Medicine’s Front Line

Making Every Moment Count

1968-2018
“The founders of emergency medicine could never have envisioned 50 years ago how influential emergency medicine and ACEP would become. ACEP today is a highly respected medical society, and emergency physicians are at the heart of the nation’s health care system. I’m so proud of what ACEP has accomplished. Fifty years from now, ACEP will still be advancing emergency care for its members and the millions of patients they see each year.”

— Dean Wilkerson, JD, MBA, CAE  
Executive Director of ACEP
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Emergency Medicine Today

The American College of Emergency Physicians (ACEP) promotes the highest quality of emergency care and is the leading advocate for emergency physicians and their patients.

ACEP is the nation’s oldest and largest body representing emergency physicians. Founded in 1968 by a group of eight emergency physicians, ACEP has grown to more than 38,000 members in 2018, its 50th anniversary year. The organization’s history is inextricably linked with the recognition and development of emergency medicine as a medical specialty in the United States. In 1979, just 11 years after ACEP’s formation, emergency medicine was formally recognized as the 23rd medical specialty by the American Medical Association and the American Board of Medical Specialties.

Today, emergency medicine is a state-of-the-art, technologically advanced, mature medical specialty. Emergency physicians are well-prepared to face the challenges and stress that are an inevitable part of this demanding profession. They conduct cutting-edge research to improve the practice of medicine and the care of patients; advocate for emergency physicians and emergency patients at the local, state and national levels; work to improve emergency medicine worldwide; all the while, adapting to the dramatic advances in technology and the changing health care universe.

For 20 years, emergency visits have grown at twice the rate of the U.S. population. Each year more than 141 million patients arrive at the doors of America’s emergency departments, making them a health care safety net for everyone — available 24 hours a day, 7 days a week — caring for all people, regardless of their ability to pay.

“I am proud to be an emergency physician. Every day we have an opportunity to help others. Serving the patient’s best interest, regardless of socio-economic status, being able to provide timely interventions, being able to bring people back from the dead. These are moments that truly tell me that I’m doing the right thing for the right reasons.”

Dr. Amado Alejandro Baez

ACEP Membership Growth

1968
August 16, 1968
Eight original members met in Lansing, Michigan

1969
First ACEP publication — ACEP Quarterly Report
First ACEP Chapters established in Massachusetts and Michigan

November 1968
ACEP formed

1970
1,060

1980
10,203

1990
13,681

2000
21,881

2010
28,406

Current
37,013

0
5,000
10,000
15,000
20,000
25,000
30,000
35,000
40,000

ACEP Membership Growth
Two-thirds of emergency visits occur after hours, when doctors’ offices are closed. Emergency departments bridge the gap to save lives, despite a broken health care system that people find harder to access. The Centers for Disease Control and Prevention (CDC) has classified only 4 percent of visits as “nonurgent,” and other research has called into question whether many emergency department visits deemed unnecessary really are.

Emergency physicians focus on protecting access to emergency care and protecting fair insurance coverage for emergency patients. In its 50th year, the specialty is engaged in confronting the policies of health insurance companies that deny insurance coverage for emergency care and promoting solutions to overcrowding, calling for an end to “holding” or “boarding” of patients, often psychiatric patients, in the emergency department hallways. They are also calling for transparency by health insurance companies in calculating payments for emergency care and the use of independent charge databases, such as FairHealth.org.

How emergency visits have increased over the years

<table>
<thead>
<tr>
<th>Year</th>
<th>Emergency Visits (in millions)</th>
</tr>
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<tbody>
<tr>
<td>1958</td>
<td>18</td>
</tr>
<tr>
<td>1960</td>
<td>23</td>
</tr>
<tr>
<td>1970</td>
<td>49.3</td>
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<tr>
<td>1980</td>
<td>82</td>
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<tr>
<td>1992</td>
<td>90.8</td>
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<tr>
<td>2000</td>
<td>100.4</td>
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<tr>
<td>2004</td>
<td>110.2</td>
</tr>
<tr>
<td>2010</td>
<td>125.8</td>
</tr>
<tr>
<td>2014</td>
<td>141</td>
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</tbody>
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Source: Centers for Disease Control and Prevention
Physicians who specialize in emergency medicine provide an essential community service and are unique in possessing lifesaving skills and expertise that allow them to manage the emergencies of every medical condition.

Emergency physicians are called upon to care for multiple patients at once with health issues ranging from allergic reactions and broken bones to crushing chest pain and stroke. They often must make assessments and critical decisions quickly, without having the full medical histories of patients. Emergency medicine is an intense and emotionally charged specialty, but it is also very rewarding, especially when a life is saved. There is no other medical specialty like it.

Residency Training
Like all doctors, emergency physicians complete four years of college and four years of medical school. They then train for three to four more years in a residency program at an accredited teaching hospital.

Residency programs provide formal training and direct, hands-on experience in a wide range of adult and pediatric emergencies, including medical, surgical, trauma, cardiac, orthopedic and obstetric. Residents must expand this technical training and develop keen recognition and intervention skills for dealing with a wide range of social emergencies, including substance abuse and family violence.

“Our founders would be amazed at the credibility that emergency medicine has across the system. There’s something special about being an emergency physician, and it is recognized across the board. We are respected, our expertise is sought out and our ability to interface with the health system is growing in leaps and bounds.”

— Dr. Kathleen Clem

“My first day at medical school, I was lucky enough to be assigned to the emergency department. I realized quickly that these were my people. I enjoyed the work, I liked the thought process behind rapid decision-making, often with limited data.”

— Dr. Jordan Celeste

Who Are Emergency Physicians?

Emergency medicine is the heart of the nation’s health care system, touching every part, and the unique skills of emergency physicians equip them to serve in leadership roles at the state and national levels.


Landmark Workshop Conference on Education of the Physician in Emergency Medical Care held, hosted by the American Medical Association, leading to path for emergency medicine residency programs and specialty status
As of January 2018, there were 221 emergency medicine residency programs in the United States — up from 144 in 2007 — approved by the Accreditation Council for Graduate Medical Education (ACGME). In addition, 46 emergency medicine residency programs were approved by the American Osteopathic Association (AOA). Combined, these programs graduated 2,105 residents in 2017.

**Board Certification**

Board certification in emergency medicine is the gold standard of practice. In 1997, ACEP passed an historic resolution changing membership criteria (beginning after December 31, 1999) to require either board certification in emergency medicine or completion of an emergency medicine residency program.

**Diversity**

Emergency physicians are as diverse as the populations they serve. ACEP’s commitment to diversity means it is an inclusive organization that reaches out to people of all ages and ethnic backgrounds.
Military Emergency Medicine

Today, more than 1,000 emergency physicians serve in the U.S. military in America and overseas. They are active duty military emergency physicians, reservists and National Guard members who work in civilian hospitals and in veterans’ hospitals.

“The battlefield has served as a catalyst for creating some of the basic ideas which define emergency medicine as a distinct medical discipline, and a crucible for refining existing medical knowledge…. Battle injuries have not only led to advances in patient evacuation systems; wartime also sees significant advances in devices, resuscitation concepts, and the place of emergency medicine in the greater medical system…. The framework for these incredible advances that have occurred over the past 50 years was created by the first generation of military emergency physicians. These leaders created the concept of the military emergency physician, and carved a place in the military medical hierarchy for the specialty.”

Military emergency physicians have been instrumental in applying research in the battlefield, and subsequently in America, and enhancing many emergency medical techniques and technologies. These include trauma, ultrasound, blood substitutes, tourniquets and helicopter transport, first used in the Vietnam War.

“As a military emergency physician, I quickly learned on the battlefields in Iraq that unless you stick with your platoon, you’re not going to survive. ACEP is metaphorically that platoon. It is an organization that has your back, but it also has the patient’s back. It’s a great way to get opportunities to meet your colleagues from across the country.”

— Dr. Sudip Bose
In addition, the training of pre-hospital providers in a revolutionary system called Tactical Combat Casualty Care is not only used by the military on the battlefield, but also by law enforcement SWAT medical teams, disaster teams and other civilian first responder units.

**Disaster Emergency Medicine**

Disaster medicine, the term used to describe delivery of medical care to patients in a natural or man-made disaster, grew out of an innate American desire to assist their communities in times of need. America’s veterans came back to their communities having learned that they could improve outcomes and survival by applying immediate medical care at the site of injury, followed by rapid transport of traumatized soldiers to specialized “trauma centers.” Soon trauma centers were developed in conjunction with Emergency Medical Services throughout the United States.

Emergency physicians who specialize in disaster response are involved with planning, preparedness, response and recovery for disasters in their communities and at their hospitals.

They treat the victims of fires, floods, earthquakes, tornadoes, hurricanes, riots, mudslides and snow storms. They care for people at sporting events and political rallies. They lead and train response teams from the National Disaster Medical System, Federal Emergency Management Agency, Urban Search and Rescue and others, and provide leadership in the federal government to such agencies as the Department of Veterans Affairs, the Centers for Disease Control and Prevention and the Department of Homeland Security. Emergency physicians have provided advice to Congress through testimony and worked at the highest levels of government, both federal and state.
In the past 50 years, emergency medicine has evolved into a state-of-the-art medical specialty.

**From Battlefield to Local Hospital**

In the United States, organized field care and transportation of wounded soldiers began during the Civil War, but the actual beginnings of modern emergency medicine emerged in the late 1950s. During the conflicts in Korea and Vietnam, physicians practicing on the “home front” began to recognize that procedures and techniques developed for the battlefield (such as timely triage and beginning treatment in the crucial first minutes after an injury or onset of illness) could also be used in local hospitals to help save lives.

As a result of advances in medical science, the availability of diagnostic equipment and the public’s growing demand for access to medical services, emergency visits almost tripled between 1954 and 1964. The increased demand focused attention on improving emergency care.

**Inadequate Care Structure**

Despite this growing demand, even as recently as the early 1960s, emergency care in the United States was, at best, inconsistent. Much of the care was provided by inadequately equipped emergency “rooms,” frequently staffed only by nurses. Interns or on-call physicians — physicians from other specialties who were required to pull “ER” duty to maintain admitting privileges — were called in as needed.

As late as the mid 1960s, many U.S. hospitals still didn’t have emergency departments, and some

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“**Development of a Medical Specialty**

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“I don’t believe there would be emergency medicine without ACEP. The founding fathers of ACEP shaped the entire specialty, and we owe them a great deal of gratitude for that, as do our patients.”

— Dr. Jennifer L’Hommedieu Stankus

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1977 American Board of Emergency Medicine held first ABEM Certification Exam Field Test in Lansing, Michigan

1979 Emergency medicine recognized as a medical specialty by the American Board of Medical Specialties and the AMA

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critical care patients were transported to emergency rooms in a hearse, because they were the only vehicles available in which people could lie flat. Prehospital care was almost nonexistent and medical treatment usually didn’t begin until a patient arrived at the hospital. While the emergency care system of the 1960s represented a remarkable advance from the days of hot air balloons transporting wounded soldiers to clinics stocked with leeches, hearses were hardly equipped to provide lifesaving care.

**National Academy of Sciences Report**

In 1966, the National Academy of Sciences published its landmark report, *Accidental Death and Disability: The Neglected Disease of Modern Society*, pointing to the deficiencies in the nation’s emergency care system. The awareness that unintentional injury was a leading cause of death and disability in America and the importance of emergency care quickly led to a mandate from patients and physicians alike: improve the American system of emergency care.

**Alexandria Plan**

It was becoming clear that emergency care required uniquely different skills and staffing structures from general medical practices. Hospitals began experimenting with staffing patterns that used doctors from various medical specialties to improve emergency care and provide 24-hour coverage. For example, in Alexandria, Virginia, Dr. James DeWitt Mills and four other physicians established what became known as the “Alexandria Plan,” which enlisted a dedicated team of doctors to care for emergency patients 24/7.

Significant advances were made, but emergency physicians still had to contend with the lack of training and recruitment, as there were no training programs for young doctors interested in practicing emergency medicine.

“*In the early 70s, I was a resident in the midst of the South Bronx in New York City, and I worked 24 hours on and 24 hours off without supervision. That would be unheard of today.*”

— Dr. Lewis Goldfrank

“*I remember when the first ambulances were hearses. I remember learning about CPR on my way to do CPR because someone had drowned. Back then, we put them on their stomachs, pressed the middle of their backs and raised their arms up like a chicken. Boy have we come a long way.*”

— Dr. Jay Kaplan, former president of ACEP

“*I began my practice almost 40 years ago when there were hardly any CAT scans. The first place I worked did not have one, because a nearby facility had one. We also did not have the methods we have now to resolve heart attacks. Procedures like putting in stents did not exist. So many changes have occurred in the past 50 years.*”

— Dr. Diana Fite

1980 First emergency physicians certified by ABEM
ACEP headquarters moved to Dallas, Texas

National Emergency Medicine Political Action Committee (NEMPAC) formed

1981 ACEP membership increases to 10,000

1982 First issue of *ACEP News* published
Emergency Medical Treatment and Labor Act

In 1986, to ensure that emergency care was available to anyone who needed it, Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA). EMTALA mandates that all patients who come to the emergency department must be given a medical screening examination and be stabilized if they have a medical emergency, regardless of their ability to pay or insurance status. This federal regulation places great responsibility on emergency physicians to provide a health care safety net for the nation’s most vulnerable populations — the poor, the underinsured and the uninsured.

ACEP Formed

On August 16, 1968, a group of eight physicians who shared a commitment to improve the quality of emergency care met in Lansing, Michigan. In November, they founded the American College of Emergency Physicians. From the beginning, ACEP’s overarching goal was to educate and train physicians in emergency medicine to provide quality emergency care in the nation’s hospitals.

“Without ACEP, there wouldn’t be emergency medicine. Emergency medicine today is the most coveted medical specialty. It is one that draws the very best and brightest that medicine and medical schools have to offer. Our ability to troubleshoot, to innovate, to make lemonade out of lemons is so consistently good and reproducible. We’re a coveted asset not only in the hospital where we work, but also in leadership and in public policy where our skill set uniquely suits us to finding solutions when others fail.”

— Dr. Steve Stack, emergency physician and former president of AMA
Standards Set, Specialty Formally Recognized

ACEP moved quickly to improve care by setting standards for educating and training emergency physicians. In 1969, ACEP sponsored a national meeting — called Scientific Assembly — in Denver, Colorado, which was attended by 128 physicians. It was the first of what was to become an annual forum designed to present clinical courses and the latest advances in emergency medicine. By 1970, ACEP had developed a practice-based curriculum for emergency medicine residency programs and instituted a program of continuing medical education.

To achieve recognition as a medical specialty, ACEP created a board certification exam and promoted the establishment of a certifying board in 1975. Four years later (in 1979), emergency medicine was formally recognized as America’s 23rd specialty by the American Medical Association and the American Board of Medical Specialties — and ultimately achieved primary medical board status in 1989. In May 1980, ACEP moved its headquarters to Irving, Texas.

The American Board of Emergency Medicine (ABEM) offers the certification examination, a comprehensive assessment of competence in emergency medicine. The core content was approved by ACEP, ABEM and the Society for Academic Emergency Medicine. In 1998, ACEP recognized the American Osteopathic Board of Emergency Medicine (AOBEM) as a certifying body in emergency medicine, opening the door to allow doctors of osteopathy who are certified by AOBEM to join ACEP after the new membership requirements took effect.

ACEP was founded in 1968 by eight physicians in Lansing, Michigan:

George C. Fink, MD
Robert N. Leichtman, MD
Richard W. Ligenfelter, MD
Eugene C. Nakfoor, MD
Robert J. Rathburn, MD
John T. Rogers, MD
John A. Rupke, MD
John G. Wiegenstein, MD

In the past 50 years, ACEP’s role has grown from its first office in Lansing, Michigan, to its new headquarters in Irving, Texas, and an office in Washington, DC, for advocacy and media relations.

ACEP has 53 chapters representing each state, plus Puerto Rico and the District of Columbia, as well as a Government Services chapter representing emergency physicians employed by military branches and other government agencies. ACEP provides staffing support for the Emergency Medicine Residents’ Association (EMRA), the Society of Emergency Medicine Physician Assistants (SEMPA), and the Council of Emergency Medicine Residency Directors (CORD).

Governance

To meet the diverse needs of emergency physicians, ACEP operates through a system of elected representatives, governed by a Board of Directors, consisting of elected directors. The officers of the board are the president, president-elect, chairman, vice-president, secretary-treasurer and immediate past president.

The Board of Directors serves as ACEP’s policymaking body, responsible for its management and control. Board members are elected by the ACEP Council at ACEP’s annual meeting to serve three-year terms, with a limit of two consecutive terms. The board elects officers of chairman, vice president and secretary-treasurer, to serve one-year terms.

ACEP’s Council is led by a speaker and vice speaker and is made up of more than 200 councilors representing the organization’s 53 state chapters, EMRA and ACEP’s sections (groups established among diverse areas of interest within emergency medicine). Each chapter has at least one representative and an additional representative for every 100 chapter members. Council officers are elected for two-year terms, with a limit of two consecutive terms. ACEP’s sections of membership, representing special interest groups, have one representative each.

“ACEP has been with me every single step of my career. From the very beginning when all it meant to me was coming here for some CME and maybe meeting up with a few friends to helping me with my research, to providing leadership opportunities. ACEP has been a life-long companion.”

— Dr. Sandy Schneider, former president of ACEP

“Chapters have become the proving grounds for national leaders. They are where young doctors learn leadership on the state and national levels. We’re a strong part of making ACEP what it is.”

— Diane Bollman, past executive director of the Michigan Chapter of ACEP

1990 First clinical policy published by ACEP — Management of Chest Pain
1994 Hit TV series “ER” premiers on NBC
Advocacy

ACEP aggressively and successfully promotes emergency medicine issues at national and state levels and in both the legislative and regulatory arenas. It has worked to protect access to emergency services, for universal health coverage and to expand and improve the nation’s EMS system. ACEP’s legislative efforts have produced numerous successes including inclusion of emergency care as an essential benefit in the Affordable Care Act and establishment of the prudent layperson standard of emergency in the Affordable Care Act and the Medicare and Medicaid managed care programs. (This standard bases a health plan’s coverage of emergency care on a patient’s symptoms and not his or her final diagnosis.)

In 1980, ACEP established the National Emergency Medicine Political Action Committee (NEMPAC), through which ACEP members support the election or reelection of congressional candidates who share their commitment to emergency medicine. In ACEP’s 50th anniversary year, NEMPAC ranks among the top four physician specialty PACs with receipts of more than $1 million per year from ACEP members. There are more than 4,000 emergency physicians who are active in the 911 Network and who act as resources and health care experts to members of Congress and their staffs.

ACEP works to improve the environments of emergency physicians and emergency patients through promoting federal regulations on practice and reimbursement issues, many of which affect the future of the practice of emergency medicine. For example, ACEP supports the use of technology to improve patient safety and is working with the federal government to develop quality improvement measures that advance patient care. ACEP also has worked to revise the guidelines used to enforce EMTALA, promoted funding for graduate medical education, and revised the problematic documentation guidelines that support levels of care and payment rates for services.

ACEP engages in public education by providing health and safety tips to the public; promoting emergency physicians as medical experts; and using spokespersons and communications tools, such as press releases and a consumer website — EmergencyCareforYou.org. More than 650 media-trained emergency physicians are part of ACEP’s Spokespersons’ Network, serving as voices for emergency medicine, participating in campaigns and providing real-time information to the news media in breaking-news situations.

“It’s important for every emergency physician to be part of ACEP, because it allows us to speak with one voice on a host of issues, including political advocacy, education, speaking to the public, disaster medicine — really letting all of us work as one.”

— Dr. Peter Jacoby

1997 Historic resolution passed by ACEP changing membership criteria to require either board certification in emergency medicine or completion of an emergency medicine residency program

1997 Congress passed the Balanced Budget Act of 1997, extending the prudent layperson standard for Medicare and Medicaid and managed care patients, as supported by ACEP
“Like emergency medicine, the growth of Annals has been amazing and inspiring to experience. Having come on board in the 1980’s as a reviewer, I have witnessed most of that ride. In the early days, submissions were only in the hundreds, not the thousands we receive now. Today everything is electronic and fast, and our authors, reviewers and editors have become increasingly more skilled. One thing that is still relatively slow, however, is intelligent appraisal of the papers, but even there we cut our decision time from weeks or months, to days. I am confident that Annals will continue to adapt, improve, and take us into rewarding new territory. And our promise to our readers — to continue to do our best to deliver carefully selected scientific information of value and reliability.”

— Dr. Michael L. Callahan, editor-in-chief

Annals of Emergency Medicine

ACEP publishes and promotes the premier journal of emergency medicine, Annals of Emergency Medicine, which presents peer-reviewed, clinical research on issues pertinent to emergency physicians and the general public.

Annals has been reviewing, improving and publishing the best emergency medicine research for 46 years. The science it publishes has steadily increased in rigor and volume (submissions have increased 292 percent since 2000). It is number 1 among the 23 emergency medicine journals tracked in the Impact Factor, and its performance puts it in the top 6 percent of all scientific journals tracked by this metric. It has the largest circulation (38,000 individuals and 8,000 institutions) among emergency medicine journals, and 1.8 million full text downloads are implemented each year. Half of these are from outside the United States, as are about half of the submissions, illustrating its worldwide reach as an international journal.

Annals editorial leadership has been at the forefront of setting best practices, through providing leadership in standard-setting scientific publication organizations, as well as conducting and publishing scientific studies of the peer review and publishing process itself. They have also helped train research editors of the future through a one-year resident fellow program in scientific publication, established over 15 years ago. Graduates of this fellowship include a major section leader at the CDC and at WHO in Geneva, Switzerland.

Research in emergency medicine has evolved and matured over the past 50 years. Initially, emergency physicians asked and answered questions focused on practical issues; often this was how to deliver or implement care based on others’ standards and knowledge, occasionally looking at new devices to aid care.

Now, emergency physicians lead investigative teams that share new knowledge in many platforms, including Annals of Emergency Medicine and other journals, such as NEJM, JAMA, Lancet and others. Emergency medicine-led research news hits the television, print, radio and internet media. It touches all, citizens and policymakers, always focusing on people in need.

Emergency medicine research tells the biology of acute illness or injury and recovery, the ways to deliver better care in all early care settings and methods to help avoid needing that care in the future. The most impactful work – in trauma, stroke, myocardial infarction, sudden death, infection and sepsis, toxicology and drug abuse and interpersonal violence – all start with emergency medicine insight and effort. That is the vision a group of wise people had 50 years ago – leading the way of improving emergency medicine.
Emergency Medicine Foundation
Since 1972, the body of knowledge in emergency medicine has continued to expand, in large part due to the work of the Emergency Medicine Foundation (EMF). To ensure excellence in practice and patient care, ACEP founded EMF, a 501(c)(3) nonprofit organization, dedicated to supporting emergency medicine and its investigators. Since its founding, EMF has distributed more than $16 million dollars in research funding, building a cadre of investigators within the specialty. From medical students to residents, early to mid-career researchers, EMF funds have paved the way for grantees to obtain multi-million dollar awards from the National Institutes of Health for their work. The results of these studies have saved countless lives and continue to enrich the care given by emergency physicians.

EMRA
The Emergency Medicine Residents’ Association is the voice of emergency medicine physicians in training and the future of the specialty. Founded in 1974, EMRA is the largest and oldest independent resident organization in the world, representing more than 16,000 students, residents, fellows and alumni.

For more than 40 years, EMRA has been the launching pad for young physicians who have gone on to become leaders in health policy, research, medical education, government, nonprofits, the private sector and more. Leadership opportunities include serving on EMRA’s Board of Directors, Committees, Medical Student Council, Representative Council or as an EMRA Representative to ACEP Committees/Sections.

EMRA is known for:
• Creating unique, in-person experiences for members at national conferences, including the EMRA Quiz Show, 20 in 6 Resident Lecture Competition, MedWAR and CHAOS in the ED.

EMRA members also receive six issues of EM Resident Magazine per year. In addition, they have access to EMRA Match, an award-winning, collaborative, crowd-sourced, filterable directory of residency and clerkship programs.

In addition to providing valuable leadership development experiences, products and programming, as the voice of the largest group of emergency medicine residents in the world, EMRA maintains close relationships with numerous organizations inside and outside of emergency medicine and serves as a tireless advocate to improve the education and lives of physicians in training.

2005  First ACEP president-elect to be elected by the Council
2006  First Report Card on the State of Emergency Medicine is released by ACEP
# The Future of Emergency Medicine

Leaders in emergency medicine share their thoughts about the future of emergency medicine.

<table>
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<tr>
<th>Quote</th>
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<tbody>
<tr>
<td>“What’s never going to change is that emergency physicians will continue to be there 24/7 for our patients. If people don’t have coverage, if they don’t have access to medical care, if they don’t have housing, we’re the medical specialty that’s there for them, and that’s going to continue.”</td>
<td>Dr. Alison Haddock</td>
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<td>“In the next 50 years, I think ACEP will be exactly where it is today. We are the leaders of emergency medicine — the go-to for resources. There wouldn’t be emergency medicine without ACEP. Emergency physicians are teachers, we’re innovators, we’re the ones who people come to when they have a problem. We will continue be the number one resource for people in need of emergency care.”</td>
<td>Dr. Al Sacchetti</td>
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<td>“If ACEP did not exist, my career in emergency medicine would be extraordinarily different. It would lack focus and lack the sense of belonging and family that ACEP has brought into my life. ACEP is headed into a future where we’re going to lead the way — in payment reform — in regard to universal health care and in terms of increasing the diversity of our workforce.”</td>
<td>Dr. Aisha T. Liferidge</td>
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<td>“Emergency medicine is 50 years old, and there are more than 50 years left. What I’d like to see 150 years from now is a specialty that is bright and energetic and as forward thinking as it is now.”</td>
<td>Dr. Angela Gardner</td>
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<td>“As chair of ACEP’s 50th Anniversary Task Force, I’ve come to realize that just 50 years ago, there were only a few members and one residency program. We’ve come a long way in a very short period of time and in an environment in which we weren’t always welcome. The current generation benefits from the fruit of the labors of the pioneers of emergency medicine, I’m excited about what our current generation can do in the next 50 years.”</td>
<td>Dr. Nick Jouriles</td>
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<td>“ACEP is emergency medicine, and ACEP is the future of emergency medicine. If ACEP didn’t exist, my career would not have been what it is, and I don’t think we would have procedures, such as conscious sedation. It’s only with ACEP that we have a chance to fight. ACEP is the organization that is thriving in the house of medicine and ready to take on the fight for the future of emergency medicine.”</td>
<td>Dr. Nathan Schlicher</td>
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<td>“I love emergency medicine. I love it in my very bones — my very being. I love the fact that we are constantly creating order out of chaos and creating a path forward for patients and a light at the end of the tunnel. As we look to the future, I’m sure this will stay the same.”</td>
<td>Dr. Charlotte Yeh</td>
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<td>“The first 50 years has been a heck of a ride. I will be 91 years old when ACEP turns 100. My genetics say that I won’t make it that far, but I’m going to do my best to stay around, because I want to be there to see where we are in another 50 years.”</td>
<td>Dr. Ryan Stanton</td>
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<td>“Looking to the future, ACEP’s commitment to our patients, the specialty of emergency medicine and our members, will stay the same. But I will tell you we’re in exciting times. We’re no longer just an emergency department, we are the hub – the center of the health care system.”</td>
<td>Dr. Kevin Klauer</td>
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Emergency Medicine Sub-Specialties

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<td>Sports Medicine</td>
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<td>Undersea and Hyperbaric Medicine</td>
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<td>Hospice and Palliative Medicine</td>
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<td>Pain Medicine</td>
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</table>


II CDC “National Hospital Ambulatory Medical Care Survey: 2014 Emergency Department Summary Tables.”

III CDC “National Hospital Ambulatory Medical Care Survey: 2014 Emergency Department Summary Tables.”

IV Fierce Healthcare. NYC Health and Hospitals Embed Care Management in ER, Connects More Patients To Primary Care.”
