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A History of Emergency Medicine: How the Field Grew & Changed Healthcare Forever

Narrator:
Welcome to ReachMD. This special edition of The Pulse of Emergency Medicine is supported by the American College of Emergency Physicians. Here's your host, Dr. John Russell.

Dr. Russell:
Two thousand eighteen marks the 50th anniversary of the American College of Emergency Medicine. Joining me to discuss this milestone, and to look back at the history of ACEP and its roles in advancing the emergency medicine field is Dr. Brian Zink. Dr. Zink is Professor and Senior Associate Chair for Education and Faculty Development at the University of Michigan Medical School. He's also the author of the book: Anyone, Anything, Anytime: A History of Emergency Medicine. Dr. Zink, welcome to the program.

Dr. Zink:
Thanks for having me.

Dr. Russell:
So, to begin with, can you give us some insight? Who were the first fulltime emergency physicians, where and when did they start?

Dr. Zink:
So the first fulltime practitioners in emergency medicine were in Alexandria, Virginia, in 1961. So a guy named Jim Mills, Jr., was made the Chief of Staff of Alexandria Hospital and he had a big problem in their ER at the time because they couldn't keep it staffed. They couldn't find enough physicians to work there and the emergency department volume was going up. It was kind of a suburb of Washington that was rapidly growing, and he needed to find a solution to the problem. So he had the idea. He was a GP, a general practitioner. He had the idea to start a small group with three other physicians. And he found three other experienced physicians, these were not young people, and they decided they would cover the emergency department 7 days a week. They would work 12-hour shifts, on and off, and they started out in July of 1961 to provide that service under a contract with Alexandria Hospital, and that became known as the Alexandria Plan of doing this fulltime staffing under contract with a hospital. And over about the next 4 or 5 years, it spread around the country so that there were many of these groups that were adopting what they called the Alexandria Plan.

Dr. Russell:
So starting out with these four physicians, how do you then get factors that led some of these early emergency room physicians to form a national organization, which we now know as the American College of Emergency Physicians, or ACEP?

Dr. Zink:
So the way that developed was that there was an Alexandria Plan-type practice in St. Lawrence Hospital outside of Lansing, Michigan, and that group there had a physician named John Wiegenstein. And he was very concerned that the emergency physicians all had gaps in their practice, that they were trained in different disciplines and some might be trained as surgeons and not know the medical stuff and vice versa. And so he recognized that some national organization could provide educational conferences CME, to help fill out the training and the education of emergency physicians, so they could be able to handle everything that came into the emergency departments. And so education was a big part of it. Also they needed to know how to set up their emergency departments, how to staff them; so there were the logistics of that which they wanted to share with each other in a national organization. And then the other part of it was just recognition and power within hospitals in the medical community. Wiegenstein and others thought that having an organization together would be favorable for that. And finally, just from the economics of it, they wanted to promote fair and reasonable billing and reimbursement for emergency physicians, because at that time the insurance companies didn't quite know how to pay for emergency

visits. They were paying at a very low rate, just kind of a standard rate no matter if you sewed up a cut or if you saved someone's life, resuscitated them, you would still get a very small payment. So the economics were drivers in terms of people coming together. So eight physicians in 1968, came together in Michigan, and they were kind of presumptuous. They called themselves the American College of Emergency Physicians and then they became aware of the people in Virginia and they got together a national meeting later in 1968, and that was really the start of the American College of Emergency Physicians. And they put together a national meeting in 1969 that had about 130 people attend it the first year, but then by the second year, it was up to 650 people attending this national meeting and that really kind of took off. They went from having just a few people in the late 1960s, and they were up to several thousand members by the mid 1970's.

Dr. Russell:
So in starting in the early '60s you have a lot of experienced physicians coming together to form this body, but you really didn't have a training program and there really wasn't accreditation for training programs, and so, how did ACEP help to organize emergency medicine as a discipline with regard to training programs?

Dr. Zink:
The founders of emergency medicine were for the most part not academicians and they didn't practice in the big academic centers. So they didn't know a lot about establishing residencies, but they knew that this was going to be necessary for them to advance the field and eventually form a specialty. So it was left to some people that kind of came together, almost by happenstance, at a few places around the country, and in each place there was again a problem in the ER with staffing and burgeoning patient volumes. And so, for instance, in Cincinnati there was an internist that was assigned to run the emergency department and he got the idea of forming an actual residency in emergency medicine. His name was Herbert Flessa, and he needed a guinea pig to do it, to start the residency, so he pulled in a University of Cincinnati medical student named Bruce Janiak to serve as the first emergency medicine resident in a 2-year residency that they put together. At that time residencies had to be approved by the AMA, so they got approval for a residency. And then other places like Medical College of Pennsylvania in Philadelphia, and LA County USC Medical Center in Southern California; they all had similar processes where they saw a need, a physician who was in another specialty was put in charge of the emergency department and then they had the idea of forming a residency. So the first residency was at Cincinnati in 1970. And then by 1975 you had about 35 or so residencies had formed by then, and they were mostly in the Midwest. They were not at the powerhouse academic centers that we think of in American medicine. They were at places where emergency medicine could grow and develop without having a lot of resistance from the traditional specialties in medicine.

Dr. Russell:
If you're just joining us, this is The Pulse of Emergency Medicine on ReachMD and I'm your host, Dr. John Russell. With me today is Dr. Brian Zink, to discuss the history of emergency medicine physicians.
So when did it become recognized as a specialty?

Dr. Zink:
Yes, that happened in 1979 and that was a struggle. The other specialties were a little resistant to having emergency medicine come in. And at the time, people thought there were too many specialists in U.S. medicine anyway and so it was a long slog with ACEP leading the way and forming the American Board of Emergency Medicine. The way it works is you have to form the board before you actually get it approved from the American Board of Medical Specialties. And so ACEP got together, put this together. They had to form the exam. You had to do the exam, which they developed an innovative type of exam that had both a written and oral component. And they pushed and pushed and in 1977 they put it forward to the American Board of Medical Specialties. And they were pretty confident it was going to get passed and it actually got voted down 100 to 5, so they didn't count their votes very well in advance. And then in the next couple of years they developed a lot of compromises with the other medical specialties and the biggest compromise was to put members of the other specialties on the initial board of the American Board of Emergency Medicine. It was called a modified conjoint board that they put together. And with those assurances they were able to get it passed in 1979 as this modified conjoint board. And then 10 years later, in 1989, emergency medicine became its own primary board specialty.

Dr. Russell:
So thinking about ACEP and the challenges for board recognition and establishing training programs, what were some of the other obstacles that the ACEP faced in the early years?

Dr. Zink:
Well some of it was related to…their main focus was getting a specialty established. So they had just a lot of resistance and that was something that they had to deal with, all the other medical organizations, just kind of explaining what was emergency medicine practice, how was it different? It certainly wasn't related to a specific disease or organ system, but that it was this specialty that focused on taking

people from falling off the brink, whether that was from medical illness or trauma or psychological problems, and kind of putting them back up to where they needed to be. So, some of it was just getting that recognition out there, that this was a credible specialty. But then ACEP had, as an organization, financial challenges. It was a new organization; it had to develop some sustainability, in terms of the infrastructure of the organization, and it really took about 10 years for that to work out, for it to become a financially sustainable medical organization. There were, as I said, the interface with other professional organizations. They had to establish an office in Washington to try to help influence legislation that related to emergency medicine, and there were a lot of government interactions at the time. So it related to things like what was called the prudent layperson definition, so there were both government payers and insurance company payers that would, for instance, look at a visit for say, chest pain, and if it didn't turn out to be something serious they would say, "Well, we're not going to pay you for all the testing you did and all the work you put in because it turned out to be nothing." So ACEP tried to advocate for the idea that if a person has bad chest pain and they come in and they have an evaluation that it should be paid for, no matter what the outcome is. That you can't do this kind of Monday-morning quarterbacking to decide that it wasn't really that serious after all. So there were things like that. There was a lot of work on the EMTALA area, which was the transfer of patients between hospitals and making sure that people were not inappropriately transferring patients from one hospital to another, especially as it related to patient's insurance status and the like, so a fair amount of that. And then ACEP was also very involved in emergency medical services and was very influential in the Emergency Medical Services Act that was passed in the 1970s that tried to up the level of pre-hospital care and paramedics training, and the resources that would be needed to set up excellent EMS services around the nation.

Dr. Russell:
So I don't think it's a leap to say that emergency medicine has probably changed more since the early '70s than any other specialty. So if we could talk to some of these pioneers from once upon a time, what advice would they give to the current leaders of ACEP?

Dr. Zink:
I think you're right in that if you look at what's changed in American medicine from the 1970s to now, the development of emergency medicine is clearly one of the most striking developments. And it really is almost mind-blowing to think of where we were in the 1970s in terms of having no one who was really trained in the field, and just the level of care was just not good at that time compared to now. But I think the founders of the field would say as they struggled to get to where they wanted to be in terms of specialty status and like they would say that if you're trying to advance a cause or take a position that is right or good for the people or helps others, but it's facing resistance, that you have to kind of take the long view and be willing to compromise, but keep on task, and don't give up. John Wiegenstein had a great quote that I included in my book and he said something to the effect, I'll paraphrase it and he said, "Politics can put up roadblocks and be frustrating to deal with, but time always wins if it's right." The idea that if you're doing something for the right reason, that it's going to help people, that politics can only resist it for so long and eventually you'll get there. So I think that was always good advice. And then, I think secondly, to keep focus on patients, to listen to them, see what their needs are, and try to meet those. I think we've always been, obviously especially, that's right in the dirt with patients and just trying to understand what their needs are. Sometimes their social needs may be greater than their medical needs, and just trying to be aware of that. And then third, I think the other lesson would be, from the founders, would be use education and data and science as your way forward in the world of medicine. The early leaders even though they weren't very academically oriented, they realized that they needed to partner with people who were academic and who could do research. And they always stimulated research in emergency medicine, ACEP did, through grant programs and helping to advance the careers of people who would do groundbreaking research, whether it was in cardiac care or stroke or trauma. So they always had an idea toward the academic side of things, which I think, and when you talk to the founders now, one of the things they're most proud is the academic advancement of the specialty.

Dr. Russell:
So the hockey great, Wayne Gretzky, used to say, "I don't care where the puck is, I care where the puck is going." So where is emergency medicine going over the next decade?

Dr. Zink:
Well, it's interesting I think. We went in the 1990's, I think we were viewed as being the safety net for a lot of medicine, and then after the Affordable Care Act things kind of switched in emergency medicine and the emergency departments kind of came under fire for "unnecessary visits, for being an expensive place to get care." And so that's kind of switched and it kind of caught us by surprise a little bit because we didn't feel like things had changed that much. But if you look at emergency department expenses they're probably about, in a study that I did and published, it was about 6% of all U.S. healthcare expenses. But we have a big role, obviously, as a gatekeeper, especially as it relates to hospitalization, who comes in the hospital for admissions, and that's an extremely expensive part of medicine. And so we've always been innovators, so we'll need to look at how we handle, for instance, the less-acute cases that may not need to come to the emergency department through telemedicine and other venues to get that more minor care. But the big spend is on the complex, chronically ill, often elderly patients, and we need to think about how we can better care for them. Is it possible to do

some amount of care in the emergency department and then have them cared for at home? We're doing a lot more observation medicine now. We are partnering with, for instance, paramedics now doing some home care in the community. We're doing more telemedicine; we're doing more care pathways, and in general, just trying to communicate better with other providers. And people malign the electronic health records to some extent, but it does allow us to have the patient information out there and share it a lot easier than we could a decade ago. So I think those are some of the things that we need to work on, in terms of the future, but I think we're right in the mix of everything. So many patients, 140 million, come through the emergency departments every year, so it's a great place to try to implement programs that could both help people and hopefully get our healthcare costs under control.

Dr. Russell:
Well, it certainly sounds like there's a lot of challenges ahead in emergency medicine and through ACEP. I'd like to thank my guest, Dr. Brian Zink, for joining me to talk about the history of emergency medicine. Thank you, Dr. Zink.

Dr. Zink:
Thank you very much.

Narrator:
You've been listening to The Pulse of Emergency Medicine on ReachMD. The preceding program was supported by the American College of Emergency Physicians. If you have missed any part of this discussion, visit ReachMD.com/EmergencyMed. Thank you for listening.