EDITORIAL

Professional development over the course of a physician's career

La evolución personal a lo largo del ejercicio profesional

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Anyone who has not practiced emergency medicine on some occasion does not know what it is to be a doctor. The first medical act must have been an emergency. In the movie "2001: A Space Odyssey," when the ape menacingly throws the femur of a fellow-ape up in the air to the music of "Thus Spake Zarathrusta", one appreciates that a higher degree of intelligence allows one to use a tool, and this means that power lies in its hands. But what an emergency physician might think, half in jest, is who would attend the head trauma that femur would produce before too long. Could such an event be the first medical emergency in history?

Ours is a young specialty, as reflected by the fact that there is not a single reference in "La Historia de la Medicina" by Don Pedro Lain Entralgo[1]. However, Emergency Medicine (EM)[2,3] is an exciting field. Whoever decides to make it their profession, not the practitioner by circumstance, is a rara avis, and does so because he/she likes and loves it. Some years ago, a few emergency physicians (EPs) in Toledo had an interview with a Health official, just when the decree on core subjects was in final draft form, and we had asked for a hearing. The task was entrusted to the general directors of specialized attention and research, teaching and training. "But what are you doing working in emergencies at your age?" I will refrain from explaining how the meeting panned out.

But indeed, age does affects this rara avis. When one starts, everything suggests that this professional life will never end, that the career will be eternal. Obviously, it is not. In the present issue of the Journal there is an article "Evolution of health care activity of a stable workforce of emergency physicians over time" published by Busca et al.[4]. It attempts to determine the different aspects of care of a group of EPs with varying degrees of experience and see how their care attitudes change over time. It is an original and courageous study, but (there's always a but) on opening this melon it turns into something much bigger. The work seems more like a descriptive study which concludes that there are discrete but significant changes in stable EPs based on accumulated experience. In principle these changes in attitude have to do with attending a smaller number of serious cases, although these are admitted on fewer occasions, and less inter-consultation with other specialists.

On the other hand, experienced EPs see a greater number of less severe cases, order more imaging tests (plain x-rays mainly) and take longer to discharge them. These results are surprising, at least at first glance, as the authors say. This study is unique to date because no other work assesses EPs during several years (seven years in the present study) comparing their care activity and productivity. Other studies have compared different specialties, residents versus fixed staff, etc., but not EPs themselves based on their years of experience. The work by Busca et al. is limited by being a single center study, which does not allow us to generalize since results may be influenced by local issues such as, for example, the fact that most of the fixed staff were trained in the same hospital. But the melon is now open. Now we only need others to confirm or refute these results.

In their professional practice. I believe EPS have evolved tremendously. When one starts, everything is done running to get on with the job: the medical history, now computerized (thank God); diagnostic test forms; all in order and everything in its place. And when one has the diagnosis, treatment must start. Later on, one feels good, when one begins to skill fully manage the techniques of this specialty: central lines, difficult intubation, advanced cardiopulmonary resuscitation, chest tubes. But what good are these maneuvers? To try and cure the patient or at least alleviate the pain and discomfort, that is what we are here for. And the rest is ego, papers and bureaucracy. The difficulty is not how to do things, but knowing when to do them. Treat while trying to diagnose. Analgesia before receiving the results of tests. Save a life, an organ, a function before knowing the diagnosis. The difficult thing is not to place a chest tube: it is knowing when to place it, and also whether it is possible to do something which prevents having to place it. One ends up learning all this. And one's evolution also involves engaging with the emergency service, in general: it is important to organize and program one's activities. And to be involved in training, teaching, research[5]. And at a higher level there is management, clinical and departmental. Use the appropriate antibiotic: can I prevent sepsis?[6]. And what about care indicators, quality, the management of crowding and beds?

The evolution of one's professional career as an EP is fascinating, as is the entire field. It could not be other-

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wise. But then towards the end "with the sun setting on one's working life", to paraphrase Professor Lain, the doctor is a more of a doctor than he/she was before: "This is not an emergency!" becomes "Leave it to me, I'll attend to this one." And giving advice takes longer; one orders the x-ray anyway, knowing it isn't necessary[7], and the patient is convinced, much better and will probably not return for the same problem. One's degree of satisfaction increases and probably the good results and the perceived quality of care too; and most importantly, patient safety, with a proper diagnosis and treatment, the first norm of safety. These parameters are not analyzed in the work by Busca et al. and I would encourage the authors to do so in the future in addition to what they now communicate. In addition, the veteran physician does not trust the first label, probably from triage[8], and proposes a wider differential diagnosis. And that means a delay. And in certain pathologies the veteran consults with other colleagues, allegedly vertical specialists in the field. And he/she values their qualified opinion, a touch of quality[9]. Sometimes it's just about distributing workloads, and the emergency services, by the way, are well staffed in that respect[10].

On reaching this point, I wonder: What is more difficult to manage, a patient with severity level 1 and 2 or, on the contrary, levels 4 and 5? A serious case will always be admitted to hospital. With a less severe case, we can always err by hastily discharging them and not really knowing their true condition. In rapid diagnosis, in time-dependent diseases, in the subtle diagnoses, that's where the veteran is needed. One needs to be able to smell a real emergency! The sense of smell, that ability one detects in the puppy hunting dog and manifests, unfortunately, in almost senescence. Order a D-dimer! Do a CT scan! Start treatment now! And the merit for case resolution is all yours, young doctor, you're doing well.

But it is the task of the manager, the boss, to ensure that the EP is more comfortable at work, considering the great heterogeneity[10] that exists between us in knowledge, skills and abilities, which I think is greatly influenced by self-training. Management, responsible for the different units of emergency medicine[11], may be a solution.

Conflict of interest

The author declares no conflict of interest in relation to the present article.

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