To the Editor: In Expectation of a More Evidence-Informed Perspective on Emergency Medicine Education

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We read with great interest the article "Building the Future Curriculum for Emergency Medicine Residency Training" with the authors' proposed changes to emergency medicine (EM) residency program requirements, most notably the mandated 48-month total training length for all EM programs beginning in 2027.[1] Currently, of 289 accredited programs, approximately 81% are 3-year (n=235), and 19% are 4-year programs (n=54).[1] A postgraduate year (PGY) 1-3 model has existed since 1975 and the PGY 1-4 model has existed since 1988.[2]

First, we must declare that the authors of this reply were trained at and are academic faculty at a 3-year program. Secondly, we must acknowledge that we are neither arguing for nor against a 3- or 4-year training format. However, we are deeply interested in the evidence used to create and justify an increased length of training, the additional core curricular requirements, and changes to Key Index Procedures.[1]

The evidence for the increase in training length is sparse. The objective evidence presented relies on a single survey of EM residency program directors (PDs).[1] The article also references subjective feedback from "stakeholder" groups. A previous study found that PDs from both 3-year and 4-year programs suggested an increase in total training time, given choices of additional clinical experiences.[3] However, those authors concluded that the ideal training length was prone to response bias by the training time of programs the PDs directed and the training time completed by the PDs when in residency.[3] These biases would be difficult to mitigate and remain evident in the authors' conclusions.[1]

We acknowledge the increase in emergency department boarding, a decrease in patient encounters, and the potential impact on our residents' education. But are these causing a decline in EM resident performance? Evidence from a recent American Board of Emergency Medicine study suggests that neither a 3-year nor a 4-year training length is superior regarding in-training, qualifying (written), or oral examination scores.[4] Another study analyzed the Milestones 2.0 and found an insignificant increase in overall average levels for 4-year vs 3-year graduates.[5]

There are several oversights in program recommendations by the authors. First, they present inadequate rationale for changes to Key Index Procedures.[1] Second, requirements for specific numbers of point-of-care ultrasounds were removed but still exist in radiology and interventional radiology requirements. Third, they fail to address the increased administrative time spent by program leadership to implement and monitor the additional requirements. Fourth, there are several discrepancies between clinical experiences that PDs deemed essential and the authors' recommendations.[1] Lastly, the authors do not reference any objective data from graduates' and employers' perspectives on graduate readiness for autonomous practice.

We acknowledge the challenge the authors propose for EM to evolve, and desire improvements in resident education that adequately prepare our trainees for their future practice. We challenge the stakeholders and authors to commission a more complete and robust study of the EM workforce that includes patients, graduates, faculty, medical directors, department chairs, and current residents in both training formats to accurately capture the practice of EM today and anticipated needs for the future.

References

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