**To the Editor:**

The Canadian Severe Acute Respiratory Syndrome (SARS) experience of last spring repeatedly has demonstrated a systemic, ongoing, and potentially lethal disconnect between Public Health Policy planning officials and essentially all Emergency Medical Services and Medical First Response agencies. A recent meeting with leading Emergency Medical Priority Dispatch agencies in the United States provided significant indications that this public health-public safety agency disconnect is not just a Canadian, but a North American phenomenon.

Historically, the liaison between Public Health and Emergency Medical Services agencies in most North American jurisdictions has ranged from minimal to non-existent. Working at opposite and distinct ends of the health care continuum, Public Health in disease prevention, Emergency Medical Services in emergency response and disaster management, the prehospital Emergency Medical Service Systems understandably have been given little or no consideration in Public Health planning or policy development. Only recently have the more proactive Public Health agencies begun to consider the role of Emergency Medical Services in the development of pandemic and bioterrorism protocols.

The resulting lack of Public Health awareness and training in Emergency Medical Services, roles and responsibilities, paramedic scopes of practice, medical control methods, medical priority dispatch criteria, regional event mapping and data management capabilities, and the multi-agency response processes of such services, has left many Public Health practitioners unaware of the sophisticated surveillance and patient-care capacities of the modern Emergency Medical System. Concurrently, this lack of emergency medical system awareness in public health circles has placed Public Health policy-makers at profound risk of under-estimating and mismanaging the potential disease transmission presented by poorly briefed, Emergency Medical Services professionals and the thousands of volunteer Medical First Response agencies that precede them into tens of thousands of calls annually.

I am deeply concerned that North American public health policy-makers are woefully unaware of the risk presented by and the resources available from their Emergency Medical Services colleagues when it comes to dealing quickly, effectively, and uniformly with diseases that have transmission profiles such as does SARS. I have been equally concerned at the lack of disease surveillance and situation analysis processes that I have witnessed, in many Emergency Medical Services communities when dealing with this disease.

This lack of organizational connectivity between Public Health and Emergency Medical Service agencies in Canada early in the SARS, prompted outbreak, the establishment of a weekly, nation-wide teleconference to connect Canada's largest Emergency Medical Services agencies so that clinical and responder pre-alert communication protocol information on how to cope with SARS, could be exchanged. At the same time as Emergency Medical Services Safety officers and Managers tried to infiltrate the Public Health planning "table" in their respective regions. Ironically, once identified as a "player", the Emergency Medical Service systems in several Canadian cities were given planning and educational responsibilities for the public safety agencies in their areas by Public Heath Officials

In Canada, we now speak of a "new normal", that is, how our practices will change to prevent the spread of the next SARS-type virus. I write to sound the alarm that if we do not resolve the obvious and systemic disconnect between Public Health Policy-Makers and Emergency Medical System leaders, we will not do well by our collective patients. We will be held accountable in both the court of public opinion as well as to our respective Professional Colleges and Municipal and Labor Councils to explain why we did not deal with this major and easily identified communications concern, and why we did not prepare all elements of the Health Care System equally to deal with such viruses.

We immediately and collectively must begin to think beyond the curb of the hospital and in terms of Health Care systems. Public Health and Emergency Medical Systems must collectively be better prepared and integrated locally, regionally, and nationally to exchange accurate surveillance information, develop best practices, and publish clear public information campaigns and treatment regiments so we can better prepare our communities for the next challenge Mother Nature sends our way.

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## To the Editor

This is written in response to the article, Doctor-based Basic Cardiopulmonary Resuscitation Course (Lam KK, Lau FL, Chan WK, Leung KS, Chan TF: Doctor-based basic cardiopulmonary resuscitation course: An alternative to the conventional approach. *Prehosp Disast Med* 2002; 17(4):209–212):

First, the title was misleading—a course for physicians? A course taught by physicians? The Cardiopulmonary Resuscitation Course (CPR) course offered in this article was developed by the United Christian Hospital whose target audience was patients, patient's relatives, and citizens. The course was taught by a physician, nurse, and assistant tutors. The article stated that the instructors are not "qualified instructors", but implied that they had life experiences to teach this subject matter. Were the physicians supposed to replace competent instructors? The course was not sponsored by the European Resuscitation Council, American Heart Association, or the American Red Cross, which are based on standardized theoretical principles and skills with certified instructors. This article stated that courses offered by the above two agencies were complex and advocated a pass-fail mentality. In this study, public participants were given a written pre-test to ascertain their knowledge base before the CPR session, then a written post-test upon completion of the CPR session. Is this not adding to the stress of public participants and advocating for a pass-fail mentality? Performance of ventilations and external chest compressions were measured by mannequins that had several indicators and alarm lights. Adequate ventilation is measured by providing enough air to make the chest rise and fall and effective chest compressions is measured by an adequate pulse. The demand for a perfect CPR strip? That has not happened since the 1970s. There were no clearly identified objectives for this course. The program should have clearly identified the following: nature of the problem, purpose of the study, background and significance of the problem specific to this country, and relevant comparison data.

The American Heart Association (AHA) offers various courses in CPR training. Each course targets a specific audience. The knowledge and skills learned in these courses enables the course participants to save the life of a family member, friend, co-worker, a patient in the hospital/clinic, or a citizen in the community. The AHA uses the following teaching methods-lecture, video-based training, instructor demonstrations, participant return demonstrations, and a post, written knowledge-base test (course dependent).

AHA instructors for CPR courses, initially take a 16-hour instructor course. They are required to teach at least four courses every two years. This instructor certification assures consistency, accuracy of information transmitted, knowledge of current clinical relevance, and new product information. This allows for the provision of quality training. Instruction is based on adult learning principles and presented in a positive, encouraging environment.

The following are CPR courses offered by the AHA (AHA, Instructor's Manual-Basic Life Support, 2000) with accompanying information on specific target audience, length of course, instructor-participant ratios, and information regarding objectives:

1. *Healthcare Provider Course*—This is a 3-hour course intended for licensed and certified healthcare professionals. Instructor-participant ratio is 1:8 maximum. A written test is required at the end of the session to obtain certification. Learning objectives are clearly defined for each training module: Basic Life Support in Perspective; Anatomy and Physiology of the Respiratory, Cardiovascular, and Cerebrovascular Systems; Coronary Artery Disease and Acute Coronary Syndromes; Acute Stroke, Risk factors for Heart Disease and Stroke; Adult CPR; Automated External Defibrillation (AED); Adult Foreign-Body Airway Obstruction; Pediatric Basic Life Support; Safety During CPR Training and Actual Rescue; Special Resuscitation Situations; and CPR and Defibrillation: The Human Dimension.

   Skill performance sheets are available for the following return-demonstrations: Adult and Pediatric 1-Rescuer CPR; Adult and Pediatric Bag-Mask Ventilation; Adult and Pediatric 2-Rescuer CPR; Adult and Pediatric Foreign Body Airway Obstruction (FBAO)-Responsive and Unresponsive; and AED.
2. *Heartsaver CPR*—This course is designed to teach CPR and relief of foreign-body airway obstruction. The instructor-participant ratio is 1:8 maximum and the course length is 3–6 hours. Certification is obtained upon successful completion of a written test and return demonstration.
3. *Heartsaver AED*—This course is the same as above with the addition of AED training.
4. *Heartsaver First Aid (with CPR & AED)*—This a 2–4 hour course intended for the public. Instructor-participant ratio is 1:10 maximum. There is a written test and certification upon successful completion of the course. Objectives are defined by each training module-general principles of first aid, medical emergencies, injury emergencies, CPR, AED, and environmental emergencies.
5. *Family and Friends*—This is a 2–4 hour course designed simply to provide essential information regarding 9-1-1, rescue breathing using mouth-to-mouth ventilation, 1-rescuer CPR, and relief of FBAO. Instructor-participant ratio is 1:10. There is no certification.

Was there really a need to develop another course?

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