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APPLICANTS WITH PRIOR TRAINING

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Abstract—Emergency medicine (EM) has its challenges, downsides, advantages, and accompanying lifestyle. Additionally, graduates of EM residency programs have abundant job opportunities. Accordingly, there is an increased interest in residency training in EM, even among residents with prior training. Transitioning from another specialty to EM can be complicated yet achievable, especially if EM is the transitioning physician's passion and career goal. Therefore, in this article, we elaborate on the transition process from another discipline to EM in light of changes in residency funding. We also explore the advantages and disadvantages of transitioning to EM with previous training in another specialty. Moreover, we expand on credit equivalencies for months already completed in another training programs, as well as the difficulties to be anticipated by transitioning physicians.

Despite recent changes in funding for residency training as a result of the Balanced Budget Act (BBA) of 1997, this is still a great time to transition into emergency medicine (EM) from another medical specialty. Board-certified emergency physicians (EPs) have abundant job opportunities in emergency departments (EDs) around the country, where the quality of care has been considerably improved with the development of EM as a specialty. Although physicians who are not board-certified in EM often staff small community hospitals, more hospitals are requiring their EPs to be board certified. According to the emergency care workforce analysis conducted in 2018 by the American College of Emergency Physicians, 61% of EPs are board-certified (1). For physicians considering a fulfilling and lasting career in EM, the completion of a residency in an accredited EM training program and the achievement of certification through either the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) has become a necessity. As stated in the American Academy of Emergency Medicine mission statement, ‘‘A specialist in emergency medicine is a physician who has achieved, through personal dedication and sacrifice, certification by either ABEM or AOBEM’’ (2). It is therefore not a surprise that EM residency training is not only preferred, but also a requirement of an increasing number

of hospitals, medical networks, EP groups, and medical staff. Additionally, EM residency training also appears to be associated with greater income, as well as better and lower cost of patient care (3–6).

Change from Another Discipline to EM in Light of Recent Changes in Residency Funding

Changes by the previous Health Care Financing Administration, now referred to as the Centers for Medicare and Medicaid Services, have made transitions between residency disciplines more difficult but still possible. The BBA of 1997 stipulated that Medicare direct graduate medical education funding (which covers residency salary and benefits) cover the first 3 years of the initially declared training period and additional years would be funded at 50% of baseline (7). For example, consider the case of a medical student who initially declared, matched, and then engaged as an intern into a family medicine (FM), internal medicine (IM), or pediatrics residency. If this intern then subsequently switched to EM after 1 year of training, Medicare would fund only 50% of the third year of the EM residency (ie, the fourth postgraduate year). This means that the hospital, institution, or department would be responsible for the difference. Similarly, if the resident completed an IM, FM, or pediatrics training program, then all 3 years of the subsequent EM residency would be funded at 50% of baseline. Interestingly, when transitioning from other disciplines, such as surgery, the number of years fully paid by Medicare can be up to 5 years. Therefore, residents transitioning from general surgery after 2 years can complete a 3-year EM program without any funding limitations (8).

According to a survey by the Council of EM Residency Directors, despite these guidelines, 80% of EM programs continued to take residents with previous training (8). The remaining 20% of programs either did not consider applicants with previous training or placed limits on the amount of previous training that was acceptable. This limitation is usually a function of the institution and not the training program. This survey was published in 2001 and currently it is unclear how residency programs handle resident applicants with previous training. Most academic medical centers are over their cap for Direct Medical Education and Indirect Medical Education funding. Although most EM programs currently accept applicants with previous training, this may continue to change in the future, and applicants should definitely inquire about the presence of specific institutional or departmental policies.

Advantages or Disadvantages of Transitioning to Emergency Medicine from Previous Training in Another Specialty

In general, the advantages of previous training outweigh the disadvantages. From a residency program director's (PD) point of view, physicians with prior training tend to be more experienced residents compared to those residents that have just completed medical school. They often demonstrate a higher level of clinical acumen and a better comfort zone when dealing with patients in general. Residents with prior experience may excel on off-service rotations, as well as in the ED. These residents have typically already obtained some ED and off-service experiences during their previous training and therefore may have an elevated skill level and greater confidence. However, this must be weighed against the fact that previous training outside EM is unlikely to have as many

ED months as most EM residency programs. Therefore, although these residents may have more clinical experience, they are likely to have less ED clinical experience than similar-level EM residents.

Despite the advantages experience offers, some PDs may be wary of applicants who have had difficulties in other specialties, or residents who are entering EM for the wrong reasons. It is reasonable to expect a number of PDs to be concerned that physicians with prior training may be difficult to teach and may have developed practices that may not easily adapt to the practice of EM. It is imperative for residents who are transferring to EM to have considered the difficulties of actually making this transition from another specialty, and to be willing to concentrate on their own weaknesses. Creating opportunities while in another specialty to display one's ability in an EM setting could alleviate some of these fears. It is also important for applicants to be willing to use their experience and strengths to assist their colleagues and to avoid being overconfident. The transition to EM will require support letters from a previous PD or associate PD to verify the transferring resident is in good standing in their program.

A significant percentage of the EM residency applicant pool is composed of physicians who have previously trained in other medical specialties. Additionally, programs occasionally have vacancies that arise due to transfer, disability and other causes—many of these are filled by physicians with prior training.

The reasons for changing careers to EM vary. Some applicants had very little exposure to EM during medical school, while others are attracted by the lifestyle and excitement that the specialty offers. These residents should be prepared for the intensity of EM training programs, which often include many surgical, medical, and critical care rotations in addition to intense time in the ED. Regardless of the motivation for the career change, these are some important considerations when making the transition from another medical discipline.

Receiving Credit for Months Already Completed in Another Training Program

One of the advantages for applicants who have previous training is gaining credit for work completed in another specialty. The resident must have completed at least 24 months without repeating a postgraduate level or rotation in an Accreditation Council for Graduate Medical Education (ACGME)-accredited program or a combined specialty program that has been approved by both specialty boards (9). The 24 months must have been in a clinical specialty and must count toward the requirements of that program. ABEM requires PDs to apply for credit for this resident immediately after the match and prior to starting the EM training program, and the request must be approved by ABEM before starting the program. Residents can now receive a maximum of 12 months credit for previous training if approved by ABEM (10). ABEM can approve rotations in other specialties for advanced credit as long as these rotations are also required by the EM training program. Up to 2 of these months can be EM months, as long as these months were completed at a location that has an ACGME-accredited EM residency training program (9). These previously completed months must be completed within the 5 years prior to beginning the EM residency training program (9).

Difficulties to Be Expected by Physicians with Prior Training During Their Transition to EM

The transition from another medical specialty into EM, while well worth the effort, can be arduous initially. In many ways, the first year of EM, compared to other specialties, seems to be more difficult. For example, first-year residents in other specialties like surgery or obstetrics and gynecology tend to work in a more dependent manner, with almost all of their activities prescribed by senior residents and attending physicians. In contrast, EM residents must adapt to a fast pace and an unpredictable load of high-acuity cases. Additionally, they are expected to function fairly independently early on in their EM training, at least up to the point of presenting the case to the senior resident and attending. Therefore, sound clinical judgment and the ability to deal with unexpected clinical and non-clinical challenges early during residency training is often unavoidable in EM. Moreover, EM training often challenges the resident with increasing numbers of patients and greater patient acuity, even in the early years of training. In fact, at times there is no ‘‘buffer zone’’ between the resident who is new to the specialty and the attending physician who has been ‘‘doing it for years.’’ This may elicit feelings of fear, anxiety, or self-doubt in the transitioning residents whose expectations are that they should already know the answer. Despite these difficulties, there will be close supervision of patient care and of resident progress throughout EM training within an established framework based on the ACGME requirements for EM (11).

Regardless of which specialty the resident trained in previously, he or she can expect major differences in EM training. As an example, a former surgical resident who was accustomed to spending hours in the operating room, rounding on patients, and rotating on services mainly in the surgical subspecialties, will now perform procedures in the ED and rotate on a variety of surgical, medical, and pediatric services. Similarly, former IM residents, accustomed to rounding on patients multiple times per day, performing thorough workups, and spending hours searching through old records and baseline laboratory test results, will now spend less time with patients and present them concisely with less information and more focus on clinical history and physical examination. They will also rotate on surgical, pediatric, and obstetric services to which they have had very little exposure since medical school.

One additional challenge that is fairly specific to EM training is the lack of downtime during ED clinical shifts. All other disciplines have times when patient care responsibilities are less intense; there is time to read, to go to the cafeteria, meet some colleagues, and just relax. This is not an option when rotating in the ED. EM practice tends to be very intense with little time for relaxation during a shift. Although this is directly related to the root of what makes an EM career exciting, it can also be an intimidating part of the practice.

In this regard, all EM residencies provide residents with an organized orientation program that includes specific scheduled activities. Activities include presenting the institutional and EM program expectations, teaching in focused didactic sessions and practical clinical skills workshops, and providing early opportunities for residents to socialize with their senior colleagues. Program expectations of residents in the first year of training take into account the difficulty of learning such a large body of clinical information in a relatively short period of time. Residents are expected to improve as they

gain more experience in the ED. There is a certain amount of patience required, especially in the first year of training because the learning curve is very steep. Many programs also offer elective time to concentrate on any areas of specific interest or weakness that are identified during the training.

Another obstacle encountered by physicians who plan to transition into EM is the requirement to serve again in the capacity of an intern or junior resident. Being demoted in the medical hierarchy with respect to rank and salary can be frustrating and a humbling experience at times. This is particularly true for anyone who has completed a previous residency and worked as an attending, or anyone who has already ‘‘paid their dues’’ as a junior resident in another specialty. One must be able to appreciate the value of repeating various experiences in order to learn the basics of EM. There are countless examples of leaders in EM who had prior training in other disciplines before going through an EM residency. However, it probably would make sense for the transitioning resident to make a conscious effort to be ‘‘teachable,’’ to dispel any generalizations or misconceptions their instructors may have regarding previous training.

Final Words of Advice to Residents or Practicing Physicians Considering Transitioning into EM

Transitioning physicians should consider the practice of EM carefully, including the pros and cons of an EM career, its pitfalls, rewards, challenges, and associated lifestyle. They should also make sure their decision is an informed choice and not an exit or a reaction to a discontent with the first discipline that they chose. In addition, they should consider that the next 3 or 4 years of training will be intense, exciting, and empowering, while offering one of the steepest learning curves of any specialty.

Moreover, if EM is the transitioning physicians’ passion and career goal, it can still be achieved regardless of the type or duration of previous training. However, strong support is needed from the PD or associate PD of their previous residency to make this transition to EM possible. This in addition to making a conscious effort to turn their previous training into an advantage to themselves as well as their new colleagues, like focusing on special skills that they might bring to their new program and understand that there are multiple ways to care for patients that they may not have been exposed to before.

Also, it would be a good idea for transitioning physicians to choose specific attendings or senior residents as their mentors and strive to improve their skills to become comparable to those of their mentors by the time they complete their training.

They should keep in mind that, short of fellowship training, this will be the last and best organized learning experience they will have the opportunity to participate in for the rest of their career. So, they should make the most of it.

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