



## **Emergency Rooms: Overwhelmed & Underfunded**

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**The difficulty of finding on-call specialists is just one part of a worsening situation.**

*Emergency care is one of the community's most important health care services - but problems are mounting for a constellation of reasons. John Loofbourow, MD, a member of the Editorial Committee and a retired ER physician, moderated a panel convened at the Medical Society on January 30 to discuss the crisis. The comments, edited to reduce their length, appear on this page. The panelists:*

- *Loren Johnson, MD, ER Director at Sutter Davis Hospital and President-Elect of the California Chapter of the American College of Emergency Physicians.*
- *Larry Maas, Chief Operating Officer of Sutter Medical Center, which has emergency departments at Sutter General and Sutter Memorial Hospitals.*
- *Ralph Koldinger, MD, gastroenterologist practicing in Sacramento since 1971, and President of Sutter Independent Physicians IPA.*
- *Charleen Milburn, Managing Director of the Government Relations Division, California Medical Association. She previously worked 28 years for state legislative and executive branches.*
- *Steve Maron, MD, former Emergency Department Director at Woodland Memorial Hospital and now President of Valley Emergency Physicians, which provides emergency medical care for about 20 rural Northern California hospitals.*
- *Harold Strauch, MD, orthopedic surgeon and Medical Director of Sutter Orthopedic Institute, whose responsibilities include creating the ER backup list for two Sutter hospitals.*

*Also participating were Robert Midgley, MD, Kaiser gastroenterologist and President of the Sierra Sacramento Valley Medical Society; Bill Sandberg, Executive Director of the Medical Society; Ed Rudin, MD, retired psychiatrist and Editor of Sierra Sacramento Valley Medicine; and Ted Fourkas, Managing Editor of the magazine.*

**Dr. John Loofbourow:** Please address the ER and on-call situations and their impact.

**Dr. Loren Johnson:** Emergency departments in California are overcrowded, overwhelmed and underfunded. The whole system is in danger of collapse. The on-call

backup problem is one of the most serious aspects of the overall emergency care crisis; it represents a loss of our most precious human resource infrastructure, one that would be very difficult to replace.

We can't just go out and buy more power at a higher price, like the utility crisis. Ambulance diversions and gridlock in our major cities can perhaps be likened to rolling blackouts; but it isn't going to be getting any better soon. Hospitals are losing money, medical groups are losing money, our best talent in medicine are leaving California and retiring from practice, with no hope or prospect of correcting the situation soon, save through legislation to reform the system.

The problem is not just an issue of ethics. All the stakeholders understand our shared ethical responsibility to take care of communities. It's also a huge question with respect to reimbursement for on-call services, including the standby component of service. Even if you were able to solve the reimbursement issues, you need to have system reform, so doctors can have a safe system to practice in. No one wants to be left holding the bag for patients who can't be given proper care.

**Loofbourow:** Is there a similar problem in smaller rural communities?

**Dr. Steve Maron:** Very much so. At the nuts and bolts level, a patient requires a specialist's care, but no one on your hospital panel is available. There is nobody on-call that day, so you call the larger hospitals in the bigger cities. What we find now is they are not interested in receiving our transfers, be it an uninsured or an insured patient. Sometimes we have to go to the largest, the University hospital, as the only hospital in the area that will accept a patient.

There's a lot of consternation in the emergency department as you try to find a physician to care for this patient, and the whole time you realize you are caring for someone beyond your level.

As the patients stay in your emergency department, there are fewer beds for new patients. Before long you have to put your hospital on diversion. Patients from your rural community can't come to your hospital, and they end up being taken long distances to physicians and hospitals they don't know.

**Loofbourow:** What percentage of the time is your hospital in Woodland closed to traffic?

**Maron:** The percentage is small, but it is growing. We go on diversion for a couple of hours at a time, maybe a couple of days per month. Marysville/Yuba City went on diversion in early January for the first time in 13 years, and now has been on diversion twice. Their nearest hospital is 30 - 40 miles away.

**Johnson:** Ambulance diversion in Sacramento reached its highest levels in history in the months of June, July and August 2000. Previous total diversion hours for the region were always highest in the winter, indicating that this is now a capacity crisis.

**Charleen Milburn:** The State Department of Health Services has estimated that there is a hospital on diversion every day in the state, so it is a massive problem.

**Larry Maas:** To bring that a little closer to home, in downtown Sacramento an emergency department is now on diversion almost all the time. If it's not Sutter General, it's UCD - or both. It has almost become the norm that somebody is on diversion.

**Loofbourow:** What's the situation about specialists on backup call?

**Dr. Harold Strauch:** There are too many calls for care in the emergency room, and too many days on-call. With poor reimbursement, there is not the opportunity to be like a

Robin Hood, to take it up in certain spots and give it out in another - there's just not that opportunity. So it's very difficult to get physicians to come in.

Only about nine orthopedic surgeons take calls downtown and that means each works at least three to four days a month. But they are also taking call at other facilities, Roseville and the like, and under those circumstances, it becomes three and four days a week on-call. Physicians are just not able to do that, given their families and other responsibilities.

**Loofbourow:** Is the situation the same in gastroenterology?

**Dr. Ralph Koldinger:** The burden on gastroenterologists in the emergency departments has been lessened by the hospitalist programs. We typically get involved in a case after someone has agreed with a hospitalist to admit the patient.

This issue varies greatly from one specialty to another. Orthopedic surgery is more impacted than some of the others. I suspect that cardiologists are called to the emergency room more often than gastroenterologists, and probably rheumatologists are very infrequently called.

**Loofbourow:** What steps could be taken to resolve this problem?

**Johnson:** Well, the first step is what we're doing here tonight, acknowledging that we have a collective crisis in health care and bringing medical staff leaders and hospital leaders together. Then we must involve the community, and develop public policy to address this as a public health care crisis.

We've done some good things so far. We've highlighted the problem in California, and it is now recognized to be a nationwide problem. We care about our communities, and our services - particularly emergency services, which are as essential as fire, police and other public safety services and health care infrastructure. It's our turn to make sure that this rises to the level of a public policy concern.

We're not going to solve all the problems of health care by focusing on this one issue, but it's a good first step that involves all elements of health care. The on-call crisis is a proxy for the ills of health care in general; reform in this area just might be a good first step in solving other problems in health care.

**Loofbourow:** Larry Maas, how does this problem impact hospital organizations?

**Maas:** Our health care system is struggling in so many ways, but this is one of a hospital administrator's worst nightmares. Because of the burden it places on physicians, particularly in certain specialties, it's a divisive problem that prevents us from building physician relations. If we could solve it with money, we would, but the funding for health care in most cases doesn't allow that - and most of our physicians tell us that there is not enough money to make them want to take ER call.

One reason our ER's are overwhelmed, underfunded and burdened is because many ER patients don't need to be there in the first place. Access to primary care physicians is a huge problem and another indication of underfunding in health care. When those patients can't receive care on a timely basis, where it is best and most cost-efficiently provided, they end up in an overburdened emergency department that sees the sickest first, requiring specialists who are already burdened with other activities.

**Ted Fourkas:** Is it a problem of too much population? Too little money? Too few specialists? What is causing all of this?

**Milburn:** There are many, many facets to the problem, but to build on what Larry was talking about, we know that over 9.3 million patients were seen in emergency departments throughout the state. Fifty-three percent of those patients were Medi-Cal, and we know

payment for Medi-Cal and the uninsured is either low or nil. Eighty percent of the uninsured in emergency departments are not there for emergency type services, they are looking for primary care services.

Emergency departments lost over \$350 million statewide, and physicians had another \$100 million of estimated losses. So right off the bat, we're looking at over \$450 million in lack of funding in the emergency departments.

There are other issues of access to specialties and on-call stipends and reimbursements, but it all starts with patients coming to the emergency rooms who should not be there.

**Maron:** I have a bit of disagreement about specialty backup. I don't think it makes a huge difference if patients are going to emergency departments "inappropriately," because specialists are only called for patients who require a higher level of care. If someone shows up in the emergency room and the emergency physician believes there is a need for a specialist, the patient is there appropriately.

**Loofbourow:** My experience is similar. Emergency rooms try to separate the people who have true emergencies from those who don't; but you still have situations where you don't have enough backup for people who desperately need care.

I'm trying to sort out what part of the problem is money and what part of the problem is the system.

**Johnson:** One of the problems is getting the critical mass for regional provision of services. It's awfully hard for three or four orthopedists to cover one emergency department, or one or two hand surgeons to cover a hospital. Regionalization of services into emergency centers of excellence would be one approach - to consolidate those services, deem them critical access services, and designate that facility as a critical access facility for that service.

Trauma centers, for example, would automatically qualify as critical access services. The trauma folks have similar huge problems over lack of funding, and trauma centers are pulling out of the system in Los Angeles. We would view trauma as a subset of emergency services. Indeed, you can't solve the problems of one without addressing the other. You have to have a coherent system. No part of the system can stand alone.

**Maas:** Outside of altruism and professionalism, why would anyone volunteer for a 3 a.m. call to take care of a high-risk condition with no promise of getting paid? And further, to subject themselves to the potential for a \$50,000 fine under the Emergency Medicine Treatment and Labor Act, and all the other liability and patient ownership problems, of situations that sometimes can be very cumbersome, not only to deal with on an emergency basis, but to deal with in follow-up.

**Strauch:** A number of orthopedists would be willing to take no doctor calls from the ER. They realize their responsibility to do it, but a number of situations really upset them. One is contractual arrangements with the hospital over which the physician has no control - such as when medical groups just send their patients to the ER. The groups are making money but not paying the physicians responsibly who take care of the patients.

Another is when ERs close. The patients get to an open ER, and someone has to see them right away and assume responsibility, a physician/patient relationship, a medicolegal responsibility. Yet the next day, when beds open up at another facility, the patient is transferred out, so the initial physician loses control and care is diminished. Frequently, people look for someone to blame for an injury, and the next thing you know, you're stuck with a medico-legal problem.

In orthopedics, we have another problem: the subspecialists, the ones who do just hips or knees. There is a tremendous debate in our hospital whether subspecialists, with basic orthopedic training some years before, are capable of handling everyday orthopedic

problems that show up in the emergency room, like a dislocated shoulder.

Generally, you do get rusty on things you don't do very often. I have some sympathy with this. Groups need to come together to draw on someone else to come in. Money is not going to change those things; collegiality will.

We need to get passion back into medicine, and I'm not sure how we're going to do that. Society has changed so much. People are moving here and there, and they have no roots - both patients and doctors.

These issues are every bit as important as money. Who is responsible, who is going to help take care of and direct these patients?

There's another problem we're dealing with in the ER. If we had enough nurses, we'd probably keep ERs open more. We build a new place at Sutter and then we can't open it because we don't have the staff. Those kinds of problems are probably not going to be solved with money and legislation.

**Milburn:** If relationships with patients aren't the same any more, is it the geographic mobility of Californians, or the movement from one managed care plan to another?

**Strauch:** In our community, probably the insurance programs are really making the greatest dislocation. On the other hand, there is a lot of movement of people. Look at the number of new people in Roseville, Rocklin - those places are just growing by leaps and bounds. There is not enough time for doctors and patients to get to know and trust each other. That contributes to the ER problem.

**Loofbourow:** From the standpoint of the hospital, Larry, do we have common ground to work on together?

**Maas:** Generally, yes, I think we do. There's no question that money will not solve all these issues, but it certainly will help, and it's a first step. Just recruiting qualified people to staff these emergency departments, for instance. Money will help, but recruiting is a critical issue in health care, and it trickles down to emergency care.

We will continue to have tremendous growth in the greater Sacramento area, but ER capacity is not keeping up with that growth.

**Maron:** When a Kaiser patient comes into the emergency department, I almost have a sense of relief, because I have access to whatever specialist I may need. If the patient is stable, Kaiser may transfer the patient to the specialist. If the patient is unstable, then Kaiser authorizes a specialist to come in. That may make it easier to find one. Many HMOs don't guarantee access to a specialist for their members. Kaiser, I think, does a good job there.

**Loofbourow:** Bob Midgley, do you have any thoughts about promoting the Kaiser model?

**Dr. Robert Midgley:** Well, we have a good model, because of close ties between the health plan and medical group sides. We do take ownership of the patients, whether they are in our ER or in somebody else's, and we try to get them back in our own system as soon as we can. I think we're probably similar to other insurance plans in that respect, but we're not in the habit of denying care. I don't know that you can extend the Kaiser Permanente model across the community, though; it hasn't happened yet, and we've been around for about 50 years. You don't have that closeness in other systems, and I think that's one of the problems with other systems.

**Johnson:** Physicians, especially those who may be interested in providing on-call services, should understand that the Bergeson Act of 1995 requires health plans to pay for

out-of-plan emergency care. It also requires that after the patient is stabilized, the health plan is to respond to a call from the emergency department within 30 minutes so that a mutual decision can be made on whether the patient needs to be admitted on-site or is stable enough to be transferred to an in-plan facility.

**Dr. Ed Rudin:** Why isn't that happening?

**Johnson:** The problem is that these are small claims made by individuals who have no ability to consolidate claims to health plans. Subcontracting entities, especially under Medi-Cal managed care, often have huge discrepancies in their payment performance. During the first three years of the Medi-Cal managed care program, there were over 30,000 appeals brought to the Department of Health Services with no action and, in the end, no definitive oversight by the state.

**Loofbourow:** How much would a stipend provision help ameliorate the on-call specialist problem?

**Strauch:** The two downtown hospitals do have stipends for some specialties - orthopedics is one - and most people tell me, "I don't care about the stipend. I don't want to take the call anyway." They have too many other responsibilities. It probably does influence a few people - those who get paid directly. The daily cost of your office is probably around \$1,000 per physician. Under those circumstances, you can't go very long without some money coming in, so the stipend can take care of office expenses for the day.

**Rudin:** Volunteer fire departments do a great job, but we know that when the city gets big enough, it needs to have a paid, full-time fire department. Should emergency departments have specialists on staff who are paid for providing services on-call, 24 hours, as needed?

**Strauch:** Yes, you could probably do that, but we can't even get any orthopedic specialists to come to Sacramento. We're desperate and we've got feelers out, and we're lucky to have maybe a couple of young orthopedists who went to school here come back to town, but nobody else wants to come here.

**Maron:** The model for what Ed is suggesting might be the trauma center, which has not only the hospitalists in internal medicine, but also an in-house general surgeon.

**Maas:** You can do it with regionalization and creating critical access services of excellence to address those specialties in acute short supply.

We have essentially accomplished what you are talking about via stipend, by reimbursing people on a 24-hour basis for standing by, awaiting a case. The stipend varies, depending on the burden of ER call. If there are lots of cardiologists, you can have high volume but the burden is relatively light. In orthopedics, we have two dynamics - the volume is very heavy, and we don't have that many orthopods to take that call, so their stipend is relatively heavy.

Stipends have evolved over the last decade, in Sacramento anyway. They have solved some immediate crises, where we've got a specialty that isn't covered; we have a regulatory obligation via EMTALA to provide coverage or close down that whole department. So we provide stipends. They have solved some short-term problems, but have created a tremendous amount of ill will.

I believe the situation is very different in orthopedics and in general surgery, as opposed to cardiology and ENT, but a lot of members of my medical staff don't agree with me. Stipends have been a slippery slope, in terms of the politics and the divisiveness as well as finances.

**Rudin:** Can one use a stipend to recruit orthopedists?

**Strauch:** Medical groups won't take someone new until they basically have his or her day full. The groups have to make some guarantees and so, generally speaking, no one wants to do that without knowing some funds are coming. It might help out, but I don't know.

**Johnson:** There are two services being delivered here - the standby on-call service and the actual service to the patient. Stipends tend to incentivize standby coverage. They don't necessarily buy the hospital better service, and they're not going to fund the cost of the medical infrastructure.

In fact, the California Health Care Association estimates that stipends are costing hospitals in California more than \$200 million annually, and the problem is getting bigger.

The bottom line is that we are in this boat of taking care of the community together, and we've got to get the oars rowing in the same direction. We must figure out what it's going to cost to rebuild the system. Our public trust is to have a system that works, and we have to decide how to do that first. No one else understands this system and can basically advocate for it like we can.

**Maron:** Kaiser physicians are in the same market area we are. It sounds as if this HMO has coverage for all the necessary specialists all the time. How is that achieved?

**Midgley:** We actually don't have great coverage in some specialties. We have problems with neurosurgery, for example. Kaiser facilities in Fairfield and Vacaville funnel neurosurgery cases to Sacramento. We have the same problems, overworked neurosurgeons who are very reticent to come out in the middle of the night, even though they have a responsibility to see these patients, because they've just been in the OR for 12 hours that day. We, too, have problems recruiting orthopedics. If you can't recruit orthopedists in the community, Kaiser is going to have trouble as well.

One helpful thing is our primary care structure. We have mechanisms for funneling non-essential patients away from ER's into urgent care centers and to primary care doctors. We lighten the load that way.

**Bill Sandberg:** A large for-profit HMO has such extreme access problems with orthopedists, they sent patients by taxi and ambulance to the Bay Area, to Stockton and to Folsom. They went to Kaiser and to the University to try to contract for orthopedic coverage. They said they were willing to hire an orthopedist and pay off that orthopedist's entire educational debt, if that individual will see their patients for one or two years. That's how severely pressed they are with 80,000 patients.

There may be some creative solutions that involve the HMOs themselves. They are not really looking forward to legislative solutions, which may be more painful than working with medical groups or hospitals to find solutions.

**Johnson:** The decimation of our on-call panels is not that different from the nursing shortage. The public just hasn't encountered the issues with the on-call problem as much as the nursing shortage, because we haven't done as good a job of making it a public health issue. But it's more deep-seated than the nursing shortage, because it's going to take a lot longer to replace this human resource infrastructure, this brain trust, intellectual capital, if you will, than it is to train and hire nurses.

**Maas:** What worries me is that we are narrowly dodging bullets, in terms of not just EMTALA violations and regulatory issues, but the kind of care that we want to provide. One of these times, it's going to hit the headlines, and we're going to have government reacting to a crisis orientation, instead of from a thoughtful, proactive process. We have to reach consensus on what we want to advocate to legislators, what we want to come out of that process.

**Maron:** We had a patient at a hospital who came in with an upper GI bleed. I called for a gastroenterologist and couldn't get one. I called for a second and a third. I couldn't get anyone. I had now transfused her six units. I called a general surgeon, and said, "Even though it's not your type of case, would you do it?" Finally, one gastroenterologist said, "If you promise not to call me again, I'll come in." He came in, but the patient died in the endoscopy suite.

And that's how it's going to play out in the papers. One of these is going to be the son, daughter, wife, mother of somebody prominent. At that point, it's going to hit the paper, and then it's going to get dealt with.

**Maas:** I'll give you another case. It's not as dramatic, but still illustrates the point - a hand case, just a complex hand case, not life-threatening. We wanted to save that hand and its function. The patient sat in our emergency department for hours and hours and hours until we finally had to transfer the patient to San Francisco because we could not get a hand surgeon locally who could handle that case.

**Milburn:** Is it a resource problem? Why are those calls not being answered?

**Maron:** Well, I called three GI doctors in the community. They were concerned about quality of life, giving up time with their family. None of the three asked about insurance. That wasn't the reason.

It's giving up quality of life. It's not having a relationship with the patient. It's that the patient is at risk of dying, and they may be held liable if the patient dies.

**Johnson:** A member of our association called me from a small town outside of Bakersfield, where they have a little hospital. They haven't been able to get a patient transferred into the city of Bakersfield for the past six months, and he sends all his hip fractures and strokes and the like 150 miles to Loma Linda. Sacramento is not alone in these problems, and it adds up to gridlock and massive amounts of suffering for patients.

The legislation that we're looking for may take a while to reach the level at which policy makers have to respond, but in my view, they will respond. This is not just a problem of indigent access. This is every person in California who gets into a car accident and can't get the timely care needed to save their lives.

**Rudin:** I'm not sure we have heard what we think the Legislature should do. What answers do we suggest?

**Milburn:** The California Medical Association looked at what we thought was causing the problem, and we took one piece of it. It's a big piece, a system reform, but it doesn't get to physician/ patient relationships. Our legislation doesn't get to the ownership of the patient, and it seems to me that what I'm hearing here is more important, or just as important, to the solution.

**Maron:** We've talked about legislation that requires the HMOs to provide emergency services for their contract patients. If the Legislature could mandate a fund that HMOs contribute to, based on the percentage of the population that they insure, that would provide adequate funding for paying for emergency specialty coverage. You could do it regionally or statewide.

**Johnson:** We've had this debate for quite some time in emergency medicine. You have to differentiate those plans - like Kaiser - that provide emergency services to their members and also provide the best level of reimbursement for out-of-plan emergency services.

The problem is on the network HMO side, and the scrambling effect of changes of plans and changes of primary care doctors, and identification of where the financial responsibility lies. The on-call problem has been with us for more than a decade. At first it

was an issue of defining responsibility and having an organized system. We had the resources then. On-call was based on good will - the whole system was based on good will. There was no issue of whether or not you were going to get paid. For most doctors, it was a professional responsibility that came with being part of the medical staff.

Now, all of that has been displaced by network managed care, as differentiated from Kaiser's group model managed care.

**Midgley:** Some of the problems of the supply of physicians is probably a federal problem that started 10 or 20 years ago. There was this belief that there were too many doctors, so the federal government started cutting back funding to medical schools, and then mandating that medical schools turn out a certain percentage of general practice specialties and cut back on the other specialties. Now we're paying for it.

The state could underwrite medical school tuition and medical school debt in exchange for students practicing in California when they get out, much like the military did. This may be something to propose to the Legislature.

**Johnson:** We're not going to solve this problem with regulation or bully-ragging physicians to take call. You have to provide the incentives for people to work in this system. That's not to say that the young doctors we recruit into the system are going to enjoy the lifestyles of some of their predecessors. But they need to make a decent living.

One problem is with our aging on-call infrastructure. Most of our solid specialists who have been providing coverage all these years have got their 401Ks and their grandchildren, and we can't expect them to continue bearing this load much longer. We have to figure out ways to recruit specialists and keep them in California. I particularly like Bob's comment about figuring out some sort of inducement. You don't solve the on-call problem without working on the whole health care system and problems of access.

**Milburn:** A couple of bills were passed last year to expand grants and loans to medical students, but the governor vetoed them. His focus was that the feds weren't kicking in enough money and that there shouldn't be state funds in this program. That concerns us, and we have been meeting over the last several months with the universities and medical schools to find out from them what kinds of incentives and work with the medical students will keep them in California.

Another issue is what Dr. Jack Lewin calls the "brain drain" in California. We need information on the 85,000 physicians in California. We estimate that 35-50,000 are in practice, but where are they? Are they leaving the state? If so, why?

**Maas:** Increasingly, even tonight, I've heard the analogy to our electrical system and its problems. We downsized the number of physicians intentionally, while the population in California was growing. Right away, there is an analogy to the electrical situation.

Just as we have to re-engineer our electrical distribution systems in this state, we may have to re-engineer this whole ER thing. I don't know the solution. But asking the Hal Strauchs of the world to continue to do this into the future is just insanity, it's just not going to work.

**Strauch:** We've heard why we're down. Not enough physicians are being trained. Young people's attitudes are different; they're eight to five-ers, and they will only take call if it's not more than once a week, or something like that. Nobody wants to do it. Some of the doctors have two-income families, so they don't have to work as much, and they don't want to. They want to be together and share things.

A tremendous number of physicians are not participating in the delivery of health care. They are doing management type services, protocols, and evaluations of data about outcomes and costs. Ultimately there are not as many people delivering health care to a larger population. It's ludicrous to say that everyone can be a primary care doctor, because

they can't - nor can you rely on them if you have a GI bleeder or a brain trauma.

There are just not enough specialists, and it takes a long time for the pipeline to produce some of those very heavy specialties.

**Maas:** Steve, do you foresee the end of the volunteer on-call panel, where people will do on-call work without being compensated?

**Maron:** It's pretty hard to be optimistic. In the low burden specialties, there are a fair number of specialists and a low frequency of call.

But, in the higher volume, or higher burden specialties - and there used to be maybe three of them, but now it looks like there are maybe seven - it's just insanity to think that they're going to continue to do it on a voluntary basis, or even with a stipend. So, I'm not optimistic.

**Loofbourow:** In emergency medicine, a lot of the younger physicians are a lot smarter than I was, and they don't work as hard. They're going skiing for two or three weeks at a time, and that's it, and they're going to spend time with their children. I applaud that.

**Rudin:** We haven't really acknowledged how much more we can do for patients when they get to the emergency room. Patients who might have been allowed to die as recently as 10 years ago now have a reasonable expectation of survival and function. But that takes more difficult and more time-consuming and costly procedures.

Have we paid sufficient attention to the change in our expectation about what to do for patients and the greater demand that this puts on doctors? It means that the volunteer physician can't be expected to do that. I go back to my earlier analogy with the volunteer fire department, a great service, but it's not the most sophisticated.

**Johnson:** By every measure, we're seeing older patients, sicker patients, dispossessed elements of society, folks who are byproducts of abuse. We're the substation for the criminal justice system. It comes right back to the fact that we're an essential public service that is expected to perform at higher and higher levels, not only for the specialty of emergency medicine, but for all of the specialists that back us up.

We are all in the emergency care business, and that business is getting extraordinarily complex. We somehow have to figure out how to meet public expectations.

It's merely a matter of time before government responds. We don't want to let that happen. We want to lead this change, and craft the system the way it ought to be, to serve our patients and our communities.

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