



# American Board of Emergency Medicine

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June 29, 2016

David J. Shulkin, M.D., Undersecretary for Health  
Jennifer Lee, M.D., Deputy Under Secretary for Health for Policy and Services  
Chad S. Kessler, M.D., National Program Director for Emergency Medicine  
Veterans Health Administration  
810 Vermont Ave. NW  
Washington, D.C. 20420

Dear Dr. Shulkin, Dr. Lee, and Dr. Kessler:

The American Board of Emergency Medicine (ABEM) has received information from several ABEM-board certified emergency physicians (diplomates), regarding a Veterans' Administration hospital policy, Out of Operating Room Airway Management (OORAM), and its national mandate that all non-anesthesiologists be OORAM certified. ABEM believes that board certification and maintenance of certification supersedes any need for credentials that are established by third party standards.

Airway management, including intubation, is an integral competency for an ABEM-certified physician. ABEM believes that the acquisition of knowledge, skills, and abilities as described in The Model of the Clinical Practice of Emergency Medicine (EM Model), are ensured by obtaining and maintaining board certification. The content of the OORAM module is already included in the EM Model, as airway management falls within the scope of practice for an ABEM-certified emergency physician.

The EM Model is the foundational document for designing an Emergency Medicine residency curriculum. It is also a document on which ABEM bases the content of its certification and continuous certification (ConCert™) examinations. The EM Model includes the following section:

## 19.0 PROCEDURES AND SKILLS INTEGRAL TO THE PRACTICE OF EMERGENCY MEDICINE

### 19.1 Airway Techniques

- 19.1.1 Intubation
- 19.1.2 Airway adjuncts
- 19.1.3 Surgical airway
- 19.1.4 Mechanical ventilation
- 19.1.5 Non-invasive ventilatory management
- 19.1.6 Ventilatory monitoring

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The Emergency Medicine Milestones were jointly developed by the Accreditation Council for Graduate Medical Education (ACGME) and ABEM to track the acquisition of critical competencies during the course of residency training. The Milestones also include the subcompetency of airway management. The Emergency Medicine Milestones describe the necessary airway management skills of an emergency physician as follows:

“Performs airway management on all appropriate patients (including those who are uncooperative, at the extremes of age, hemodynamically unstable, and those who have multiple co-morbidities, poorly defined anatomy, high-risk for pain or procedural complications, sedation requirement) and takes steps to avoid potential complications, and recognize the outcome and/or complications resulting from the procedure.”

Assessment of an emergency physician’s airway management skills by Anesthesiology does not provide an accurate reflection of the skills that are needed in an emergency setting, nor does it recognize the training and mastery of the skill attained by the successful completion of an Emergency Medicine training program and acquisition of ABEM certification.

The OORAM requirement appears to have resulted from adverse outcomes from intubation events largely, or even possibly entirely, involving non-ABEM-certified physicians. For physicians who are not board certified in Emergency Medicine, completion of periodic, short courses in airway management may be valuable and provide enhanced familiarity with necessary skills. However, a similar assessment should not be required of any board certified emergency physician who consistently performs within his or her scope of practice, and for whom the institution does not have any significant concerns for quality of care. Such concerns would be best addressed on an individual, case-by-case basis, rather than requiring mandatory OORAM assessment for all ABEM-certified emergency physicians who are satisfactorily performing airway management.

The following Emergency Medicine membership organizations are supportive of this position, in that third party standards such as the OORAM are not necessary for ABEM-certified emergency physicians:

- American Academy of Emergency Medicine (AAEM)
- American College of Emergency Physicians (ACEP)
- Council of Emergency Medicine Residency Directors (CORD)
- Society for Academic Emergency Medicine (SAEM)

Included with this letter is a copy of the ABEM Policy on Third Party Standards for your review, as well as similar policies adopted by AAEM and ACEP. The attached policies are also available on the websites of each of these organizations.


Collectively, our organizations are requesting that you reconsider the Veterans’ Administration hospital policy on OORAM, and remove this as a generalized requirement for hospital privileges for ABEM-certified emergency physicians who are in good standing.

If you have questions regarding this, or any other ABEM policy, please feel free to contact the ABEM office at 517.332.4800.

Sincerely,



Barry N. Heller, M.D.  
ABEM President



Kevin Rodgers, M.D.  
AAEM President



Jay A. Kaplan, M.D.  
ACEP President



Saadia Akhtar, M.D.  
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Andra Blomkalns, M.D.  
SAEM President

Enclosures: ABEM Policy on Third Party Standards  
AAEM Position Statement on the Advanced Cardiac Life Support Course  
AAEM Position Statement on the Advanced Trauma Life Support Course  
AAEM Emergency Physician Credentialing  
AAEM's The Value of Board Certification and Residency Training in Emergency Medicine  
ACEP Policy Statement on the Use of Short Courses in Emergency Medicine as Criteria for Privileging or Employment

Cc: Linda L. Lawrence, Col, USAF, MC

Via email



## Policy on Third-Party Standards

### BACKGROUND

The American Board of Emergency Medicine (ABEM) wishes to clearly state its position regarding requirements that go beyond ABEM specialty certification and maintenance of certification (MOC). These include institutional requirements such as short course completion or mandatory continuing medical education (CME) credits in a specified content area of Emergency Medicine. ABEM unequivocally states that ABEM certification and ABEM MOC supersedes any perceived need for credentials that are established by third party standards. Specifically, it is unnecessary for an ABEM-certified physician who is actively participating in ABEM MOC to also acquire and maintain credentialing by third parties through short courses such as Advanced Pediatric Life Support (APLS), Advanced Cardiac Life Support (ACLS), or Advanced Trauma Life Support (ATLS), in addition to a specific number of CME hours in a specified content area of Emergency Medicine.

This does not negate the responsibility of the Emergency Physician to be engaged in continuous professional development through the ABEM MOC program. This continued learning and development should reflect the physician's professional needs in such a way as to enhance the care that is being delivered to the patient. Specifically, physicians should adjust their MOC and CME participation in such a way as to meet patient needs in their practice settings.

### POLICY

ABEM believes that the acquisition and certification of knowledge and skills as described in *The Model of the Clinical Practice of Emergency Medicine* (EM Model) are best assured by the completion of an Accreditation Council for Graduate Medical Education–accredited Emergency Medicine residency program combined with the successful completion of the ABEM initial certification examinations and participation in the ABEM MOC program. Board certification and maintenance of certification demonstrates comprehensive training, knowledge, and skill in the practice of Emergency Medicine. Certificates of short course completion may serve as evidence of focused review; however, the content of such courses is part of the EM Model, and ABEM certification supersedes evidence of completion of such courses. Additionally, MOC requires mandatory, secure, high-stakes, psychometrically valid retesting, as well as CME, making short course completion redundant.

Accordingly, for ABEM-certified physicians who are participating in MOC, ABEM strongly opposes the use of certificates of completion of courses such as APLS, ACLS, ATLS, or other similar courses, *or* the completion of a specific number of CME hours in a specified content area of Emergency Medicine, as requirements for privileges, employment, or qualification by hospitals, city or state agencies, or any other credentialing organization to provide care for designated disease entities encompassed by the practice of Emergency Medicine.

### EXCEPTION

None

## Position Statement on the Advanced Cardiac Life Support Course

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AAEM recognizes the value of the ACLS curriculum for non-EM boarded physicians and other health care providers who need to be familiar with the principles of acute cardiac care. However, AAEM believes that board certification in Emergency Medicine establishes expertise in acute cardiac life support beyond what which is taught in the ACLS course.

Therefore, ACLS should not be required of physicians board-certified in Emergency Medicine. And furthermore, ACLS certification does not meet the standards of board certification in Emergency Medicine and does not meet the standards of care in Emergency Medicine.

*Adopted by the AAEM Board of Directors, February 19, 1998.*

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## **Position Statement on the Advanced Trauma Life Support Course**

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AAEM recognizes the value of the ATLS curriculum for non-EM boarded physicians and other health care providers who need to be familiar with the principles of trauma care. However, AAEM believes that board certification in Emergency Medicine establishes expertise in trauma care beyond that which is taught in the ATLS course.

Therefore, ATLS should not be required of physicians board-certified in Emergency Medicine.

*Adopted by the AAEM Board of Directors, February 19, 1998.*

## Emergency Physician Credentialing

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Whereas higher care quality, improved patient safety, and decreased medical legal risk can be directly linked to qualified Emergency Medicine specialists; and

Whereas emergency physicians should be involved in the process by which they are credentialed; and

Whereas AAEM has become the lead organization in promoting the practice of Emergency Medicine only by qualified practitioners;

Therefore be it resolved that AAEM asserts that health care organizations obtain, verify, and document the following information when credentialing emergency physicians for practice in emergency departments:

1. Documentation of ABEM or AOBEM board status and, for those not yet ABEM or AOBEM certified, completion of an ACGME or AOA-approved postgraduate training program in Emergency Medicine.
2. Lifetime medical licensure history.
3. Health care related employment/appointment history (including terminations, challenges or decisions pending, and voluntary resignations/relinquishments).
4. Past 12 months' clinical activity (approximate number of patients treated and clinical setting).
5. Previous 10-year malpractice history (including claims, suits, and settlements).
6. Sanctions by licensing or regulatory agencies.
7. Lifetime criminal record.
8. Signed professional references (attesting to adequacy of clinical knowledge, technical skills, judgment, communication skills, overall professional performance, and adherence to rules and bylaws) by emergency physicians who have observed the applicant first-hand.

AAEM already recognizes that ABEM or AOBEM certification provides training superior to that provided in ACLS and ATLS courses and, as such, those credentials should not be required of board-certified emergency physicians.

## **The Value of Board Certification and Residency Training in Emergency Medicine (8/8/2011)**

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*\* The views expressed in this article are those of the author(s) and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, or the United States Government.*

### **Introduction**

The 1999 Institute of Medicine (IOM) Report “To Err is Human: Building a Safer Health Care System” focused attention on the quality of medical care in the United States.<sup>1</sup> However,



concerns regarding patient care in the nation's emergency departments (ED) have existed since the 1950s.<sup>2</sup> The data from the Harvard Medical Practice Study, which played a key role in this IOM report, supported these concerns as the ED was the hospital area with the highest rate of adverse events due to negligence.<sup>3</sup> Emergency Medicine has existed as a formal specialty since 1979 but the current supply of board-certified emergency physicians meets less than two-thirds of the demand.<sup>4</sup> As health system and graduate medical education reform progress it is important to consider the physician needs related to care in the ED. The intent of this paper is to examine the evidence regarding the value of residency training or board-certification in emergency medicine (EM) and how it affects the quality of care in the ED. This matter is of importance to policy makers and others in decisions regarding the future ED physician workforce.

### **Evidence regarding board-certification in EM and the quality of care**

The best evidence that board certification and residency training in EM leads to improved quality of care comes from studies that examine what happens when a hospital emergency department transitions to such physicians from non-board certified physicians. Data comparing the quality of care before and after the addition of board-certified EM physicians or an EM residency demonstrates improvement in several areas including treatment of acute myocardial infarction (AMI), airway management, chest pain, abdominal pain in females, head trauma, headache and extremity lacerations.<sup>5-9</sup>

Weaver, et al, showed that the addition of qualified EM faculty resulted in a significant decrease in median time to thrombolytic administration and a significant increase in the percent of patients receiving thrombolytic therapy within 30 minutes of hospital arrival in patients with an AMI.

The hospital length of stay was also significantly decreased. There was also a non-significant decrease in mortality noted.<sup>5</sup>

Airway management has also been shown to improve with the presence of EM faculty or residents. In a study by Jones, et al, the success rate of first attempt intubation improved from 46% to 62%. Intubation requiring more than six attempts for completion decreased from 2.9% to 1.1% and the overall mean time to intubation improved from 9.2 minutes to 4.6 minutes with EM faculty present.<sup>6</sup> Friedman, et al, concluded that the addition of an EM residency reduced the number of patients who were admitted to the hospital without undergoing clinically necessary endotracheal intubation in the ED.<sup>7</sup> Chang, et al, reported a decrease in the need for surgical cricothyrotomy, a surrogate marker of improved airway management, in trauma patients after the institution of an EM residency training program at a Level 1 trauma center.<sup>8</sup>

Good documentation reflecting the process of care is believed to reflect good medical practice. ED physician documentation was evaluated for patients discharged home with five chief complaints: non-traumatic chest pain, lower abdominal pain in women, head trauma, headache and extremity laceration. These complaints were selected because they are frequently encountered in the ED and represented areas identified as high risk for malpractice claims.

After the addition of EM residents and EM faculty, there were statistically significant improvements in the process of care for all of the complaints.<sup>9</sup>

Existing EM residency programs also seem to impact the quality of care. Taylor compared patient outcomes in ten Level 1 trauma centers and found that those with an emergency medicine residency training program present had a significantly lower complication rate, death rate and shorter hospital stays despite seeing an older population.<sup>10</sup>

## **Evidence from malpractice data**

The risk of litigation involvement for the EM physician is high due to a lack of a continued physician-patient relationship, frequent interruptions and interactions with patients and their families at stressful or traumatic times. A study by Branney, et al, examined 218 closed insurance claims against “emergency medicine physicians” and found that 61.4% of the claims were against non-certified EM physicians. These claims accounted for 71.5% of money paid. There was on average 1 closed claim for every 30.2 doctor years for non EM trained physicians versus 1 closed claim for every 72 doctor years for EM trained physicians .<sup>11</sup>

Press, et al conducted a retrospective analysis of malpractice claims and awards from August 1984 to July 1990 in a pediatric emergency department. In 1987, their ED changed from part-time attending coverage (coverage was provided part of the day by physicians in training without supervision) to full time attending coverage (e.g. 24 hour supervision). Their data showed a 41.7% decrease in the numbers of claims. Prior to attending coverage they averaged 1 claim for every 10,196 visits, and afterwards, 1 claim in 15,296 visits. There was also a 44.3% decrease in the amount of money paid out in claims.<sup>12</sup> In a sister study, Press et al looked at the same information for their adult ED. In 1987, they increased their attending coverage from 6000 hours per year to 26,280 hours. This change resulted in an 18.5% decrease in claims filed and a 70.1% decrease in monies paid.<sup>13</sup> Although the data from these two studies did not directly examine whether the physician was board certified in EM they do suggest that the presence of more senior physicians decreases the malpractice risk in the ED.

## **Discussion**

The available literature indicates an improvement in quality of care in the ED with the presence of board-certified emergency physicians or a residency training program in EM. This is not surprising as board certification in other specialties has been shown to improve the quality of care and patient outcomes. This has been shown regarding anesthesia related deaths,<sup>14</sup> complications of surgical procedures,<sup>15</sup> the inpatient care of acute myocardial infarction,<sup>16</sup> prenatal care and birth outcomes,<sup>17</sup> and the delivery of preventive services (hemoglobin A1c monitoring, mammography, colon cancer screening, and influenza vaccination).<sup>18</sup>

## **Conclusion**

There is clear evidence in the literature that supports that board certification and residency training in EM improves the quality of care provided to patients in the nation's emergency departments. The public, hospitals and the government should be aware of this fact.

## **References:**

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Approved 8/10/11



## **Clinical & Practice Management**

### **Use of Short Courses in Emergency Medicine as Criteria for Privileging or Employment**

Revised and approved by the ACEP Board of Directors January 2016 and April 2012

Reaffirmed by the ACEP Board of Directors September 2005

Revised and approved by the ACEP Board of Directors titled "Use of Short Courses in Emergency Medicine as Criteria for Privileging or Employment" June 1999

Revised and approved by the ACEP Board of Directors June 1997 and August 1992

Originally approved by the ACEP Board of Directors titled "Certification in Emergency Medicine" January 1984

The American College of Emergency Physicians (ACEP) believes that board certification by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) demonstrates comprehensive training, knowledge, and skill in the practice of emergency medicine. Although short course completion may serve as evidence of focused review; the topics covered in such courses are part of the core curriculum of emergency medicine. ABEM or AOBEM certification in emergency medicine supersedes evidence of completion of such courses. Additionally, maintenance of board certification requires mandatory retesting and continuing medical education (CME), making updated short courses redundant.

ACEP believes that the Comprehensive Advanced Life Support (CALS) course is a valuable educational experience and is an equally acceptable alternative to other advanced life support and/or trauma life support courses. CALS may be of particular value to those who practice rural emergency medicine as it is more comprehensive than other life support courses.

However, for physicians certified by ABEM or AOBEM, ACEP strongly opposes requiring completion of courses such as Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), Pediatric Advanced Life Support (PALS), CALS, and Basic Trauma Life Support (BTLS), or a specified number of CME hours in a sub-area of emergency medicine, as conditions for privileges, renewal of privileges, employment, qualification by hospitals, government agencies, or any other credentialing organization's standards to provide care for designated disease entities.

### **Related Links**

#### **Certification/Credentialing**

[Use of the Title "Doctor" in the Clinical Setting](#)

[Emergency Ultrasound Certification by External Entities](#)

[Sedation in the Emergency Department](#)

[Patient Satisfaction Surveys](#)

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#### **Medical Education**

[Use of the Title "Doctor" in the Clinical Setting](#)

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