EDITORIAL

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Father Time and Baby New Year
(Not Necessarily in That Order)

For most of us, December is a month of frenzied holiday activities followed by a time to reflect on the year that is ending and the new one about to begin. The old and new years are frequently depicted by an aged and stooped Father Time carrying a scythe and an hourglass, accompanied by an energetic Baby New Year in diapers. This season, I find myself thinking about how emergency medicine is dealing with patients at both extremes of life.

When EM was first recognized as a distinct medical specialty in 1979, one might have assumed that it would encompass patients of all ages, and to a large extent it still does. Yet, only a decade after EM itself became a specialty, pediatric emergency medicine was recognized as a subspecialty of both EM and pediatrics. At that time, many pediatricians didn't think they needed any additional training in EM to manage childhood emergencies, while many EPs didn't think they needed any additional pediatric training.

The EM and pediatric boards (ABEM and AAP), however, were more enthusiastic about such fellowship training, and the common belief then was that about half of the PEM fellows would come from each of the two primary specialties. It didn't exactly work out that way, and today over 90% of fellowship-trained, board-certified PEM physicians initially train in pediatric residencies. One concern expressed by many EPs then and ever since is that a subspecialty in PEM would split off emergency care of children from EM, leaving EPs even less prepared to deal with pediatric emergencies in the absence of a discrete pediatric ED and/or a PEM physician. This, in fact, is a reality in many urban academic tertiary care centers, particularly those with nearby children's hospitals. But in most other settings the need for trained and qualified EPs to expertly manage pediatric emergencies is no less now than it was before PEM was created. Nevertheless, concerns about slicing the EM pie also continue.

In this setting, enter Father Time with his hourglass and a rapidly increasing group of friends. Dare anyone think of additional training in geriatric emergency medicine? Are the needs of this segment of the population so different than those of other adult patients? And if so, will additional training to manage the other extreme of age further fragment EM? I believe the answers to the last two questions are yes, and no.

Patients in their late 70s and beyond differ in many respects from children and younger adults by their diminished reserve to handle acute traumatic and nontraumatic emergencies, their comorbidities, their responses to medications and, perhaps most dramatically, by the different ways their acute illnesses present—suggesting possible medical treatments for some causes of acute confusion.

But GEM training need not carve out another piece of the EM pie. Every properly trained EP should be able to expertly care for the elderly, while those who have a special interest in the clinical, educational, or research issues of GEM should have an opportunity to pursue them. This might ideally be accomplished in a 2-year GEM fellowship culminating in an MPH degree.

With the passage of time, conditions change. PEM became important in 1991, GEM makes sense now. EM should not be timid about redefining or reinventing itself as needed. After all, EM owes its own creation to needs unmet by older established specialties 40 years ago. Happy New Year! **EM**