

The EMRA/SAEM Guide to Academic Careers in Emergency Medicine

Academic Emergency Medicine in the Year 2001

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That medicine has been altered substantively this past decade greatly understates the case. The powerful influence of financial change, in particular, has spared no specialty. That said, academic emergency medicine offers a professional life rich with options and flexibility and one filled with satisfaction. In order to describe academic emergency medicine career opportunities, this discussion will center upon integral forces, options available, pathways, and above all, the reasons for choosing an academic career in emergency medicine.

FORCES

Financial Constraints

This subject is exceedingly complex, mostly uninteresting, a moving target, and one with an immutable punch line. That is, the amount of money available to academicians generally and emergency medicine academicians specifically, has and continues to decrease significantly. The Balanced Budget Act of 1997 includes a number of provisions that will negatively impact graduate medical education funding. Among these are the FTE cap which establishes that the number of residents for which a teaching hospital will be reimbursed under Medicare for both direct (DME) and indirect (IME) medical education is restricted to the number reported on the respective hospital's most recent reporting period ending on or before December 31, 1996. Indirect medical education (IME) payments are being reduced from a level of 7.7% in 1997 to 5.5% by the year 2001. Disproportionate share (DSH) payments are being decreased as well. Finally, the remarkable New York Demonstration Program trades voluntary reductions by hospitals in the number of their residents in exchange for incentive payments.

In the area of research, all granting sources are on tighter budgets. The most prominent governmental funding agency, the National Institute of Health, is struggling to maintain status quo. The Agency for HealthCare Policy and Research (AHCPR) has been similarly limited. Regardless, while emergency medicine research has made very considerable strides, it continues to be less competitive for this federal funding, mostly due to the relative newness of the specialty. This has compelled many in emergency medicine to rely more heavily upon corporate sponsorship, notably from the biotechnical and pharmaceutical industry.

The third major area impacting funding of academic centers is the increasing penetration of managed care. Private medical insurers, Medicare, and Medicaid each play a role. In addition to receiving lower reimbursement rates for the same level of care, teaching hospitals have been at a significant disadvantage as they provide sophisticated and

expensive specialized care, have a higher ratio of un- and underinsured patients and are compelled to overcome the inefficiencies inherent in residency program directed care.

Clinical Directives

The Health Care Financing Administration (HCFA) oversees several pieces of legislation that have significant effect on healthcare providers. Patient care documentation requirements have become more lengthy, detailed and complicated. Then, with direct regard to academic centers, the long-standing Teaching Rule has been strengthened and more ably enforced. This requires that the attending academic physician establish clearly via documentation that his or her supervision is integral to a patient's management, such that reimbursement for that attending's role is appropriate above and beyond that already provided through Medicare Part A. Failure to comply with these assiduous requirements has resulted recently in penalties to several teaching institutions in the tens of millions of dollars.

There is one important piece of legislation that is highly favorable to emergency medicine and the patients to whom it provides. In 1986, the Emergency Medicine Treatment and Labor Act (EMTALA) was developed primarily to protect hospitals from the process of "dumping." This statute has undergone several iterations since its inauguration and has become more encompassing and more complex. However, it, in addition to certain tenets of the Balanced Budget Act of 1997, ensures that patients have access to emergency care, irrespective of their payer status. In addition, various states have enacted prudent lay person legislation that protects the patient and the healthcare institution from payment denials by insurers.

Academic Directives

In the past two decades in particular, physicians, including emergency physicians, and politicians have promulgated a host of measures intended to discourage ethical breaches in the provision of medical care or undertaking of clinical research. These have been directed at physician integrity, issues of fraud and misconduct and the real or perceived conflictual relationships between researchers and sponsors. These have helped clarify the sanctity of the relationship between academic physicians and patients.

Increased managed care penetration and decreased federal funding have not simply tightened the financial screws. The Teaching Rule and other documentation requirements have resulted in greater pressures on the academic department. To remain competitive, the provision of clinical care at medical centers must be enhanced by decreasing length of stay, optimizing resource utilization, maintaining a low medicolegal risk profile and attaining a high rate of satisfaction with patients, primary care providers and managed care operatives. Taken together, these should reap long-standing contractual relationships with healthcare companies. The prize for the academic emergency physician is having a sufficient emergency department census for teaching purposes, maintaining a sufficient measure of nonclinical time for faculty, and acquiring extramural and intramural funding for a variety of research and clinical missions. This is simply

how it is, and academic emergency physicians need to be creative and aggressive to assure their role as vigorous teachers and scientists. The chair, in particular, needs to promote academic endeavor and protect resident education while assuring cost containment in this exceedingly difficult paradigm shift.

OPTIONS

What is available to the academic emergency physician can be sorted by position description, type of teaching hospital and even the amount of time one is able to give professionally.

Position

Emergency medicine faculty are generally organized into functional divisions. These are either explicit or tacitly understood and include the following: education (residency program, fellowship training, medical student teaching, continuing medical education), clinical operations (clinical policies, personnel issues, scheduling, materials management), research (grants and contracts, personnel and equipment, protocol development), administration (budget and contracts, quality assurance, clinical paths, risk and complaint management), emergency medical services (online and off-line protocols, transfer agreements, personnel), and specialty services (toxicology, HBO, occupational medicine, trauma, injury control, other).

Virtually every physician member of an academic emergency medicine faculty provides direct patient care and housestaff supervision. The amount of clinical time depends on the needs of the faculty, the desire of the individual faculty member, and the other academic and administrative responsibilities of that faculty member. In the traditional model, faculty positions are more generic and less compliant regarding clinical service. Today, more programs and their chairs, have become increasingly inventive to ensure academic productivity. With this more flexible mind-set, the square peg wedged into the round hole theory is scrapped. For instance, a program can create a clinical division whose members' primary responsibility is the provision of clinical care and bedside teaching. This very popular position allows an emergency physician to work primarily with residents, spend a good measure of time in the patient care arena, and have a minimum of other academic or administrative duties. At the same time, the archetypal academician can more easily maintain an appropriate amount of clinical time with patients and residents but can devote a greater number of hours to conducting clinical or bench research, didactic teaching, program direction, administrative leadership and the like.

Therefore, the up and coming academic emergency physician has a broad menu from which to choose. There's a range of positions from one dedicated primarily to clinical care in a teaching setting to another committed almost exclusively to research. Not only is there a greater array of options, but individual faculty can shuffle their clinical, academic, and administrative time allocations month to month and year to year.

Hospital

The type of academic emergency medicine program will be reflected at least in part by the type of institution in which it is housed. These include university, community and municipal type hospitals. Two principles should be understood. First, a large segment of emergency medicine teaching programs have more than one clinical site, and, in fact, may include one or more of each of these three categories of hospital in which their residents train. Second, there is tremendous variation within each of the three categories regarding the attitude and dedication toward clinical service provision versus academic productivity. In emergency medicine, community and municipal hospitals have had particularly strong opportunities to develop academically, given the newness of the specialty and having fewer obstacles imposed by certain traditional university-based academic medical centers.

The amount of funding available within an institution will likely be the vital determinant of the size of the faculty, the number of resident and fellowship positions, and the amount of time dedicated to direct patient care as opposed to academic endeavors. The direction of the individual faculty member will also be influenced greatly by the promotions track chosen, and the specific obligations cited by the medical centers' Promotion and Tenure policies for that particular track.

Commitment

The flexibility available to the academic emergency physician applies not only to the job description and the promotion track but to the number of hours worked as well. Full-time positions are the rule, but a good number of programs, particularly those with clinical positions, are able to extend part-time and half-time positions to faculty on a temporary or permanent basis. These are particularly helpful to those men and women with significant nonprofessional obligations. In addition, formal and informal sabbaticals with varying periods of leave are available to many faculty in academic emergency medicine.

PATHS

The opportunity to serve on a faculty rests upon several factors. Among these are what the individual aspirant desires, what the faculty requires at that moment and in its future, and where geographically the faculty candidate wishes to practice. These typical questions frame the concerns of the prototype academic candidate:

- *Does it matter what length training program I attended?* Roughly three-quarters of the training programs in emergency medicine are three years in length. Many of those that extend to the PGY4 year will not take on a faculty member who has three years of residency training until he or she has acquired one additional year of fellowship training or practice. This is to avoid conflict between residents in training and the new faculty member.

- *Do I need fellowship training?* This is highly variable. The position sought may have definitive requirements. For example, an emergency physician who will serve as a toxicologist will very likely need to have acquired subspecialty training in toxicology and be subspecialty board prepared. This may also be the case for pediatric-emergency medicine and sports medicine, the two other subspecialty certification boards within emergency medicine.

However, there are a number of non-ACGME-approved fellowships in emergency medicine, including research, emergency medical services (EMS), and administration. It is less likely that these will be required by the department or hospital, and whether or not they are preferred depends on the respective emergency medicine faculty. The main intent of fellowship training, particularly in these non-ACGME categories, should be to build skills and experience in a particular area.

- *Should I have clinical practice under my belt before joining the faculty?* This is absolutely not necessary and is far more likely to be a discretionary issue for the faculty candidate than the faculty.
- *Does it matter what part of the country I train in as far as getting an academic position?* As for any job anywhere, there's a huge amount of luck and timing involved. A number of departmental chairs and directors subscribe to the bird-in-the-hand theory. That is, if a great graduate is coming out of their own program or one in their city, and a faculty position becomes available, the deal is done. In this scenario, it does help to have "grown up" and performed admirably among the local and regional faculty. However, particularly in academics, it is likely that the chair or director will seek applicants from well outside this geographic circle. In either case, the main ingredient of success will be the talent of the candidate and the say-so of that individual's chair, program director and other faculty. That main ingredient is built from all the usual parameters and includes intellectual skills, work ethic, attitude and vision. These combine to form one's academic potential.
- *Can I expect to get the job I want?* This, of course, depends mostly on the measure of one's academic potential. As in every other walk of life, those who have been highly successful in their training or prior experience, are more likely to find and negotiate successfully for their preferred positions. Usually, a new faculty member will be hired into a mutually agreed upon slot, for example, assistant residency director, but be expected to take on other, perhaps less endearing responsibilities as well.
- *Do I need other training or experience?* This training could include, for example, a course that provides one or more academic skills in teaching, administration or research, or an advanced degree in health or business administration. It is far more likely that the individual candidate will want any of these for his or her own sake, rather than the faculty seeking or requiring it.

There are two summary considerations about the pathway to an academic emergency medicine career. First, you can get there from anywhere and at any point in your professional life. There are no exclusion criteria. By taking a look at most any faculty today, one is sure to see tremendous variety in the routes traveled by the respective members. Second, becoming a faculty member is not so different from becoming an intern. You don't know quite what to expect, you tend to emulate one or more persons in a higher position, and you learn as you go, relying mostly on the qualities and experience you already possess.

RAISON D'ETRE

Are there compelling reasons to be part of an emergency medicine faculty? Academic and clinical practice opportunities overlap considerably in scope. However, there are characteristics more likely to be found in an academic emergency medicine career. These will not be cited here as advantageous or disadvantageous necessarily as there is considerable variance in how each quality is perceived.

- *Compensation:* Based purely on empiricism, it seems irrefutable that academic emergency physicians work more hours for less money. This is more likely to be the case in the early post-residency years. But as the academic emergency physician climbs in rank, the salary and benefits package increases commensurately. This is generally not the case in clinical practice. The SAEM 1998-1999 Salary Survey for academic emergency physicians demonstrates this principle, and that compensation is competitive at all entry levels.
- *Schedule:* The 1998-1999 SAEM Salary Survey also reveals that considering every faculty type, academic emergency physicians work an average of 23.7 clinical hours and a surprisingly low 44.7 hours overall. The total hours component may substantially underestimate the case, particularly for the highly productive faculty member.

The fewer clinical hours of the academician's schedule relative to that of clinicians suggest that academic emergency physicians may have fewer evening, weekend and night clinical shifts than their private practice counterpart. On the other hand, the academic emergency physician may be using those off-hours to give to academic and administrative projects.

- *Variety:* In general, the academic emergency physician conducts a mix of clinical, teaching, research and administrative practice. This offers great diversity and challenge.
- *Patient Care:* Nearly every academic emergency physician provides direct patient care as well as supervision to residents, medical students and allied health professionals.

- *Charity Care:* Emergency departments are the only portals of universal access for patients in this country. The federal statute, EMTALA, protects the rights of emergency patients and women in active labor to receive care. As a result, emergency medicine is a true safety net for the more than 50 million under- and uninsured patients in the United States.
- *Niche Building:* The usual academic emergency physician discovers an area of special interest early in a career. At the beginning, there is a developmental phase in which the individual gives lectures locally on the subject and perhaps begins to study its research potential. With time, that faculty member acquires and is recognized for his or her expertise and is accordingly sought for collaboration in research, participation in grants, speaking opportunities, and peer and nonpeer writing projects. If the faculty member maintains genuine enthusiasm for the niche, a life-long endeavor results.
- *Specialty Advancement:* The specialty of emergency medicine has truly leaped and bounded from its beginnings less than 3 decades ago. There has been remarkable growth in the scope and depth of textbooks, journals, curricula, and clinical and bench research. In just the last 10 years, the number of emergency medicine residency programs and academic departments of emergency medicine at medical schools have climbed from 77 and 17 in 1989 to 122 and 57 in 1999, respectively. Positions of considerable influence in health care, as for example, in the United States Senate and deanships in medical schools, are now held by emergency physicians. Thus, the academic emergency physician has opportunity to add to the existing foundation of the specialty through teaching, research, and participation in hospital and governmental activities.
- *Teacher:* Finally, the academic emergency physician works day by day, side by side with emergency medicine residents. It is especially in this role that the academician can teach the unique biology of emergency medicine as only an emergency physician can. That teacher can share not simply the hands-on tools of the trade, but the intangible essence of the discipline as well.

CONCLUSION: Medicine is inherently a very giving profession. Emergency medicine, because of the socioeconomic features of many of the patients cared for is particularly so. And perhaps academic emergency medicine, by virtue of its combined clinical service, teaching and research opportunities, can be extraordinarily so. In considering the banquet of privileges tendered the academic emergency physician, this chance to provide to so many within and outside the field of emergency medicine is the most rewarding and cherished of all.

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