

section one I

Emergency Medicine
The Specialty



chapter 1

Evolution of Emergency Medicine as a Specialty

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Last I remembered, Dave Wagner, John Wiegenstein, Ron Krome, and George Podgorny were welcoming a new generation of emergency physicians into the field of emergency medicine and mentoring us in the art of leadership.

From Dave Wagner, we learned vision—he lit the fire of pediatric emergency medicine, about 25 years ago when everybody else could only focus their near-sighted eyes on the immediate emergency medicine development tasks.

From Ron Krome, we learned when to be aggressive and how to stand up for our rights as emergency physicians.

From John Wiegenstein, we learned about statesmanship and diplomacy, and how to develop partnerships with physicians in other specialties. He is remembered by the Wiegenstein Award given each year by the American College of Emergency Physicians (ACEP).

From George Podgorny, we learned about tough love as the way to deal with the obstructions other specialties put in the way of the development of our specialty.

We all owe a debt to those first emergency physicians, and many others whom I do not have the opportunity to name here, for they made it possible for us to have wonderful medical careers in this exciting and challenging specialty.

Emergency medicine really began in the 1960s in Alexandria, Virginia, where a group of physicians led by James Mills, MD, organized themselves as the first emergency medicine specialists. Jim served as president of both ACEP and ABEM and was smart, calm, and politically very savvy. He practiced emergency medicine in Alexandria until the end of his career, and is remembered by the James Mills Award given by ACEP each year. The “Alexandria Plan” produced a set of physicians who devoted their practice to staffing the emergency department 24 hours a day. Previously, U.S. hospitals used a system of rotating medical staff to cover the emergency department as part of their responsibilities for hospital privileges. That meant dermatologists, ophthalmologists, otolaryngologists, etc., were expected to diagnose and treat all emergencies, or find suitable individuals to help them out.

About the same time, physicians throughout the United States interested in emergency care founded ACEP, and a group of academic surgeons responsible for trauma organized the University Association for Emergency Medical Services (UA/EMS) in Ann Arbor. This organization, UA/emergency medicine, evolved into the SAEM of today. By 1970, The University of Cincinnati developed the first emergency medicine residency. Its first graduate, Bruce Janiak, became president of both ABEM and ACEP. In 1973, the federal government demonstrated the importance of emergency medicine and emergency

medical services to the nation by creating the Emergency Medical Services (EMS) Act. Federal funds provided seed money to develop emergency medicine residencies, and by the late 1970s there were about 50 emergency medicine residencies in the United States. As residencies proliferated, ACEP organized the Liaison Residency Endorsement Committee (LREC), which identified the essential components of an emergency medicine residency and developed criteria for residency approval. Bob Daley was the first LREC chairman, and we tried to balance a need for rapid growth of the specialty with a need for quality training programs. There were extremely heated discussions about whether or not academic emergency medicine could develop while providing 24-hour faculty coverage for our residents in the emergency medicine. I'm proud to say that the 24-hour rule won out. The essential components developed in the 1970s remain in the basic structure of the approval process we use today. When emergency medicine received official recognition as a primary specialty, the LREC was reorganized under the ACGME as the Residency Review Committee for Emergency Medicine (RRC-emergency medicine).

While emergency medicine was popular and rapidly accepted by community hospitals and private physicians, medical schools remained generally disinterested. Some traditional specialists were downright hostile to both the concept of, and individuals promulgating, emergency medicine. Many academicians thought that emergency medicine lacked a unique knowledge base. What finally persuaded them was the fact that the administration, management, and operations of emergency medical services were functions unique to emergency medicine. So it was emergency medicine services that became the cornerstone of emergency medicine and was a leading factor in its eventual acceptance as a specialty. It is important for all of us to remember that.

Work was under way in earnest to develop a core curriculum. ABEM began developing a certification examination. That process was funded through voluntary donations from physicians practicing emergency medicine throughout the United States. Emergency medicine was the first specialty to develop a criterion-referenced examination (as opposed to norm-referenced examinations where the lowest percentiles fail). It was also the first specialty to require regular recertification examinations. The board examination was actually written, validated, and ready for administration before emergency medicine was approved by the ABMS (American Board of Medical Specialties). Some fiercely advocated going ahead, giving the exam, and forging our own course. Moderate views prevailed, because it was necessary to follow the rules of organized medicine in order to ensure the future of the specialty.

The first American Board of Emergency Medicine approved by the ABMS in 1979 was a conjoint board. This board consisted of a majority of emergency physicians but also had membership from other specialty boards, including internal medicine, obstetrics and gynecology, family practice, psychiatry, and otolaryngology, to guide and advise the emergency medicine directors. While the concept of a conjoint board was difficult to swallow, it did allow for a much smoother entry of emergency medicine into the world of the ABMS. In 1989, the ABMS voted to change ABEM into a primary board. The last vestiges of that first conjoint board disappeared about 2 years ago when all non-emergency medicine specialties ended their participation in ABEM. To me, this was a great milestone, but it occurred with barely a whimper. I thought it should have been heralded by fireworks and parades; it was that significant an event.

Obviously the very first emergency physicians developed the specialty by "bootstrapping." That is, they developed emergency medicine residencies when they themselves did not have the opportunity for such training. It was for this reason that a time-limited practice track for board eligibility was designed when the specialty originated. Time-limited practice tracks were not an innovation unique to emergency medicine—they were the mechanisms also used by other specialties such as internal medicine and family medicine, when those specialties originated. The practice track was phased out in 1989.



From about 1989 on, emergency medicine moved on a fast track. Emergency medicine residencies are thriving in many nations. I have visited many of these programs and find the practice, problems, and vision of emergency medicine are very much the same all around the world. It is amazing that emergency medicine has come so far in so short a time. We are compassionate and energized physicians who really make a difference. My own enthusiasm for the practice, research, and teaching of emergency medicine continues, as I know yours will in this fascinating, demanding, and fun specialty.

Emergency Medicine: A National Perspective

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Our specialty was born out of adversity a little over three decades ago in places like Lansing, Michigan, and Alexandria, Virginia. Americans had a better chance of surviving serious illness and injury on the battlefields of Vietnam than on the streets of our major cities. The physicians who staffed the “emergency rooms” of the day were there as punishment. The workforce was made up of physicians who were at the beginning, end, or low point of their careers. How times have changed. We are now the most sought-after specialty, and our residency graduates are the best and the brightest American medicine has to offer.

When we look at the external environment, we’re faced with unprecedented challenges. With them come opportunities to transform our health care system into one that can provide high-quality care for all Americans, regardless of their age, sex, race, creed, color, primary language, or ability to pay. When the government or organized medicine puts together a team to take on a tough challenge, emergency physicians are among the first to be asked to step forward. Instead of being a fly on the wall, we have a seat at the table, often a seat at the head of the table. Although we are relatively small in number compared to other specialties, we are disproportionately represented in leadership roles.

The same skills set that makes us good at what we do clinically makes us the perfect docs to bridge the gaps between medicine, business, and the government. Our knowledge base is miles wide, and we’re able to speak intelligently about almost any aspect of medicine. We see the big picture and are good at cutting through the minutiae to focus on what is really important. We thrive in stressful environments where decisions must be made with less than complete information. We’re good stewards of precious resources. We tend to be good politicians. We’re seen by the public as healers more concerned about doing what’s in their best interest than ours. There’s a universal connection to what we do and a natural desire to associate with us because every person we meet is just a heartbeat from being one of our patients. We heal sick people, band-aid sick systems, and hold the greatest promise to resuscitate our flawed health care system.

Economic, demographic, and social factors are forcing fundamental change in our health care system. Emergency medicine has long been the safety net, and as a result has borne the brunt of the health care system’s woes. Concerns to our specialty include: ensuring universal access to emergency medical services; ensuring the highest quality of care is provided to all our patients; improving the liability climate to ensure both emergency physicians, and the consultants who they rely on, can provide needed emergency care; easing the crowded conditions in which emergency physicians provide care; improving our emergency department’s and hospital’s ability to respond to natural and terrorist disasters; and ensuring adequate reimbursement for the services provided by physicians, much of which is uncompensated.



The spectrum of disease witnessed by the emergency physician is unparalleled and is often the draw for medical students choosing a career in emergency medicine. Your future training goes well beyond the bedside, however. As suggested, the challenges before the American health care system are significant. However, there is no group better prepared to lead this transformation than emergency physicians.

Patients have spoken with their feet, seeking our care in unprecedented numbers. We are the ones you come to when you're really sick, possibly sick, or kind of sick and in need of rapid evaluation, diagnosis, and treatment. We are the place you come to when you cannot or will not wait for others to find a place in their schedules for you, and the site of medical refuge when you don't know where else to turn. Despite limited resources, unrealistic expectations, and impossible demand, emergency medicine delivers on our promise to provide the best possible care to every patient regardless of their ability to pay or what time of day they choose to seek care.

Alan Kay once said, "The best way to predict the future is to invent it." We're in an inventing mode and are being presented with a historic opportunity to define both the future of our specialty and of American medicine. The opportunities in emergency medicine are endless and by choosing this career you will become a leader and a champion for the health care needs of your patients. The challenges before our health care system and emergency medicine are significant, but the rewards and honor of providing care to our communities are limitless.