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ACEP, Open Wide the Gates

Rick Bukata, MD

The great debate over allowing non-boarded EM physicians into ACEP is a battle that doesn't make sense anymore. Here's why ACEP needs to open its doors a little wider.

There has been a longstanding debate on what credential you need to be a member of ACEP. I completed my residency in EM in 1975 – before some of you were even born. I was ABEM certified in the first year certification was available. SO I completely understand the angst associated with EM being recognized as a specialty. I have now been an ACEP member for about 35 years.

That being said, I believe that ACEP members who want to limit inclusion to only EM boarded physicians are making a huge mistake. I have heard all of the elitist arguments in favor of this model – and yes, I think the best way to learn EM is to take a residency. But there are simply too many compelling reasons why the college needs to open membership to all who practice emergency medicine.

This sense of exclusivity ignores the fact that emergency medicine is now being practiced, and will always be practiced, by well-intended, sincere physicians who are not EM-trained. At least 10,000 (probably closer to 14,000) physicians practice emergency medicine without the EM board stamp of recognition. Many of these docs practice in rural envirnoments, covering the ED at a local hospital. It is a bit of a slap in the face to exclude them from the club even though they're showing up and doing the same work.

Then there is the fact that excluding non EM-boarded docs is hypocritical because we are readily and happily handing over EM duties to PAs and NPs, and welcoming them into the fold. Would it be better to have all EM-boarded physicians seeing every ED patient in the country? Probably. But, realistically, that's never going to occur. I know large, multicontract groups where 30% of all patients are seen by PAs or NPs. So who is kidding whom? Why relegate our non-boarded brethren to second-class status when we readily admit the vital role of advanced practice providers?

We also need ALL emergency care physicians to be involved in ACEP for the sake of EM advocacy. It is not just about educational opportunities or e-mails and news updates. It is about these physicians being needed to help carry the legislative advocacy ball. Although I don't know the percentage of ACEP dues that are allocated for legislative advocacy, it is significant. And that doesn't count the additional funds raised for the ACEP Foundation, which would also benefit from enlarging the rolls.

To look at it a different way, currently, EPs who are not ACEP members get all of the benefit of our extensive, expensive advocacy efforts without paying a dime. And the advocacy also is present on the state level. IN my state chapter in California, I'll bet that at least half of discretionary income goes to advocacy. And we, too, have a Foundation in which even more money can be spent for advocacy. Widening the net and getting more emergency medicine docs to pay dues just makes practical sense because they are benefiting from these initiatives.

I know that suggesting that all physicians who practice EM should be allowed membership in ACEP will ruffle feathers – especially at the residency level. But, honestly, the residency fight is over. Emergency medicine is recognized as a specialty; boarded EPs will get good jobs and non-boarded EPs are not going to replace boarded EPs. The fear that the American Academy of Emergency Medicine was going to siphon off all the boarded EPs if ACEP didn't also mandate boards is largely behind us – ACEP and AAEM are at least cordial now. The contract management corporations don't control ACEP, and the people on the ACEP Board are reasonable folks with no hidden agendas. It's OK to open up a bit.

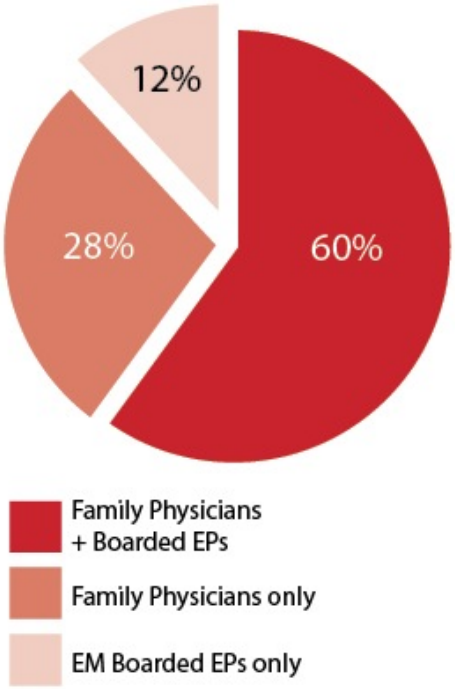
Let's follow the lead of other medical societies. The majority of specialty societies allow some sort of membership for non-boarded physicians. Non-boarded physicians who are allowed into ACEP can become "affiliate" members, or what have you. They can be counted, or not counted, when determining the number of councilors from a state for the ACEP council. (I would count them because they do provide care in settings in which EPs either are not available or choose not to practice and they have a great deal to offer the College.)

Finally, opening up the ACEP gates is the right thing to do because we need to provide more support to our colleagues working in rural areas. For decades, ACEP members who work in rural areas have bemoaned the lack of attention paid to this very important aspect of emergency care. Not every hospital has 24-hour CT scan access, ultrasound on demand, MRI capabilities and house staff and specialists available 24/7. In many ways, it is a lot harder working in the rural setting than in large hospitals. And when you look at who teaches at most conferences, you see that it's the academics, the people with virtually no experience working in a resource-limited rural setting.

Take a look at these stats: According to a recent study (see opposite column) of emergency department staffing in Iowa, only about 12% of EDs are staffed exclusively by boarded EPs. About 60% are staffed by family physicians and boarded EPs and about 28% are staffed by FPs only.

The numbers have remained steady from 2008 to 2012. A similar study is underway in Wisconsin – and I bet it will produce similar results.

PHYSICIAN MIX –
A recent study showed that in Iowa, only 12% of EDs are staffed entirely by EM boarded physicians



So, please let's have ACEP represent all of the physicians who provide emergency care. It makes practical, fiscal sense, and it's the right thing to do.

1. BOARD-CERTIFIED EMERGENCY PHYSICIANS COMPRISE A MINORITY OF THE EMERGENCY DEPARTMENT WORKFORCE IN IOWA
Groth, H., et al, West J Emerg Med 14(2):186,March 2013

BACKGROUND: It has been estimated that family physicians (FPs) provide nearly one-third of emergency care, particularly in rural areas where 42% of EDs are located. A three-fold increase has also been reported from 1993 to 2005 in the proportion of ED visits managed by PAs and NPs.

METHODS: These multicentered authors, coordinated at the University of Virginia, surveyed the administrators of all 119 Iowa hospitals with EDs in 2008 and 2012 regarding ED staffing patterns. The response rate was 100%.

RESULTS: There were no significant differences between 2008 and 2012 regarding the percentage of EDs that were staffed with board-certified emergency physicians (EPs) only (12.6% and 11.8%, respectively), a combination of EPs and FPs (63% and 60.5%), or FPs only (22.7% plus 1.7% staffed with IM residents vs. 27.7%). However, there was a significant increase in the percentage of EDs with solo staffing by PAs and NPs for at least part of the week (38.7% vs. 60.5%). In 2012, the mean population of communities supporting exclusive ED staffing by EPs was just under 85,000. Reasons for staffing with FPs most commonly included low availability of EPs, low patient census and satisfaction with the care provided by FPs, while reasons cited for staffing with EPs included high availability of EPs and patient census, and the quality of care provided by EPs. Low salaries and low physician availability were often cited as reasons for hiring PAs and NPs for solo ED coverage.

CONCLUSIONS: Physician staffing of Iowa EDs did not change substantially between 2008 and 2012, but there was a significant increase in staffing by advanced practice providers (APPs). Without ED coverage by FPs, it would not be possible to provide emergency care for large areas of the state. 17 references (hans-house@uiowa.edu – no reprints) (PMID: 23599868)

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