Post Graduation in Emergency Medicine : Master of all Arts?

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Abstract :
Emergency medicine (EM) is an evolving medical speciality which involves care for undifferentiated, unscheduled patients with acute illness. Apart from handling emergencies, EM physicians also treat a wide variety of minor illnesses, since they provide care 24 hrs a day when primary care offices are closed.To weigh pros over cons in EM Post Graduations (PG). To stress upon few things which are to be looked into by the Medical Council of India to make PG in EM better. EM encompasses care involving the acute care of medical and surgical conditions. This is the only speciality where one can get the feeling of a surgeon, physician, obstetrician, orthopaedecian, intensivist etc., in short "Master of all arts".

Emergency medicine (EM) is a fast paced team oriented speciality where doctors can have tremendous impact on patients. Emergency physicians are experts in diagnosing and managing the acute undifferentiated patients. Emergency medicine residency training began in the 1970s and the American board of Emergency medicine was recognized in 1979. In USA dramatic growth in EM residency programmes boosted in the number of EM specialists now staffing Emergency department (ED) through out the country[1]. In India, Medical council of India recognized MD Emergency medicine as a speciality from 2009. Here are some of the pros & cons one should consider before opting for a career in EM.

Advantages :

- **Feeling like a real Doctor** : Emergency physicians are trained to handle virtually any emergencies. Although many patients require additional care (for example surgery), the emergency physician has the tools needed to begin the management of any acute medical or surgical illness or injury. They will manage sick patients everyday and have the opportunity to perform life saving procedures, both routine & during critical states.
- **Making the diagnosis**: Emergency department has become the diagnostic centre for health care system. Patients come to the ED to find out what is wrong and EM physicians can often make a diagnosis during ED visit that could take hours or weeks longer in an out-patient setting.
- **Variety of patients** : Emergency physicians see a tremendous variety of patients of all ages, babies to elderly,who are critically ill, pregnant, psychiatric etc from every walk of life. Emergency physicians manage patients with all types of medical & surgical illnesses & injuries. Within hours of a shift, they may reduce a shoulder dislocation, manage poly-trauma following road traffic accident etc.
- **Flexible schedule**: EM physicians typically work 8-12 hours at a time at all hours. Due to intense nature of EM, the EM physicians work between 1500-2000 hours/year. Most EM practices don't have on call time. This allows EM physicians to pursue outside interest such as administration, leadership, research education or entrepreneurship.
- **Chance to build team work & relationships** : Emergency physicians work closely with other medical staff (surgeon, general physician, orthopedician etc) creating an excellent interpersonal relationship & works well as a team member[2].

Disadvantages :

- **Stress level** : EM physicians work very hard often managing many critical patients at one time. Some patients die in front of them. They will see patients who are victims of child abuse, rape or other terrible situations. Litigation stress is common[3]. It is widely speculated that EM physicians have high rates of burn out & shorter effective career than other doctors[4,5].

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- **Difficult patients** : EM physicians handle more difficult patients than most other specialities. Their patients & patients' families are typically under strain from their acute medical conditions. Sometimes they will treat EM physicians who they have not met before inappropriately. Many of the patients and their attendants are intoxicated. Violent, out of control patients often threaten & sometimes even assault members of the health care team.

- **Difficult colleagues** : Unfortunately EM physicians are sometimes mistreated by their colleagues of other specialities, who may be upset of being contacted during off hours to help manage patients that they might not otherwise take into their practice.

- **Practice settings** : Majority of the EM physicians work either directly for hospital as an employee or work for a regional or national practice management. EM physician in these settings may have less autonomy, earn less compensation & have fewer practice rights because of lack of due process or restrictive covenants.

- **Crowding** : ED patient volumes continue to rise each year. The national hospital ambulatory medical care survey estimates that ED visits have grown from 94.9 million in 1997 to 123.8 million in 2008[6,7]. EDs are becoming more crowded as a result of an aging population, higher acuity, more regulation, more advanced testing & rapid facilities. In addition, hospital in-patient capacity continues to decrease which in turn increases the number of patients in the ED. In many EDs patients wait a long time & are seen in halfway stretchers during peak times.

- **Lack of continuity in patient care** : Many practicing EM physicians consider this as a significant drawback as there is no follow up of the patients whom they have treated at the ED with a critically ill state.

- **Lack of personal job satisfaction** : Sometimes EM physicians have the feeling of their job being compared to a casualty medical officer who is more qualified to handle & do some interventions in a critically ill or injured patients & later on referring over to the respective specialists, thereby their job may resemble " Jack of all arts but Master of none".

- **Lack of indepth knowledge of any speciality** : As EM physicians deal with only patients presenting to the ED and are efficient in managing any critical illnesses or injuries with patients' age ranging from child or neonate to an aged patient & cases vary from surgical, medical, obstetrical, orthopaedic etc. There is definitely a feeling of incompleteness regarding knowledge in any particular subject among EM physicians, as they don't dwell indepth into any of the speciality, thereby making them being just like referral doctors & they can never be the primary consultant in future too. And for the same reason they don't get the credit for their efforts & the work they do.

- **Inconvenient schedule** : Most of the EM physicians tend to work mainly evening & night shifts as the ED is a 24/7 unit with highest volumes in the evening. Many EM physicians as they get older find it difficult to work late hours & often staffed weekends or on holidays so they often miss family & social activities due to work responsibilities.

- **Lack of social recognition** : The society or the public will not recognize EM people as specialists & they just know that he or she is working in a crowded unit of a big hospital of their city.

As the cons weigh more than the advantages, better to opt for a core clinical branch than EM, if one is keen in pursuing a clinical speciality. Though I've passed the MD EM exam recently with fairly good score, I don't have the feeling of being a primary consultant what my colleagues feel in other core branches. But still I feel satisfied & that adrenaline rush is there always whenever I save a dying patient by immediately doing some of the invasive interventions in ED but at same time subjecting myself to high stress levels quite often than expected. Apart from stress levels in ED, I couldn't master any one of the subject (medicine or surgery or pediatrics etc) in these three years of residency. But what I felt during training is that any clinical resident should know the life saving interventions and as earlier days during the pre-emergency speciality period, let each of the residents of every department be made available all time in the ED so that each will have to bear with his or her share of stress. Then the question arises what the EM residents are supposed to do in ED if every other speciality residents are being made available round the clock. What's happening in most institutions at ED is just stabilizing the serious patients & later on handing over the case to concerned speciality as told by my friends who have freshly passed out in EM, not just in Karnataka but other states too. Whenever a case is admitted under ED, the concerned speciality faculty feel that we are handling their case & whenever anything untoward happens to the patient, there is fear among us that are we supposed to admit such critical cases under ED, because the care takers of the patient may question us in the court as none of us are either physicians or surgeons but still their patient is under our treatment. This is not against the institutions which have started this course of MD (EM), in sight for future postgraduate students not to regret

opting this branch. The Medical council of India should seriously look into the matter as most of the institutions are keen & eager to get post graduate seats for monetary gains so they try to project that ED is as per norms of Medical council of India.

Few of the things which Medical council of India can look into at EM residency are-

- Compulsory 5 core specialist namely physician or a core EM physician, surgeon, orthopedician, intensivist & a pediatrician as active teaching faculty in th ED (for example- If a child or a neonate arrives in ED, question doesn't arise for requesting on call pediatrician to treat because our own department has a paediatric faculty, holds true for any orthopedic or surgical interventions if required).
- Mandatory emergency ICU of atleast 10-12 beds with proper monitoring facilities & ventilator care.
- Admitting patients till 72-96 hours under ED.
- Making emergency OTs fully functional under ED.
- Clearing few doubts of EM residency, here I mean to say whether EM physicians can operate if a surgeon or orthopedician is there in their team (for example- Can an emergency physician conduct laporotomy in case of perforation of hollow viscus or blunt trauma abdomen or can he/she do an emergency LSCS. Otherwise EM physicians are just meant to stabilize the patients, even though its ED case.
- Making post MD EM qualified people eligible for DM courses (namely cardio, gastro, nephro, neurology) as few may have aspiration to become superspecialists in future.

Institutions start their ED with vision not only to provide efficient care to their patients but also for monetary gains. The worst affected are the passed out candidates who will be more of referral doctors or glorified casualty medical officers at corporate sectors and colleges (though with good salaries but less job satisfaction), if stringent measures aren't taken to channelise course curriculum in coming days.

Finally this speciality of MD EM has the potential to become one of the top most sorted out branches in future provided some changes are brought about in the institutions running this course & those planning to start this branch as soon as possible because this is the only speciality where one can get the feeling of a surgeon, physician, orthopedician, pediatrician, intensivist & obstetrician in just three years, in short **"master of all arts**". I had joined this speciality with this kind of foresight but I feel I ended up doing extended internship for 3 years & not even a master in single speciality". But I will not give up my aspiration & dream till it's achieved - being optimistic. Last but not the least, to all my junior friends soon graduating & about to attempt postgraduate exams, right **decision making & clarity of the branch** is very crucial during counselling while opting for a speciality.

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