EMERGENCY MEDICINE®

EDITORIAL

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The (Friendly) Ghosts of Emergency Medicine Past, Present, and Yet to Come

Past…

Almost 40 years have elapsed since the American Board of Medical Specialties recognized emergency medicine (EM) as the 23rd medical specialty. Though the fundamental principles of patient care, medical education, and certification established by the American Board of Emergency Medicine (ABEM) have stood the test of time, the ED of today is a very different place than the "ER" of 1979. So too, today's emergency physicians (EPs) are not only better trained and more capable of providing the highest quality of care in the ED, but are also increasingly doing so in venues outside of the traditional hospital-based ED.

Present...

In 1996, The New York Hospital – Cornell University Medical Center recruited me to be their first emergency physician-in-chief and EMS medical director, and to establish a first-rate academic ED and EM residency program. Starting with an "ER" staff of eight full-time and part-time non-EM-boarded attending physicians and a varying number of medical and surgical residents, over the next 20 years I expanded the complement of board-certified attending EPs to over 50, added attending-supervised nurse practitioners (NPs) and physician assistants (PAs), recruited a residency director, and helped him start a 4-year EM residency on both our Cornell and Columbia campuses. I also supported the initiation of 1-year ED nurse, PA, and NP residency programs. In corroboration with the chair of radiology, we added 24-hour dedicated sonography technologists to supplement the bedside emergency sonography that we had just been credentialed to perform, and established one of the very first divisions of emergency radiology, headed by EM board member and columnist, Keith Hentel, MD. Keith staffed his division with 24/7 attending radiologists to interpret all ED radiographic studies and provide imaging advice. More recently, I was able to arrange for dedicated 24/7 ED pharmacists, 24/7 ED social workers, and a patient safety/quality assurance division.

When I arrived at New York – Cornell, I supported the expansion of the ED patient services already in place, headed by an incredibly skilled and compassionate director, Constance Peterson, MA, who always insisted that her small office open directly off of the ED waiting room. Constance recruited and supervised a group of dedicated patient greeters and facilitators to ensure that no patient would get lost or fall through the "cracks" of our ever-expanding ED.

The plans for a new ED located at the front entrance to the hospital had literally been "carved in stone" by the time I arrived, but a decade later a magnificent gift from a donor gave me the opportunity to design a fourth patient-care area that expanded our ED to two full city blocks. I designed the new addition to serve the specific needs of a rapidly aging population and to provide a secure unit capable of managing patients with new or emerging infectious diseases and those with compromised immune systems. I also included in the new unit a large, state-of-the-art gynecologic (GYN) examination suite for conducting sexual assault exams and other GYN exams while providing the patient with a maximum level of comfort.

To coordinate activities throughout the ED and to provide a rapid expansion of staff when needed to manage surges in patient volume, I divided the ED into three acute areas and one urgent care area, each headed by an attending physician 24/7. One of the attendings was designated as the "administrative attending" or "AA." Among other responsibilities, the AA was required to e-mail me and Associate Director Jeremy Sperling, MD, (now chair of EM at Einstein/Jacobi) a detailed note on patient volume, rate of new registrations, and any problems, at the end of every 8-hour

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shift—or more frequently when the need arose. Whenever patient volume was in danger of exceeding capacity, Jeremy immediately sent an urgent e-mail to all of our attending EPs, PAs, and NPs, offering double the hourly rate for 4 to 8 hours of patient care, while adhering to all relevant work-hour requirements. To cover the cost of these additional emergency clinical hours, I made a small portion of our fee-for-service revenues available. Two years ago, I initiated a physician scribe program to restore the physician-patient relationship during patient evaluations and treatments.

With the successful establishment of our EM residency program by Wallace Carter, MD, in 2003, I started 1- and 2-year fellowships in new disciplines for a 21st century ED—using a portion of our fee-for-service revenues designated for research and development to supplement the part-time attending base salaries of non-ACGME fellows. Beginning in 2005, I established the nation's first geriatric EM fellowship, supported our newly established global EM program, recruited one of our attending EPs, Jay Lemery, MD, to start a wilderness medicine program in the Adirondack Mountains with Cornell (University) Outdoor Education, and appointed a director of EM/critical care. The ED expansion in 2009 enabled me to hire five attending EPs who were also board eligible/certified in medical toxicology, creating a "tox" group for bedside guidance and care in the ED and consultations throughout the hospital. The tox group also provided invaluable assistance to our secure psychiatric ED, headed by renowned emergency psychiatrists Lisa Sombrotto, MD, and Sharon Hird, MD. I also supported the activities of the pediatric EM fellowship, which had been established and nurtured by our extremely capable chief of pediatric EM, Shari Platt, MD. Most recently, I began to develop a new program in women's health emergencies.

To expedite emergently needed care for an increasing number of oncology patients, I created a special "fast-track" to ensure that febrile cancer-treatment patients received needed antibiotics within an hour of arrival. I created a second fast-track to expedite the diagnosis and treatment (ie, transfer to the OR) of patients with surgical abdomens, and a third track to expedite the care of patients with community-acquired pneumonia.

And Yet to Come…

The programs and divisions described were developed over a 20-year period, always mindful of the standards and quality measures first promulgated by ABEM in 1979. New hospital-based ED initiatives will undoubtedly continue to be created in the future by EPs who are challenged to develop new and effective ways of caring for the ever-increasing numbers of patients in the face of continued hospital and ED closings.

At the same time, the increased numbers of patients seeking care in EDs, most recently created by the Affordable Care Act of 2010, is leading many EPs to apply the skills they learned as residents and their hospital-based ED experiences in new venues for emergency care. In recent years, there has been a virtual explosion in the number of urgent care centers, freestanding EDs, "convenient-care" centers, and even remote patient care in the form of "telehealth" or "telemedicine." In 2014, when the National Hockey League mandated the presence of EPs at all games, I negotiated a contract that also enables our attending EPs to have senior residents accompany them and observe the practice of EM outside hospital walls. Prehospital and "interhospital" care also continues to expand with an increasing need for critical care and long-distance patient transfers to and from hospitals, and with a growing interest in community para-medicine programs.

In an October 2012 editorial (*Emerg Med*. 2012;44[10]:4), I wrote about French high-wire acrobat Philippe Petit who had rigged a cable between the two towers of the World Trade Center in August 1974, and then "aided only by a long, custom-made balancing pole, crossed, re-crossed, and danced on the wire without a safety net, for 45 minutes." Most observers that day were certain he would fall to his death, and no one imagined that he would survive and outlast the 110-story towers he had anchored his cable to. So too, with EM: Hospital-based EDs will certainly remain an essential part of EM in the years to come, but EPs will also have increasing opportunities to practice their specialty in other important venues as well. The EP of the future will not be bound to a particular location to practice EM.

As I have this time of year for the past 11 years, I wish all of our readers, and all EPs everywhere, a joyous and safe holiday season and many happy and healthy new years to come.