

# PERSPECTIVE

## Rural Emergency Medicine in Perspective: Celebrating the Birth of a Journal

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### What is Rural Emergency Medicine?

Can you define rural? Is a “rural ED” defined strictly by size (of the hospital or community) or staffing – or according to access to specialty care and “academia”? The United States (U.S.) census bureau says that 84% of us are urban and occupy only 10 % of our country’s land and 16% of us “rural folk” reside on 90% of the land. I have forged a career as a hybrid by working in both worlds during the course of my 40-year Emergency Medicine (EM) career. The first 20 years were in South Dakota and Wyoming, followed by 20 years at Washington School of Medicine in St. Louis. I hope that the path of my career has provided me with a unique perspective about the overlap and dissimilarities between rural and urban emergency care. The objectives of this essay are two-fold: (1) To highlight my enthusiasm about the new *Journal of Rural Emergency Medicine*; (2) To differentiate the intentions of this new Journal from existing emergency medicine publications.

I trained as a general surgeon but early on in my residency became an advocate for EM, mainly because I trained in Detroit alongside the late icon Dr.

Ronald Krome. The early formative years of EM were tough, to say the least. The practice of EM in rural areas was inherently challenging and for various reasons the politics of the new specialty was even worse than in urban areas. In fact, rural challenges were the one thing that were not in short supply and included:

- 1) Whether the practitioner should be board certified in EM.
- 2) EM group contracts competing with local practitioners.
- 3) Hospital administrators wanting to improve their “ER” quality of care (shame on them for wanting to improve quality of care and calling an emergency room a department!).
- 4) Lastly entrenched hospital medical staff often had to be convinced to support the new ways and in favor of the old ways (translation -can you pronounce “income”) of ED coverage.

The EM politics of the 70’s through the mid 90’s was definitely tougher than the practice or the scientific advancement of the specialty, yet patients never stopped coming to rural or urban EDs. As detailed in Brian Zink’s historical treatise “Anyone, Anything, Anytime”, the American College of Emergency Physicians (ACEP) was founded in 1968 and the American Board of Emergency Medicine in 1976 and it was from these dates through the mid 1990’s that contemporary EM emerged.

### Our Rural EM Providers Journey to Academia

In 1983, I left South Dakota and moved to Wyoming to become director of the hospital EM department in Casper, WY. The volume was 30,000 and we had a Life Flight helicopter program, Family Practice Residency, and an eight bed ED. The medical standards at the hospital were excellent, but the politics of rural EM were ongoing and never ending as it was in the rest of the U.S.

In 1993, I left Wyoming to become an Emergency Medicine Attending at Washington University (Wash U) School of Medicine in St. Louis. It was a culture shock going from “down to earth/boots on the ground” rural EM to a top-notch academic center.

Over the years my Wash U students, residents, and staff labeled me as “old school”, mostly in an affectionate manner, but not always. The old school label I proudly wear is emblematic of my diploma from the school of hard knocks and my baptism by fire during the early days of rural EM. I would relive those days again in a heartbeat if given the chance.

### The Birth of a Rural EM Curriculum, Journal, and Textbook

At last, those of us who call ourselves rural EM docs now have an advocate with this first edition of the *Journal of Rural Emergency Medicine* (JREM). This journal will survive as long as physicians practice EM in rural areas of the world. The ACEP Rural Section has spent over two-years developing a well-

rounded curriculum for the healthcare providers who staff the non-urban EDs of the 21st Century. The curriculum includes the Comprehensive Advanced Life Support (CALS) course, *JREM*, and eventually a textbook of rural EM. The time is now for our specialty and our specialty organizations to realize that rural EM is not urban EM. It is different in so many ways that I am compelled to list some of the differences that I see as pros and cons of rural practice.

#### Cons

- a) the definition of professional fear is a very sick patient on death's door and only you with one nurse in a very small ED
- b) no matter the hype of modern day electronic media, you will still experience professional isolation
- c) lower income compared with your urban colleagues
- d) long hours and sleep deprivation
- e) inconsistent availability of ancillary services and specialty consultants
- f) despite your best efforts in a resource- and manpower-constrained environment, your transfers will be second guessed by most medical centers and accepting physicians
- g) skill and knowledge degradation because you don't see the "rare stuff" on a regular basis

#### Pros

- a) smaller patient volumes and slower paced ED's
- b) lifestyle (can you say fly fishing, hiking and the tranquil beauty of rural settings) without the urban mayhem and crime
- c) personal relationships with many patients
- d) your marriage will improve it's chances of survival and your children will be better prepared to deal with life's highs and lows
- e) you will become to know yourself as a human being and start to feel truly grounded about life –yours and others

## Why Now?

In my younger years, I would have asked how the *JREM* could possibly improve rural EM care. Seriously, there are over 20 EM journals in existence in 2014 and I am not sure that many practicing physicians (rural or urban) read any of them! My response would be three-fold. First, none of the existing EM journals includes a section for rural physicians to publish research, essays, or reviews. Since the majority of existing journals' subscribers reside in and practice in urban and academic settings, their reviewers and readers reflect this demographic. In addition, rural health journals currently lack sections devoted to EM. Therefore, rural physicians lack a representative voice in the House of Medicine and these impedes efficient, two-way "knowledge translation". Second, rural EM providers are often not physicians. Instead, they are physician extenders like physician assistants and nurse practitioners who are not eligible for membership in many existing EM professional organizations. Therefore, they probably do not receive any current EM journals or peer-reviewed sources of continuing medical education. Third, technology like telemedicine is rapidly evolving to close the geographical gap between rural settings and academia. Rural is not uniquely American, either. Rural settings exist on every continent and all will require emergency care at some point. The implementation science required to bridge rural providers with variable levels of EM training and academic medicine will require a peer-reviewed voice from both perspectives.

I proudly share the vision of the *JREM* Editorial Board and ACEP Rural Section to derive a high quality, broad-based curriculum for these rural providers. ACEP apparently supports these efforts, too, since the ACEP Strategic Plan includes multiple priorities with which *JREM* aligns.

**Goal 1, Objective A** – Identify, support, and promote delivery models that provide effective and efficient emergency medical and acute care in different environments.

The rural EM environment is different (low tech, generally lower volume, geographic isolation from tertiary care, limited access to specialists) and ivory tower recommendations from textbooks, research, and guidelines often lack representation of the rural voice. In addition, as noted above and in some of the research presented in this first issue of *JREM*, economic realities and the historical development of EM as a specialty mean that most rural EDs will be staffed by non-EM trained/boarded physicians or physician extenders for decades. Nonetheless, the science of EM must incorporate the rural setting and permeate practice so that these patients can receive effective and efficient medical care. The ACEP Rural Section is handing ACEP a viable solution for this objective.

**Goal 1, Objective B** – pursue solutions for workforce issues that ensure access to high quality emergency care.

This very first issue of *JREM* contains original research contributions detailing a few of the barriers to obtaining high-quality emergency care in rural settings. Future issues (and the textbook) will provide additional ideas for ACEP to provide increased access to high quality emergency care.

**Goal 2, Objective A** – increase total membership.

Although many rural providers would not be eligible for ACEP membership (non-physicians or non-EM boarded physicians), some rural providers will be eligible and *JREM* will provide a vehicle through which ACEP can do so.

**Goal 2, Objective B** – provide robust educational offerings, including novel delivery methods.

Developing, funding, and launching a new journal is truly novel for an ACEP section. Research conducted by the *JREM* Senior Editorial Board indicates that current EM journals have published less than one rural EM manuscript yearly for 20 years and that the trend is not increasing. In addition, as noted above existing “rural medicine” journals rarely publish EM-relevant research or reviews. Therefore, the educational offerings for rural providers are few, increasing the complexity of finding pertinent CME materials for the rural EM provider and acting as an obstacle to their engagement in ACEP.

**Goal 2, Objective C** – ensure adequate infrastructure to support growth.

Growth of ACEP in the rural market will require a meaningful voice for rural physicians within the organization. A meaningful voice means more than a Section that meets once per year and receives a half-dozen emails throughout the year. A meaningful voice includes a journal and textbook written by rural EM providers for rural EM providers based upon decades of experience in the unique rural setting. ACEP cannot attain any of the above objectives in the rural setting without this voice on behalf of these providers. CALS, the rural EM textbook project, and *JREM* provide viable methods to capture, deliver, and refine that voice, as well as a two-way source of information exchange between ACEP and the rural providers. In addition, rural providers exist worldwide in austere settings and ACEP could expand into these rural environments globally since no other EM textbook project, and *JREM* provide viable methods to capture, deliver, and refine that voice, as well as a two-way source of information exchange between ACEP

and the rural providers. In addition, rural providers exist worldwide in austere settings and ACEP could expand into these rural environments globally since no other EM organization currently provides a designated voice for these international rural physicians.

My final message is that rural providers ought to stand tall, be proud, and support the *JREM*. This journal is an impressive step forward so send it to your EM colleagues, both rural and urban. Consider submitting an essay, letter, or your research to *JREM*. Become a reviewer for *JREM*. Contact your state ACEP office and ask them to consider supporting this new journal, either through advertising or purchasing group subscriptions for all rural members.

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