Clinical Laboratory Consolidations in New Brunswick

The Minister of Health has given the green light to inviting proposals to plan a consolidation of Clinical Laboratory Services in New Brunswick. Great idea for all the right reasons!

In 1962 I was allowed each Friday afternoon to visit the Lab at the Yarmouth Regional Hospital where the Chief Technologist was a personal friend. I learned the basics of how hospital labs work, learned how to do Haemoglobin tests with a hand-held device, and learned how to use pipettes and test tubes. That was sufficiently fascinating that I determined to choose Medical Lab Technology as a career. Later in my development my career path changed but the memories remain!

In the 1980's, visionaries in Ontario could see the impact on health care that would be brought by new technologies and computerization together with predicted labor supply issues and consolidation of hospital and health programs. So we saw the beginnings of the development of large central labs springing up in the population centres. This enabled highly expensive, state of the art equipment to be consolidated where it could be used around the clock, seven days per week.

I presume that government, at that time, determined that developing high volume production centres was more cost effective than maintaining small individual labs particularly when the driving distance between health care structures and the labs often was just minutes.

It has long been established through these commentaries that our health system struggles to maintain multiple service sites serving what is a total population no larger than a suburb of Toronto. In the 1992 initial implementation of hospital regionalization, it was believed that over time all of the systems that support excellent health care services at the point of care would have to be re-organized and integrated. That process of service consolidation has not moved at the pace that one would see in other provinces, largely due to lack of will to deal with important issues.

In New Brunswick we have, of course, a small population base distributed over the province although 85% (or more) of the population lives within 50 kms. of a major centre. With the health authorities and laundry consolidations there is a regular shuttle that connects small and large centres and nursing homes on a regular basis. So getting lab specimens from point of care to a consolidated lab should not be a huge challenge.

In the 1996-97 the Department of Health, in collaboration with the Region Hospital Corporations, appointed a committee chaired by Jean Castonguay who was then Assistant Deputy Minister of Health, tasked with conducting a detailed analysis of lab services in NB. Senior managers, pathologists, and technologists were involved as were experts in laboratory service from the private sector. The committee published a report that had the unanimous assent of committee members. The report was disregarded by the region hospital corporations and remains in the archives.

This lack of will was best illustrated for me in 1998 when, as the newly appointed Executive Director of the NB Department of Health Hospital Services Branch. One of the first significant matters on my desk was the idea of consolidating Microbiology labs in Moncton. What we had were two major, excellent

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hospitals just a few blocks apart, both treating the same types of patients, both with booming Laboratories and wonderful professional staff.

But the question was raised: why do two hospitals that close together, need to maintain such highly expensive technology? Specimens could be taken back and forth and results could be sent easily over the internet via computer. The caliber of professional staff required to maintain such a laboratory are not in great abundance in Canada so despite any cost benefits, consolidation would make better use of highly skilled professional staff. With the volume of activity it might, also, allow staff to sub-specialize in their professional activity and interest.

Consolidation did not happen largely because one hospital was English, the other Francophone. Yet in other major cities in North America such facilities operate with a high percentage of Spanish or Italian or Greek speaking personnel. Language is not nor should it be a barrier to excellence and efficiency.

What has also happened at break-neck speed is the rapid development of point of care testing. At the time of regionalization in 1992, the regional administrations were dealing with new issues of maintaining diagnostic services in small rural communities. This is a huge problem because unless graduates of Medical Laboratory Technology particularly want to live with their families in a rural setting, the majority opts for the positions in regional or larger centres. They do that for many reasons, mostly lifestyle.

Some rural communities have been enormously blessed when local people take lab training and want to return to their rural home community. In many situations in Canada, the local facilities have made it financially worthwhile for such persons to live and remain in the small community. Rural small communities have much charm and much to be said for them; but the point is that in filling key positions, recruitment has many more challenges than are experienced in the cities.

In the early days of regionalization, we raised the issue of *point of care testing* as an option not only for rural communities but for urban, as well. At that time the diagnostic services companies were developing small hand-held devices that, with a pin prick, enabled the user to get multiple determinations from a drop of blood. And they were telling us that soon we could be doing blood sugar monitoring easily at point of care and many other tests routinely used by physicians.

That was not a popular discussion and professionals were, with justification, concerned about accuracy and reliability of test results. What was not acknowledged in those discussions is that with any testing done in conventional ways by the hospital system, there is a recognized level of “false positive” testing. I was first exposed to the incidence of false positives when I was CEO of a major teaching hospital and we were doing some serious analysis of diagnostic service volumes.

At the time I was told by seasoned clinicians and pathologists that getting accurate results on tests that form the basis of medical decision-making and therapy, it is essential to do multiple tests. As they explained to me, the first may or may not be totally accurate so if there is any doubt a repeat is necessary.

Fast forward to 2010 and point of care testing has become well established in managing chronic disease. Many diabetics, and others with conditions requiring regular monitoring and medication adjustment, have devices at home, some wearable and others carried in the pocket.

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The same principle has now extended to routine home monitoring of cardiac status with simple, easy to use blood pressure monitoring devices and hand-held Electrocardiogram devices. Space technology has revolutionized diagnostics and it is fascinating to see how the bodily systems of astronauts are monitored on land when they are thousands of miles away.

The important thing for New Brunswick is to ensure that those who guide this development be those who have done it before. All too often we establish a dream then wonder why it fails or struggles. One central reason for failure is our failure to populate the team with experienced people who can recognize minefields and act on them.

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