. There will always be exceptions in emergency medicine training, but those exceptions should not be used to conclude that the programs produce similar results. All 3 training pathways are essential in providing quality emergency medical care in Canada.

Dr. Ducharme is Professor, Emergency Medicine, Dalhousie University and Clinical Director, Department of Emergency Medicine, Atlantic Health Sciences Corporation, Saint John, NB.

*Competing interests:* None declared.

**Correspondence to:** Dr. James Ducharme, Atlantic Health Science Corporation, c/o Saint John Regional Hospital, PO Box 2100, Saint John NB E2L 4L2; DUCJI@reg2.health.nb.ca

## Emergency medicine practice and training in Canada

Ivan P. Steiner

β See related article page 1548

In the late 1970s, emergency departments of urban hospitals were staffed by physicians without formal training in emergency medicine, which was not recognized as a distinct, specific discipline. Comprehensive emergency care was rare. Most university emergency departments did not provide round-the-clock coverage by an attending physician, and during the night shift unsupervised junior residents made all decisions related to patient care. Undergraduate education in emergency medicine did not exist, and a 1-year rotating internship was often sufficient in many jurisdictions to obtain a licence for general practice and to practise emergency medicine.

In June 1980, the Royal College of Physicians and Surgeons of Canada (RCPSC) recognized emergency medicine as a free-standing specialty requiring 4 years of residency training. (This was subsequently extended to 5 years.) Concurrently, the College of Family Physicians of Canada (CFPC) identified the need to upgrade emergency medicine education for family physicians (FPs) and created the administrative framework for a 1-year training program. As a result, emergency care in Canada today is provided by a heterogeneous group of clinicians. In urban centres, emergency departments are staffed by specialists who hold fellowships from the RCPSC (FRCPCs), FPs with certificates of special competence in emergency medicine from the CFPC (CCFP-EMs) and progressively fewer FPs

and clinicians with a general licence.<sup>1</sup> The situation is different in smaller regional and rural hospitals, where the latter 2 groups provide virtually all emergency care. This diversity of emergency care providers reflects the varied educational, economic and geographic realities of our vast country, and it is further complicated by an overall shortage of Canadian emergency physicians.<sup>2-4</sup>

Moorehead and colleagues<sup>5</sup> have calculated that, in the United States, physicians certified or trained in emergency medicine fill 58% of full-time-equivalent positions in acute care hospitals, and FPs and internists account for most of the rest. Adapting their formula to a Canadian setting, we can calculate that physicians certified in emergency medicine in this country fill about 45% of full-time-equivalent positions and that FPs fill the rest. In the United States, 124 emergency medicine training programs produce 1136 graduates each year.<sup>6</sup> In Canada, at present, there are 27 training programs: 11 for FRCPCs and 16 for CCFP-EMs, with 20 and 70 postgraduate entry positions, respectively.<sup>7,8</sup> Even with 2 educational tracks, the proportion of residency positions that are in emergency medicine is 21% lower in Canada than in the United States.

In Canadian urban and regional settings, career emergency physicians are coming increasingly from these 2 educational tracks and provide comprehensive, round-the-clock patient care. This workforce comprises a large cohort of full-