



November 5, 2018

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Dear Dr. Nasca,

The American Academy for Emergency Medicine (AAEM) has over 8,000 members and was established in 1993 to represent board-certified emergency physicians whose goal is to promote fair and equitable practice environments necessary to allow emergency physicians to deliver the highest quality of patient care. Within our mission statement, we place a priority on the personal and professional welfare of the individual specialist in emergency medicine, and support residency programs and graduate medical education, which are essential to the continued enrichment of emergency medicine and assurance of high quality care for all patients.

We write with great concern for the upcoming possible changes to reduce the required protected time for emergency medicine core faculty. We appreciate the many months of dedicated work that it took to put these guidelines together, and respect the goals of promoting patient safety, resident well-being, and inter-professional team-based care, with an expansion to Section VI to give greater emphasis to patient safety and resident and faculty member well-being. We ask that you consider the following with respect to the proposed changes.

There is a high rate of burnout in medicine, and the specialty of EM has a high ranking in that unfortunate category. Burnout is associated with a deterioration of wellness and an increasing rate of physician suicide. It is incumbent upon us all to prevent these tragedies by utilizing our resources and education to recognize and mitigate the pressures that can create an environment conducive to burnout and its sequelae.

All physicians are naturally highly internally motivated, and will rise to the occasion to improve practice, education or other areas that demand time, energy and resources, and EM physicians are no exception. We all recognize the natural tendency to volunteer our time to fill a need, and to go above and beyond to get the job done. In the field of medicine, we are responsible to teach our juniors following the apprenticeship model.

This requires that we teach while taking care of patients. In the specialty of EM, we are also vulnerable to high patient volumes and the need to expedite patient care so that no emergent patient, such as those with a myocardial infarction or smoldering appendicitis, is neglected and suffers complications. We do not have the ability to cap our practice, or turn patients away, but need to give every

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patient our best-undivided attention as they come through the doors of the hospital. In the years from 2006 through 2014, ED visits have increased by nearly 20%, while the rate of admission from the ED decreased by 10%. This translates into a busier ED environment, while decreasing the work of the admitting teams who are admitting fewer patients. This is not, in fact, due to lower acuity, since the patients with the highest acuity are those whose admission rates decreased most significantly.¹

With pressures such as these, the time and energy that can be devoted to teaching residents and medical students suffers. We supplement bedside teaching with the ACGME required hours of didactic, simulation and small group education. These educational endeavors take time to prepare for and implement. Developing a lecture or a simulation takes multiple hours to prepare and expedite. Within our scope of practice, many uncommon medical problems present, such as mass casualty management, emergency cesarean section or emergent thoracotomy. Although these incidents and procedures are rare, it is essential that our skills be perfect at the moment at which we need them in order to meet the public's rightful expectation of the highest level of emergency care.

This necessitates training outside of the clinical realm, using simulation and other techniques in addition to didactic methods. The average simulation exercise requires 4 hours of preparation for every hour of teaching. Without protected time to invest in teaching methods and preparation, teaching in emergency medicine will suffer. Emergency medicine has been among the most innovative in medical education, being pioneers in Free Online Access to Medical Education (FOAM), and the flipped classroom, for example. Our educational efforts benefit EM residents, but are also delivered directly to, and indirectly improve the practice of all residents in the house of medicine as well as medical students. We are routinely chosen by the ACGME and the RRC to pilot test innovations such as the Milestones Project.

These innovations have put EM on the map as education mavericks. Without protected time, in order to protect well being and balance, EM physicians will either decrease the amount of personal time given to develop and deliver innovative education, and/or they will continue giving an extraordinary amount of time above and beyond clinical requirements and suffer from burnout and its sequelae. Emergency Medicine is unique in its need for protected time for education, due to the nature of clinical work in the ED, the need to teach rarely seen procedures and experiences, and the higher risk of burnout.

We urge you to consider the unique nature of emergency medicine, its importance to the rest of the house of medicine and the need for protected time in order for EM core faculty and administration to continue the important work of educating future emergency physicians in the care of an ever-increasing population of patients.

Sincerely,



David A. Farcy, MD FAAEM FCCM
President, American Academy of Emergency Medicine

1. Lin MP, Baker O, Richardson LD, Schuur JD Trends in Emergency Department Visits and Admission Rates Among US Acute Care Hospitals. *JAMA Intern Med.* 2018 Oct 15 E1-E3. PMID 30326057