

The Status of Emergency Medicine in the USA
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I. Brief History of EM in the USA

Pre-1960:

The call for modern Emergency Medicine in the United States of America (USA) was first initiated in the mid-1950s. One can look back earlier and uncover interesting historical tidbits about EM (ex. hearses often doubled as ambulances in the early 20th century) but the genesis of a comprehensive emergency department (ED) service with full time emergency physicians is a relatively recent event. Anyone familiar with the popular USA television show M*A*S*H will note that the concept of bringing acute care close to the battlefield was fully implemented in the Korean War. Those crack surgical teams returned to a less developed system stateside leading a noted surgeon, Robert Kennedy to comment that the weakest link in the chain of care of the injured patient was the ED phase.(1)

As the decade progressed there was further recognition of the “problem” in the ED. Several factors had caused a steady increase in ED visits in the USA in this time period and the haphazard staffing was called into question. In many places the ED physician staff consisted solely of interns with no attending support. Shortliffe, et al surveyed 90 hospitals from the Midwest USA to the Atlantic seaboard and they reported a 400% increase in ED patient volume between 1940 and 1955.(2) Shortliffe commented that the current staffing patterns did not meet the increased demand and complexity of the cases. The editorial staff at the New England Journal of Medicine agreed stating that an experienced physician is the “indispensable sine qua non” of quality emergency care.(3) This editorial was essentially a call for the creation of the specialty of EM. (It is interesting to note that despite this, New England was one of the last places in the USA to get on board with EM).

1960s:

USA EM historians generally point to 1961 and the “Alexandria (VA) Plan” as the start of the first full-time group of dedicated emergency physicians under the leadership of James Mills, MD. That same year saw the creation of the “Pontiac Plan” in Michigan where 23 physicians agreed to dedicate part of their time as a group to the ED. In 1966, the American Medical Association’s (AMA) Department of Hospitals and Medical Facilities reviewed the “ED problem” once again and noted the same issues as Shortliffe regarding physician staffing. (4) The problems related to trauma care received national attention with the publication of the landmark monograph “Accidental Death and Disability: The Neglected Disease of Modern Society” by the Committee on Shock and Trauma of the National Academy of Sciences (Washington, DC, 1966). One year later the Committee on Emergency Medical Services of the AMA published a comprehensive four-part article covering the scope of EM. (5)

The first physician organizations dedicated to emergency medical care soon followed. On August 16, 1968 in Lansing, Michigan 8 physicians founded the American College of Emergency Physicians (ACEP) under the Presidency of John G. Wiegenstein, MD. At a meeting of physicians interested in EM convened by Reinald Leidelmeier later that year in Virginia, the ACEP representatives were able to convince the attendees to go with their structure and a true national specialty took off. Another important event in 1968 was a meeting of six surgeons who served as ED directors over lunch at the American College of Surgeons meeting in San Francisco. This event gave birth to the academic organization known as University Association for Emergency Medical Services UA/EMS (now known as SAEM, the Society for Academic Emergency Medicine). (6)

1970s:

ACEP and UA/EMS would serve as the nidus for the growth of the specialty in the 1970s. Several important events occurred in this decade including the following:

1970- Bruce Janiak becomes the first EM resident at the University of Cincinnati
1971- First academic departments of EM at the University of Southern California and Louisville
1972- JACEP (now Annals of EM) the first peer-reviewed EM journal is created
1973- The AMA recognizes EM with provisional section status
1975- A test committee starts work on a board exam
1975- STEM, the Society of Teachers of EM created
1976- ABEM, the American Board of EM is incorporated
1979- ABEM is approved by the American Board of Medical Specialties assembly as the 23rd official medical specialty receiving “modified conjoint” board status

1980s:

The administering of the first ABEM examination in 1980 heralded a decade of rapid growth and development of EM in the USA. The offering of the first board exam culminated the efforts of those who answered the call of the 1950s and 1960s to create the specialty of EM. As many of the founders of EM had not been through an EM residency, the ABEM examination was open from 1980 to 1988 to those emergency physicians who qualified under what was known as the “practice track”. The qualifying criteria for this track included 5 years of full time EM practice with at least 5,000 clinical hours practicing EM. This practice track is no longer open and to become certified by ABEM a physician must now first complete an accredited EM residency. The current requirements for osteopathic board certification through the American Osteopathic Board of Emergency Medicine (AOBEM) are similar.

By 1981, there were 56 residencies in EM with more being added yearly. In 1983, the American Journal of Emergency Medicine was inaugurated with J. Douglas White as Editor-in-Chief. One year later, Peter Rosen did the same with the Journal of Emergency Medicine, which is now the official journal of the American Academy of Emergency Medicine (AAEM). As the decade drew to a close the final step in full specialty status came in 1989 with ABEM receiving “primary” board status which placed it on equal footing with the other specialties. Primary board status also opened the door to subspecialty training in EM related areas such as toxicology and pediatric EM.

In 1989, the Society of Teachers of Emergency Medicine merged with the UA/EMS to form the Society for Academic Emergency Medicine consolidating teaching, research and other academic matters under one umbrella. Other academic related groups were created at this time, however, including the Council of EM Residency Directors (CORD) and the Association of Academic Chairs of EM (AACEM) to represent the special concerns of those smaller but growing groups. By the end of 1989 there were 17 full academic departments of EM in the nation’s medical schools. For those interested, a more comprehensive review of the history of academic EM may be found at the SAEM web site (www.saem.org).

1990s and 2000s:

The American Academy of Emergency Medicine (AAEM) was started as a new professional society in 1993. An independent think tank, the Josiah Macy, Jr. Foundation from New York City issued a report in 1994 entitled “The Role of Emergency Medicine in the Future of the American Medical Care.” The report, a summary of which is on the SAEM web site (www.saem.org) made several recommendations and specifically pointed out the need to improve the quality of the physicians staffing the nation’s emergency departments. AAEM extended its reach into international EM by combining efforts with EUSEM to hold the largest international conference in EM to date in September of 2001. The current conference builds on and hopes to exceed those efforts.

II. EM Specialty Status

EM is fully accepted as a specialty in the USA. The American Board of Emergency Medicine has certified over 19,000 physicians while the osteopathic equivalent AOBEM has certified an additional 1,100. Currently, there are 64 academic departments of EM in the nation's 126 allopathic medical schools. Residency programs (MD and DO combined) are producing approximately 1,300 graduates per year, a number that is sufficient to meet the number of physicians retiring or leaving the field. Soon most emergency departments will have access to board-certified emergency physicians. There exist 4 accredited sub-specialties in EM: toxicology, pediatric EM, sports medicine and undersea and hyperbaric medicine. Numerous other fellowship training programs exist including ultrasound, research, geriatrics and education.

A minor dip in visits to the nation's emergency departments in the late 1990s has been reversed and the demand for such care has reached over 100 million visits per year with the expectation of continued growth. Clinical advances and expansion of the capabilities of emergency physicians is paralleling the rest of USA medicine. The concept that one physician, the emergency physician, is fully capable of handling all patients presenting to the ED is generally accepted in the USA. The ever increasing ability to provide timely definitive care in the ED has assured EM's future role in the health care system. EM physicians have expanded beyond the ED by providing coverage in short stay/observation units and in some areas, critical care units. EM physicians are supported by a number of highly qualified professionals including pre-hospital providers, certified emergency nurses and physician extenders. Emergency nursing has its own professional organization the ENA.

Pre-hospital care systems vary by locale with many large cities having this run in conjunction with the fire department services. Private systems exist and the level of provider ranges from those with basic experience to highly qualified personnel. Professional flight teams and hospital operated air transport are common in large referral centers. EMS professionals have led the way in the deployment of automatic external defibrillators in public places. The reader is referred to the web site of the EMS physician organization for further reading in this area (www.naemsp.org).

Things are going well on the research and scholarly side as well. The Society for Academic Emergency Medicine has ensured a strong research base for the field and is developing an impressive funding source for research. Currently, a number of EM physicians hold NIH funding. There are 4 major journals solely focused on EM including Academic EM, the American Journal of EM, Annals of EM and the Journal of EM. National and regional scientific meetings are held in addition to an extensive array of educational meetings for the practicing physician.

III. Challenges and Strategies

One of the major problems currently challenging the specialty of Emergency Medicine in the USA is crowding of the ED especially in large urban hospitals. This has been recycled from the late 1980s. Much of this relates to the lack of available inpatient beds causing prolonged stays in the ED for admitted patients. There is also a nationwide shortage of nurses in the USA that contributes to the lack of inpatient bed availability as well as problems with nursing support in the ED. This crisis has led to declines in physician and staff morale and has affected patient care in some circumstances. EMS systems are also stressed as the crowded ED will "divert" the patient to another more distant ED. Solutions for this crisis require both local and national efforts. Nurse recruitment has been a focus in many areas and there has been attention to the need to shift patients from a holding status in the ED to inpatient status. Hospitals, however, continue to struggle financially and are reluctant to open more beds that they may not be able to staff.

A second major problem in EM in the USA is a combination of poor reimbursement for care and the rising costs of malpractice insurance. US emergency physicians speak of the "unfunded mandate" of EMTALA, a federal law that ensures emergency care for all without assuring that the care will be paid for. All of US medicine has been hit by the rising cost of malpractice insurance.

A number of states are losing physicians to departure, early retirement or decrease in the scope of practice. The poor reimbursement for emergency care services and increased malpractice risk has affected the willingness of support specialists such as neurosurgeons to make themselves available for emergency cases. Funding issues have led many USA emergency physicians to call for alternative ways to fund emergency and trauma care. Such calls include those for a government run health care system with guaranteed coverage for emergency care for all citizens. However, this debate has gone on without resolution for decades in the USA. Certainly, many USA emergency physicians would agree that the above factors indicate that the “safety net” of emergency medical care in the USA is under stress and at risk of failure. The terrorist events of September 11, 2001 have been used by some to point out the need for more support of this safety net. Whether this comes to pass remains to be seen.

References:

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