Reflections on Becoming a Specialty and Its Impact on Global Emergency Medical Care: Our Challenge For the Future

Michael T. Rapp, MD, JD, FACEP
Department of Emergency Medicine, George Washington University, 2150 Pennsylvania Avenue NW, 2B-417, Washington, DC 20037, USA

George Podgorny, MD, FICS
American Board of Emergency Medicine, 2115 Georgia Avenue, Winston Salem, NC 27140, USA

The widespread interest and enthusiasm among United States emergency physicians and their international counterparts in improving emergency care globally is evident from the information provided in the preceding articles of this edition of Emergency Medicine Clinics. These efforts, termed international emergency medicine, include providing direct patient care internationally, education, training, and emergency care system development. The challenges faced in embarking on any of these activities are significant. They vary among different countries generally according to their stages of economic development and their health care system's characteristics. This article considers the experience of the United States in developing its system of emergency care and reflects on the role played by the rise of the specialty of emergency medicine. Although the United States is in many ways unique, its emergency care system has developed to a high level of quality. It is important, therefore, to consider the extent to which the United States experience and its model of emergency medicine as a primary specialty of medicine may serve to guide future efforts to improve emergency medical care globally.

The term "primary specialty" is used for the purposes of this article to identify one of the primary specialties of medicine as recognized through the American Board of Medical Specialties (ABMS) process. The term is used to distinguish specialties from subspecialties. There are 24 recognized
ABMS specialties of which emergency medicine is one by virtue of the American Board of Emergency Medicine being a member board. The significance of member board status is that the specialty members become primarily responsible for determining training and certification requirements for its specialists. By contrast, a subspecialty is dependent on one of the primary boards or specialties for determination of training and certification requirements. For practical purposes, the ABMS process defines specialties and subspecialties in the United States healthcare system. It is recognition through this process that the leaders of emergency medicine successfully accessed to establish emergency medicine as a specialty. Information on the ABMS process and a list of the member boards is available at www.abms.org. The American Osteopathic Association has a parallel certification process for physicians with DO degrees.

Development of emergency care and the specialty of emergency medicine in the United States

Emergency medicine has become so well established in the United States that today's students and residents are scarcely aware that just over 25 years ago emergency medicine did not exist as a recognized specialty. It was not until the early 1960s that the development of the current system of emergency care started and not until 1979 that emergency medicine was recognized as a specialty of medicine. The American Board of Emergency Medicine became the twenty-third specialty board recognized by the American Board of Medical Specialties in September 1979 [1].

A number of forces coalesced to initiate and support the development of the modern United States emergency care system. A principal factor was patient demand. Increasing numbers of patients presented to hospital emergency departments for care during the years after World War II. This is explained in part by the decline of the general practitioner, who in the pre-war United States provided a principal access point into the health care system. Rather than having large numbers of physicians pursue general practice, specialty training became the norm for physicians after World War II. This led to an assortment of specialists but not as convenient an access point to health care for patients as the family general practitioner. Another factor that promoted the use of hospital emergency departments was the increased mobility of the population as more people moved to cities and suburbs. The prosperity of the post-war years meant that more people had private health care coverage. This provided for emergency care often in preference to physicians' office-based care. With the increasing numbers of patients presenting to hospital emergency departments, hospitals and their medical staffs had to modify the practice of calling on-call staff physicians from home to attend patients who came to the emergency department.
In 1961, Dr. James D. Mills, Jr, and three colleagues in Alexandria, Virginia became the first physicians to establish a full-time practice of emergency medicine. Their model, called the Alexandria Plan, had several features. They restricted their practice to the emergency department and provided coverage 24 hours a day. They would see all patients who presented without regard to the ability to pay. The physicians did not use admitting privileges or maintain outside medical practices. Instead, they referred all patients for admission or outpatient care to the patient’s regular physician or to other physicians through an on-call roster of medical staff members. Finally, they entered a contractual relationship with the hospital describing a set of mutual rights and responsibilities.

The Alexandria plan was initially only one of the models that hospitals used to provide for its emergency department staffing. It rapidly won out over other staffing methods, such as rotating coverage by medical staff members or resident house-staff coverage in teaching hospitals, and became the predominant form of physician emergency department staffing. It established the standard desired by hospitals—the “full-time emergency physician.” Even more importantly, it set the stage for the development of the specialty of emergency medicine by establishing what emergency physicians would do and how and where they would practice.

During the 1960s, public and private interest in emergency care grew. Technology was one stimulus, particularly the development of the electronic defibrillator and improvement in cardiopulmonary resuscitation techniques. In addition, Emergency Medical Services (EMS) became a subject of widespread attention with the 1966 report of the National Academy of Sciences and the National Research Council: Accidental Death and Disability: The Neglected Disease of Modern Society [2]. The need for improved emergency care standards and more rapid response at the pre-hospital setting and hospital level became apparent.

By 1968, there was an increasing number of emergency physicians practicing in various parts of the country. The recognition that educational resources were insufficient for physicians practicing in this new field led Dr. John Wiegenstein and Dr. John Rupke, from Michigan, to found the American College of Emergency Physicians (ACEP). Soon thereafter they met with other interested physicians in Virginia, and the decision was made to promote ACEP membership on a national level [3].

Specialty status for emergency medicine

The next major development for emergency medicine was the decision by the leaders of the ACEP, shortly after its founding, to pursue recognition of emergency medicine as an independent specialty. With the input of emergency physicians familiar with the requirements to achieve such recognition, a roadmap was developed that ACEP and other emergency medicine leaders actively pursued.
The validity of efforts to establish a new specialty was by no means self-evident to physicians in charge of the medical establishment. To many, emergency medicine's primary characteristic was a place of practice, not a particular body of knowledge. Moreover, the specialty of family medicine was in development and had a broad knowledge base. Without the determined pursuit of the goal of specialty status, emergency medicine could easily have become a subspecialty of family medicine or part of one or more other specialties. The need for medical supervision and improvement of prehospital emergency medical services was persuasive to many that the specialty of emergency medicine would fill a unique role [3].

In their pursuit of specialty status, the leaders of emergency medicine first achieved section status in the American Medical Association. This was the preliminary step needed for specialty recognition. In 1976, the American Board of Emergency Medicine (ABEM) was incorporated through the sponsorship of ACEP and the predecessor of the Society for Academic Emergency Medicine. Members of ACEP further supported the development of the initial examination though a special assessment and gave the examination to ABEM. In 1979, the goal of formal specialty recognition was achieved by acceptance of ABEM as one of the member boards of the American Board of Medical Specialties. This goal was achieved only 9 years after the founding of the American College of Emergency Physicians. The specialty of emergency medicine had achieved a place in the United States equivalent to the other primary specialties of medicine.

Significance of specialty status and characteristics of emergency physicians

It is difficult to overestimate the importance of emergency medicine specialty status as a factor leading to improvement of emergency care within the United States. By achieving primary specialty status, wide opportunities arose for emergency physicians to address the needs of the public for emergency care. Instead of focusing on another specialty and its limited perspective on emergency care, emergency physicians viewed the entire breadth of emergency care as the essential object of their training, skill, and interest. Emergency physicians became directly responsible for emergency medicine training programs. Emergency physicians were placed in charge of defining, refining, and training physicians in the body of knowledge constituting emergency medicine.

Emergency physicians have demonstrated their unique value in many venues. These include community, academic, military, and disaster settings. Recently, emergency physicians have become increasingly important to public health authorities through emergency medicine's role in the surveillance and treatment of new illnesses or outbreaks. Among the characteristics of emergency physicians that have been most important in their contribution to high-quality emergency care are (1) highly specialized skills in emergency care without the limitations of traditional specialties,
(2) a belief in open access for all patients who would seek care, and (3) a highly integrated role in the overall health care system.

Generalist with highly specialized emergency care skills

The primary skill of the emergency physician is the ability to recognize, assess, and treat the most severe and life-threatening emergency medical problems. This is coupled with the ability to care for several patients at once and rapidly organize their care. Despite a role for many other specialists in emergency care, there are no physicians that approach the emergency physician in terms of breadth of these skills. Every other specialty limits what they do by categorizing patients by age, gender, type of therapy needed, body system, or organ and tends to take care of patients in sequence. By contrast, the emergency physician may go from caring for a child to an adult, from a surgical to a medical problem, from a gynecologic problem to a male genitourinary complaint, and from a problem involving one organ system to any other while dealing with multiple patients simultaneously.

Twenty-five years after its recognition as a specialty, emergency medicine maintains its generalist approach to emergency care. There are few recognized subspecialties of emergency medicine. This is despite a broad movement in the United States toward specialized centers of care or centers of excellence. These include cardiac care, poisoning, trauma care, burn care, stroke care, and pediatric care. Even in institutions where several such specialized centers exist, emergency physicians maintain their primary role in initial evaluation and treatment of patients and in the rapid organization of their care.

The value of the generalist emergency physician was somewhat slow to be recognized in certain health care institutions, particularly research-oriented academic medical centers. Some of these have been the most recent to establish emergency medicine residency training programs. In addition, achievement of academic department status has tended to be slowest in these institutions. However, recent acceptance of emergency medicine on par with other specialties in such institutions further supports the value of the traditional generalist emergency physician even in centers providing the most specialized services.

Supporting open access to care

Emergency physicians are subject to the Emergency Medical Treatment [4] and Labor Act (EMTALA), which requires hospitals and emergency physicians to provide a medical screening examination and stabilizing treatment to all who present to a hospital emergency department. This ethic to provide emergency care to all who would seek it has been part of the make-up of emergency physicians since their inception. As such, emergency
physicians are unique in requiring no more from a patient, before providing medical services, than that the patient seek care.

Regarding policy initiatives that emergency physicians are involved in, they are the quickest and most insistent in opposing any policy that would limit access of patients to emergency care. One example of this is the prudent lay person standard for emergency care to counter insurance company policies that would restrict emergency care. This standard makes coverage for emergency care dependent on the patient's impression of the urgency of medical symptoms, not the concluding impression of the physician after evaluation and testing. This definition has been adopted in a majority of states and has been adopted into federal laws governing Medicare and Medicaid. The role of emergency physicians has been paramount in this effort in that emergency physicians developed and persistently lobbied nationally for adoption of these laws.

Quality emergency care depends above all on access to such care. Any limitation of emergency care to the few undercuts its basic value. The specialty of emergency medicine has been highly instrumental in opening and maintaining access to such care for the public at large in the United States.

Emergency medicine's integral role in an organized system of care

In the United States, emergency physicians practice primarily in the hospital setting. Because of this, United States emergency physicians have access to the tools and resources of a hospital without which they could not fully benefit the patient. In the hospital setting, emergency physicians must interact with virtually every aspect of the hospital and its personnel as they provide initial evaluation and treatment or arrange ongoing inpatient or outpatient care. As a result, they fulfill an integral role in supporting an organized system of hospital care. At the hospital level, emergency physicians are influential in assuring that the patients have access to inpatient and outpatient follow-up care. In the legislative arena, emergency physicians initiated the call to amend the EMTALA statute to require hospitals to maintain an on-call roster of other specialists to support the overall care needs of patients presenting to the emergency department.

In addition to their hospital role, emergency physicians play an important role in the EMS system of pre-hospital care. Unlike in other countries where EMS may be independent of physician control, medical direction is a defined part of the United States system of EMS, and emergency physicians serve as the primary EMS medical directors. Moreover, the development of EMS and the specialty of emergency medicine have played an important symbiotic role. The needs of EMS for medical direction, training, and supervision have served to stimulate aspects of the development of emergency medicine (one example of this is the Emergency Medical Services Act of 1973, which included provisions for federal funds to
assist in the development of new emergency medicine residency programs). The involvement of emergency physicians in their role providing EMS supervision and medical control has served to greatly augment the skills, capabilities, and reliability of EMS personnel.

Utility of the United States primary specialty model of emergency medicine internationally

The model of emergency medicine as a primary specialty has been successful in the United States. It is not certain whether advances in emergency care in the United States could have been effectively achieved with other specialty models or whether the United States experience is transferable to other countries. However, the marked successes of the specialty in the United States argues in favor of considering the United States primary specialty model widely. Having significant numbers of physicians whose primary focus is the broad field of emergency medicine and not just the emergency aspects of some more limited specialty presents many potential benefits to health care systems. Even where the health care infrastructure is generally inadequate, the emergency care system provides a barometer of health care deficiencies that is likely to prompt the emergency physician to seek to address them.

Despite the success of the primary specialty model in the United States, it exists in relatively few countries. Primarily, these are economically advanced Anglophone countries. In several other countries, emergency medicine is recognized as a specialty, but it is not a primary specialty and is instead part of one or more other specialties. Even with respect to those countries with a primary specialty model and a mature stage of emergency medicine development, the United States system is somewhat unique. In particular, the residency training requirements in the United States allow residents to enter directly into an emergency medicine training program, without lengthy preliminary training, under the direction of emergency medicine faculty, and complete training qualifying the physician after 3 years to take the ABEM certification examination [5].

The countries that are least receptive to the United States emergency physician model are economically advanced non-Anglophone countries that have organized their emergency care in the Franco-German model. In this model, the emergency physician works primarily at the prehospital care level. Underlying this approach are hospital systems with often specialized centers limiting care to certain conditions or groups of conditions, each with individual receiving areas. Physicians in such countries frequently see themselves as having advanced systems of emergency care on par with the United States and understandably wonder why they should change. If change were to come in these countries, it would likely require some adverse outcomes that would prompt a reassessment of the value of physicians with limited resources providing extended care in an out-of-hospital setting. This
is as opposed to the United States model in which patients are expeditiously brought to the hospital where the skills of a physician can be more fully used and where substantially greater medical and hospital resources are available to the patient.

Countries that tend to be the most receptive to the United States model often have relatively underdeveloped emergency care systems. The advantage in these instances is that the need for improvement in emergency care is more evident, and there is more flexibility in structuring a system of care. Like in the United States, the need to improve the EMS system may stimulate interest in the primary specialty of emergency medicine. Even in such countries, however, the existing medical establishment may resist change, as was experienced in the United States.

Despite some reluctance to adopt the primary specialty model of emergency medicine, the gradual acceptance of emergency medicine at every level in the United States medical system makes it likely that it has a broader benefit than in the limited number of countries currently using it. The challenge is how to effectively promote this model internationally as a means to improving emergency care globally.

Role of the United States in promoting emergency medicine as a specialty internationally

The focus of this edition of emergency medicine clinics is likely to have a positive impact on the efforts of the many physicians interested in assisting with the continued development of emergency care globally. However, it can be argued that the most significant impact that United States emergency physicians may have to improve emergency care internationally would be through helping physicians in other countries to achieve recognition of emergency medicine as a primary specialty. If this is achieved, it could be expected that those individuals functioning as specialists in emergency medicine will adopt the beneficial characteristics of the United States emergency physician. One could anticipate that they would optimize their own skills in emergency medicine; support access for all patients to emergency care; integrate emergency care into the overall health care system at prehospital, hospital, and follow-up levels; and promote ongoing academic development of the specialty.

To achieve specialty recognition on a wider basis, all emergency physicians involved in international emergency care should seek to identify ways to support efforts by physicians in other countries to achieve specialty recognition. Each country is different, and the roadmap to success in achieving specialty status is different for each. If the United States experience is to provide guidance, there are several factors to note. First, for success, there needs to be an interested and committed group of local physicians. Second, these physicians need to have a firm understanding of the steps needed in achieving specialty recognition in their country. Third, the
local physicians need to be organized and persistent in the pursuit of their goal. Fourth, the organization of appropriate training programs under the direction of emergency medicine faculty is an important part of the process. Although the essential work needs to be done by the individual physicians in a particular country, there are ways in which United States emergency physicians can support the move to specialty recognition internationally.

First, physicians involved in international emergency medicine need to know the history of the development of the specialty of emergency medicine in the United States, how this was achieved, and the benefits of this achievement to high-quality emergency care. By considering these matters, physicians involved in the international arena will be more ready to assist local physicians who have a goal of seeing emergency medicine recognized as a primary specialty in their country.

Second, United States emergency physicians should be alert to identifying specific roles that specialists in emergency medicine could play in the context of the particular health care needs in the country under consideration. A desire to develop a functional EMS system may be a stimulus to establish emergency medicine as a specialty as it was in the United States. Another possibility may be to facilitate disaster management. Mexico, for example, was stimulated to develop the specialty of emergency medicine after a disastrous earthquake in 1985 and the obvious need for skills of the type possessed by emergency physicians. Finally, military needs may be a stimulus to establish the specialty in a particular country given the utility of the skills of emergency physicians in a military organizational setting.

Third, United States emergency medicine training programs should seek to train more non-United States physicians in emergency medicine with the goal that they will return to their home countries as emergency medicine leaders and educators. In the United States, the specialty's early leaders had entered the practice of emergency medicine without formal training. This is happening in other countries. However, many early United States emergency medicine residency graduates entered such programs with the admonition that they were being trained to become the leaders in academic and clinical emergency medicine. Similarly, local physicians who have completed formal United States training and certification would be ideal advocates for emergency medicine as a specialty and therefore are more likely to be effective in dealing with the decision makers in their efforts to achieve specialty recognition. Furthermore, such physicians could most effectively institute training programs in support of this newly recognized specialty.

It is relatively difficult for United States training programs to accept such noncitizens due to accreditation, financial, and immigration considerations. This has led to observation programs for non-United States physicians to avoid such problems. Nevertheless, United States emergency medicine training programs should pursue the effort to train non-United States physicians formally in emergency medicine, which is of great importance to the successful development of emergency medicine as a primary specialty.
Internationally. Alternatively, United States emergency physicians may seek to serve as faculty during the preliminary phases of the establishment of an emergency medicine residency abroad. This, however, may lead to many of the same cross-border problems as in training non-United States physicians in the United States.

Fourth, United States emergency physicians should support local physician leaders in their interactions with their health care system's decision makers. For those of us practicing in the United States, it can come as a surprise how much control health ministers have over medical practice because we have no real equivalent. Health ministers have a national governmental position whose responsibilities can include physician licensing, workforce decisions and planning, criteria for specialization, whether a specialty is recognized, health care financing, and health care improvement. At times, limited effort, such a letter written from an emergency medicine leader, provides the needed support. At other times, it may be necessary to provide a formal presentation and discussion as to the merits and experience in the United States with the specialty of emergency medicine.

Fifth, United States emergency physicians are frequently asked to speak at international emergency medicine conferences. Such conferences should routinely consider emergency medicine models, including the potential value of emergency medicine as a primary specialty. In this context, the benefit of having health ministry officials present at such events to interact with influential emergency medicine leaders and educators can be high.

Finally, United States emergency medicine organizations with different areas of focus should work cooperatively to support the common goal of expanding the specialty of emergency medicine internationally. Each United States emergency medicine organization has its area of emphasis, but each area of emphasis supports the specialty in some fashion and could support physicians in other countries in the development of emergency medicine. The problem is that global development of the specialty is often looked upon as something of secondary importance, of interest to particular individuals, or as a solo pursuit. The challenge for United States physicians and the organizations in which they participate is to achieve an overall organization of the efforts to help more successfully support widespread establishment of emergency medicine as a primary specialty.

Summary

International emergency medicine development includes many activities. Among them are efforts to establish and support the development of the specialty of emergency medicine. In carrying out such activities, it is important for emergency physicians to be aware of the story of the establishment and development of the specialty of emergency medicine in the United States and to seek ways to support similar efforts in other countries.
The benefits of specialty development toward improving emergency care globally are likely to be immense.

References


