EDITORIAL

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"My Patient"—More Than Ever

In teaching hospitals, "off-hour" errors by young doctors are sometimes considered a necessary price of training future physicians. This should never be the case. In 2009, an act of split-second decision making, skill, courage and leadership by an airline pilot saved many lives and captured the attention of the world, but also demonstrated that patient care need never take a back seat to medical education. The following is adapted from my March 2009 Emergency Medicine *editorial.*

In the months before fourth-year medical students choose a residency program for their postgraduate training, they fly all over the country visiting programs and interviewing with program directors. One important question rarely asked or addressed, though, is: "Who will be teaching me in the middle of the night?"

On January 15, 2009, US Airways flight 1549 took off from LaGuardia Airport in New York City at 3:25 PM with First Officer Jeffrey Skiles flying the plane. Ninety seconds after takeoff, the Airbus A320 encountered a large flock of Canada geese, causing both of its engines to suddenly lose power. Immediately afterward, a scripted exchange took place in the cockpit between Captain Chesley Sullenberger and Skiles. **Placing his hand on the controls, Sullenberger said, "My aircraft," to which Skiles responded, "Your aircraft."**

During the next 4 minutes, pilot Sullenberger tried unsuccessfully to start the automatic ignition sequence for the engines, looked for a possible landing site, 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 never previously performed with a large commercial jet and, according to accounts, not even an option offered by flight simulators.

That the more experienced captain was not flying the aircraft at takeoff, but was able to immediately take control and avert a disaster, is strikingly similar to a fundamental characteristic of our specialty of emergency medicine. By insisting on the constant presence of an attending physician at or near the patient's bedside, **emergency medicine is organized to ensure both the best patient care and the best training for new emergency physicians.** There is, of course, also an appropriate supervisory role for a chief or senior resident, because training senior residents to be attending physicians a few months later requires that they, too, know how to teach and supervise. But primary supervision of a first-year (PGY-1) resident should never be assigned to a PGY-2 resident, and postgraduate medical education should not be characterized by the motto under which many of us trained years ago: "See one, do one, teach one."

Sometimes the ED provides a temporary fix or treatment for a problem, with definitive care provided when it can be scheduled later during "normal working hours." But, in either case, when an unforeseen complication or medical catastrophe occurs, everything depends on who is operating and who is standing a few feet away, ready to take over at a moment's notice. Emergency medicine is one of an increasing number of specialties that already understand and require the practice of "my patient" at all hours, while other specialties are beginning to embrace it.

Progress note

In the 4 years since the first version of this Editorial was published, the aviation industry principle of "my aircraft" has been increasingly applied in teaching hospitals throughout the country. Internal medicine hospitalists, including "nocturnalists" now often provide and supervise inpatient care, and "nighthawk" attending radiologists interpret imaging studies and advise clinicians during off hours. Other specialties are showing increased interest and beginning to provide more extensive 24-7 on-site attending care, supervision, and—oh yes—teaching. **EM**