Definition of Emergency Physician

The American Academy of Emergency Medicine (AAEM) board of directors recently approved its definition of "emergency physician." AAEM defines an emergency physician as someone who has either completed an accredited training program in emergency medicine, or is certified in emergency medicine by a recognized certifying body.

In the U.S., legitimate emergency medicine training is accredited by the ACGME RRC-EM, or the AOA COPT-EM. The only recognized emergency medicine certifying bodies in the U.S. are ABEM or AOBEM. In the case of pediatric emergency medicine, the ABP is also included.

Countries other than the U.S. should define the legitimate training approval and certification process for their nation. Further, nothing in this definition is intended to exclude those pioneering physicians around the world who have or are advancing the specialty of emergency in their countries by starting practice in a reasonable establishment phase during which formal training is not widely available. This establishment phase ended long ago in the U.S.

AAEM firmly opposes referring to any physician who works in the Emergency Department as an "emergency physician." Emergency medicine has consistently maintained that it is defined by its unique body of knowledge, not the site of practice. Referring to any physician who has not been formally educated in the unique body of knowledge that is emergency medicine as an emergency physician is a misrepresentation of their credentials.

There is a significant shortage of emergency physicians in the U.S. This workforce problem can only be solved by correctly categorizing the ED workforce into emergency physicians and non-emergency physicians. If a physician of another specialty background is practicing in an ED, they should represent themselves, and be represented, to the public as "(other specialty physician) providing emergency care."

Please note that AAEM is not applying this definition to other countries and encourages other countries to define legitimate training approval and certification process for their nation.

Emergency Medical Services in New South Wales, Australia

Brett Rosen, MD

I was fortunate to spend the month of April integrated into arguably one of the best combined EMS and retrieval systems in the world based in New South Wales, Australia. I spent my time with the Ambulance Service of New South Wales in the air and on the ground, including days with the Special Operations Team rapid response vehicle, the urban search and rescue team drill, and in the medical retrieval unit command center. The territory is vast, with many areas not densely populated, and presents the need for a unique approach on how to best serve the tourists and over 5 million people that live in the state. In the retrieval service, a combination of road vehicles, fixed-wing aircraft, state-of-the-art helicopters, specially trained paramedics of the Special Casualty Access Team (SCAT) and physicians bring the hospital to the patient as their primary goal.

Photo Courtesy of Dr. Cliff Reid

Thoracostomies, needle decompressions, intubations and ultrasound are commonly performed in the field by the physicians and paramedics of the retrieval service. They winch off helicopters, engage in water rescue, scale down mountains and cliffs, enter caves, and are trained to enter damaged buildings to stabilize and treat entrapped patients while awaiting extraction. They are called on for the most serious and dangerous cases in the state. These elite units are found in all helicopters and save countless lives, as transport times of many patients can be well over an hour, even by a fixed wing aircraft, to the closest trauma center.

The retrieval unit operations center is directly linked to the state 000 (their 911) center. Unit officers check all call reports to determine the highest priority patients potentially needing the retrieval services. I still recall one case of a 000 call for a neck injury at a beach in the southern part of the state. Within 45 seconds of the 000 call being placed, a helicopter crew was already notified and was ready to take off. Fifteen minutes later, a critical care helicopter crew composed of a physician and a SCAT paramedic was on-scene winching off the helicopter to take this patient to the closest trauma center nearly 150km away.

They are integrated into the urban search and rescue teams of New South Wales and participate in their disaster training exercises. Additionally, the retrieval service has its own personalized ground ambulances specially fitted to its needs for a primary response or a critical inter-hospital transfer. Their jobs last anywhere from a couple of hours to needing two teams for a 36 hour mission, transferring everything from BiPAP patients with high oxygen requirements to head bleeds and STEMIs.

I encourage everyone, students and residents, to do a rotation outside of the country if you can. It is an incredible learning experience to see how other countries practice medicine and to learn from those with different experiences to integrate into your own practice. Coming away from this elective, I have a new set of clinical tools and tricks to add to my clinical knowledge base. Most importantly, it has sparked an interest in an area of emergency medicine that most of us are not exposed to in our own country and has given me a new outlook on ways to improve our own system. Whereas textbook material can be learned anywhere, experiences are an invaluable aspect of our training.

I would like to give a special thank you to Dr. Cliff Reid, Dr. Karel Habig and all of the men and women of the Greater Sydney Area Helicopter EMS Division of the Ambulance Retrieval Service of New South Wales for the incredible opportunity and experience I was able to have under their leadership and commitment to education and patient care.