What it’s like to specialize in emergency medicine: Shadowing Dr. Clem

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Staff News Writer

As a medical student, do you ever wonder what it’s like to specialize in emergency medicine? Meet Kathleen Clem, MD, a featured physician in the AMA Wire® “Shadow Me” Specialty Series, which offers advice directly from physicians about life in their specialties. Check out her insights to help determine whether a career in emergency medicine might be a good fit for you.

“Shadowing” Dr. Clem

Specialty: Emergency medicine.

Practice setting: Group practice at a community hospital that has an emergency medicine training program.

Employment type: Employed by a group.

Years in practice: 24.

A typical day and week in my practice: It depends on which shift you are working, but in a busy shift, I usually come on and take reports from the doctors who are going off. We review any of the patients who are still in the emergency department and who will need my care. As the other physician is transitioning off, I follow up on those patients.

I like to do what I call “front-load,” which means I pick up as many patients as I safely can, right at the outset of the shift. That allows me to get patient work-ups started right away. I work to see the people already placed in a room, but that can often be interrupted by an emergency such as a trauma, heart attack or stroke. A patient who is coming in by ambulance in need of immediate evaluation by a physician will be seen soonest. Once I get my patients’ work-ups started, I go back and check the labs, other tests, and x-rays to give the patient’s information and a plan. If it’s a trauma, a heart attack, a stroke or somebody delivering a baby urgently, or another immediate emergency, those patients are going to get my undivided attention until I have dealt with that emergency.
When I come on to my shift, I don’t have any clue what I’m going to see. The entire shift is going to be a mystery until I get into it. And not knowing what’s coming through the door is part of the fun of what I do.

The typical emergency physician will work three to five shifts a week. Five is high, but there are some weeks during which that type of workload is necessary. We try to either group our shifts, so for example work all night shifts, or we do what’s called a waterfall. During a waterfall, I would work one shift at 6 a.m., then the next day at 3 a.m., then the next one from 3 p.m. to 11 p.m., and then I could do the next one from 11 p.m. to 7 a.m., then I’d have a day off to reset my clock. A lot of doctors like to have all their shifts at the same time, so that they get into a routine. I like to separate my night shifts out, so I’ll do them as a single event.

The most challenging aspects of emergency medicine: People think the most challenging part is the traumas and all of the really sick patients. For me, that’s not it. I love challenging cases. I’m trained for that and know how to take care of really sick patients. The hardest thing for me is patients with unrealistic expectations. In certain instances, patients think that “No matter what’s wrong with me I’m going to the ER and that doctor should figure it out and provide a cure,” or “I have this problem I have had for a long time and I’m going to go the ER and my problem is going to be fixed right away.”

Those kinds of things are difficult. It’s also difficult when a patient comes in with the expectation they will be admitted to the hospital and it turns out that it’s safe for them to have their work-ups done—after we check for an emergency—as an outpatient. They can be very disappointed and feel that the emergency physician should have the power to admit them. Patients have to meet pre-specified indications to be admitted to the hospital. It’s really not entirely up to the emergency physicians to determine if someone will be admitted.

The most rewarding aspects of emergency medicine: I absolutely love to be where patients are when they need help the most. I went to medical school to help people, and there’s not a shift that goes by where I can’t go back and say, “I really helped somebody today. I helped make their life better.” To go through an emergency with someone, to be qualified and trained to help them and make the emergency turn out as well as possible—really is what keeps me going.

Three adjectives to describe the typical emergency medicine: I’m better off with phrases, so I would say: You should enjoy working with people from all walks of life; you need to be high energy; and you should be a team player.

How my lifestyle matches, or differs from, what I had envisioned: It’s what I expected. I expected to have a schedule that was not routine. I prefer that. My days off will often be in the middle of the week, instead of the weekend. I knew I had signed up to work nights, weekends and holidays the rest of my career. I planned on that and I’m happy to serve. The only part I didn’t anticipate, and this is true for all specialties, is the amount of time I have to spend on a computer.
Skills every physician in training should have for emergency medicine but won’t be tested for on the board exam: To work well, you have to have a high emotional IQ to thrive as an emergency physician. Because, by necessity, you are dealing with people you haven’t met every shift, and you have to be able to know how to work well with a team that you may or may not have worked with before. So understanding your roles and how to flex and evaluate your team rapidly are keys. You also need to know where to trust others and where to double-check on things.

One question physicians in training should ask themselves before pursuing emergency medicine: How well do you tolerate interruptions? An emergency physician gets interrupted multiple times every hour. If you’re annoyed by that, you probably won’t be a happy physician. It’s necessary for your team to interrupt you. All of them are your partners, your eyes, your ears; they are there to help you provide care. They are giving you feedback on your patients and the timing for that feedback isn’t anything that you can necessarily plan.

You might be getting a call from the lab to let you know that your patient’s cardiac enzyme is positive and the patient is having a heart attack, and at the same time a triage nurse is telling you a stroke just arrived, and at the same time the nurse for room 12 is going to tell you that Ms. Smith is going to leave against medical advice if you don’t come see her. I can get all of that information within 30 seconds. But my thought is that this is my team and I am so grateful they are giving me all that information. It’s up to me, as the captain of the ship, to decide what I need to respond to first. I start with whatever is life-threating first and I move through that way.

Books every medical student in emergency medicine should be reading: Tintinalli’s Emergency Medicine Manual, by Judith Tintinalli, MD; Rosen’s Emergency Medicine: Concepts and Clinical Practice, by John Marx, MD, Robert Hockberger, MD, Ron Walls, MD; and Rosen & Barkin’s 5-Minute Emergency Medicine Consult, edited by Roger M. Barkin, MD, Jeffrey J. Schaider, MD, Stephen R. Hayden, MD, Richard E. Wolfe, MD, Adam Z. Barkin, MD, Philip Shayne, MD, Peter Rosen, MD

Quick insights I would give students who are considering emergency medicine: Take every rotation that you go through during medical school and act as though you want to practice that specialty. Say to yourself “I am going to be a pediatrician” or “I am going to be a neurologist.” The reason I would say that is that in emergency medicine you need to know about the emergencies associated with all specialties. So go to each rotation with gusto and focus on it.

I don’t think about what is the most common when a patient comes in. I first think, “What is the most dangerous thing that this could be? What is the most life-threatening thing this could be?” Only then do I think about what is the most common thing this could be. Most of the rest of medicine looks for a pattern. What does it fit most? And I do that too, but first I think about what is life-threatening. Because I’m working in an emergency department, and I have to think about that for every patient I see.
So the patient that comes in with a stroke I’m going to do a very brief and focused exam to determine if I think it’s a stroke or not. Then I would move from there to consult a neurologist and order whatever test. Then you can go back later and do a detailed neurological exam. But I first need to do a very focused exam to determine if it is a stroke. When I call a neurologist in, he’s going to do a very detailed exam. It probably will take a good 30 minutes. That’s exactly what they should be doing. But if I took 30 minutes to do that before setting the stroke team into action, my patient could have a completed stroke and never recover. Emergency physicians do focused exams first.

What’s difficult about emergency medicine is that you are making decisions based on limited amounts of information. My colleagues have had the luxury of time. They get more details and have time to look into more questions than we do in the ED. Sometimes they will second-guess whatever decision I made with the limited amount of information that I had. Sometimes they say that in emergency medicine we practice “fish bowl medicine” because every specialty is watching what we do. I am comfortable with that. An emergency physician has to be an expert on everything for the first five minutes.

**Song to describe life in emergency medicine:** I like “Stayin’ Alive,” by the Bee Gees. That is what I sing in my head while I’m doing CPR. It’s the right beat.