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Emergency Medicine / Critical Care Medicine and the Need for a Practice Track: Are we Cutting off our Certification at the Root?

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In the past two years, Emergency Physicians who were practicing Critical Care Medicine (CCM) have seen a dizzying progression of events as the various primary specialty boards have come together with the American Board of Emergency Medicine (ABEM) to co-sponsor pathways to subspecialty board certification in CCM. Given the current physician workforce shortage in CCM, this should be a welcome development for patients and hospitals as well as individual practitioners [1]. While this is a promising development for current and future EM residents, the impact on those nearing graduation or those who have already completed fellowship training the future is far from certain.

What happens to those who trained (or currently training) in CCM before the requirements were in place?

In 2010, Mayglothling et al. [2] identified and surveyed 104 EM-CCM physicians that were in training (n=31) or had completed fellowship (n=73), of which 54 were practicing some combination of EM and CCM [2]. The vast majority of this cohort works in surgical or surgical subspecialty ICU's. Only 16 were either board-certified or board-eligible in the US, though over half had planned to take or had completed the European Diploma in Intensive Care (EDIC) examination offered by the European Society of Intensive Care Medicine (ESICM) [3]. Therefore, the impact of decisions about emerging board certification requirements for EM-CCM physicians have particular import for this subgroup of highly-motivated individuals.

Recently the American Board of Internal Medicine (ABIM) and the American Board of Emergency Medicine (ABEM) agreed to jointly sponsor a path to US board certification for EM-CCM physicians [4]. It is ironic that this came through an agreement between ABIM and ABEM. First, because the training options available for IM-CCM are the most varied of any of the existing programs [5]. Second, according to Mayglothling, et al. [2], only a small subset of EM-CCM practitioners actually practice in medical ICU's. Nonetheless, the broad outline had been formed and a pathway was finally established for EM grads that were lucky enough to obtain spots in IM-CCM programs. The agreement did not stipulate that IM-CCM programs accept EM grads - only that those who had completed such programs could sit for the boards.

The American Board of Surgery (ABS) [6] and American Board of Anesthesia (ABA) [7] are following suit. There are broad areas of consensus:

1) The total fellowship time will be a minimum of two years.

2) Twelve months of clinical training in CCM are at the core.

There are areas that are most definitely controversial, and where the various boards have not yet come to agreement, or have identified areas that may concern EM-CCM physicians who have already completed their training:

1) What about a practice track?

2) What is the composition of the second year?

3) What about reciprocity between programs - particularly ABA *vs.* ABS accreditation?

For physicians who have completed their training, the news is not so good. The ABS currently will not allow practice track certification, but that it is requiring an additional year of training that is not currently defined, and will not be available until July, 2013 [6]. While this requirement may be valuable for new graduates and help round out their training, for those who had completed a surgical critical care fellowship (which is historically one year) they remain ineligible for board certification. Moreover, this extra year will need to be completed prior to entry into the CCM training program.

While the ABA provides a practice track, they also require an additional year of training [7]. They will not provide reciprocity with ACS programs, though historically frequently programs are dual-accredited so that both surgery and anaesthesia graduates can attend the same program and be eligible for certification for their respective boards. Moreover, the year of additional training is restricted to ACGME-accredited fellowship training, when many of the newer ABEM-recognized subspecialty programs have yet to achieve this status [8].

While the current situation is admittedly in flux, it is evident that the very people who were instrumental in shaping the subspecialty of EM-CCM may have difficulty obtaining certification. There are several possible solutions to this problem:

1) Provide a more realistic "grandfathering" option for those who have been fellowship-trained and in practice prior to the beginning of board certification. Such a program will need to include 12 months of CCM clinical training. For those who completed two-year fellowships of any sort, the remaining time can be considered to serve as the elective time (as would be the case in an ABIM-style program). For those who completed only a one-year program, an additional one year of practice (plus a letter documenting clinical competence from the current department head) might suffice.

2) Create a new "EM-CCM" certification that is independent of the joint board certifications, but involves the aforementioned requirements. The prerequisite training would consist of a two-year fellowship with a minimum of 12 months of critical care and the remaining 12 elective months could be traditional electives (such as a 2-year ABIM program or the proposed 2-year ACS program), or another EM-recognized subspecialty (EMS, toxicology), or electives tailored to the individual candidate (e.g., research or educational fellowship). The certificate would be granted by ABEM alone.

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3) Create a petition process where this small number of individuals (still likely less than 200) could create a portfolio similar to a promotion and tenure packet describing their training, qualifications, current employment status, letters of support, and the reasons why they should be allowed to sit for the exam. Basic requirements would include 12 months of critical care. Ideal candidates would not only have additional fellowship training, but would also demonstrate significant commitment to the field of EM-CCM (e.g., scholarly work, research, participation in SCCM or ESICM committees, etc.).

4) Do nothing and exclude a large number of individuals who have made valuable contributions to EM-CCM from board certification.

The desirability of being inclusive with this small group of individuals should be obvious. It is reasonable to conclude that this group of individuals who pursued fellowship training when there was no certification option available in the US demonstrates intrinsic motivation and commitment to the field of EM-CCM. This is further reinforced by the fact that many of these individuals are contributing to the literature in this emerging subspecialty [2,9-11]. The fact that over half of them have pursued or completed the EDIC indicates that they are willing to go to great lengths of time and expense to obtain a certification that recognizes their accomplishment, and the fact that many of them have already passed the EDIC further reinforces the notion that they are well-trained and would likely be successful if allowed to sit for board certification in the US.

Hospital credentialing in many environments is dependent in part upon being board-certified or board-eligible in a given subspecialty. While such a requirement may have been waived for those EM-CCM physicians in practice prior to their being a pathway to board certification, denying them the ability to sit for the board exam may impair their ability to obtain hospital privileges in the future. This would have the unintended consequence not only of denying recognition to a select group of individuals but also to interfere with their ability to obtain gainful employment.

It is also possible that the issue of hospital credentialing could create a worse problem than individual unemployment - the irrelevance of the subspecialty certification itself. Allowing this small group of individuals the ability to sit for the exam strengthens the notion of the EM-CCM certification as the recognized standard of excellence. Exclusion from EM-CCM certification then becomes an issue of clinical competence - not birthright.

Finally, it is most important to remember that when options such as "grandfathering" or a "practice track" are discussed these by no means of amount to automatic attainment of board certification. The question at hand is how to provide an appropriate process to allow individuals who have completed training and are currently in practice the ability to sit for the exam. It is entirely up to the candidate to possess the relevant knowledge and skills to successfully complete the exam itself.

A small cadre of forward-thinking Emergency Physicians have obtained training and a privilege to practice CCM long before certification in the US was a viable option for them. As pathways emerge to provide board certification for EM-CCM dual-trained physicians, it is important that our specialty not leave these pioneers without a pathway to eligibility to attain board certification. Despite potential barriers for these physicians based on varying requirements between the various boards, the clear mandate at the core is a minimum of 12 months of CCM clinical training with additional elective time or other experiences to complete a total of two years of training. Because the evolving EM-CCM requirements are new, there is no reasonable way that could have been foreseen by EM physicians completing fellowships prior to 2012, and therefore it makes no sense to penalize a small and highly qualified group of physicians by failing to provide an avenue whereby they can demonstrate equivalency in their training and be offered an opportunity to sit for the examination.

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