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## PRESIDENT'S MESSAGE

Paul Windham, MD, FAAEM  
CAL/AAEM President

### Rural Emergency Physicians

For a decade, we have been witnessing the consolidation of healthcare delivery systems, with hospitals merging facilities or specific specialty services to reduce the overhead cost needed for a designated community or region. Trauma care and interventional cardiology are only two of the specialty services that have been affected, therefore becoming concentrated in large regional facilities. One force behind this change has been the increasing cost of maintaining the technical skills standards and equipment required to provide state-of-the-art care. Only large regional facilities can afford to purchase and maintain such equipment and to attract the staff and physicians needed to provide this specialized care.

This has always left rural areas in the lurch. However, the disparity over the years has continued to increase. I have long believed that if a rural town could have only one physician, it should be a specialist in emergency medicine. Stabilization of emergency conditions prior to transport to definitive care is one of the things we do best. As transport times increase due to regionalization and the closure of EDs, initial stabilization becomes even more important. The question then becomes, "How do we get specialists in emergency medicine to practice in rural areas?"

This has become of personal interest to me, as I am leaving a regional referral center to practice in a small rural hospital during this summer. For me, it was a lifestyle decision. I was once a wilderness ranger for the Forest Service in Oregon, and have always preferred the woods to the city. Most emergency physicians, even those from rural areas, prefer to practice in metropolitan areas. It is easy to see why: higher reimbursement, better clinical support in terms of equipment, support staff and on-call back-up, and more developed levels of

culture and entertainment are presumably available in a metropolitan referral center. The old song said it pretty well – "How are you going to keep them down on the farm after they've seen Paree?"

It comes down to incentives. Some physicians, like me, like the slower pace and close community ties that only rural areas can offer. That is obviously not enough incentive to meet our perceived needs to staff rural areas in California with specialized emergency physicians. We will likely need to develop financial incentives as well. Oregon has taken the approach of tax subsidies. They give a \$5,000 annual income tax credit to any physician practicing in a rural area. Increases in Medicare and Medicaid reimbursement for rural hospitals are currently in the works in Washington, but we should have those increases for rural physicians as well. With adequate reimbursement, we can have a fully functional and high-quality emergency services delivery system in rural California. If you crash your car while on vacation in Lassen National Park, you want a board certified emergency physician in Susanville who can put in a chest tube and drain the cardiac tamponade found with bedside ultrasound prior to transport to the regional trauma center in Reno.

We will have to work at the state and national level to bring this scenario to reality. Your active involvement in your specialty organization is essential. Your participation in our letter-writing campaigns, in our electronic news service, and in the annual California legislative conference is the vehicle to do this. Your financial contribution to our united EMPAC, the emergency physician political action committee fund, is the vital ingredient to carry your voice into the state legislative process.

Email us at [calaaem@aaem.org](mailto:calaaem@aaem.org) and we will be glad to provide you further details, to get you enlisted or involved, and to do our best to answer your needs and concerns.