COMMENTARY

Re: National Study on the Contribution of Family Physicians to the US Emergency Physician Workforce in 2020

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Since our article a "National Study on the Contribution of Family Physicians to the US Emergency Physician Workforce in 2020"[1] was accepted for publication, the workforce in emergency medicine has continued to turn upside down. For the first time in the 40-plus-year history of the specialty, there is a surplus of emergency physicians in urban areas and larger communities. The COVID-19 pandemic and a number of market forces combined to create this sudden upheaval. This came as a shock to many, since only a few years ago most workforce experts predicted that the emergency physician supply might never meet the demand. A dramatic increase in the number of emergency medicine residencies, an increasing number of emergency department advance practice providers (APPs), and the "corporatization of emergency medicine" combined to create this surplus. The American College of Emergency Physicians (ACEP) Policy Statement on the Emergency Medicine Workforce was updated in April to reflect this new reality, describing that "that there will likely be a surplus of emergency physicians by 2030."[2]

But this national study by Bennett et al shows that there is still a maldistribution of emergency physicians, and it is unclear if the surplus of emergency medicine (EM) physicians will help rural emergency department (ED) shortages. ACEP recently collaborated with 8 emergency medicine organizations to "determine the current and projected supply (of emergency providers)."[3] But family medicine (FM) (eg, the American Academy of Family Physicians and the American Board of Family Medicine) was not included in this effort. This national study by Bennett et al provides essential data about the segment of the emergency medicine workforce that is not included in ACEP's workforce models. Although ACEP states it is committed to continued collaboration with other emergency medicine organizations, FM has little voice in these discussions.

A year before this, ACEP convened a Rural Emergency Care Task Force.[4] The task force report was released just before the surplus became dramatic but showed that without attention to the role of family physicians in rural EM, there may be "a far worse situation and forecast." They also discussed that many rural patients are being treated autonomously by nonphysicians. APPs (nurse practitioners [NPs] and physician assistants [PAs] working solo) have become the de facto solution to many rural ED staffing shortages. Patients who are not seen by a physician are the most at-risk population across the spectrum of rural ED patients. Staffing rural EDs with PAs and NPs working as solo practitioners should not occur, and when EM-trained emergency physicians (EPs) are not available to supervise, policy must advocate for supervision by FM EPs.

The task force also made recommendations on ways to incentivize more EM physicians to work in rural areas, which will be essential now that there is a surplus. They proposed more economic incentives for EM graduates and stressed

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See Related Article on Page 1221.

the need for the Accreditation Council for Graduate Medical Education to increase rural rotations for EM residents. They correctly describe that EM needs a "cohesive strategy" for rural EM workforce issues that integrates the role of FM EPs.

The "National Study on the Contribution of Family Physicians to the US Emergency Physician Workforce in 2020" is being published at a unique time in the history of the EM workforce. It provides crucial data that should not be ignored, since the workforce surplus in urban areas does not automatically solve rural ED shortages. It supports the task force's conclusion that ACEP needs to "better support rural EPs regardless of their EM training or EM board-certification status."

To see this article online, please go to: http://jabfm.org/content/34/6/1265.full.

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