Introducing the CJEM emergency medical services (EMS) series

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Beginning with the current issue, the *Canadian Journal of Emergency Medicine* (*CJEM*) will feature an eight-part series of invited commentaries dedicated to emergency medical services (EMS). These commentaries and accompanying original research will feature topics in EMS that are relevant to emergency medicine (EM) practice. With the pressures of providing quality, fiscally responsible health care, and the advances of evidence-based practice, the roles of EMS are evolving beyond transport of the sick and injured. There are no more "ambulance drivers," and it is no longer about a patient transport vehicle. Professional paramedics represent the majority of health professionals in EMS systems, and they are joined and supported by communication officers, nurses, physicians, respiratory therapists, researchers, accountants, administrators, and more. EMS encompasses a system, working to provide the right care to the right patient, in the right place, by the right provider, and at the right time. The worlds of "out-of-hospital" and "in-hospital" emergency care are becoming closer. In this series, we will use the term EMS to refer to the system that provides the traditional roles of emergency care and transportation along with the diverse new roles. Collectively, we will endeavour to find a term that truly captures the breadth and depth of this expanding field.

THE RELEVANCE OF EMS ARTICLES TO AN EM AUDIENCE

As the series will illustrate, there is tremendous benefit on both sides of the emergency department (ED) door to having the EMS and EM communities working as an integrated system. The first two commentaries will explore how research in both environments has, could, should, and should not influence care. In the subsequent commentaries, the far-reaching impacts of one domain on the other will be discussed and include the regionalization-of-destination policy, transfer-of-care delay, and the joint approach to the increasing care needs of our aging population. The use of a triage system is especially significant in communication, patient safety, destination choice, and benchmarking performance, so one commentary is directed at the EMS use of the Canadian Triage and Acuity Scale (CTAS) or its prehospital iteration, preCTAS. An illustration of the importance of evidence-based practice and the leadership that EMS has demonstrated in this area will be presented. The last issue will feature community paramedicine, including examples of paramedics in primary care, ED, and long-term care health teams. Understanding these expanding roles is key to partnering paramedics and ED, for online medical consultation, and for imagining new options for patient care and disposition.

EMS IN CANADA—A PRIMER

The traditional EMS model in Canada, the United States, and other countries around the world has involved providers, typically a team of two, travelling in an ambulance in response to requests through a 911 (or similar) system. Those providers have followed a protocolized response to the chief complaint of the patient and have transported the patient to the ED. In Canada, paramedics have been trained to meet national standards for the basic (Primary Care Paramedic or PCP), advanced (Advanced Care Paramedic or ACP), or Critical Care Paramedic (CCP) level. There are now national paramedic exams. In several provinces, paramedics are regulated by their own college.

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In most of Canada, EMS is a third emergency service (the other two being police and fire). Depending on the acuity, type of call, and local protocol, the fire department and police may respond, as well as the paramedics. Driven by local need, political pressure, and the maturation of the profession, paramedics have entered new roles within the health care system. This series will highlight the evolution of EMS and paramedicine, the importance of working together in the broader health care system, and the lessons that we may learn by looking beyond traditional models, toward the future of health care delivery.

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