Episode: *Ethics Talk: Time as a Critical Resource in Rural Emergency Medical Services*

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[mellow theme music]

[00:00:03] HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. Emergency medical services, or EMS, are the most immediate health care resource for many US residents living in rural areas. EMS workers are also often a key resource available to some rural residents who need non-emergent health assessments like wellness checks. But even a short visit with a remote patient can require an EMS team to travel for several hours. Telehealth and air transportation capability can help EMS clinicians respond more efficiently or quickly in some cases, but the infrastructure required to maintain reliable access and integrate new service models can be slow to deploy and costly to establish and maintain. Resource shortages also mean that many EMS teams must rely heavily on volunteers.

One reason for resource shortfalls being so common in EMS operations is that most US states, including many with large rural populations, do not designate emergency medical services as "essential." And while it might sound surprising that potentially lifesaving services delivered when and where you need it most is viewed by some local governments as not essential, a reality in rural America is that EMS services are already woefully underfunded by state and regional officials and public policymakers. These and other challenges to EMS service delivery and resource management deserve our attention as a source of clinical, legal, and policy-level questions neglected in health care ethics and equity discussions.

Joining us on this episode to discuss how limited EMS resources are managed, and which legislative tools can help ensure countrywide equitable and reliable access to EMS services, is Representative Eric Emery, a paramedic, the emergency medical services director for the Rosebud Indian Reservation, and a representative in the South Dakota House of Representatives. [music fades] Representative Emery, thank you so much for being here.

REPRESENTATIVE ERIC EMERY: Thank you for having me.

[00:02:14] HOFF: One reality of rural health care in the US is that EMS might be called upon to administer what turn out to be non-emergent wellness checks. Can you give us a couple of examples of these and then explain how these kinds of calls influence EMS capacity and personnel limitations?

EMERY: Yeah, so, definitely. I mean, EMS, I think in a rural area—not just here in South Dakota, but probably in rural America—is that stopgap a lot of times for people who are, you know, don't have access to a primary care physician or just live in the middle of nowhere, and they don't have that easy access to an urgent care or a clinic or such. So they rely heavily on EMS to come do vital signs checks, blood pressure, come check their blood glucose level for their diabetes, come look at minor wounds and such that they may have. So a lot of times, if they choose to go to the hospital, those transport times maybe could be 30 minutes to an hour to a couple hours, depending on where you are. And that really leads to burnout, strain on reliability of ambulances to be able to respond to other calls. Because a lot of times in rural EMS, you may only have a handful of people that are able to respond because they're volunteer, and they just have to walk away from their job to jump on the ambulance. So they may not be able to leave their job during the day or in the middle of the night. They may know that that two-hour transport to X-Y-Z hospital is going to take a round-trip four hours. They got to go to work at 8:00. They may not be able to get back by then, so it strains their resources a lot.

[00:04:08] HOFF: Yeah, I'm glad you brought up time specifically there. Time obviously is a key resource for all health professionals, but especially for EMS, especially travel time specifically. So how does time management tend to differ in rural versus urban EMS settings, and what matters ethically about these differences?

EMERY: So I think a lot of times what I kind of point out to, especially my staff here in Rosebud, is that what we learn in EMT school, paramedic school, whatever it might be, whatever level they are, we get to see those interventions work. Whereas in a urban setting, that hospital or that emergency department may be five minutes away, three minutes away, so you may only have enough time to get basic demographics and a small amount of interventions. Whereas in rural America, or rural South Dakota, giving that drug, you may be able to see that drug really take effect, and you may have to continue that intervention, or you may have to change that intervention, depending on the severity of the patient. So you get to build a lot of critical thinking skills. And I always say that EMTs or paramedics, because of the roles that we sit in, we develop a lot of good critical thinking skills because we're always having to think two or three steps ahead of time to prevent that patient from crashing, or just anticipate what's going to, what may happen with that scene or with that patient.

[00:05:49] HOFF: Most US states do not designate emergency medical services as "essential," which means that the state is not required to provide or fund them. You know this, of course, because one of your political goals is to designate EMS as essential in South Dakota. But especially in states where opposition to tax funding of public services is robust, there can be little progress expected about improving rural EMS service. So can you help our audiences understand this relationship between taxation and EMS services?

EMERY: Yeah. So, in the bare bones of it, what I always tell people is, well, we don't have volunteer police officers. We have volunteer firefighters, we have volunteer EMTs, but that's becoming harder and harder to fill those roles because volunteerism is just

becoming something that people just don't do. And I don't know if that's a society change or what that is, but we just don't have volunteers like we used to, probably 20, 30 years ago. That's dwindled down a lot. So, what a lot of states have done is to implement EMS as essential service to gear funding toward making sure that we have recruitment and retention, able, that those services are able to buy new equipment, buy new ambulances, and then actually pay the providers themselves. Because a lot of times they are volunteers. When we say volunteers, they're not doing it completely free. They may receive some sort of stipend. I think a lot of the services I talk to, it's like anywhere between $50 to $75 a call that they get paid to go do that call, but that's not sustainable. You can't live on that. So, what a lot of states have done is to designate as an essential service, and that was one of my goals here in South Dakota.

[00:07:44] I've been in the legislature in Pierre for three years. I just finished my third session with South Dakota Legislature. And I had this idea about two years ago, but I knew it wasn't quite ready. What we like to say in Pierre is it's not ready for prime time, and I knew it wasn't ready for prime time. So I spent about 18 months just researching back and forth, talking to other EMS leaders in different states about what they did, a lot of older EMS professional leaders that are now retired that I knew just from various things over the years. So I talked to them, got some good ideas from them, went back to the Legislative Research Council with the South Dakota Legislature, and said, okay, this is what I want to do. Help me draft this piece of legislation. Originally when I got the research in South Dakota, it was going to cost about $50 million to get this off the ground. I went back, said, okay, well, what is a more realistic number? And we got it down at a good starting point to $1 million is what my legislation that I introduced this past session was.

What that would've done was created an EMS fund under the Department of Health, who would administer this grant program to give to one of or however many of the a-hundred-and, I believe there's 116 services in South Dakota. So they would be able to go into this fund, apply for recruitment or retention, employee replacement of equipment, or just whatever it is to keep their operations going, and then levy a tax, a .10 tax on every $10,000 of evaluation. I knew it was going to be a tough sell just because, say in South Dakota where we're really tightening our belt on spending, a lot of the money that came into South Dakota with ARPA and CARES money was dwindling away. And South Dakota's really good about making sure that they don't create programs on not-reoccurring dollars. So, this would've been one of them. So we looked at it. It wasn't something that was sustainable right now. There's a big push for property tax evaluation and fix here in South Dakota. So, to ask to add an additional tax on property tax now when the fight in South Dakota is to really decrease property taxes, it just wasn't the right time. So my legislation never made it past the hearing committee to go to the House floor or to the Senate floor for a vote.

HOFF: And ARPA, for listeners who aren't familiar, is the American Rescue Plan Act of 2021.

EMERY: Yeah.

HOFF: And the CARES Act is the Coronavirus Aid, Relief, and Economic Security Act.

EMERY: Yes.

[00:10:53] HOFF: A bill that you sponsored in 2023 that, as far as I understand, has passed, created a community paramedic endorsement in South Dakota. Can you tell us more about this bill and how it helps address some of these issues that we've discussed today?

EMERY: Yeah. So, to kind of understand what community paramedic is—so community paramedic, it's actually called community paramedicine—it's a health care model that extends the roles of paramedics to provide primary and preventative care in the communities, often in a non-emergent setting. So, what that is, is that these community paramedics will go out to the various residents or different parts of their response area and provide non-emergent care to them, whether that's kind of what most EMS is already doing—doing blood pressure checks, doing vital sign checks, doing blood sugar checks—and then really to focus on preventative care to stop these patients or these individuals from reoccurring clinic visits, reoccurring ED visits, and to provide health care in their home. What's interesting about that model, and what I pointed out to a lot of people, is that the Indian Health Service created a program called the CHR Program, the Community Health Representatives. And what they do is they go into the homes. They do exactly that. They check blood pressures, they take vital signs, they do wound care checks, various things that can just be done in a home. And then again, stopping the reoccurrence of clinic visits, ED visits. And Indian Health Service developed this in the late 1970s, and it took—and they're still doing it today—and it took 30 years before the rest of the United States really looked at this model, or maybe 25 years, looked at this and said, hey, this is really working. Let's try this. And it's really worked.

The problem with a lot of the community paramedic programs throughout the country is they're not a Medicare or Medicaid-funded program. There's not really a taxonomy code or a code to bill for that service. So, what ends up happening is that cost gets either put on the locality or gets put on a local health care system. And there really is no money to be made from paramedicine. It's to help cut costs or help cut losses in health care delivery to that health care system. That's kind of what it was really pushed for in a lot of bigger cities. In places like South Dakota, it would really close that gap where we have a very small amount of providers in small towns, so our EMS or community paramedics would fill that gap.

[00:13:49] And I recognize that two, three years ago that South Dakota did not have the ability to certify community paramedics. Being an EMS myself, or being a paramedic myself, I said, well, we need to fix that. It's not a very hard task to achieve, and it really wasn't. I mean, we were able to get it both through the House and the Senate fairly quickly in what's called the consent calendar. So there was really no debate on it. It got voted through both in 2023. This past session, I reintroduced it. Because of a minor glitch that was wording, I guess the best way to put it, there was some language that was hindering people from being able to, or paramedics, to be able to apply and become community paramedics. And quite literally, it was just changing "and" or

changing “or.” Or I’m sorry, changing “and” to “or.” And that’s all it fixed, and it will go into effect July 1st. So hopefully, we’ll see a lot more community paramedics here in South Dakota. Right now, from my understanding, there’s three people that are certified as community paramedics here in South Dakota, but they are not delivering community paramedicine as of about a month ago.

[00:15:08] HOFF: I wanted to wrap up with a question that we often ask our guests about what you think the most important thing for health professions students and trainees who are looking to get into EMS or having their first exposure to EMS, what should they know about this field?

EMERY: Compassion plays a huge role in your everyday functions as a health care worker and specifically within EMS. You’re going to see people at their worst because you are coming to them at a time where the event that they’re having is probably the worst thing that’s ever happened to them. So on top of compassion, you have to be ready to deal with a vast amount of emotions and really have those critical thinking skills because you’re dealing with their emotions, you’re dealing with the injury or the illness that they may be having, you may have to deal with family, you may have to deal with weather conditions. [theme music returns] So there’s just a lot of variables that fit into an everyday job as an EMT or as a paramedic.

[00:16:13] HOFF: Representative Emery, thank you so much for your time on the podcast. I appreciate you sharing your expertise with us.

EMERY: Thank you for having me. This was great.

HOFF: That’s all for this episode of *Ethics Talk*. Thanks to Representative Eric Emery for joining us. Music was by the Blue Dot Sessions. To read the full July 2025 issue on Rural US Emergency Medical Services for free, visit our site, journalofethics.org. For all of our latest news and updates, find us on Bluesky @amajournalofethics, and we’ll be back next month with an episode on Existential Health Care Ethics. Talk to you then.