Putting Patients At Risk:

Interviews with Ontario Paramedics on the Consequences of Closing Local Hospital Emergency Departments

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Who We Are

The Ontario Health Coalition is the province's largest and broadest public interest group working to protect and improve our public health care system. We are a non-profit non-partisan coalition comprised of a network of more than 70 local health coalitions in every part of Ontario, more than 400 member organizations and thousands of individuals committed to preserving our public health system under the principles of the Canada Health Act. Our members include seniors' organizations, nurses, health professionals, unions, doctors, ethnic and cultural organizations, women's groups, students, municipalities, non-profit health and social service agencies, patient advocates and many others. We are funded through donations, memberships and monthly giving plans from individuals, and we do not accept any corporate funding.

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Background on Paramedic Services in Ontario

In the in-depth interviews in this report, we have surveyed more than 50 primary care and advanced care paramedics in every geographic region of Ontario to get a true picture of the impact of small and rural hospital emergency department closures for ambulance services and the patients they serve. These interviews comprise a representative sample of the paramedics working in the areas threatened with emergency department closures.

In Ontario, paramedics are classified according to their level of certification. Paramedics have a defined scope of practice – that is, they are authorized to perform certain medical acts – according to their level of training or paramedic certification. The minimum level of certification is "Primary Care" paramedic. There are three different levels of training for paramedics for land ambulances:

- Primary Care
- Advanced Care
- Critical Care

Each level of certification has a defined scope of practice – or set of procedures that the paramedics are trained to provide.

In Ontario, the majority of paramedics are Primary Care paramedics. Some regions of Ontario are served exclusively by Primary Care paramedics. Many regions also have Advanced Care paramedics who have a broader scope of practices, but they are fewer in number and are not found in all regions of Ontario. Critical Care paramedics have the largest scope of practice, and this certification requires many years of training and experience. Critical care paramedics are the smallest in number and many regions have no critical care paramedics.

Method

This report is based on in-depth interviews with 50 paramedics of different levels of training in all geographic regions of Ontario. The interviews were conducted in May and June 2009.

Classifications of Paramedics Interviewed

Advanced Care (Level II) – 27%
Primary Care (Level I) – 71%
PCP Plus (Primary Care plus additional training) – 2%

Areas Covered by Paramedics Interviewed

Southwestern Ontario
Dunnville
Elgin County
Hagersville
Jarvis
Lambton County
Norfolk County
Oxford County
St. Thomas

Central Ontario
Barrie
Simcoe County
Wasaga Beach

Hamilton- Niagara and Region
Ancaster
Burlington
City of Hamilton
Flamborough
Fort Erie
Glanbrook
Grimsby
Hamilton-Wentworth
Haldimand County
Niagara Region
Pelham
Port Colborne
Saint Catharines
Six Nations
Stoney Creek
Welland
Winona

GTA
Brampton
Mississauga
Township of Caledon

Northern Ontario
Algoma East
Algoma West
Beardmore
Blind River
Chapleau
Duberville
Echo Bay
Elliott Lake
Gearaldton
Greenstone
Hornepayne
Jellico
Killarney
Manitoulin Island
Manitouwage
Nekina
Nipigon
Orient Bay
Ouimet Canyon
Rocky Bay Indian Reserve
Sudbury
Terrace Bay
Thunder Bay
Upsala
Wawa
White River

Eastern and Southeastern Ontario
Bancroft
Barry's Bay
Belleville
Brighton
Cobden
Cobourg
Hastings County
Dacre
Deseronto
Foymount
Frontenac County
Gananoque
Havelock
Kawartha Lakes
Kingston
Lanark County
Leeds and Grenville Counties
Lennox & Addington County
Napanee
Northumberland County
Pembroke
Perth
Peterborough & Peterborough County
Picton
Port Hope
Prince Edward County
Quinte West
Rankin
Renfrew
Renfrew County
Smith Falls
Trenton

Summary

In the in-depth interviews in this report, we have surveyed more than 50 primary care and advanced care paramedics in every geographic region of Ontario to get a true picture of the impact of small and rural hospital emergency department closures for ambulance services and the patients they serve. These interviews comprise a representative sample of the paramedics working in the areas threatened with emergency department closures.

Key Findings

- Every paramedic expressed concerns about the closures of local emergency departments.
- Every paramedic we interviewed stated that ambulances cannot replace the functions provided in local hospitals' emergency departments. A list of the services that paramedics cannot provide in ambulances is in Section II of the report.
- Every paramedic gave concrete examples of how the plan to close local Emergency Departments will increase risks for patients, worsen wait times, deprive communities of access to care, or cause poorer care outcomes and even death.
- Most paramedics reported, from their experience, that the plan to close local emergency departments would lead to new costs for more ambulances, more paramedics and more training requirements. These have not been put in place in any area where the local ERs are under threat of closure.

The claims that equivalent or better care could result from the closure of a local emergency departments led the Ontario Health Coalition to do in-depth interviews with 50 paramedics of different levels of training in every geographic area of Ontario. The goal was to determine the clinical implications for patients of closing down local community emergency departments and the impact on regional

Ontario's Paramedics Respond

What does the closure of local Emergency Departments mean for patients? For ambulance services? Can you replace all local Emergency Department care in an ambulance?

In Their Own Words

"To take the small town hospital away would put a huge hole in the health care system, not just for the immediate community, but for the whole province it'll strain the system."

"It denies access to a good portion of the patients we service and it'll put extreme pressure on ambulance services because we're already experiencing offload delays and it'll just increase those offload delays."

"Ultimately this will result in patients dying because they need care from a physician. Ultimately patients will die, without question…and those that survive will have poorer outcomes. The longer patients wait before they have definitive diagnosis and care in an emergency department with physicians the greater the chance of a permanent deficit as a result of the injury."

"An ambulance is an uncontrolled environment. We don't have diagnostics. A CTAS 1 patient needs blood work, x-ray, that sort of thing. You can't sustain life in a 10 by 12 area. We don't have the drugs that may be needed, we have a handful, but not the whole gamut of drugs."

"… you're going to require physicians. You can't replace them in an ambulance. That's absurd."

ambulance services. Could local Emergency Room care not only be replaced in ambulances, but patients could somehow be safer traveling further for their emergencies? The answer was a resounding "no".

Paramedics save lives. They are a vitally important part of the health care system. The paramedics we interviewed expressed pride in their work and the care that they are able to provide. Many gave examples of excellent care provided by paramedics and the importance of pre-hospital care. Many spoke with frustration about long offload delays in which they are held up waiting with patients in overcrowded emergency departments. Many reported that the offload delays are already a serious problem – even before the planned ER closures. Many reported a need for more support for paramedic training.

There was total consensus among the paramedics we interviewed across Ontario that the plan to close local emergency departments will put patients at risk.

"We don't have x-rays, chest tubes, advanced airway techniques. I can intubate someone but if the intubation fails I have no backup adjuncts. You can do a chest needle but if that fails I can't do a chest tube. There is equipment at the hospital I don't have and it's just me, on person. It's not the same as a team of people. If you're lucky you might have a fireman to hand you things, but it's not the same."

"We can't initiate IV therapy, intubation, advanced cardiac life support, and under advanced cardiac life support includes drugs. We can't do manual defibrillation. We can't pace them. There's no blood products. There's no capability for central lines. These are things physicians would be able to do."

To say we can provide all the care necessary is an impossibility – we're not ER physicians. There's no way we can put the equipment required in the back of an ambulance. For example CTAS level 1 and 2 patients, car accidents. You get a good multi trauma. That patient needs blood work. They need diagnostic procedures to determine the severity of their injuries and the course of action….Sure you can stack your shelves in an ambulance, but they need blood transfusions and we don't have the blood. If you spread the blood out among all ambulances it would make the shortage of blood worse. Plus you'd need refrigerator units to keep the blood cool. It's just not feasible."

Widespread Misinformation Among Politicians and Local Health Integration Networks (LHINs)

The provincial government is moving forward with plans to close emergency departments in local hospitals in small, rural and large communities across Ontario. These plans have been created by local hospitals and by Local Health Integration Networks (LHINs) as a result of provincial hospital budget underfunding which has pushed more than 70% of Ontario's hospitals into deficit. Subsequent to the decision to cut services, LHINs and political figures have developed a "quality of care" rationale.

> *"McGuinty says he supports the plans to consolidate ER services, saying it's about creating a centre of excellence so people can receive better care. He says he knows it's a difficult decision for the community, but his responsibility is to ensure the best quality of care."*
>
> Canadian Press, "McGuinty Defends Health Care Ahead of Protest", April 29, 2009. Premier McGuinty made this mistaken claim to the media in response to a protest of several thousand people at the legislature over the closure of local emergency departments

Clinical rationales for the plans to close local emergency departments by LHIN officials and MPPs exhibit a disturbing degree of confusion and misinformation. In some areas, Local Health Integration Board members have claimed that ambulances can "replace" emergency departments without worsening patient outcomes. Politicians – and even the premier - have used the term "Centres of Excellence"(meant to delineate facilities for highly complex, highly specialized and often less common health care procedures) when talking about regular hospital services such as birthing, inpatient beds or emergency departments that are not highly specialized. For these services, the moniker "centres of excellence" does not apply; for example, there is no such thing as a "centre for excellence" general care emergency department.

In no case where an emergency department is under threat of closure in Ontario have these officials commissioned nor produced any studies projecting the impacts of ER closures on patient outcomes and mortality.

It is our hope that this study adds a credible resource and an urgent voice to those municipalities, physicians, nurses, hospital workers, patient groups and others who have been working to get the provincial government and the LHINs to more seriously assess the consequences of their policy of small and rural hospital emergency room closures.

Section I

100% of Paramedics had serious concerns about patient safety, long waits, less access, poorer outcomes or even death as a result of closure of local Emergency Departments

We asked the paramedics their response to the government's plan to close local emergency departments. The responses were unanimous. Every paramedic expressed serious concerns that emergency department closures will lead to longer wait times, less access to ambulances as they are forced to drive patients further, worse patient outcomes and even increased death rates.

In particular areas, such as St. Joseph Island (near Sault Ste. Marie) where the hospital ER is slated to be closed, paramedics pointed to poor weather and closed roads making access to other hospitals impossible. In Hamilton, paramedics noted that many hospitals are already regularly redirecting patients to other ERs and the closure of McMaster's ER for adult patients would likely worsen this situation. In Niagara, paramedics worried about losing the vital "stabilize and transfer" function provided in the ERs slated for closure in Fort Erie and Port Colborne.

In every geographic region, paramedics noted that offload delays (the length of time they have to wait in Emergency departments with patients) are already very lengthy in the larger centres and in some medium sized hospitals. Paramedics reported deep concern about the worsening of offload delays as a result of the closure of local ERs. In fact, before any further services are removed, the concerns reported by many of the paramedics about current offload delays – and their impacts on access to pre-hospital care - warrant serious attention.

In many cases paramedics expressed in strong language that the plans to close local Emergency departments are ill-conceived, and that consequences for patients, paramedics, hospitals and municipalities have not been duly considered by political decision- makers.

<u>What They Said</u>

Q. Have you heard of the provincial government's plan to close emergency rooms? What do you think of this plan?

"I don't think [the closure of the ERs] plan is a very good one at all. If you close the hospital – emergency specifically – that means I'd have to go to a bigger centre. In this area that would be London. So that means I have a longer transport time. If I have someone whose life is threatened their chance of survival goes down….Patients will have limited medication available to them until they get to a hospital. In an ambulance, there is going to be more stress on a patient because they

are in the back of a vehicle. And when I get to London there are already 2- or 3- hour delays. Can you imagine how long it'll be if they have to take all these patients from outlying areas?"

"I think it's terrible. These emergency rooms are already overloaded and if they close the ERs, the other hospitals are just going to be more overloaded. We already have offload delays of up to 6 hours and that problem will just increase, and it will just spill into the neighbouring regions."

"The less ERs, the longer the travel times, obviously. Depending on what we are treating you for there could be dire consequences if you are in need of advanced life support."

"I think it's a bad plan. My transport times would obviously be significantly higher, certainly it would put the public at risk as far as transport times."

"Patients are going to go to the urgent care centre when they should go to the ER at another hospital and we'll have to transport them from one hospital to the other. That is what already happens in Kingston [where they closed the Emergency at Hotel Dieu Hospital]."

"I think it's idiotic. Totally idiotic. They're talking about performance agreements which are nothing more than fiscal targets…. Our big concern from the EMS [Emergency Medical Services] standpoint is that if they become urgent care centres then they become ambulance unfriendly so that means we have to hang onto our patients for upwards of 45 minutes longer than we had to before."

"They've already done one [closed the ER at Chedoke Hospital in Hamilton] which were against. Closing McMaster's ER to make it a children's hospital makes longer transport times for the patients. We're already busy and closing one hospital would just make the other three busier."

"What I think is it's silly. It's centralizing all the health care services in all of the big cities and anyone who lives in a rural community ends up either having to travel by car or anything that is an emergency now falls on the backs of emergency services. So now instead of being with a patient for 10 minutes with most of our call volume in the immediate area of the hospital, that will extend the time that I'm with someone who's critical to about half and hour."

"I think it's ridiculous. A lot of rural ambulance services do not have advance care paramedics….Closing down [ERs] would be horrible. It would cause more strain on urban centres and transportation. A lot of the small facilities are able to put CTAS 1 and 2 patients in some adjunct to stabilize the patient until a higher level paramedic can come to transport them to a more acute care facility. But to take the small town hospital away would put a huge hole in the health care system, not just for the immediate community, but for the whole province it'll strain the system."

"This is not a good plan. It jeopardizes patient care."

"It's horrible. Especially for the CTAS 1 and 2 who are more critical and need to be stabilized. If they have to go another half an hour down the road to the next hospital that can be huge. Especially when you consider trauma patients and the golden hour to get to an emerg, from the time of injury. So if you're normally 10 minutes from Wallaceburg and that's shut down and now you have to go 40 minutes and you may be on scene for 15 minutes to half-an-hour to extricate that person from a car or from under a tractor or whatever the case may be, you've missed the hour that you have to save that person, basically. It's horrible."

"It's going to be detrimental to everybody."

"Ultimately this will result in patients dying because they need care from a physician. Ultimately patients will die, without question….and those that survive will have poorer outcomes. The longer patients wait before they have definitive diagnosis and care in an emergency department with physicians the greater the chance of a permanent deficit as a result of the injury."

"It denies access to a good portion of the patients we service and it'll put extreme pressure on ambulance services because we're already experiencing offload delays and it'll just increase those offload delays."

"That's horrible. It's going to be detrimental because it will probably effect the morbidity mortality rates for patients."

"It's going to really impact us. It takes ambulances out of the area which means there are none left to respond to heart attacks or whatever else happens when you're away…. For example, if we are out of Brighton and we have to go to Cobourg it's 25 minutes instead of 10 minutes. And if we have to take them to Peterborough we're stuck on an offload delay. And if there are more ambulances going there it's going to be awful."

"I think its wrong."

"It's terrible. They don't know what they are doing. For one, they are passing the debt to municipalities because the municipality will have to increase their EMS funding to deal with the backload if these ERs close. They'll need more paramedics because there will be more paramedics sitting in hospitals waiting with patients in increased offload delays. They will need to bring in more ambulances to cover for when we have to go out of town. It's a ripple effect."

"It's a very poor plan…It's not going to treat people who are truly sick and need to be seen by a higher level of care…. The patients are going to suffer, they won't be treated as well as they should, there's going to be delays in getting appropriate care."

"I know we'd have an increased death rate because we get a lot of trauma….You're now delaying care for the patient. They're waiting longer for what they need. It increases risk for the patient. It just puts the public at risk."

"For the smaller communities there'd be no intermediate hospital. It would definitely not be a good thing."

"It's a stupid plan. In the last couple of years I know of 6 people who would have died without the hospital on St. Joseph Island."

"I think it puts lives in jeopardy."

"It's very dangerous. There's going to be major lives lost."

"It will certainly increase offload delays because there aren't empty beds or staff to take the patients…more people coming in with less beds…"

"It doesn't make sense….It endangers our community members."

"It's ridiculous. It's not appropriate. It's not beneficial to taxpayers."

"I hate it. It means we're going to have more patients going further and further. The golden hour [life saving time frame] will be compromised. Nothing good is coming out of this especially in rural areas where it's miles and miles before the next hospital."

"I think my offload time just got a whole lot worse. It'll just jam up the larger hospitals. We cover 500 square miles and if you close down a local hospital someone is going to bleed to death before you get them to a hospital."

Section II

100% of Paramedics said they cannot replace care that will be cut when local Emergency Departments are closed

The provincial government's plan is to replace local hospitals – and their emergency departments – with "Urgent Care Centres". Most Ontarians do not know what Urgent Care Centres are, and almost all who do not work in health care are unaware of the distinctions between various levels of triage. However, under the provincial government's plan, patients would need to self-triage (a function currently done by Registered Nurses) and go to the appropriate facility. The complexity of this requirement is compounded by the fact that patients who might initially be at one level on the triage scale might change to another more serious level on the triage scale if their condition worsens.

An "Urgent Care Centre" is not what ordinary Ontarians understand as a "hospital". Urgent Care Centres do not take ambulances. Urgent Care Centres cannot provide Canadian Triage and Acuity Scale (CTAS) Levels 1 & 2 care; for example, patients with heart attacks, strokes, difficulty breathing, traumas, severe abdominal pain, and other extremely serious conditions. Urgent Care Centres are supposed to provide care to less urgent CTAS Levels 3 – 5 patients. For a further explanation of the difference between an emergency department and an Urgent Care Centre, see Appendix II.

The closure of a local hospital emergency department and its replacement with an Urgent Care Centre means that patients with the severe conditions described by CTAS Levels 1 & 2 would have to travel to a hospital that has an emergency department. If a patient goes to their local Urgent Care Centre with any of these severe conditions, there will be an additional delay for a patient to receive definitive care as they are transported to another hospital with an emergency department.

We set out to determine what risks patients presenting as CTAS Levels I & 2 would face if their local hospital emergency departments closed and they had to travel further for services. We asked the paramedics if they could replace emergency department CTAS Levels 1 & 2 care in their ambulances. Every paramedic we interviewed, from all levels of training, in every geographic region of the province, said they cannot provide all CTAS Levels 1 & 2 care. They gave examples of the care that cannot be provided in an ambulance. These are listed in the following chart.

Primary Care Paramedics (the most common type of paramedic in Ontario) gave the following examples of care they cannot provide:	Advanced Care Paramedics gave the following examples of care they cannot provide:
• IVs (intravenous lines) • Diagnostics, including X-ray, CT scan, Ultrasound • Many drugs including pain drugs, cardiac drugs • Intubation (establishment of artificial airway) • Blood transfusions • Manual defibrillation • Chest needles • Cardioverting • Pacing • Suturing • Thrombolysis (clot busting for strokes etc.) • Completely obstructed airway – (crikes/ needle cricothyroidotomy) • Surgery	• Completely obstructed airway (crikes/cricothyroidotomy) • Chest tubes insertion • Surgery • Sequencing for intubations • Thrombolysis (clot busting for strokes etc.) • Administration of many heart medications • Complex obstetrical care • Diagnostics, including X-ray, CT Scan, Ultrasound • Blood transfusions

What They Said

Q. Can all CTAS levels I & II care be replaced in ambulances?

"We can't replace body fluids, we can't do IVs, we can't give any cardiac and that's a big thing. If someone has a heart attack, I can give them symptom relief but I can't give them cardiac drugs so the longer that person is without an emergency facility the worse it is." (Primary Care Paramedic)

"An ambulance is an uncontrolled environment. We don't have diagnostics. A CTAS 1 patient needs blood work, x-ray, that sort of thing. You can't sustain life in a 10 by 12 area. We don't have the drugs that may be needed, we have a handful, but not the whole gamut of drugs." (Primary Care Paramedic)

"You can't replace CTAS levels 1 and 2 here. There's no advanced life support in Simcoe County. We're limited in our protocols and we don't do intubation or heart drugs or that sort of thing. If you have a heart attack all we can do is CPR but I have no heart drugs on board." (Primary Care Paramedic)

"Certainly not at my level, but even at an ACP (Advanced Care Paramedic] level you don't have 100 per cent of the resources required. There is an extensive amount of stuff that can be done in an emergency department that can't be done in an ambulance to make sure that CTAS II patients don't become CTAS I patients." (Primary Care Paramedic)

"There are greater risks of further complications in the time getting to the hospital. If a local hospital closes down and there will be fewer ambulances available at times because some of the ambulances will be out of town unloading patients rather than available to respond." (Primary Care Paramedic who works with an Advanced Care Paramedic)

"For instance a VSA [Vital Signs Absent] is a CTAS 1. We can defibrillate and we can do CPR and we can control the airway and that's it. We are not trained to give Atrapine, Epinephrine or any of the other drugs that the ALS guys have.

Even if they trained all of us the problem is it becomes a function of call volume and can we maintain those skills." (PCP Plus)

"If we have a bad trauma, and we get lots of traumas because we have these country roads and people driving 100 K an hour and not watching where they're going. We have some serious impacts. We can only start an IV and do so much for so long. We need pain meds, x-ray, blood work and a lot of other stuff that needs to be done in a very short term. Sometimes these people are in such pain that they need to be knocked out and bagged, especially things like burns and that." (PCP Plus)

"We can't intubate and we cannot start IVs and our airway management is limited and we're only given a small list of symptom relief drugs. We don't have any Advanced Care Paramedics in Lennox and Addington County." (Primary Care Paramedic)

"Just because of the weight restrictions and the size of the ambulance we can only carry so much equipment and disposable stocks such as IV fluid. We don't carry blood. You have to go to the blood bank to get blood and only critical care does that. Bouncing down the road, it's not the best type of care." (Primary Care Paramedic)

"There's no critical care on land ambulance outside of Toronto. We can't do surgery. If they expand our scope of practice then what we do is expanded but we still can't do x-rays, CT scans, ultrasounds. We don't do IVs where I am. We can stabilize a fracture but we don't have pain management on our ambulances." (Primary Care Paramedic)

"We can't administer blood products, for example. Most ambulances around the province, especially in rural communities, in my experience, most of them are staffed by Primary Care Paramedics. So they only have a few drugs they can give. They can't do intubations, chest needles, cardioverting, pacing…there are so many things we can't do." (Primary Care Paramedic)

"We'd put out huge dollars to train all paramedics in these areas to a minimum Advanced Care Paramedic Level, but even ACPs can't administer blood products. If you have someone who is hypovolemic and bleeding out they'll die without blood. We can do only so much for so long but ultimately that person needs an emergency department." (Primary Care Paramedic)

"We can't give advanced care drugs, we can't even give morphine, unless the government wants to fund everyone to become an ACP or CCP but good luck with that. For that matter, patients in those cases need a doctor." (Primary Care Paramedic)

"We can't initiate IV therapy, intubation, advanced cardiac life support, and under advanced cardiac life support includes drugs. We can't do manual defibrillation. We can't pace them. There's no blood products. There's no capability for central lines. These are things physicians would be able to do." (Primary Care Paramedic)

"We used to say "seconds save lives" and they do. It is very hard to work in the back of an ambulance where you have cramped quarters to stabilize and maintain life. You can stabilize someone better in a controlled environment. It is very hard to ventilate and maintain ventilation in an ambulance, but if you are in a hospital you can get them on a resuscitator. There are just so many variables." (Primary Care Paramedic)

"The maximum number of patients you can fit in an ambulance is two so that's an issue. And there's only so much you can do based on your level of certification but even the highest level isn't the same as having a doctor." (Primary Care Paramedic)

"We had one case last winter…the roads were closed and the bridge was closed because of a snowstorm. The only way off this island is that bridge. If the hospital wasn't here patients would die without the hospital." (Primary Care Paramedic)

"We don't have any advanced or critical care paramedics in the area. Regardless, the longer transport times takes care away from the population." (Primary Care Paramedic)

"We can't do suturing. We can't thombolyse. We can't do any crikes. We can't take care of any major bleeds." (Primary Care Paramedic)

"There are situations where we would have to take a patient to a hospital such as a completely obstructed airway." (Advanced Care Paramedic)

"No, we can't replace the care. We can't do any type of surgery. Trauma patients would need chest tubes, OR to fix any internal bleeding. We can't do anything about that." (Advanced Care Paramedic)

"CTAS 1 and 2 you're going to require physicians. You can't replace them in an ambulance. That's absurd." (Advanced Care Paramedic)

"The answer is huge. There are a lot of things we can't do. Sequencing for intubations you can't do. OBG in an ambulance is very basic and rudimentary. We can't do obstetrical emergencies very well in an ambulance. The list is huge." (Advanced Care Paramedic)

"To say we can provide all the care necessary is an impossibility – we're not ER physicians. There's no way we can put the equipment required in the back of an ambulance. For example CTAS level 1 and 2 patients, car accidents. You get a good multi trauma. That patient needs blood work. They need diagnostic procedures to determine the severity of their injuries and the course of action….Sure you can stack your shelves in an ambulance, but they need blood transfusions and we don't have the blood. If you spread the blood out among all ambulances it would make the shortage of blood worse. Plus you'd need refrigerator units to keep the blood cool. It's just not feasible." (Advanced Care Paramedic)

"I can't deliver certain medications. Let's say I have a rapid heart. I can cardiovert them or I can given them Adenazine but I can't give them all the drugs that would be required to really stop that rhythm. People having heart attacks, I couldn't give them anything. No clot busters or beta blockers and I don't have the diagnostic tools to determine what drugs to give."(Advanced Care Paramedic)

"We can implement the immediate treatment but there are some things you can't delay like the services of a respiratory tech may be required for more advanced treatment. Surgical airways we can't do … you need a doctor and that can't be delayed. Stabilizing critical trauma patients – you need several hands of that and one person in the back of an ambulance isn't enough." (Advanced Care Paramedic)

"We don't have x-rays, chest tubes, advanced airway techniques. I can intubate someone but if the intubation fails I have no backup adjuncts. You can do a chest needle but tf that fails I can't do a chest tube. There is equipment at the hospital I don't have and it's just me, on person. It's not the same as a team of people. If you're lucky you might have a fireman to hand you things, but it's not the same." (Advanced Care Paramedic)

Section III
Clarifying the misinformation

1. Physician Specialization and Emergency Department Staffing

It is more usual than unusual for family doctors to staff emergency departments. This is not just a feature of small hospitals. Family doctors work in emergency departments in every size of hospital - including medium, large and teaching hospitals – in every geographic region of Ontario. The fact that family doctors rather than emergency specialists staff emergency rooms is long-standing. We have extensively searched the medical journals, contacted and searched through all the resources available from clinical research organizations in Ontario, and we were not able to find any evidence or "best practice" to support any claim that family doctors cannot provide safe effective emergency room care. In fact, according to Ministry of Health data, if all emergency departments led by family doctors were to be closed, then 96% of very small hospital ERs and 74% of small hospital emergency departments across Ontario would have to be closed.[1] Certainly the risks to patients for traveling further for emergencies would need to be weighed against any benefits (and we were not able to find evidence of any benefits) from closing all of the ERs that are run by family doctors.

Further, the Institute for Clinical and Evaluative Studies (ICES) research has noted benefits from family doctor staffing of ERs as follows:

- "As GPs/FPs [General Practitioners/Family Physicians] reduce their work in EDs [Emergency Departments], they will have limited contact with an environment that may provide enhanced peer interactions and varied clinical exposure. Such exposure may help GP/FPs to maintain their clinical skills in the management of complex patients." The study goes on to note, "Planners should also recognize that different areas have different needs. Small rural communities, in particular, may prefer having GP/FPs staff their EDs because they may not have the critical mass to sustain a group of physicians dedicated to working primarily in EDs….Planners and physician groups should also consider the future role of the GP/FPs without emergency medicine certification in the staffing of EDs, since they will continue to be needed in this capacity in the foreseeable future." *Chan, Benjamin T.B.; Schull, Michael J.; Schultz, Susan E. "Emergency Department Services in Ontario", Institute of Clinical and Evaluative Sciences Atlas Report.*

If the provincial government is setting policy for new standards of training required by Emergency Room physicians, this should be clearly articulated by the Ministry of Health and Long-Term Care – with evidence to justify such policy change and support to preserve accessible emergency services while training is implemented.

[1] A report, jointly written by the Ministry of Health and Long Term Care and the Ontario Hospital Association shows that in very small hospitals the "most responsible doctor" is a family physician or GP 95.7 percent of the time. In small hospitals, the "most responsible doctor" 74.2 percent of the time. *(Joint Planning and Policy Committee of the Ontario Hospital Association and Ministry of Health and Long Term Care, Multi-Site Small Hospitals Advisory Group. "The Core Service Role of Small Hospitals in Ontario" Phase I Report, 2006; exhibit 3.14 (page 17).* According to the Canadian Journal of Emergency Medicine survey of rural and regional ERs in southwestern Ontario "(70.1%) physicians had no formal emergency medicine (EM) training. (*Nov 2007 CJEM Vol 9, No 6, p449)*

2. Hospital Restructuring Experiments in Ontario and Saskatchewan Did Not Realize Cost Savings As Predicted

The provincial government and the LHINs risk pursuing a program of small and rural hospitals that is unlikely to solve the hospital deficits, and may in fact incur higher costs while harming patients' access to care, worsening health outcomes, downloading costs to municipalities and damaging to local economies. There is no evidence that the small and rural hospitals are the cause of hospital deficits. Indeed, the evidence from Saskatchewan's closure of small hospitals is that "savings" to the public purse were minimal, while patient dislocation and political consequences were severe. In Ontario, the last round of significant hospital closures, cuts restructuring was characterized by very high costs that ran into the billions of dollars.

In fact, in Saskatchewan, 52 very small hospitals (8 inpatient beds or less) were cut in 1993- 1995. Subsequently, Health Minister Janice MacKinnon noted that total cost "savings" from closing 52 hospitals was much less than anticipated, at only $30 - $40 million.[2]

In 1999 and 2001, in Ontario the report of the provincial auditor revealed the costs of hospital restructuring under the Harris government. While costs for hospital restructuring were originally estimated at $2.1 billion, the auditor revealed that costs had reached $3.9 billion; an increase of $1.8 billion over expectations.[3] Fully 51% of the increase in hospital spending over the period was accounted for by costs associated with restructuring.[4]
Thus, billions were spent cutting beds, closing hospitals and laying off staff. Hundreds of millions were spent in subsequent years reopening beds and recruiting staff to deal with the planning errors and to restore some stability to the health system.

In his analysis, the auditor criticized the provincial government for failure to budget for demand for health care services as well as poor sequencing of restructuring and failure to plan for necessary capital costs leading to cost overruns in restructuring. All of these problems, in addition to the problem of laying off scarce hospital staff only to have to re-hire again in the near future, are very much in evidence in the current round of restructuring.

Since this current restructuring is driven by an attempt to contain costs, a full costing of the restructuring itself is urgently needed. A sober evaluation of the costs and consequences of the current proposals should be conducted by an independent party with strong public interest credentials. This assessment should include the factors that drove up costs and reduced services the last time. It should also include the costs downloaded to municipalities and patients as a result of moving services further away from home communities and established transportation routes. Finally, it should assess whether there is any evidence at all that closing small hospitals and moving services into large hospitals will reduce costs.

[2] Lang, Michelle. "Health cuts cripple small town hospitals" *Calgary Herald*, February 7, 2009.
[3] See pp. 315 from provincial auditor's 2001 report.
[4] Block, Sheila "Health Spending in Ontario: Bleeding Our Hospitals" Technical Paper #4 Ontario Alternative Budget 2002, page 7.

3. There is no such thing as an Emergency Department "Centre of Excellence"

"Centres of Excellence" are used for highly complex and often less common health-care procedures that require a high degree of specialization. Normal local hospital services such as emergency departments, inpatient beds, birthing are not applicable. The centralization into facilities with a high degree of expertise in certain very specialized cancer treatments and other high-tech, highly specialized care is appropriately described as creating a "Centre of Excellence". Simply closing down local hospital services does not make "Centres of Excellence" and the misuse of this term by policy makers and LHIN board members does not serve the public interest.

Appendix I

CTAS: Canadian Triage and Acuity Scale

The CTAS levels are designated so that level I represents the most sick patients and level V represents the least ill group of patients. A more in depth explanation with examples are outlined in the following table:

Level I- Resuscitation	Conditions that are threats to life or limb (or imminent risk of deterioration) requiring immediate aggressive interventions. Examples of types of conditions that would be Level 1are: Cardiac/Respiratory arrest, major trauma, shock states, unconscious patients, severe respiratory distress.
Level 2- Emergent	Conditions that are a potential threat to life limb or function, requiring rapid medical intervention or delegated acts. Examples of types of conditions which would be Level 2 are altered mental states, head injury, severe trauma, neonates, MI, overdose and CVA.
Level 3- Urgent	Conditions that could potentially progress to a serious problem requiring emergency intervention. May be associated with significant discomfort or affecting ability to function at work or activities of daily living. Examples of types of conditions which would be Level 3 are moderate trauma, asthma, GI bleed, vaginal bleeding and pregnancy, acute psychosis and/or suicidal thoughts and acute pain.
Level 4- Less Urgent	Conditions that are related to patient age, distress, or potential for deterioration or complications would benefit from intervention or reassurance within 1-2 hours). Examples of types of conditions which would be Level 4 are headache, corneal foreign body and chronic back pain.
Level 5- Non Urgent	Conditions that may be acute but non-urgent as well as conditions which may be part of a chronic problem with or without evidence of deterioration. The investigation or interventions for some of these illnesses or injuries could be delayed or even referred to other areas of the hospital or health care system. Examples of types of conditions which would be Level 5 are sore throat, URI, mild abdominal pain which is chronic or recurring, with normal vital signs, vomiting alone and diarrhea alone

http://www.calgaryhealthregion.ca/policy/docs/1451/Admission_over-capacity_AppendixA.pdf

Appendix II

Urgent Care Centres versus Emergency Room [1,2]

A full-service Emergency Department takes every level of patient, from those suffering a life-threatening heart attack or car accident, to those with a minor ear infection or sprained ankle. Ambulances take patients to Emergency Departments and ED physicians admit patients to acute care (medical/surgical) beds or mental health beds. Emergency Rooms are hospital departments that provide medical and surgical care to patients arriving at all times with life threatening conditions and the need for immediate medical attention.

Urgent or Prompt Care Centres (these terms are interchangeable) are for those patients who have bumps and bruises, mild infections or injuries. Urgent Care Centres do not accept ambulances or critically-ill patients and Urgent Care physicians do not admit patients to an inpatient unit, although they may keep a patient for several hours for observation. Patients who go to an Urgent Care Centre but require more detailed diagnostic tests or treatment are transferred to a full-service Emergency Department. Urgent Care Centres have services for patients without appointments who need treatment for non-life threatening conditions during the day, in the evening and on weekends. These centres are often closed during late nights.

The following table compares lists of conditions for which each has the capacity to provide treatment and care.

Emergency Rooms Treat:	**Urgent Care Centres Treat:**
• Chest pain • Shortness of breath • Severe abdominal pain • Dizziness • Sudden, severe headaches, vision problems, sudden weakness, numbness and/or tingling in the face, arm or leg, trouble speaking, or dizziness (stroke symptoms) • Numbness in your arms or hands • Major injuries • Mental health issues	• Broken bones, sprains, sports injuries • Cuts that may need stitches • Minor burns • Minor abdominal pain (nausea,vomiting, flu) • Ear, nose and throat problems • Coughs and colds • Eye problems

[1] http://www.niagarahealth.on.ca/stories/2009/2009-06.html
[2] http://www.health.gov.on.ca/ms/healthcareoptions/public/index.html