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Rural Emergency Care is Essential
Access Must Reflect Population Needs, Not Politics

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Across Canada, rural emergency care is in crisis. Emergency departments in small communities are closing overnight, shifting to "urgent care" models, or shuttering entirely. Patients are left to travel farther, wait longer, or go without the care they need. One rural emergency department in New Brunswick has been "temporarily" closed overnight for more than three years—so long, in fact, that it's no longer tracked as a closure because it is now considered routine. These examples reflect the growing normalization of rural care withdrawal.

This is not a coincidence. It's the result of years of underinvestment, reactive planning, and a lack of coherent system design. And it raises an urgent question: **Do all Canadians have the right to timely, high-quality emergency care—no matter where they live?**

We believe the answer must be yes. But that doesn't mean every small town needs a full-scale trauma centre. It means designing **smart, sustainable networks** of emergency care that meet the real needs of patients and populations—especially in rural and remote communities.

Emergency Care Close to Home Saves Lives

Some commentators have suggested that so-called "real emergencies"—like heart attacks, strokes, and trauma—can only be treated in large urban hospitals. But this isn't backed by evidence. In fact, the opposite is true: the *earliest possible intervention* for time-sensitive emergencies is critical to preventing death and disability.

The "golden hour" in trauma, "time is brain" in stroke, and "door-to-needle time" in cardiac care all reinforce the same message: **timely, local access to emergency care saves lives.** Rural emergency care providers play a crucial role in stabilizing patients and initiating treatment long before transfer is possible.

Dismissing rural emergency care as unnecessary—or conflating it with walk-in clinics—ignores the real-world complexity of medical emergencies and the realities of rural geography. In an integrated EMS system, **bypass protocols are already in place** to route patients directly to tertiary centres when appropriate, such as major trauma or STEMI cases. But these systems

depend on having skilled rural providers and functional local emergency care sites to evaluate, stabilize, and initiate transfer.

Form Must Follow Function

CAEP's EM:POWER report—a national blueprint for emergency system redesign—offers a more thoughtful path forward. It emphasizes that **form must follow function**: the design and resourcing of emergency care should be based on *what patients need*, where they are, and what access barriers exist.

Rather than debating whether rural communities "deserve" an emergency department, we should be asking:

- What kinds of emergency care are most needed in this community?
- How far is the next available access point?
- What travel risks, geographic factors, or weather barriers exist?
- What are the population demographics, and how do they shape service needs?

When rural access points are closed or downgraded, it's not just convenience that's lost—it's the ability to respond quickly to stroke, sepsis, trauma, and more. That's why **blanket policies to centralize emergency care are not evidence-based**. They oversimplify the problem and overlook geography, infrastructure, and local risk.

Rural Emergency Care Is High-Quality Care

Rural emergency care is not lesser care. The College of Family Physicians of Canada (CFPC) explicitly trains its graduates to deliver emergency care—including the initial management of heart attacks, strokes, trauma, and anaphylaxis—in rural and remote settings. Rural providers work in close partnership with transport teams, specialists, and virtual care supports.
When rural emergency care sites face challenges in meeting community needs, it is not due to a lack of provider knowledge or skill, but rather reflects systemic disparities in infrastructure, staffing, and resource allocation—factors well documented in Canadian emergency care literature and emphasized in the EM:POWER Report.

What rural care needs is not replacement, but **respect and resources**: fair compensation, stable scheduling, team-based staffing, and meaningful health human resource planning that matches service expectations with workforce realities.

The Path Forward: Networks, Not Silos

EM:POWER calls for a system where **emergency care access points are categorized, integrated, and supported** as part of a coherent network. Not every site needs to offer the same services—but every region must ensure timely access to emergency care for its population.

That includes:

- Transparent classification of emergency care sites, including rural access points
- Quality and safety standards for all emergency care providers, regardless of location
- System planning that considers geography, population need, and health equity
- Accountability frameworks to track access, closures, and care outcomes

Too often, rural access points are closed or downgraded without a clear plan for where patients will go—or what impact that will have on outcomes. Patients are left to navigate systems that weren't designed with them in mind.

Conclusion: Evidence Over Assumptions

Canada's emergency care system must be redesigned to reflect modern realities—not outdated assumptions. The idea that urban hospitals can meet all emergency needs is not only unrealistic—it's dangerous. Rural emergency care is not optional. It is essential. And when governments allow that care to erode, the consequences are felt in ambulance delays, avoidable deaths, and widening health inequities.

We need a system where **care follows need**, **form follows function**, and all Canadians—urban, rural, remote—receive timely, high-quality emergency care, close to home. We call on provincial health leaders to develop regional networks that guarantee timely access for all populations. The EM:POWER framework offers the roadmap—what's needed now is the will to follow it.

About CAEP

As the national voice of emergency medicine (EM), CAEP provides continuing medical education, advocates on behalf of emergency physicians and their patients, supports research and strengthens the EM community. In co-operation with other specialties and committees, CAEP also plays a vital role in the development of national standards and clinical guidelines. CAEP keeps Canadian emergency physicians informed of developments in the clinical practice of

EM and addresses political and societal changes, that affect the delivery of emergency health care.

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