An Unfulfilled Mandate: FPs Vital to EM

BY W. ANTHONY GERARD, MD; PERRY A. PUGNO, MD, MPH; & WILLIAM MACMILLAN RODNEY, MD

The perception of emergency physicians has dramatically improved over the past 30 years. The house of medicine and the public now recognize emergency physicians as highly skilled specialists. TV shows such as “ER” and “Code Black” dramatize the skills of EPs in the urban EDs of LA and other big cities, and these highly skilled emergency specialists deserve the limelight. But this isn’t just a rural issue. Many emergency physicians as highly skilled specialists, and may look down on family physicians as generalists. But we have forgotten some core values and our history. Emergency medicine and family medicine should be working together because we are developmentally and intrinsically linked. (Texas J Rural Health 2000; 18[1]:19.)

Family physicians were among the pioneers when emergency medicine was approved as the 23rd medical specialty in 1979. Thousands of family physicians helped start the specialty and took the ABEM practice track exam during the 1980s. Dialogue between the leaders of family medicine and emergency medicine in the early years of ABEM “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.” (JACEP 1976;5[11]:909.)

Today, emergency medicine rarely collaborates with family medicine. The Institute of Medicine’s report on emergency medicine in 2006 provided a mandate that has been unfulfilled. The IOM called for “more collaborative efforts...because family physicians are an essential component of the Emergency Department (ED) workforce...certifiably ABFM rather than ABEM ... but with 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.” In spite of this, emergency medicine still ignores family medicine in health policy discussions.

Emergency medicine still ignores family medicine in health policy discussions.

Emergency medicine and family medicine have much in common. Both have broad scopes of practice, and see patients regardless of age, gender, or organ system. But emergency medicine rarely acknowledges its similarities with FM. Emergency medicine in the United States is often equated with the kind of EDs portrayed on television: fast-paced, high-tech, multiple consultants. Many emergency physicians consider themselves specialists, and may look down on family physicians as generalists. But we have forgotten some core values and our history. Emergency medicine and family medicine should be working together because we are developmentally and intrinsically linked. (Texas J Rural Health 2000; 18[1]:19.)

Family physicians were among the pioneers when emergency medicine was approved as the 23rd medical specialty in 1979. Thousands of family physicians helped start the specialty and took the ABEM practice track exam during the 1980s. Dialogue between the leaders of family medicine and emergency medicine in the early years of ABEM “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.” (JACEP 1976;5[11]:909.)

Today, emergency medicine rarely collaborates with family medicine. The Institute of Medicine’s report on emergency medicine in 2006 provided a mandate that has been unfulfilled. The IOM called for “more collaborative efforts...because family physicians are an essential component of the Emergency Department (ED) workforce...certifiably ABFM rather than ABEM ... but with 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.” In spite of this, emergency medicine still ignores family medicine in health policy discussions. (J Emerg Med 2010;39(2):210.)

Health policy leaders until recently predicted that the United States would eventually have enough emergency medicine residency-trained physicians to meet workforce needs. But it is now clear that this is unlikely to happen, and family physicians are needed on next page
**LETTERS TO THE EDITOR**

**Robust Counterpoint**

Editor:

I am shocked that EMN published this article without a counterpoint or this possibility of comments on the website. (“Do Simple Abscesses Need Antibiotics? Probably Not,” EMN 2016;38[8]:1; http://bit.ly/2aZwMK.) A positive trial is said by the reviewer as leading to no change in practice because enough people get better without the intervention anyway?

Given the wide distribution of your publication, I would advise a modification of your editorial process to allow for more robust counterpoints or ability for readers to comment so that physicians in training are able to appreciate an alternative viewpoint, particularly when publishing such controversial reviews.

Christopher Zammit, MD
Rochester, NY

**Recertification an ‘Insult’**

Editor:

I stand with those emergency physicians who will not be participating in the recertifying examination in the next cycle. This needless recertifying exam in my opinion does nothing to ensure quality, efficiency, ethical conduct, knowledge, or patient safety. (“Isn’t It Time to Abandon the Recertification Exam?” EMN 2016;38[6]:7; http://emn.online/MindfulJune16.)

Despite the platitudes and blather regarding the need for recertification via testing, I remain in strong opposition. I consider this process an insult considering the countless hours and sacrifices we as board certified emergency physicians make to achieve our original board certification.

I am prepared to take the consequences of my decision and support others who are similarly inclined.

Andrew Garlisi, MD, MPH, MBA
Chardon, OH

**LEARN is not What Makes an Organization LAME**

Editor:


People are not cars! Of course not. Lean evolved from Toyota’s experience, but it is really about the way people organize themselves to get work done. Lean is built upon continuous improvement and respect for people. Both are essential to overcome the inevitable tension that exists between an organization pursuing its goals and individuals doing their work. Successfully navigating this dilemma explains why Lean works, not just in assembly-line manufacturing but also in software development, legal offices, nonprofits, government, and even health care. Lean is about how people function together.

The consultant berated Dr. Cotton for not seeing lower-acuity patients faster because this would have a bigger impact on satisfaction results and reimbursement.

This tension lies between quality and delivery — the need to get the work done given the demand, yet to get that work done well and in a manner safe for those doing the work and those who benefit from that work. In other words, the choices about what to do and what to do next given the demands, space, staff, and time available leads to conflict. Unexpected results that affect cost and unintended consequences that affect patients and caregivers happen despite the best of intentions. If Dr. Cotton’s organization had truly followed Lean, administrators would have recognized that profit is generated at the bedside. Physicians, nurses, and staff would acknowledge that they do it and how they do it affects financial survival. “Misconceptions about your method of production add unnecessary cost,” said Taichi Ohno, a chief architect of the Toyota Production System. People in different places in an organization see the issues differently. Executives understand the importance of quality but focus on financial viability. Physicians realize cost is important but concentrate on patient outcomes. Each responds to different concerns, expectations, requirements.

Continued on page 9

**FPs Vital**

Continued from previous page

the logical choice to supplement the EM workforce. (“Emory Med 2009;27[6]:69; Ann Emerg Med 2009;54[3]:349.”) The geo- graphically determined shortage of board certified emergency physicians will remain an unsolvable problem until EM cooperates with FM to address these issues.

The American Academy of Family Physicians (AAFP) has consistently recognized that providing emergency care is an integral part of family practice: “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 fellow- shipships in emergency medicine or additional course work, may be of added benefit.” (AAFP Policy Statement, 2006; http://bit.ly/2bP8C7v.)

No matter how persuasive the evidence, it is difficult for some academic emergency physicians to accept the idea that family physicians should be part of the EM workforce. Is organized EM remaining specialty centric instead of patient centric? (“Ann Emerg Med 2013;62[6]:645.”)

Delivering high-quality emergency care requires that emergency medical care and workforce issues be based on best practices that include family physicians. This critical challenge remains, and family medicine organizations may need to move forward on this issue independent of emergency medicine. (“Ann Fam Med 2010;8[6]:564; http://bit.ly/2cZllie.) Until patient care becomes more important than the politics of medicine, emergency medicine organizations risk continuing to ignore the IOM mandate.

**Dr. Gerard, clockwise from top left, is an emerg-**
**ency physician at Lebanon VA Medical Center in**
**Lebanon, PA, and an assistant clinical professor at**
**Penn State College of Medicine in Hershey.**
**He has been an active member of the American**
**College of Emergency Physicians and the Amer-**
**ican Academy of Family Physicians since 1990.**
**He helped develop ACEP’s Legacy Physicians**
**policy and co-founded the AAFP Member Inter-**
**est Group-EM. Dr. Pugno was formerly the vice**
**president of education for the AAFP, a family**
**medicine residency director, trauma center**
**director, and chief medical officer. His commit-**
**ment to EM and FM led to the development of**
**joint training programs between ABFM and ABEM.**
**Dr. Rodney served as a professor and the chair**
**of family medicine at the University of Tennessee-**
**Memphis and at Vanderbilt/**
**Meharry, where he was also a professor of surgery/emergency medicine.**