The future of emergency medicine in Canada: submission from CAEP to the Romanow Commission. Part 1

Canadian Association of Emergency Physicians
Working Group on the Future of Emergency Medicine in Canada*

In April 2001, the Commission on the Future of Health Care in Canada was established. The Honorable Roy Romanow was given the mandate to "inquire into and undertake dialogue with Canadians on the future of Canada's public health care system" and "to develop recommendations that will ensure the long-term sustainability of a high quality, universally accessible, publicly administered health care system, for all Canadians."

The Canadian Association of Emergency Physicians (CAEP) recognized an obligation to share in this public dialogue, to communicate the current state of emergency medicine, and to identify the components necessary to achieve excellence in emergency care. The CAEP Advocacy Committee was asked to develop a document that would educate and enlighten the Commissioner. Basic themes were identified, and authors from across the country were invited to write brief, factual essays with achievable recommendations. The resulting series of essays was presented on April 30, 2002, at the Health Care Commission's open public hearing in Calgary, Alberta.

This article, part 1 of a 2-part series, includes discussions of Urban Emergency Care Delivery, Rural Emergency Care, Emergency Care for Children, Prehospital Care and Emergency Medical Services, and National Standards for Hospital Emergency Services.

Urban emergency care delivery: crisis and opportunity

Emergency departments (EDs) have a mission to serve their communities, providing rapid diagnosis and treatment for most medical emergencies, as well as resuscitation and stabilization of patients with critical injuries and illnesses. Urban EDs are staffed by specially trained physicians committed to emergency care. They work 24-hours per day, 365 days per year and treat all comers — notably people without family physicians and those without valid health care coverage who have been turned away by others. And while some view the ED as merely an access point to hospital-based care, it is important to point out that emergency physicians provide definitive management for most problems, admitting only 10%–15% of patients for in-hospital treatment. Emergency physicians also perform vital roles in the prehospital care system, serving on emergency medical services (EMS) advisory boards, as EMS system directors, as base station physicians, and training and testing paramedics.

Crisis in the ED

In recent years, hospital closures and bed reductions, without a corresponding increase in long-term community care facilities or home care resources, have reduced our sys-

* For a list of the members of the Working Group, please see the Appendix.
This 2-part series is adapted from the online version of "Emergency Medicine: Change and Challenge. The Canadian Association of Emergency Physicians' Submission to the Commission on the Future of Health Care in Canada" (www.caep.ca/002.policies/002-04.romanow/romanow-02.htm). An adaptation of the first paper in CAEP's submission, "Emergency Medicine and Universal Health Care: A Call for Compassion," by Ovens, was published as a Commentary in the May 2002 issue of *CJEM*.

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tem's acute care capacity. Long wait times for specialists and poor access to "elective" hospital beds force family physicians to refer sick patients directly to EDs. Surgical and diagnostic test delays drive many more patients to EDs — some because of medical deterioration and others to "jump the queue." Fee-for-service remuneration has fueled rapid growth in the "mediclinic industry," where fiscal incentives encourage physicians to "skim" easy cases and refer difficult ones to the ED. But when sick patients reach the hospital, there are no beds to admit them to and they remain in the ED. Emergency physicians have truly become gatekeepers to the hospital, and EDs are providing more care, more complex care and more prolonged care than ever — with fewer available resources.

There is a crisis in emergency medicine. Overcrowded departments; stretchers full; people in pain lying in hallways; patients vomiting into wastebaskets; patients deteriorating in waiting rooms; disillusioned emergency nurses and doctors looking for new careers. What's going wrong? Health leaders and administrators view the ED as something apart — a place where admitted patients come from but not an important department with a mission of its own. This is evidenced by two phenomena that are apparent in hospitals nationwide. First is the information vacuum: Canadian hospitals collect extensive inpatient data but have little interest in ED data. Most cannot track or describe their ED case mix, care processes, workloads, utilization, efficiency or outcomes. Without data, we cannot characterize our problems or solve them. Second is the failure of hospitals to maintain functional emergency care environments. In these difficult times, hospital administrators struggle to keep vital systems functioning. They might cut surgical staffing, but would never close all their operating rooms. They might reduce critical care beds, but would never shut down their intensive care unit (ICU). There is no hesitation, however, to close entire EDs by filling every ED stretcher with admitted patients from other services.

If there are more cardiac patients than a hospital can manage, they are cared for in the ED, not on cardiac wards. If there are more psychiatric patients than a hospital can manage, they too are cared for in the ED. In a hospital with 12 inpatient nursing units and 24 supernumerary patients, one solution would be to send 2 patients to each ward. An alternate solution would be to send 1 patient to each ward and hold 12 in the ED. Sadly, the solution invariably chosen by Canadian administrators is to hold all 24 in the ED.

Administrators would not allow large numbers of off-service patients to paralyze their operating rooms, their cardiac care unit, or any other service; but every day, emergency care providers are left with no stretchers and no functioning department — no place to provide care. Emergency patients are relegated to hallways and waiting rooms, where they cannot be treated adequately or humanely. Hospitals are not providing the basic needs for emergency care, and EDs cannot fulfill their mission to the community.

Solutions

The Canadian Association of Emergency Physicians (CAEP) and the National Emergency Nurses Affiliation have proposed a series of solutions. EDs have introduced outpatient programs for patients with blood clots and severe infections. We have expanded procedural sedation techniques so patients requiring painful procedures can have these performed in the ED rather than in the operating room. We have developed short-stay diagnostic and treatment units to treat asthma, overdoses and cardiac emergencies. All of these reduce the need for hospital admission, and these types of programs can and should grow in the years ahead.

Opportunities

Adversity breeds opportunity. Emergency medicine has, arguably, been the hardest hit medical discipline, and this provides the impetus for positive change. Rules, habits and systems that evolved when we had ample hospital beds and staff no longer work today. EDs must re-engineer care paths, increase efficiency and develop solutions rather than waiting for external solutions to be imposed. Caring for more patients within existing system constraints means an organized attack on admission rates and ED lengths of stay. Streamlining care paths, eliminating redundancies, expanding nursing roles, rapid testing and increased use of ED short-stay units will help us treat more patients in fewer hospital hours. Business models have much to offer. We must identify important ED-related outcomes, including access to care, disease-specific process measures, pain and symptom relief, patient satisfaction and system utilization. Given clear objectives, we can measure performance, provide feedback and monitor improvement.

Recommendations

1. Emergency care providers need a place to work. Hospitals that hang an "Emergency" sign above the door must have mechanisms of assuring that ED stretchers are available when sick patients arrive. For several years, ED directors have tried and failed to achieve this basic need. Legislation may be required to provoke necessary change.

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2. EDs need information. ED information systems should capture patient demographics, triage acuity levels, presenting complaints and ED diagnoses. They should provide critical process data, including waiting times for nurses, physicians and ED stretchers, as well as delays from admission to ward transfer. They should generate information regarding admission rates and resource utilization, stratified by care provider and case-mix group, and they should be capable of generating standard reports to monitor department performance.
3. Emergency medicine needs research — especially research into emergency care delivery. There are few opportunities for EM researchers, and the well-supported scientists in other disciplines have neither the interest nor the knowledge to address our problems. It is important to support scientists who work with test tubes, but more important to look at where the rubber hits the road — our emergency departments.

Rural emergency care

The emergency department is particularly important to the 30% of Canadians who live and work in rural environments. Qualitatively, the ED is a vital and integral component of the health care safety net on which rural Canadians rely. Quantitatively, the rural ED provides a substantial proportion of health care. Indeed, half of all emergency care in Canada is delivered in rural (population <15 000) or small-urban (population <100 000) settings.

Trauma care provides a window into the problems of rural health care delivery. A disproportionate 70% of traumatic deaths occur in rural environments, while only 30% of Canadians live in these areas. The mortality rate of a given traumatic injury in rural Canada is approximately twice that of a similar injury in urban Canada. It is a simple truth that many Canadians die because of the cumulative effect of weather, geography and distance to definitive care. Some Canadians, however, die because of a lack of emergency medical expertise in rural EDs. US studies have demonstrated that 15% to 20% of deaths in rural EDs are preventable, and that many of these patients die because of a lack of adherence to standard resuscitation protocols. Although no such studies have been performed in Canada, preventable deaths certainly occur. As a society we must strive to minimize these unfortunate outcomes.

The following anecdote illustrates some of the unique challenges of emergency care in rural Canada. A 22-year-old male is ejected from his car at 2 am and brought to the rural ED by volunteer paramedics who have only industrial first aid training. The patient is unresponsive, and the lone nurse covering the ED determines he is critically injured. She phones the family physician on-call and, until the physician arrives, the nurse and ambulance attendants do what little they can to keep the patient alive. When the physician arrives, it is quickly apparent that this man's injuries are beyond the capabilities of the rural hospital. The physician calls the nearest referral centre, but is told that they cannot take the patient because there are no ICU beds available. The next closest referral centre also refuses transfer because they have no specialist available that night (one of their 2 neurosurgeons has recently left for the United States). The third hospital has both an accepting physician and a bed, but because of the distance involved, the patient must be flown by air ambulance. Unfortunately, the air ambulance is understaffed and won't be available for another 5 hours. The rural physician, nurse and ambulance attendants continue caring for this critically injured patient even though they lack the necessary expertise. This unfortunate scenario or a variation of it is a common occurrence throughout much of rural Canada.

What are the lessons learned? Major injuries occur in rural Canada, and the rural ED must be prepared. Unique patterns of injury are encountered in the rural workplace, be it the farm, the forest, the mine or the fishing outport. Bad weather, poor roads, lack of vehicle maintenance and inadequate use of restraint systems contribute to increased mortality rates after motor vehicle accidents. Ambulance attendants are often poorly trained and inadequately equipped. Rural EDs typically have insufficient human and technological resources to manage acute illness and trauma. Nurses may not be trained in resuscitation, and departments often lack diagnostic capabilities and standardized equipment.

Rural EDs rely heavily on community-based family physicians and, of the 6000 physicians who practise emergency medicine in Canada, only 1000 are certified emergency physicians. Family physicians, however, may not be adequately trained in emergency medicine. In most jurisdictions in Canada, there is no mandated emergency medicine exposure prior to obtaining a general licence. Furthermore, a number of Canadian studies have revealed that graduates of family medicine training programs do not feel comfortable in the ED environment. Given the relatively low volume of critically ill patients, it is exceedingly difficult for rural family physicians to maintain competence or develop

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new emergency and resuscitative skills. Finally, the obstacles to accessing meaningful continuing medical education in rural environments have been well documented.

There is a greater problem than skill, and that is the marked decline in the number of family physicians even willing to consider working in rural EDs. Nationwide, many rural EDs have either closed or reduced hours because of physician shortages. On top of staffing and training concerns, the infrastructure necessary to provide regionalized care is often inadequate. There are difficulties accessing the resources of secondary or tertiary hospitals. In this era of remarkable communications technology, rural physicians are often restricted to the use of a telephone. The ability of receiving hospitals to assist and support rural hospitals is threatened by a lack of specialists or beds. The inter-hospital transport of patients often proves to be a logistical nightmare.

There are potential solutions. CAEP's Rural and Small Urban Committee has published a framework for the provision of emergency care in the rural environment. Entitled *Recommendations for the Management of Rural, Remote and Isolated Emergency Health Care Facilities in Canada*, the document identifies important and necessary components for the provision of high quality emergency care in the diverse environment of rural Canada.

Summary

Rural Canadians have relatively poorer outcomes from acute illness and injury. This relates in part to weather and geography, but there are many reversible contributing factors. Canadians are an innovative people and can develop strategies to minimize these factors. In particular, it is clearly within our power to effect positive change by reducing medical variability. Rural Canadians deserve nothing less than our total efforts to deliver timely, effective and compassionate emergency health care.

Recommendations

1. Recruitment and retention initiatives for rural health care providers should be aggressively pursued.
2. Rural emergency care providers should be supported through improved initial training and innovative continuing medical education initiatives.
3. Facilities, equipment, diagnostic capabilities and communications technology should be standardized and enhanced to meet the unique challenges of the rural health care environment.
4. Transport capabilities should be improved. Alberta's Shock Trauma Air Rescue Society (STARS) program is a model that should be expanded nationally.
5. New regionalized models for the delivery of rural emergency care should be studied and developed.
6. *Recommendations for the Management of Rural, Remote and Isolated Emergency Health Care Facilities in Canada* should be implemented nationally.

Emergency care for children

Emergency care for children is a significantly under-resourced area. Today, most pediatric emergency care is delivered by general practitioners, family physicians, pediatricians, and emergency medicine specialists in non-tertiary care emergency departments. In tertiary centres most care is delivered by pediatric emergency physicians working in collaboration with other pediatric sub-specialists and EM subspecialists. As a result, the level of emergency care provided to children is extremely variable throughout the country. There have been ongoing attempts to improve that care through various educational experiences, both in a postgraduate setting as well as ongoing continuing medical education; however, there remains a critical shortage of many of the resources required for appropriate pediatric emergency care.

The paper, "Critical pediatric equipment availability in Canadian hospital emergency departments," published in the *Annals of Emergency Medicine*, showed that many Canadian EDs are unprepared for pediatric emergencies and lack important pediatric equipment. Many have a low volume of pediatric visits, which prevents physicians from developing the level of expertise required to deliver optimal care. There is a lack of pediatric on-call coverage in rural and tertiary centres, and educational initiatives are limited because physicians often have difficulty getting away from their practices to attend training courses or gain necessary pediatric experience.

In May 2000, the Royal College of Physicians and Surgeons of Canada recognized the subspecialty of Pediatric Emergency Medicine. But these new fellowship programs need funding. The physicians now accepting fellowship positions will be the teachers for future generations of pediatric emergency care providers and will be instrumental in improving the emergency care delivered to children across the nation. Currently, the paucity of training slots

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leads many Canadian graduates to seek positions in the United States, where there are more job opportunities, better academic support, higher financial reward and less job stress. Training programs are part of the solution, but we must provide the opportunities and incentives to keep these skilled people in Canada.

In addition, there are major financial issues involving pediatrics and pediatric emergency care. Dealing with children requires more time but involves fewer procedures than adult visits. Thus, physicians are not remunerated for the complexity of care involving patients and their families. Massive fee inequities in all of the pediatric areas make taking care of children less financially desirable.

Public expectations require significant management, especially when it comes to pediatric emergency care. Parents and families need to feel comfortable that the care they receive in their local area is appropriate, and to understand when to seek emergency services or tertiary care.

EDs across the country require additional resources, ranging from pediatric equipment to additional pediatric education for those delivering care to children. Efficient ED management requires a team of providers who can identify patients' needs, set priorities, and implement appropriate treatment, investigation and disposition decisions. The *Canadian Paediatric Triage and Acuity Scale* (PaedCTAS) was developed by representatives from CAEP, the Canadian Paediatric Society (CPS), the National Emergency Nurses Affiliation and l'Association des médecins d'urgence du Québec to assist health care workers with the triage of children.

Centralization or regionalization of pediatric care may be useful in some circumstances, to take advantage of significant expertise in a particular area. However, pediatric emergency expertise must be available to all Canadians, even if it involves medical transport arrangements or remote consultation systems.

Recommendations

1. To enhance educational opportunities, additional Pediatric Emergency Medicine fellowship slots should be funded.
2. Pediatric emergency practitioners need easier access to education and experience. Educational opportunities through telehealth programs, Internet (Web-based) learning and electronic portals should be explored and implemented by federal and provincial governments through collaborative processes.
3. The *Canadian Paediatric Triage and Acuity Scale* should be implemented in all Canadian EDs to assist health care workers with the circumstances and unique conditions of children.
4. Minimum standards of care should be defined and adhered to by all departments delivering care to children.

Prehospital care and emergency medical services

High quality prehospital care, as delivered by EMS, is an essential component of a comprehensive medical care model. But EMS does more than transport patients; it enables us to reach out into the community and initiate medical assessment and care prior to the patient's arrival at a medical facility. It is truly a multidisciplinary program; it depends upon public (911) activation of the system, dispatching through central ambulance communication centres, first-response teams, tiered response by fire departments, paramedic services, land and air ambulance paramedic services, all with medical oversight and direction.

The cornerstone of prehospital care is medical assessment and treatment by paramedics. Across Canada there is a spectrum of prehospital care ranging from advanced first aid by first responders to delegated medical acts (DMAs) performed by critical care paramedics.

The scope of paramedic practice within any region should be based on local needs and appropriate needs analysis. Paramedic skills and protocols should not be implemented on a whim, nor based on a subjective sense that the skill would be useful. Rather, as much as possible, the medical care provided by paramedics should be evidence based, and the processes necessary for certification, re-certification and maintenance of skills taken into consideration.

A national classification of paramedic competencies, describing the levels of paramedics based upon a specified skill sets, should be adopted to ensure standardization of the different levels of paramedics and the skills sets they possess. This would facilitate a common national approach to patient assessment and treatment, as well as portability of skills between provinces. The *National Occupational Competency Profiles for Paramedic Practitioners*, recently developed by the Paramedic Association of Canada and adopted by the Canadian Medical Association for accreditation of paramedic training programs, should be used as the standard for the paramedic competencies.

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Medical direction and physician oversight is another key component of prehospital care. In order to perform delegated medical acts, paramedics must be certified by a physician. Furthermore, an ongoing quality assurance program is required to monitor the care provided by the paramedic for specific DMAs. The federal government should create a national body of Prehospital Medical Directors for the purposes of standardizing medical oversight on a national basis, and EMS medical directors should be coordinated provincially to facilitate standardization of prehospital protocols and policies.

An overall systems approach is required to ensure efficient and comprehensive patient care. Each link in the Heart and Stroke Foundation's chain of survival must be strong, and the links must be coordinated. All prehospital care services and providers must be integrated and in communication, so each knows the capability and scope of the others. This is especially important in communities with public access defibrillation programs and where fire services provide tiered response. Land and air ambulance services must be coordinated to realize the greatest advantage from the specialized services they offer. Where trauma centres have been designated, local, regional and provincial policies should guide the transport of patients to the most appropriate facility. Recognizing that hospital bypass will occur, local and regional policies are required to define appropriate criteria for ambulance redirect and critical care bypass.

Recommendations

1. Paramedic scope-of-practice should be based upon a local needs analysis and, wherever possible, evidence-based.
2. The *National Occupational Competency Profiles for Paramedic Practitioners* should be adopted as the national standards for the terminal competencies for each level of paramedic.
3. Medical direction and oversight is required to ensure appropriate certification and quality assurance programs.
4. Medical directors should be coordinated provincially and the federal government should support the development of a national EMS Directors forum.
5. All prehospital care services should be integrated, with open communication between the services. This is particularly important for public access defibrillation programs and tiered-response systems.
6. Local, regional and provincial policies should be developed to advance a systems approach to trauma and critical care bypass issues.

National standards for hospital emergency services

During the last decade, Canada's health care system has undergone dramatic change — most notably, the shift from institution-based care to home- and community-based care. In many provinces, changes have occurred too quickly for adequate community-based infrastructure to be established. These changes have had a tremendous impact on hospital EDs. Emergency department overcrowding, which first attracted media attention in the late 80s and early 90s, has continually worsened, leading to heavy reliance in urban centres on ambulance redirect or bypass because EDs simply have no room to accommodate additional patients. The ED "crisis" has become a regular feature in national newspaper and television reports.

Overcrowding is largely attributable to system change: hospital restructuring, hospital closures, acute care bed closures and shortages of long-term care facilities, community and home care resources. Nursing shortages exacerbate the problem by effectively "closing" beds that cannot be staffed. Delays in surgery and diagnostic testing, and poor access to elective hospital beds contribute to the overloading of EDs.

Gatekeeping

In this milieu, EDs have evolved beyond their traditional acute care role to become key players and gatekeepers — determining how patients move through the health care system. The shortage of acute care beds means that every ED patient being considered for admission must be carefully screened and assessed not only by ED staff, but by other health professionals now routinely affiliated with the ED: community-care case managers, social workers, discharge planners, long-term care planners, and others, with a view to managing the patient in the home or community rather than in an acute care bed. Patients who are deemed worthy of admission often wait in, and are treated in, the ED for many hours or days until an acute care bed becomes available.

Patients who require further acute stabilization, and who in previous years would have been admitted to hospital, are now often treated in ED observation units (clinical decision units) for up to 24 hours prior to discharge. Some hos-

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pitals have established specific types of observation units, such as chest pain clinical decision units, to reduce the need for admission to critical care beds where the patient–nurse ratio is higher. Patients who require crisis placement in long-term care beds are often admitted to such beds directly from the ED or admitted to in-house acute care beds, again requiring multidisciplinary ED team assessment. Patients who are discharged from acute inpatient beds and those awaiting transfer to another facility for admission may be sent to the ED to wait for transfer or pick-up, and some EDs have established discharge or holding units for such patients.

Many hospitals have set up ED fast-track areas for the walking wounded and worried well. Whether in the ED or in off-site urgent care centres, these areas manage the less urgent cases who present to the ED because "after hours" service is needed or because time and work pressures are best met by the unscheduled convenience of the ED.

The safety net

Street kids and the homeless are increasing in numbers. These populations rely heavily on hospital EDs for both primary and emergency care needs, to the extent that some hospitals have established special areas within or adjacent to the ED to care for these patients. With psychiatric hospital closures and the move to manage mental illness in the community (despite inadequate community infrastructure and shortages of mental health professionals), the need to provide ED crisis management services and arrange follow-up for day programs and other community psychiatric programs has risen dramatically.

EDs are now barometers for the overall status of the health care system, and are best positioned to undertake this new role in the restructured health care system. Twenty-four–hour emergency care is an essential component of all health care delivery systems, and EDs function as the safety net for the health care system, providing unplanned but necessary health care. Despite this, the degree to which individual hospitals support their own ED in maintaining efficient 24-hour access is highly variable

Minimum requirements for hospital emergency services

ED service levels, staffing, policies and procedures vary greatly across provinces, regions and cities, and between rural and urban areas. Many hospitals still have not recognized that problems in their ED reflect hospital-wide and often region- or system-wide problems requiring broad-ranging actions and policies. Multiple hospitals serving a particular patient population often fail to collaborate on issues that bridge across facilities and require regional initiatives. Coordination between prehospital care, primary care and long-term care systems is also lacking. In an effort to enhance organization and consistency, there have been several initiatives to define minimum requirements for hospital emergency services. All specify the following necessary conditions to meet public and professional expectations for safe, efficient emergency care:

- service that is operational and accessible to the public 24 hours/day, 365 days/year;
- an administrative structure to facilitate effective and clinically accountable emergency care delivery;
- defined minimum basic skill set for all health professionals within the department;
- standardized minimum equipment and drug formulary.

The National Health and Welfare (HWC) Guidelines for Emergency Units in Hospitals (1981, 1988) attempt to categorize emergency units based on differing ability to deliver emergency services, considering geographic location, population served and availability of other medical services within the community at large. The HWC guidelines recognize the emergency unit as an intrinsic part of the hospital, one that functions within an overall emergency health services system, and which therefore should not be considered in isolation but as a component of an integrated system of care delivery.

In 1989, in response to recommendations from inquest juries and complaints from the public, the Ontario government released Guidelines for Hospital Emergency Units in Ontario. These include operational requirements to ensure that emergency units are capable of providing prompt effective care, and they also articulate the responsibility of a hospital board to ensure that the scope and capability of the emergency unit are stated in the hospital mission statement, and that supporting policies and management practices are in place to ensure that the unit is operational and accessible to the public at all times. Key policies and practices specified in the Ontario guidelines are:

- admission, discharge and bed management policies;
- responsibilities of attending medical staff;
- delegation of medical acts;
- manpower planning, deployment and qualifications;
- ambulance access policies;
- data collection;
- quality management.

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In 1997, CAEP published *Recommendations for Management of Rural, Remote and Isolated Emergency Health Care Facilities in Canada*, which defines 5 levels of rural emergency departments, each with an identified list of required equipment, drugs, diagnostics and protocols. The CAEP document also recommended that all rural physicians have the same basic emergency procedural skills, and that rural health care services and facilities be regionalized in a systematic fashion to ensure adequate patient access.

Unlike standards, which have enabling government funding, mandate compliance, and specify the achievement of performance objectives, all of the described guidelines lacked administrative clout, therefore achieved less than they could have.

Given the growing burden of problems and expectations facing emergency departments, there has never been a greater need for an organized and integrated emergency health services system. An essential first step in creating such a system is the development of national standards for hospital EDs, which establish a blueprint and framework for the provision of hospital emergency services in Canada. The standards should be focused on patients and based on evidence or best-practice. They should build on the strengths and avoid the weaknesses of previous initiatives, and they should clearly address the expanded role of today's hospital emergency services. Regionalization is essential for the development of a seamless system of care for acutely ill and injured patients. Emergency department categorization, based on a "levels of care" approach, is the first step towards effective regionalization of emergency services, and a critical component of any standards-setting endeavour. Standards should address the key elements of regional coordination: system planning, patient care activities, utilization, quality management, data collection, performance evaluation, and research. Standards must also provide direction to hospital boards, administrators, and local and regional health planners to ensure that:

- hospital EDs are capable of providing rapid assessment, resuscitation, stabilization and treatment of patients with emergent or urgent problems that may threaten life, limb, or function, and where indicated, arranging timely admission or safe and expedient transfer to a hospital offering a higher or definitive level of care, or discharge to an appropriate community-based health care service;
- emergency patient care, operations, utilization, and deployment of hospital and ED resources are optimized with respect to efficiency, effectiveness and access;
- the ED is accessible to the public 24 hours a day, 365 days a year;
- hospitals operating at similar levels and within networks of hospitals achieve greater consistency in providing quality emergency care with improved patient outcomes;
- hospitals commit to a systems approach for the delivery of emergency care within a region — including integration with the prehospital care, primary care, long term care and community-based care sectors;
- consumers are informed regarding the level of care capabilities of hospitals providing emergency services in their area, as well as other appropriate sources of after-hours care (where available);
- consumers are enabled to use emergency services more effectively;
- where appropriate, consumer self-care is supported and facilitated.

Equally important, the standards must acknowledge that emergency medicine and emergency departments are specialty areas of medicine.

Recommendations

1. The federal government should undertake the development of national standards for hospital emergency services as an immediate priority for improving the Canadian health care system. Such an endeavour would ensure that the emergency services are comprehensive, universal, portable, and accessible — guiding principles of the Canada Health Act.
2. This initiative should be conducted under the auspices of CAEP and appropriately resourced by the federal government. The standards should be evidence- or best-practice-based and should address day-to-day as well as extraordinary emergency services issues (e.g. ED overcrowding).
3. The federal government should require provincial and regional health authorities to implement the standards through mandated provincial policy or legislation, and to monitor and evaluate compliance through comparative peer group performance indicator reporting.
4. The federal government should commit to supporting regular review and updating of the national standards.
5. Federal transfer payments for health care services should be tied to provincial compliance with these and other national health care standards.

The development and implementation of national stan-

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dards for hospital emergency services, if supported by the federal government, could represent a major step toward the creation of a comprehensive, seamless emergency services system in Canada.

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