Hospital crisis? What crisis?

Charlotte Gray

On Jan. 17, Lloyd Robertson told the million or so people watching CTV's national news that "an Ontario family is planning their son's funeral as politicians and medical professionals debate whether he was a victim of the province's emergency room crisis." The Toronto teen, Joshua Flewelling, died of a severe asthma attack as an ambulance drove 18 extra minutes trying to find a hospital willing to admit him. The emergency room of the nearest hospital was clogged with flu patients and refused to accept him because it was on "redirect."

Two weeks earlier, Toronto police shot and killed a man demanding immediate medical attention for his infant son. He had pressed home his point by holding a gun to a physician's head. It turned out to be a replica of a handgun.

Elsewhere in Canada there were tales of patients stranded on stretchers, postponed surgery, overstressed hospital staff and ambulances unable to find a home because all ERs were on "critical care bypass." The media, of course, had a field day, and the word "crisis" hasn't seen as much use in Canada since the early years of WW II.

But was there a crisis? It was easy for Canadians to conclude that, after years of cutbacks, a severe outbreak of flu had pushed medicare over the edge. However, closer examination reveals 2 facts.

First, several Canadian cities were not blindsided by flu patients' annual January rush to Canada's ERs. And second, the crisis had been anticipated and preventive steps recommended in a report published last summer by Manitoba's Centre for Health Policy and Evaluation. Which leads an observer to ask whether this was a crisis of resources or management.

The Manitoba report looked at seasonal patterns of use at Winnipeg's 7 acute-care hospitals over the past 11 years to determine how often hospitals are full to capacity, and why. The researchers found that almost every winter, and at any time, there is a period lasting 1 to 3 weeks during which the number of patients arriving at the hospital jumps 10% beyond normal. The pattern was the same in the late 1980s, before Winnipeg lost 700 beds from its system, and this suggests that bed availability is not the cause.

Pneumonia, influenza and other respiratory conditions are the main reasons for the increase in the number of patients, three-quarters of whom are 65 or older. The report concluded that, in Winnipeg, such predictable bed pressure "can be anticipated and quite possibly managed."

Its suggestions apply beyond Manitoba. The first is for a "pre-emptive first step, a comprehensive campaign of flu vaccination." A second recommendation is a strategy to free up beds within the hospital system. This is far more difficult to do on short notice, so hospitals should be prepared, for example, to designate "swing beds" that could be temporarily switched from surgical to medical patients.

The authors also recommend that some surgery be rescheduled for slower periods, such as weekends. They also recommend that more outpatient surgery be done during the winter.

This year proved particularly difficult because the flu season arrived several weeks earlier than usual. Moreover, because Christmas and New Year's Day both fell on weekends, even fewer community facilities were open than usual, and family physicians had closed their offices. This meant that demands on ERs were particularly acute.

Nevertheless, the incidence of influenza-associated illnesses in Ontario was predictable by mid-November, when the number of reported cases began to rise. Yet Toronto-area hospitals did not appear to take precautionary measures such as scaling back on discretionary surgery or keeping beds open through the holidays. And from Jan. 3 onward, staff at many Ontario hospitals returned to work for the normal caseload of elective surgery, even though ERs were now clogged. Last-minute cancellations and frustrated patients were the inevitable result.

In contrast, hospitals in Saskatoon, Edmonton and Calgary did not report ER crises. This is largely due, says health policy analyst Dr. Michael Rachlis, to the local health authorities' aggressive preventive programs for dealing with the flu.

Dr. Cory Neudorf, the regional medical officer of health, says that in Saskatoon more than 90% of residents of long-term-care facilities were immunized, compared with a national average of about 70%. And if the flu did strike a nursing home in Saskatoon or in other Western Canadian cities, authorities moved fast to contain the outbreak with amantadine.

Neudorf also advised management teams that a severe flu outbreak was on the way. While institutions planned for the expected rise in admissions, the local health authority mounted an aggressive media campaign encouraging people to stay home or see their family doctor instead of going to the hospital.

With better planning, the flu could be defeated and the hospital crisis averted throughout Canada, suggests Michael Rachlis. He is concerned that the fallout from not planning for an epidemic means more than simply increased morbidity and mortality. "If Canadians lose confidence in hospitals [because of tragedies like Joshua Flewelling's death]," he warns, "they won't be interested in keeping medicare."

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