By Neal Flomenbaum, MD
EDITOR-IN-CHIEF

'My Patient'

March is the month when graduating medical students find out where they will spend the next few years learning how to be physicians and surgeons, while training programs find out which of their choices they will be responsible for teaching. Much effort and thought go into the process and in the months before the applicants' "match list" preferences are due, they fly all over the country visiting the programs they are interested in and interviewing with the program directors who are interested in them. One important question that probably never gets asked or addressed is: Who will be teaching me in the middle of the night?

When United Airlines flight 1549 took off from LaGuardia Airport at 3:25 PM on January 15, 2009, First Officer Jeffery Skiles—not Captain Chesley Sullenberger—was flying the plane. Ninety seconds after takeoff, the A320 Airbus encountered a large flock of geese and suddenly lost the power of both of its jet engines. Immediately afterward, a scripted exchange took place in the cockpit: Sullenberger placed his hand on the controls and said "my aircraft," to which Skiles responded, "your aircraft." During the next four minutes pilot Sullenberger, among other things, started the automatic ignition sequence (to no avail), looked for possible landing sites, communicated his requests to air traffic control and then, while rapidly losing altitude, saved all 155 passengers and crew on board by gliding the plane to a perfect water landing on the Hudson River—a feat that had never previously been performed in a large commercial jet and, according to accounts, an option that was not even offered by the flight simulators.

The fact that the more experienced captain was not flying the aircraft but was there to immediately take control and avert a disaster after an unforeseen "complication" represents the strongest link between that heroic feat and a striking characteristic of emergency medicine. Our specialty is organized to ensure both the best patient care and the best training for new emergency physicians by insisting on the constant presence of an attending physician at or near the patient's bedside.

This is not to say that there isn't an appropriate supervisory role for a chief or senior resident. Training senior residents to assume the roles of attending physicians a few months later must also include ensuring that they know how to teach and supervise. But supervising a postgraduate year 1 (PGY-1) resident is generally not a role suitable for a PGY-2, and hopefully we have gone beyond the motto under which many of us trained years ago: "see one, do one, teach one."

Over the past few decades, many specialties have developed two-stage procedures for treating certain types of trauma or illness. Rather than having less experienced physicians attempt definitive repairs under suboptimal conditions during "off hours," a temporary fix or stabilization treatment is performed, followed later by a definitive procedure or cure. This is somewhat analogous to replacing a damaged tire on the road with a temporary spare until the original tire can be repaired or replaced. Typically, the first step takes place in the emergency department and involves emergency physicians.

There is nothing wrong with that approach when the expected results are as good as or better than would have been the case had the definitive repair been attempted initially. But for some potentially catastrophic medical occurrences, everything depends on who is operating and who is standing a few feet away, ready to take over the controls at a moment's notice. Emergency medicine is one of an increasing number of specialties that have found the resources to adopt the concept of "my patient" at all hours, while the others are beginning to "get it." □

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