

Virtual Mentor

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HISTORY OF MEDICINE

Social Justice, Egalitarianism, and the History of Emergency Medicine

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Unlike other fields of medicine, emergency medicine (EM) arose out of a progressive social demand for services that was tied to the moral and ethical aspects of providing care for poor and uninsured people. Threads of egalitarianism, social justice, and compassion for the poor and underserved are woven into the brief history of full time emergency practice and the development of EM residency programs [1].

Many factors contributed to a tripling of emergency department (ED) visits in America between 1940 and 1960. By the mid-1950s, hospitals had become the technology-rich, always-available sites for diagnosis and treatment of acute conditions. Both the absence and presence of health insurance coverage drove people to EDs for care. Standard health insurance of the post-World War II era paid for hospital and ED visits, but not outpatient office visits, and those without health insurance found that most hospital EDs would provide care regardless of their ability to pay. At the same time, an acute shortage of primary care physicians and the rise of specialist physicians contributed to major access problems for many people—especially the poor. Fifty years later, many of these factors continue to contribute to ED use and have been central to the debate surrounding recent U.S. health care reform efforts.

Until 1961, emergency care was not the purview of any particular group of medical professionals. Large, urban teaching hospitals used house staff to work in EDs, usually with no senior physician supervision. Community hospitals patched together ED coverage by conscripting attending physicians, moonlighters, and sometimes medical students. Private physicians often met their paying patients in the ED and provided care, but poor and uninsured patients had to settle for the inconsistent and sometimes substandard emergency care provided by a ragtag collection of physicians.

In July of 1961, James Mills Jr., MD, along with three fellow internists, gave up private medical practice and entered into a contract with Alexandria Hospital in Alexandria, Virginia, to provide ED coverage. The reasons for their decision were partly pragmatic—Mills, the hospital's chief of staff in 1960-1961, had been charged with coming up with a solution to problems in his ED. Visits had increased markedly, and other methods for staffing the ED were not providing sufficient coverage. Mills and his colleagues found that they could make at least as much money in this new arrangement as in their private practices and actually work fewer hours per week.

At the same time, Mills was pursuing a humanitarian agenda. When he had previously been assigned to cover the ED, he found that many poor and minority patients used the ED for their health care. As a volunteer in organizations that served the poor and disadvantaged of Washington, D.C., Mills realized how lack of access to health care contributed to poverty. Part of the attraction for Mills in serving as a full-time emergency physician was that he could have more of an impact on improving health care for at least some of the poor and uninsured in his city. Mills died in 1989, and when other early leaders in the field were asked to describe him, they invariably emphasized his immense compassion and caring for others. That the first emergency physician in America was so concerned about the health care of the poor and disadvantaged had a strong influence on many of those who followed him.

The advent of Medicare and Medicaid in 1965 greatly increased the number of Americans who had health insurance. When doctors' offices and clinics became overwhelmed, people turned to EDs for care, causing a dramatic increase in ED visits between 1965 and 1970—from 29 million to 43 million per year [2]. Across the country, groups like the one at Alexandria were providing emergency care in many community hospitals, but in the inner cities an increasingly poor population turned, out of necessity, to urban teaching hospitals. The EDs in these hospitals became the proverbial safety net for both emergency and routine care. However, almost no full-time emergency physicians practiced in urban teaching hospitals, and care was often provided by unsupervised interns or resident physicians with little or no attending physician back-up.

In the late 1960s in Cincinnati, the poor, primarily African American residents of the neighborhoods near Cincinnati General marched on the hospital, protesting the long waits and substandard care in the ED and hospital. This demonstration, in part, led administrators and physicians at the University of Cincinnati to start the first emergency medicine residency training program in 1970. More EM residencies soon followed, associated with other teaching hospitals that cared for poor and uninsured patients in their cities, such as the Los Angeles County/University of Southern California Medical Center, Medical College of Pennsylvania in Philadelphia, Louisville General Hospital, and the University of Chicago. These physicians developed a clear understanding of the plight of those who were on the bottom of the ladder in U.S. health care, and they were mainly teaching themselves emergency medicine.

It was not until the late 1970s that EM became a board-certified specialty within the American Board of Medical Specialties. Until this happened, those who trained in EM were in some ways viewed as outcasts; many became fierce in the defense of their budding field and the key role it played in providing care for the poor and disadvantaged. Like their patients, those in EM felt like they were on the outside looking in, without a voice in American medicine. Emergency physicians were proud of the egalitarian nature of ED triage—a poor man in shock would be evaluated and treated in the ED before a rich man who had a less serious problem. The fact that

EM, unlike some other specialties, did not do a “wallet biopsy” before care was rendered was a source of pride. The social justice of good emergency care became a central theme for early leaders of the field. For example, Lewis Goldfrank, MD, who developed EDs and an EM training program in New York City that primarily served the poor, describes himself as a public servant who has confronted social and political issues through his ED work.

The egalitarian, “take anyone, with anything, at any time” mentality of emergency medicine went beyond philosophy and became U.S. law in 1986 with passage of the Emergency Medical Treatment and Labor Act (EMTALA)—in essence creating a federal right to emergency care for all people in the U.S.

In its short history, EM has also seen its share of profit-seeking, “corporate” medicine and unethical practice by some emergency physicians. But, from its inception, the field has derived its strength from an egalitarian, compassionate view of health care. From James Mills Jr., MD, to the ED physicians of today, emergency medicine has been unwavering in its commitment to focusing on and serving people who were ignored for so many years by the health care system.

References

1. The content of this article was derived from Dr. Zink’s book *Anyone, Anything, Anytime—A History of Emergency Medicine*. Philadelphia, PA: Mosby Elsevier; 2006.
2. *Emergency Services: The Hospital Emergency Department in an Emergency Care System*. Chicago, IL: American Hospital Association; 1972.

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