ACN 145 437 216

HOW TO START AND OPERATE

A NATIONAL EMERGENCY MEDICINE

SPECIALTY ORGANIZATION

OCTOBER 2014

INTERNATIONAL FEDERATION FOR EMERGENCY MEDICINE
34 Jeffcott Street
West Melbourne VIC 3003
T +61 3 9320 0444 | F +61 3 9320 0400
E ifem@acem.org.au | www.ifem.cc
Produced by: International Federation for Emergency Medicine
ISBN: 978-0-9873901-3-4

Further copies of this publication can be obtained from the International Federation for Emergency Medicine website at: www.ifem.cc/Resources/PoliciesandGuidelines

HOW TO START AND OPERATE A NATIONAL EMERGENCY MEDICINE SPECIALTY ORGANIZATION

TABLE OF CONTENTS

From the Specialty Implementation Committee of the International Federation for Emergency Medicine:

Elizabeth L. DeVos MD, MPH (USA)
Vicken Y. Totten MD, MS (USA)
Lisa Moreno-Walton, MD (USA)
C. James Holliman MD (USA)
Terrence Mulligan DO, MPH (USA)
Gabrielle A. Jacquet MD, MPH (USA)
Gautam Bodiwala MD (UK)

Reviewers:
Arif Alper Cevik MD (Turkey)
Erkan Gunay MD (Turkey)
Sally McCarthy MBBS (Australia)
N. Nwauawa MD (Nigeria)
Timothy Rainer MD (Hong Kong)
Rashmi Sharma MD (Nepal)
Anantharaman Venkataraman MBBS (Singapore)
Lee Wallis MBChB, MD (South Africa)

Introduction

A national Emergency Medicine (EM) specialty organization is as vital for a country first developing the specialty of EM as it is in a country where the specialty is well established.[1] This manuscript presents some of the considerations that founders of a new organization of EM practitioners must address as they develop their own organization and then continue to operate it. The impetus for this manuscript was to provide a reference document as a service of the International Federation for Emergency Medicine (IFEM). It addresses many requests directed to IFEM for advice on starting the specialty of EM (see IFEM's website www.ifem.cc)[2]. This manuscript reviews the general importance of the specialty of EM, structural and procedural considerations for EM specialty organization development, and some of the political considerations related to EM specialty organizations.

General Importance of EM

The clinical practice of EM and the acceptance and recognition of EM as a medical specialty have been shown to be valuable and efficacious worldwide.[3] Worldwide changes in demographics and disease epidemiology make the specialty training of EM increasingly relevant.[4] Globally, these changes include the increasing proportion of elders with their concomitant burden of chronic diseases, increasing trauma and cardiorespiratory illnesses, and the continued burden of infectious diseases. Each year, the demand for EM and its caseload grow, because Emergency Physicians are recognized in having expertise in management of acute presentations of all of these health problems.[5,6] The World Health Organization (WHO) has made a uniform consensus statement emphasizing the importance of emergency health care and trauma care and has called on all countries to develop effective systems for emergency health care delivery in its World Health Assembly Resolution 60.22[7,8] During the last 40 years, the scope of practice of EM has been delineated and EM has become recognized as an accepted and certified medical specialty in many nations.[9] In order to best serve society, an increasing number of emergency healthcare providers must receive appropriate EM training and continue their professional development. In nations where EM has not yet been recognized or certified as a medical specialty, it must overcome challenges of recognition. The public should be educated on the uses and benefits of a specialized emergency care system; the government must appreciate expertise in acute care/emergency medicine, and other medical specialties must be made aware of the scope of the field as well as the benefits which accrue to them from having well-organized EM. A major resource to facilitate the development of the specialty of EM and to overcome the challenges mentioned is to have a national EM specialty organization.

General Considerations for an EM Specialty Organization

A medical specialty organization offers individual benefits as well as collective benefits. Individual members can gain support and prestige from being a member of the organization; they can share education, knowledge and experiences. This can then improve their individual medical practice. A major role for an EM specialty organization is to promote the recognition of the specialty of EM. Recognition of EM as a legitimate and accepted medical specialty can improve employment opportunities for EM specialists. This attracts more people into the

specialty. When EM is not officially recognized as a medical specialty, practitioners may feel disenfranchised. They may have academic and financial incentives to pursue a different medical specialty. The EM specialty organization can counter these influences by offering collaborations, mentorship and practical support; and can help members find mentorship for career decisions, professional development and generally stay connected. These connections have been shown to be important in facilitating career selection, advancement and productivity.[10] A specialty organization may exist purely for academic interests or pursuits, or to serve to promote the interests of its members, or for both. The specialty organization may be a private entity or may be structured with a close relationship with official or academic organizations of the government or of other entities such as universities.
A specialty organization can provide both spiritual and practical support. Compared to an individual, the specialty society can more effectively negotiate with the government, other medical specialties, and healthcare and academic institution administrators. Many types of stakeholders who have an interest in the practice of EM would benefit from participation in, or the services of, an EM specialty organization.[1,4]

A medical specialty organization can offer many benefits to its members. Among these are providing opportunities to collectively improve members' clinical practice, endorsing the qualifications and/or certifications of members, providing recognition and acceptance by the other medical specialties, and undertaking political activities to have a greater influence on the national healthcare system structure. A specialty organization has much more political influence than does a single practitioner. Individual members of a specialty organization benefit from the opportunities provided by the organization to share knowledge, experiences and mutual support.

Many countries have just one organization representing the interests of EM. A number of countries, e.g. the U.S.A. and Singapore, have multiple such organizations, some of which include the American College of Emergency Physicians (ACEP),[11] American Academy of Emergency Medicine (AAEM)[12] and Society for Academic Emergency Medicine (SAEM)[13] in the United States and the Society for Emergency Medicine in Singapore (SEMS)[14] as well as the Chapter of Emergency Physicians[15] in Singapore. Some EM organizations represent specific facets of the discipline, such as emergency pre-hospital care (NAEMSP),[16] toxicology (Toxicology Society Singapore)[17] and resuscitation (Australian Resuscitation Council).[18] Over time, some of these various organizations have focused on performing limited specific roles related to EM, and the larger organizations have maintained a broad range of activities and services . Ideally, these multiple organizations work together to complement each other and avoid overlap and duplication of services in the overall scheme of addressing the needs of emergency medical care.

While specific matters of curriculum for EM specialist training (see the IFEM undergraduate and graduate EM Curricula[19]) and accreditation may be handled by a separate or governmental organization overseeing these issues, a national EM organization can establish standards for the education of EM specialists by setting the minimum requirements for the training and certification of its members, and can mandate maintenance of quality through re-certification requirements, which may include examinations, practice-based skills assessments, and

continuing medical education courses. Furthermore, the organization can provide the opportunity to share educational tools such as written reference articles, simulation cases, certification exam review programs, didactic lectures, and seminars and workshops.
A specialty organization can set, and hold its members to, high ethical standards. When the organization requires specific education, training, certification and continuing professional improvement of its members, membership in that organization indicates achievement and accomplishment of these high standards.

Continuous Professional Development (CPD), which can be considered to encompass, or be alternatively termed, Continuing Medical Education (CME), is an important member benefit for consideration by an EM specialty organization. A specialty organization that offers easier access to educational tools, enhances its value to members by providing resources from within their own organization to help members to keep up to date with medical practice changes, and to help advance their professional status. These resources can include written reference articles, didactic lectures, seminars, simulation cases and certification exam review programs. The organization can influence national practice standards by careful choice of its provided educational resources.[20] The organization may also mobilize specific groups of its members to create clinical practice guidelines with broad applicability.

The specialty organization can inform the public and government of the capabilities of EM specialists and can help set their expectations of EM. Public expectations for quality emergency care can have a great influence on national health policy and on the national healthcare system structure. This way, the public becomes a partner to the specialty organization in lobbying for EM recognition and governmental support.

EM addresses needs of a variety of stakeholders. The benefits the EM specialty organization provides to the stakeholders will vary by organization. Therefore, national EM organizations should be configured to meet the unique needs, standards and practices of the nation or region in which they are established. Nonetheless, the experiences of other EM successful organizations can serve as a guide for the creation and operation of new national EM specialty organizations.

Initial Considerations for Forming a National EM Specialty Organization

One of the earliest considerations in forming a new national EM specialty organization is to decide the name of the organization. This choice will reflect particular national customs, language, and government regulations. The organization might be called a “College” (as an example, the American College of Emergency Physicians or ACEP, the largest EM specialty organization in the U.S.A.), or an “Association” (as in the Canadian Association of Emergency Physicians or CAEP[21], the largest Canadian EM organization); a “Society” (such as the Slovenian Society for EM)[22], or an “Academy” (such as the American Academy of EM), or a “Federation” (such as the regional organization, the African Federation for EM).[23] Definitions for these terms are provided in Table 1.

Table 1: Definitions of the terms for names of organizations:

An "**Academy**" is "a group of persons unified by high academic achievement and a desire to educate. They may be voluntary or chosen."
An **"Association"** is "a voluntary group who offer each other mutual support towards common goals."
A **"College"** implies "a professional group of like-minded scholars. Membership is typically by application and voluntary but may be appointed."
A **"Chapter"** refers to a subgroup of a larger organization based on geography or special interest. e.g. the Ohio (state) Chapter of ACEP[24] or the Chapter of Emergency Physicians (Singapore) in the larger Academy of Medicine of Singapore.
A **"Federation"** is "an organization composed of other groups or a grouping of organizations, and may or may not accept individuals as members."
A **"Society"** is "a voluntary group of persons sharing support and goals."

After selecting the name of the organization, the next formative consideration is to compose a formal statement of the organization's mission or goals (this can be termed the "vision statement"). A vision or mission statement serves to focus the efforts of the entire organization and to inform the general public of its goals and standards. Careful attention to the meaning and wording of the mission statement is crucial. The mission statement should be re-examined periodically to be sure it is still appropriate to the evolving vision and circumstances of the organization, and should be rewritten if changes are needed. The mission statement should reflect the interests the organization promotes; the organization may be devoted to promoting all aspects of emergency healthcare, or it may focus just on the interests of emergency physicians, or on specific areas of interest within EM.

Membership is the third early structural consideration. Will the organization be composed of only emergency physicians as members, or will non-physicians such as emergency nurses, physician assistants, paramedics, emergency medical technicians, or will even members of the lay public be eligible for membership? If non-physicians are members of the organization, it needs to be decided if these members will have the same membership privileges (such as voting rights to elect officers of the organization) and the same responsibilities (such as specific membership fees or annual dues) as the physician members. The advantages of having non-physicians as organization members include better coordination of activities of all the different

professional roles involved in emergency healthcare, and a broader constituency (which may be helpful when dealing with the government or large healthcare delivery organizations). The disadvantages of having non-physician members include possible dilution of focus for the organization with activities or programs that may not be relevant to physicians, and possible lesser control or dominance of the organization by physicians.

A more inclusive organization may be helpful when dealing with the lay public, government, and large healthcare delivery organizations, and may be able to better influence national health policy. In the early stages of formation of the specialty organization, the benefits of including many types of health professionals also include more people to do the work of the organization, greater dues revenue and a larger sphere of influence. In multi-professional organizations, and especially in multi-ethnic societies, these multiple and diverse communities must be reflected in both leadership and membership of the organization. When this is not the case, additional, separate specialty organizations may emerge under different names and ideologies, often splintering the unity and effectiveness of the specialty. This can result in not presenting a unified depiction of EM to other medical groups and the public.

A more restrictive membership can focus on narrower or specific goals, or on a specific aspect of medical, educational or specialist concerns. For example, an EM specialist-only organization may convey higher prestige than a less restrictive organization; conversely, it may disenfranchise many other physician specialists and health professionals working in emergency care.

The initial advantages of an inclusive organization may change over time. When the specialty matures or circumstances change, it may become advantageous to develop affiliated, profession-specific organizations that better accommodate the needs of specific constituents, such as physicians, nurses, paramedics and other stakeholders.

Even organizations that restrict membership to physicians need to be cognizant of their potential to enhance the practice environment of other professionals who work in the emergency healthcare system. Nurses and emergency medical technicians often feel disconnected, unappreciated and dissatisfied with their work.[25] Organizations which include non-physician practitioners can offer them support and collaboration. Often this is managed by creation of special sections within the organization that addresses these specific needs without diluting the overall objectives of the organization. Organizations that offer membership only to physicians can offer instruction for EM workers on professionalism and teamwork skills, and can support the formation of other collaborative organizations for emergency nurses or technicians. Once a name, vision or mission statement, goals and objectives, and questions of membership have been considered, a new EM specialty organization should formalize these decisions into a "document."

This document's name and structure will vary depending on the laws and customs of the country in which the organization is formed. In some countries this will be a "constitution;" in others, "bylaws." The constitution or bylaws are the compilation of all the rules of the organization and act as the final authority when questions or disputes of form or function arise.

Often termed “governance,” this document describes each leadership role and responsibility, eligibility and membership criteria, and includes other specific rules and guidelines by which the organization governs itself and its membership. Regardless of its name, the document should establish and circumscribe the authority of organizational officers, committees, and/or sections of membership that do the work of the organization in carrying out its goals or mission statement. Standard components of such a document are presented in Table 2.

Table 2: Standard Components of Bylaws or a Constitution

Mission, Purpose, Vision, Goals
Classes of Membership
Membership Requirements
Leadership Structure
Voting and Holding Office
Finances/Dues
Meetings
Fellowship/Awards
Committees, Chapters, Special Interest Groups
Ethics
Review of Records and Finances
Indemnification
Amendments/Changes in the Document

Organizations change over time. It is important to build into the organization mechanisms to re-examine the organization’s mission statement and change its structure as needed, to avoid becoming obsolete. The future of the organization and the specialty of EM in the country should be considered. Initial organization membership requirements may need to change. For example, in many countries, early practitioners of EM have been trained in other medical specialties. These practitioners may be offered EM specialty organization membership because of their practice experience qualifications. Later member applicants (after EM specialty recognition and training programs are established) may be required to demonstrate formal specialty training in EM to qualify for membership.

The components of the document can be regarded or classified as of “core” importance or of “secondary” importance. “Core” components could include the mission or vision statement, membership requirements, leadership and governance structure, and the document amendment process. “Secondary” components, less crucial and more subject to change, could include finances and dues, and committee operations. Generally the “core” document components should be stable and the process to change them more deliberate, whereas the “secondary” components should be more “fluid” and easier and quicker to change or update.

Membership qualifications need to be specified in this document. Categories of membership may include: “Student,” “Trainee” (such as Registrar or Resident), “Active,” “Lifetime,” “Honorary,” “Associate,” “International,” “Retired,” or other categories as appropriate to local circumstances. The different membership classes may have different privileges to hold office, to vote and serve on committees, and dues responsibilities. These need to be specified in the document. Membership may be restricted to citizens of the country of the organization, or the organization may offer full or other categories of membership to applicants from other countries. The voting structure may be direct (each member votes for a given person for an officer position), or representative (voters choose representatives who then vote to select officers). Qualifications for voting requirements should be specified, and might require up-to-date dues (in dues-requiring organizations), verified completion of specified CPD, maintenance of licensure or specialty certification, and adherence to the ethical and practice standards of the organization.

The document should specify and describe the leadership structure of the organization, most commonly called ‘officer positions’. Most specialty organizations have, at a minimum, a “President,” “Vice President,” “Secretary,” and a “Treasurer.” The “President-Elect” and “Immediate-Past President” offices help retain institutional memory and cultivate leadership skills if the duties of the “Immediate-Past President” are to train and mentor the “President-Elect”. The qualifications, duties, terms of office, and term limits should be delineated for each officer. It is important to consider limits for both length and number of terms in office. Longer terms of office (more than one year) provide better continuity and more consistent direction of the organization’s programs and activities, but limit the opportunities for other members in the organization to have leadership experience. Therefore, many organizations have 1-year terms of office with leaders automatically moving through sequential leadership positions. For example, after being voted in as President-Elect, the officer then, after a year, moves to the position of President for a year, and then finally serves one year as Immediate-Past President, (in essence serving only once, but for 3 years in automatically sequenced officer positions following one election.)

Large organizations may need additional entities to function efficiently. A “Board of Directors” (BOD) can act on matters not requiring the vote of the entire membership, can manage day-to-day operations, and can implement strategic planning, policy and budgets. Specifying an odd (rather than an even) number of voting BOD members eliminates the potential problem of tied votes. Officers of the organization typically are voting members of the BOD, and service on the BOD can be an eligibility requirement for being a candidate for an officer position.
In an organization with a representative style of governance, an elected “Council of Representatives” can serve as a less cumbersome subset of members which meets as directed by the document, to vote on matters of importance to the organization, including selecting officers and/or BOD members, and setting organizational policy.

The document should delineate the frequency and structure of the main meetings of the organization. Generally, most specialty organizations have an annual meeting; this annual “in-person” meeting offers opportunities for social and professional networking, conducting the

business of the society, and educational sessions. It should be specified if the annual meeting will be held in the same locale each year, or if the site of the meeting will "rotate" to different locations each year. (As with other considerations, this may change as the organization matures.) In addition to annual meetings most organizations have provision for extra-ordinary general meetings to address major issues that arise at short notice and that cannot wait till the routine date of the subsequent ordinary annual general meeting for consideration.

The document should also structure the organization's "sub-organizations." Sub-organizations, such as committees, sub-committees, task forces or other subgroups should be defined, and their functions and operations delineated. It should specify whether the sub-organizations will be "standing" (i.e. in continuous existence) or "temporary". Particularly, the most important committees representing the vital functions of the organization, such as Membership, Education or Research, etc. should be described in the document.

Committees can be used to carry out the day-to-day work of the organization or deal with specific projects. Committees may need to meet more frequently than just annually. Meetings may be in person, by telephone conference, by email, or via the internet (i.e. Skype, GoToMeeting, Google Hangout, etc.); the exact method usually need not be specified. The minimum number of meetings per year should be specified in the document. Common standing committees include "Education" (which may be specified to produce educational products for the organization and/or to run the organization's annual meeting), "Membership" (which actively recruits and retains members), "Clinical Practice" (which makes recommendations regarding updated clinical practice guidelines), and "Government" or "Political" (which interacts with the government and/or health ministry) and conducts political lobbying on behalf of the organization.

Sub-groups can be permanent or "standing" subgroups that the organization expects to have in place in an ongoing manner, or they can be temporary or ad-hoc, constituted for a specified time and task only. Often, geographic sub-organizations such as Chapters (for example, a Chapter might include only members from a specific state or province) are permanent. The minimum number of meetings for standing sub-organizations should also be specified in the document.

Other sub-organizations may be "task forces" or "interest groups" which address specific member needs or interests that are limited, specific, or focused and not necessarily of interest to the organization as a whole. The document should specify how these sub-organizations can be formed and dissolved, what additional voting privileges they may enjoy, and how their activities will be overseen. Such sub-organizations may be focused by interests such as "Pre-hospital Services" or "Critical Care," "Ultrasound," or "Triage," etc.

New organizations must consider whether they will charge dues or offer free membership. All organizations require money to operate. If the organization does not require membership dues, it must depend on donations or other alternate forms of financial support. Free membership reduces barriers to involvement in the organization, but may diminish the value of membership. Dues support the work of the organization with an autonomy that is not always possible when

depending on donations. Annual dues payment also provides a structure to confirm each member's contact information and continued interest in the organization.

If the organization chooses to require dues, the cost by category of membership and mechanisms for changing dues should be specified. Often, organizations create a progressive dues structure. For example, practicing physicians may pay more than retired physicians, non-physicians, or members-in-training. The organization may have other sources of income. Typically, the fees charged to attend educational meetings, programs, or purchase products of the organization generate revenue. The actual fees charged by the organization do not necessarily need to be specified in the document, but can be set and changed by a committee. The status of the organization as "non-profit" or "for-profit" will depend on local and national laws and regulations, but should be specified in the organizational document. The difference is that a non-profit organization returns all its revenue to the organization to further its work. If a for-profit structure is chosen, the organization must clearly address to whom the profits will accrue, and for what purposes. The document should also delineate the organization's financial structure to be "transparent" so that members can review the organization's finances. Typically an annual financial report is made available to members, and is often required by local tax and business legal rules. Such financial reports may need to undergo audit by either internal or external groups before being presented to the general membership for acceptance. Again, it is important to consider these business and financial-related aspects during the initial stages of the formation of the organization, and before writing the document, since often local laws and customs can dictate or limit the organizational and governance structure.

A specialty organization may specify certain ethical standards for its members. Particularly when the organization has licensing and certification authority, it has a duty to censure and/or revoke membership from anyone who violates its ethical standards. The standard of evidence needed and process for this action should be outlined in the document.

A specialty organization may wish to establish mechanisms to offer awards, to honor or to recognize outstanding individuals. One way to do this is to confer "Fellowship" on esteemed persons who meet the highest standards of professional achievement. The organizational document should specify the requirements and selection process for Fellowship. For example, Fellowship may be contingent on career or organizational membership longevity, on attainment of EM specialist status, on leadership or service to community or the organization, or other specified criteria. Fellowship may be 'in-house' (i.e., only open to members of the organization) or could be specified as "honorary" and conferred upon non-members. Fellowship may be temporary, or once conferred, be permanent.

Legal protection of members and officers while acting on behalf of the organization is called 'indemnification.' As the laws and customs of countries differ substantially, appropriate legal counsel should take into account local and national laws and regulations, and incorporate this protection into the document. Additionally, it is common that the organization hold an indemnification insurance policy, which protects individuals acting on behalf of the organization. For an example of an EM specialty organization document, IFEM's Bylaws and Constitution are posted at the web site www.ifem.cc.

Secondary Considerations for a New EM Specialty Organization

After creating a set of bylaws or constitution, the next phase of specialty organization development involves establishing the physical structure of the organization. Initially many specialty organizations entirely depend on non-paid volunteer work by the members and leaders, but as the organization grows and undertakes more and larger activities, there will be a need for paid staff and a "headquarters" office. The details of the physical office structure and staff work assignments do not need to be specified in the bylaws or constitution, but the organization will need to have written policy papers on office operations and staff hiring and supervision. For large specialty organizations, it may be necessary to have an administrator or "executive director" to operate the headquarters office and hire and supervise the organization's office staff. The executive director may not necessarily need to be a physician or a previous member of the organization (the qualifications and responsibilities of the executive director should be specified in the document).

The organization's office needs to maintain records of membership, finances, and organizational activities in order to support the mission of the organization and to report organizational activities and finances as required by local and national regulations. It is quite possible to maintain a membership organization with only paper files, but backed-up, secured electronic files offer many advantages. Paper-based organization implies communication by regular postal mail, which in turn, entails the cost of mass mailings, which can be expensive and time-inefficient. Electronic communications may be quicker and easier to archive.
Another early consideration should be establishing an organizational web site. To be effective, the organization's web site must be updated frequently. The organization should decide if its web site will be maintained and updated by an individual volunteer, by a committee, or by specified office staff. A web presence with appropriate links, files, and contacts offers current and prospective members access to the organization's benefits and resources.
Once membership eligibility criteria have been established, the EM specialty organization should develop a membership recruitment program. Recruitment generally begins with those physicians who are active in the practice of EM in the country where the organization is being established. Recruitment typically begins with mailings to physicians working in Emergency Departments (EDs), or announcements at medical meetings, but personal contact is the most effective way to recruit.

Successful EM specialty organizations have frequently gained potential membership recruits by offering presentations, either about EM or about the organization at local EDs or hospitals (with permission from the ED director or manager), and then collecting the contact information for the attendees at the presentation. Subsequently, the EM organization emails these attendants to offer Continuing Professional Development (CPD) programs or Continuing Medical Education (CME) programs on behalf of the organization. Emergency physicians (EPs) are busy, so it is effective to pair a request for organization membership, support and involvement with an offer of education and CPD or CME. New EM organizations must often rely on their volunteer leaders or designated educators to prepare high quality presentations and then deliver them without

compensation, either at meetings or online, in orders to draw in new members. Even established EM organizations may offer some free CPD or CME as a benefit of membership. The lifeblood of any organization is the pipeline of junior members, mentored and trained to take over the leadership positions vacated by senior members as they move to advisory roles and retirement.

Where EM is not yet an officially recognized specialty, the first task of the organization is specialty recognition, and developing EM training programs. Where EM specialty training already exists, successful organizations may actively recruit physicians-in-training by speaking at local educational conferences. Additionally, they may enhance the benefits of organization membership by coupling it with offerings including: mentorship by senior physicians, political action organizations, and job networks, job banks, interview practice workshops, and reduced cost board exam review courses where appropriate. Mentorship can be offered informally by even the newest and smallest of organizations by depending upon its volunteer leaders and the gradually expanding senior physician membership.

Some EM organizations recruit by offering free or reduced fee dues to trainees at various levels. Trainees who become committee members are able to list the membership on their curricula vitae, and develop leadership skills and content expertise through committee activities. Academic physicians may benefit from the prestige of committee membership and leadership titles when they apply for promotion. As an EM specialty organization begins to grow, recruitment can be enhanced by offering opportunities for trainees and junior physicians to present research and to lecture. These experiences may improve the member's academic recognition and job opportunities.

Political Considerations for EM Specialty Organizations

Political activity is one of the potential functions and benefits of a specialty organization. The organization represents EM to other healthcare stakeholders, and can negotiate on behalf of the specialty with the government. For example, the specialty organization may be the voice of EM in national funding and policy debates, particularly those regarding public health and disaster management. In cases where the government sets practice benchmarks or determines provider salaries, the specialty organization may best be able to present the practitioners' viewpoints to the government. For example, Sweden credits the persistent lobbying of its EM specialty society with the recognition of EM as a supra-specialty in 2006, and its acknowledgement as a primary specialty in 2014.[26]

Political leverage with the other medical specialties is as important as leverage with the government. Specialty organization support can assist EPs to gain privileges to practice, and be paid for clinical procedures that are also performed by other medical specialties. Examples include emergency airway management (including endotracheal intubation), which is shared with anesthesiology; trauma care, which is shared with surgery; and ultrasound, which is shared with radiology.

In some cases, the specialty organization will also provide a voice for members dealing with clinical practice issues within EM. Sometimes, differences in mission may spur the creation of more than one EM organization within the same nation or region. For example, in Turkey, the Emergency Medicine Association of Turkey (EMAT) [27] and the Emergency Physician's Association of Turkey (EPAT), [28] both represent emergency specialists in Turkey, but have different constituencies and missions. EMAT, the first EM society in Turkey, starting as residency training began in the country, widely represents Turkish EM professionals. Physicians and non-physicians alike are accepted as full members. EPAT, on the other hand, aims to distinctly represent EM specialist physicians who have completed residency training. Both societies are actively involved in residency and post residency training with annual meetings and various training programs, statewide health policy advocacy and international representation of Turkish EM. Likewise, in the USA, there are two major EM physician organizations, which represent physicians: the American Academy of Emergency Medicine (AAEM) and the American College of Emergency Physicians (ACEP). These two organizations originally had a somewhat antagonistic relationship, but currently cooperate on governmental advocacy issues and have some of the same people as members of their Board of Directors.

Another political aspect for an EM specialty organization to consider is parity. The organization can advocate on behalf of its female or minority members who may feel that they are victims of discrimination in their EM working conditions.

Overview of Regional and International EM Organizations

There are EM organizations at many levels: global, regional, national, and local with a wide variety of structures and policies. Examining current organizations will help developers of a new organization to choose a structure most suited to their objectives. In addition, after formation of a new national organization of EM, the organization should consider joining one or more of the regional or international EM organizations.

The International Federation for Emergency Medicine (IFEM) is a global umbrella organization, which has both national and regional EM organizations as members; IFEM membership is currently not open to individuals. IFEM intentionally decided to not offer individual membership in order to encourage physicians to join their national EM organizations, or to form new EM organizations if their country did not yet have a national organization. IFEM also feels that emergency physicians from countries that do not yet have national EM specialty organizations can be and are represented through their regional EM organizations (ASEM, EuSEM, ALACED, and AFEM; see below). Regional organizations currently "cover" all of the countries around the globe that do not yet have specialty EM organizations. IFEM strongly encourages new national EM organizations to join it. More mutual benefits accrue as IFEM continues to represent all national EM organizations.

Regional EM specialty organizations include the Asian Society for Emergency Medicine (ASEM),[29] the European Society for Emergency Medicine (EuSEM),[30] for Latin America, the Asociación Latinoamericana de Cooperación en Emergencias Médicas y Desastres (ALACED),[31] (or in English, The Latin American Association for Cooperation in Emergency Medicine and Disasters),

and the African Federation for Emergency Medicine (AFEM). These organizations address topics of regional interest: for example, EuSEM's national members are discussing a single diploma pathway for all European EM physician specialists which should facilitate intra-European professional mobility, congruent with EU goals, [32,33,34] while the AFEM recently published Oxford AFEM Handbook for Acute and Emergency Care[35] and an EM curriculum for acute care practice in low-resourced settings. AFEM serves the entire African region, and membership is open to both individuals and to societies; AFEM encourages physicians, nurses and out-of-hospital personnel to join as members. The only requirement is that they are either working in or interested in supporting Emergency Care in Africa.

Other EM organizations focus on specific facets of EM. For example, the Society for Academic Emergency Medicine, (SAEM), focuses on EM education and research. It offers full, voting membership to any person who holds an advanced degree (MD, DO, PhD, PharmD, DSc, or equivalent) and who holds a university appointment, or who is actively involved in EM education or research. There are no requirements of nationality; the cost of dues depends on the Hinari World Bank classification of the country of practice. "Associate" membership is available to other health professionals, educators, government officials, members of lay or civic organizations, and the general public who have interest in the field, but Associates do not have voting privileges.

Some organizations, which limit membership to physicians, may partner with non-physician organizations to strengthen their collective voice. For example, the Society of Emergency Medicine Physician Assistants (SEMPA)[36] is an organization of Physician Assistants (PAs) who work in EM; it partners with the American College of Emergency Physicians (ACEP) (an organization whose non-honorary membership is limited to EM physicians). ACEP supports SEMPA by staffing the SEMPA office and offering SEMPA members access to ACEP conferences. Still other physician organizations incorporate others via associate memberships, typically with reduced fees. Associate members may be non-physicians, or physicians from another locale, with or without voting privileges. Non-physicians, for example, may join the European Society for Emergency Medicine (EuSEM) or the Australasian Society for Emergency Medicine (ASEM)[37] as associate members, but may not vote.

Conclusions

There are many benefits to developing an EM specialty organization including increased visibility for the specialty of EM, providing useful educational services, and effectively advocating with the government, the other medical specialties, and healthcare delivery systems.
When developing an EM specialty organization, the founders must consider sustainability from the start. Obtaining and maintaining adequate resources (both human and financial) require ongoing attention. Resources are needed to conduct the organization's business, and to maintain and grow an interested membership. Quality CPD (or CME), mentorship, clinical practice policies, education, and political lobbying are all products useful to potential members. In addition to the physicians currently training in or practicing EM, there are many stakeholders who have a vested interest in the practice of EM, and who would benefit from participation in an EM organization. These include academicians training the next generation of EM specialists,

allied health professionals, and medical students.[9] If not included as organization members, EM specialty organizations should formally collaborate with and support emergency nurses, pre-hospital care providers, mid-level providers (such as physician assistants and advanced practice nurses), and collectively interface with public health officials and politicians.

As each EM specialty organization affiliates with its regional organizations and with IFEM, the worldwide voice of EM strengthens. These affiliations increase resources for worldwide specialty development, networking, physician and student exchange, and harmonized education.

References:

1. Arnold JL, Corte DF. International emergency medicine: recent trends and future challenges. Eur J Emerg Med. 2003;10(3):180-8.
2. The International Federation for Emergency Medicine (IFEM) http://www.ifem.cc/About_IFEM/Membership1.aspx
3. Holliman CJ, Mulligan TM, Suter RE, et al. The efficacy and value of emergency medicine: a supportive literature review. Int J Emer Med. 2011;4(1):44.
4. Anderson P, Petrino R, Halpern P, Tintinalli J The globalization of emergency medicine and its importance for public health. Bull World Health Org. 2006, Vol 84 (10) 765-840
5. Mathers CD, Loncar D. Updated projections of global mortality and burden of disease, 2002-2030: data sources, methods and results. World Health Organization. October 2006. (Accessed January 5, 2014, at http://www.who.int/healthinfo/statistics/bod_projections2030_paper.pdf)
6. Guidelines for Essential Trauma Care. World Health Organization. 2004, 106 pages. (Accessed November 10, 2013, at http://www.who.int/violence_injury_prevention/publications/services/guidelines_traumacare/en/)
7. World Health Assembly (WHA). Health systems: emergency-care systems [WHA resolution 60.22]. World Health Organization web site. (Accessed November 8, 2013 at http://apps.who.int/gb/ebwha/pdf_files/WHA60/A60_R22-en.pdf)
8. Anderson PD, Suter RE, Mulligan T, et. al. World Health Assembly Resolution 60.22 and its importance as a health care policy tool for improving emergency care access and availability globally. Ann Emer Med. 2012; 60(1):35-44.
9. Anderson P, Hegedus A, Ohlen G, Holliman CJ, Williams D, Suter R: Worldwide growth of emergency medicine as a recognized medical specialty. Acad Emer Med. 2011, 18(5):S22–S23.
10. Sambunjak D, Straus SE, Marusic A. Mentorship in Academic Medicine: A Systematic Review. J Amer Med Assoc. 2006; 296(9): 1103-1115
11. American College of Emergency Physicaians (ACEP) http://www.acep.org
12. American Academy of Emergency Medicine (AAEM) http://www.aaem.org
13. Society for Academic Emergency Medicine (SAEM) http://www.saem.org
14. Society for Emergency Medicine in Singapore (SEMS) http://www.semsonline.org/
15. Chapter of Emergency Physicians http://ams.edu.sg/chapters/ChpEPhys/home
16. National Association of EMS Physicains (NAEMSP) http://www.naemsp.org

17. Toxicology Society Singapore (TSS) https://sites.google.com/site/toxicologysocietysingapore/
18. Australian Resuscitation Council http://www.resus.org.au/
19. International Federation for Emergency Medicine. IFEM Curricula for Emergency Medicine. (Accessed January 26, 2014, at http://www.ifem.cc/Resources/IFEM_Curricula_for_Emergency_Medicine.aspx)
20. Ferris TG, Vogeli C, Marder J, Sennett CS, Campbell EG. Physician specialty societies and the development of physician performance measures. Health Aff (Millwood). 2007; 26(6):1712-9.
21. Canadian Association of Emergency Physicians (CAEP) http://www.caep.ca/
22. Slovenian Society for Emergency Medicine (SSEM) http://www.ssem-society.si/
23. The African Federation for Emergency Medicine (AFEM) www.afem.info
24. Ohio ACEP- Ohio Chapter, American College of Emergency Physicians. www.ohacep.org
25. Chakroun WO, Rejeb I, Kammoun L, Nasri A, et al. Evaluation of Stress among Emergency Staff: Survey in a Tunisian Emergency Department. Ann Fr Anesth Reanim. 2013 Sep; 32(9): 565-71.)
26. Hallas P, Ekelund U, Bjørnsen LP, Brabrand M. Hoping for a domino effect: a new specialty in Sweden is a breath of fresh air for the development of Scandinavian emergency medicine. Scand J Trauma Resusc Emer Med. 2013;21(1):26.
27. Emergency Medicine Association of Turkey (EMAT) http://www.tatd.org.tr/
28. Emergency Physicians' Association of Turkey (EPAT) http://www.atuder.org.tr/
29. Asian Society for Emergency Medicine (ASEM) http://www.asiansem.org/cms/
30. European Society for Emergency Medicine (EuSEM) http://www.eusem.org
31. Asociación Latinoamericana de Cooperación en Emergencias Médicas y Desastres (ALACED) http://www.alaced.org
32. Letter from EuSEM President Abdelouahab Bellou to Dr. Leoš Heger, CSc, Minister of Health of the Czech Republic supporting the Czech Society for Emergency and Disaster Medicine. (Accessed November 13, 2013, at http://www.urgmed.cz/ostatni/2013_dopis_UM_EUSEM_2.pdf)
33. Totten V, Bellou A. Development of emergency medicine in Europe. Acad Emer Med. 2013;20(5):514-21.
34. The Manifesto for Emergency Medicine in Europe. Eur J Emerg Med. 1998 Mar;5(1):7-8.
35. Oxford AFEM Handbook of Acute and Emergency Care. Eds: Lee A. Wallis, Teri A. Reynolds, Publisher: Oxford University Press, Southern Africa,11/2013; ISBN: 978-0-19-905607-1 Usage tracked http://afemhandbook.com/
36. Society of Emergency Medicine Physician Assistants (SEMPA) www.sempa.org
37. Australasian Society for Emergency Medicine (ASEM) www.asem.org.au