

Welcome from the editor

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Practising emergency medicine in rural and small urban Canada isn't the same as practising in a quaternary care teaching hospital. In rural hospitals, emergency department (ED) physicians often perform all the procedures during a crisis, including intravenous starts, intubation, nasogastric tubes and orogastric lavage. All this while arranging the transfer to the city, monitoring a patient in labour, managing palliative care for a dying patient on the ward, helping the nurses bundle the patient for transport, and cat-napping so they can work in the clinic the next day. In small urban hospitals, emergency physicians have more resources, but can't call in residents or medical students to do admissions. Specialist back-up may be limited, and their specialists work in small call groups, so they need their sleep at night. And small-urban emergency physicians still have to know transport medicine.

Working definitions for the 2 contexts are still being

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refined. From an emergency medicine perspective, rural communities generally have populations under 15,000 and small-urban communities from 25,000 to 150,000. A typical rural ED has half a dozen family physicians on call from home or the office. A typical small-urban ED has part-time family physicians who work shifts, and several full-time emergency physicians, with variable specialty back-up and a CT scanner on site. Two-thirds of Canada's population and 90% of Canada's geography are primarily served by rural and small-urban emergency departments.

Geographic context has a profound effect on how emergency physicians translate research findings and clinical practice guidelines to their practices. Little research has been done on almost all aspects of emergency medicine practice in both rural and small-urban contexts.

In this issue, Dr. Lisa Shepherd, from a small-urban ED in St. Thomas, Ont., reviews a topic familiar to emergency physicians on the front lines in farming communities.

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