

# PERSPECTIVE

## Stigma of Rural Emergency Medicine

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I practiced for 20 years in the rural, northwest corner of South Carolina, also known as “The Upstate.” It was my first full-time job after residency. The area is wonderful. It is a place of expansive lakes, white-water rivers and the mist covered foothills of the Blue Ridge Mountains. The area includes thousands of acres of Sumter National Forest. The natural beauty is breathtaking. Our various parks are laced with hiking trails, which are lined with unique plants and trees, some found nowhere else. Fish and game abound. In fact, our (previously) wooded hospital grounds once supported a flock of at least 30 wild turkey, and deer are common; bears are no surprise.

I still live in the area, although my job has changed. We have a lot of wonderful things here, things that are gifts of the rural life. We have good people, the salt of the earth types who care about personal morality and Southern courtesy. People who bring you a glass of sweet tea when your car breaks down. We live with a fairly low crime rate, although the rate of drug use seems to be increasing steadily over time. It's a good place to raise children, overall. It was, and remains, a rewarding place to practice, where a busy summer shift can bring an acute MI, a near

drowning (from inner-tubing on Class IV white water while drunk), a pit viper bite, a bull goring and many other pathologies and outstanding attempts at natural selection.

But, as physicians in a rural area, we have always paid a price. Because we have to endure a certain stigma. The stigma is this: if you practice in a small, rural hospital, you must be less than competent. Because if you were competent, you'd practice in a large, urban teaching/trauma center. I frequently faced this deeply ingrained belief when I spoke to the out of state parents of local university students. You could tell that they were hesitant. Many were from the urban northeast, and they exuded a discomfort with any physician willing to put out a shingle in a place so far off the beaten path. They want to know about the hospital, the consultants, my training, etc. And of course, this is fine. I understand that anyone might want to know the credentials of the person caring for their sick or injured child. But, as emergency physicians, I think we should try to dispel this unfortunate stereotype among patients. I don't mean only the notions about us, as physicians, but the real concerns about the quality of rural care.

Certainly, it's more than dispelling myths. We have to continue working diligently to ensure that rural care is excellent. We must work with our fellow physicians in referral centers, and develop plans and simple algorithms that

that guide us in managing patients in rural America.

By now it's axiomatic that rural hospitals have difficulty recruiting residency trained emergency physicians. I'm not surprised. Our training, mostly in large urban centers, tends to focus us on that type of medicine. We see trauma care as effective only when provided by trauma teams. We feel that cardiac care must be supported by immediate angioplasty and, if needed, cardiac surgery capabilities. During residency, we loved to hear the thump-thump of those helicopter blades...coming into our trauma bays with things that other facilities 'couldn't handle.' Our hearts thrilled at the thought of thoracotomies for penetrating trauma. (We forget, too easily, how comforting it is to hear those same rotors as they fly away from small hospitals with limited resources, who did their best with very little. I've been on that side far more than on the receiving side.)

In emergency medicine, in large centers, it's always reassuring to see roaming bands of residents and students descend to the department to evaluate admissions in the early morning hours. It's shiny and exciting, and it's very hard to resist. And frankly, it's easier than transferring patients! I must admit, I was a victim of the rural care myth myself at first. When I first came to Oconee Memorial Hospital, now Oconee Medical Center in Seneca, SC, I was happy about the job. But somewhere deep inside I felt that I had taken the low road. I felt that, if I were “a real doctor,” I'd have gone to a trauma center in a large city. And no wonder. I moved to a town of 5000 persons. I became the fifth doctor in our

group, seeing some 27,000 patients per year in a 10 bed ED, in a 120 bed hospital. We had one cardiologist, but no cardiac catheterization lab. We had no neurologist, pulmonologist, neurosurgeon, toxicologist, trauma team or pediatric sub-specialties. We had nine ICU and four telemetry beds. Although our group, our department and our hospital staff have grown dramatically since the time I arrived, it was and still is a far cry from Methodist Hospital of Indiana where I trained. Thankfully, the staff at Methodist prepared me well for the adventure of rural emergency medicine. And an adventure it remains!

Here's why. In my rural department, in this relatively isolated area, my partners and I had to practice a very autonomous form of emergency medicine. We had neither residents nor trauma team, and for years we didn't even have access to a helicopter service; everything transferred went at least 40 minutes away by ground. Most nights we were the only physicians in the hospital at all. We had to manage the difficult airway, obtain the emergent vascular access, make the transfer arrangements and call the poison center (or look up the data on websites) and all the rest. Like physicians at many rural centers, we did it all. Of course, the pathology wasn't really all that different from that seen by emergency physicians in urban areas, but the difference was, we didn't have options.

I use the past tense because I've embarked on a new career. While my excellent partners continue to provide the best care imaginable at Oconee Medical Center, I now practice full-time locums emergency medicine. But the points remain valid, since I have largely targeted small, remote hospitals from swampy South Carolina to snowy Colorado. And I can speak from experience when I say that emergency medicine in rural America still has a long way to go.

It certainly isn't an issue of dedication on the part of nurses, physicians,

paramedics or others. They're still doing great work, caring for the sick and injured in what some sadly refer to as 'flyover country,' as if one simply flies from civilized city to civilized city with a wasteland beneath. No, those folks working in rural America, those in medicine and those whom the medical system serves, are the ones who support us in so many ways. They mine coal, drill oil and natural gas, grow grain, produce and livestock, and fish in deadly conditions. Furthermore, they offer us recreation in beautiful places and they support manufacturing industries. And those just scratch the surface. They are the essence of America in many ways.

And yet, American healthcare still seems to leave them struggling. And from what I've seen, the struggles have only just begun. For instance, with ever-tighter rules on admissions and re-admissions, I don't really know how small hospitals will survive. Particularly those in areas with poorer populations, where Medicaid and Medicare are about as good as it gets.

In addition, from an emergency medicine standpoint, recruiting to remote areas and smaller facilities continues to be daunting. Average medical school debt stands at a stunning \$170,000 per student. Thus, it's financially very difficult for graduating residents to afford work in under-served areas. Loans don't repay themselves, and student loans are not subject to bankruptcy.

Of course, many primary care trained physicians transition into emergency medicine care. And here, the house of emergency medicine itself stands guilty. We may agree or disagree with the now historical practice of grandfathering for board-certification. But if we aren't doing the work, as boarded emergency physicians, then we should at least find creative ways to help those who are. Heaven knows there are enough merit badge courses in America; why not develop an extended, distance learning program to help and encourage rural

emergency medicine providers? Maybe we could also try to find better ways to help EM residencies establish rural rotations.

Physicians need to be educated not only in core skills and competencies, but in decisions by algorithm. In other words, we need to teach rural practitioners (whether trained in EM or other fields originally) 'when to hold 'em and when to fold 'em.' One of the keys to good rural emergency medicine is knowing the who, what, when, where and why of transfers. And the other is educating those in referral centers on the capacities of outlying hospitals. Not long ago I was working in a small critical access hospital, when I had to transfer a thunderclap headache patient. Her CT was normal, but her blood pressure was very high and it was the worst headache of her life. My facility couldn't run LP fluid. Mind you, I could have done the procedure, but the lab couldn't evaluate it. The accepting physician was incredulous. I also had to transfer a young woman for a rule-out ectopic evaluation, as the hospital where I was working could do neither formal pelvic ultrasound nor quantitative hCGs. You see, those places are out there, and even as we train folks to work in them, we need to train docs how to help those facilities by understanding, not resenting, their transfers.

Fortunately, there are now resources. And you're reading one: The new Journal of Rural Emergency Medicine will be flagship journal for all of us who practice in rural areas. It's also online at <http://www.jorem.org/index.php/jorem>. In addition, a rural emergency medicine textbook is being developed. Once available, this textbook belongs in every small, outlying ED.

However, as we press on in rural emergency care, another issue has come to my attention. Sometimes, smaller facilities are resistant to change. Like so much in rural areas, whether it's new businesses or new citizens, there can

sometimes be an attitude that says, 'we've never done that and we don't see any reason to start.' Whether it means changing staffing, contracting with a new group of ED providers, hiring mid-levels or adding diagnostic capacities like 24 hour ultrasound, hospitals (and the administrative and clinical staff members who have been there for years) need to open up their minds to the idea that medicine is not a thing fixed in time or space, but mutable and ever changing. If they can't afford a change, it's one thing. But to resist based on tradition is a terrible burden for a hospital and ultimately for the community it serves.

All across the country emergency physicians at small hospitals provide excellent, state of the art care for the injured, sick and dying. But they do so with less help, less resources, and in many ways more pressure than their friends and classmates in teaching centers. The view from the large centers sometimes gets skewed because only the

sickest patients are transferred to them. So it sometimes looks like the smaller facilities do a bad job. Actually, most of them give excellent care. But patients deteriorate and patients die in hospitals of every size; from massive university centers in the urban Northeast to tiny critical access facilities near the Arctic Circle.

I believe that our specialty should redouble our efforts to encourage graduating residents to go to rural areas. I'd like to see residents taught that they can contribute to the specialty as certainly in a remote area as they would in any large city in America. There is enormous need, and there are great rewards in making a rural area safer and healthier. There is tremendous satisfaction in being appreciated by patients who might have done poorly if not for modern emergency care. When my family and I drive home to West Virginia, through rural Appalachia, I often wonder who is staffing the

departments nearby, should we become intimate with a coal truck. I always hope it is someone well trained for the job.

Rural areas require that physicians sacrifice certain big city amenities, both professionally and socially. But the payoff is worth it. And if anyone reading this is considering rural emergency medicine, I encourage them to make a difference and go to the country. They won't regret it; I certainly don't.

Nevertheless, the interests and intentions of doctors are only part of the equation. As a specialty, we have to make those places better. Better financially and better professionally. And we all need to work together to insure that Americans in rural and remote areas have the same quality of care as anyone else.

It may take a while, but it's a goal worth pursuing.

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