DECRH $200 million to fix what?

Ask people around town and inevitably the overcrowded Emergency Department and issues at the Primary Care Level loom large in conversation. It has long been established that the overcrowding in the Emergency along with the long waits are not only unnecessary but entirely preventable. Yet it goes on with no apparent light at the end of the tunnel particularly for elders.

The government of NB announced in 2017 an investment of $200 million in new construction and renovations at the hospital and the project is well underway with large steel framing visible from the highway. It is a building from the 1980's and is in need of some upgrades. But would you not think that one of the main construction elements would be the creation of a facility to eliminate the Emergency Department overcrowding? Do we have any hope that there is some solution out in the community medical practice world that is destined to fix this problem?

Not on your life and you can take that to the bank! Some family doctors are now practicing in teams which are a modern adaptation of the old group practice. But it is entirely a medical model and thus far not demonstrating impact on waits in emergency or the overcrowding.

When the Chalmers was originally planned, and we are going back to the 1970's, the planners intended the building to house an Urgent Care facility. That was to be a facility separate from the Emergency Department where persons with non-life-threatening conditions would be dealt with. This was a model then being developed in some other jurisdictions and professional hospital planners were advancing the concept in construction projects in various locations.

For reasons that I can only guess, although an educated guess, that concept did not fly in Fredericton although it did in Bangor where the Emergency Room Doctors proudly asserted patients will not wait in our Emergency Department! And the public has been at the mercy of an inconsistent system of family medicine for decades with rapidly declining capacity to respond to urgent but non-life-threatening situations.

In many areas in which proper Urgent Care services exist, what can take 14 hours in Fredericton can be cared for in half an hour elsewhere. I know! I have had that experience with my family.

So why the hang-up with Urgent Care systems in New Brunswick? No one, except for these columns, has cast that vision. But our planners should spend a few dollars from their travel budgets and go to visit some Urgent Care systems that actually work.

Another factor is, I believe, the lack of interest on the part of the Medical Profession. Doctors have, for generations, controlled what health care services are available and in New Brunswick we have had an array of "after-hours clinics" spring up as a surrogate for Urgent Care. But the two ideas are not at all the same. Great Urgent Care feeds off access to the patient history, chart, and all recent diagnostic tests and medications. In the state of Georgia, you can go to the Urgent Care where they have, courtesy of the internet, access to your records so the physician, in ordering drugs, can see what you already are

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taking. And once treatment is completed and you are back home, you can access diagnostic results on your lap top or smart phone on the portal set up for you. This is just one of many illustrations of how it could and should be in New Brunswick.

An Urgent Care service on the hospital property makes it even so much easier because already on site is the lab, diagnostic imaging, and all the other wide array of diagnostic infrastructure.

But another source of push-back is that in New Brunswick we have not yet figured out how to structure primary care so that doctors, nurse practitioners, physician assistants, nurses and others function smoothly as a team. Oddly enough that works well in some specialized clinic areas such as Diabetes where physicians, advanced trained nurses and support staff manage a full and growing caseload.

So if it can work with specialty areas, why not at the Primary Care level? Could I suggest it is a factor of inspired leadership or the lack thereof? Part of the issue simply is the method of compensation which we have known for decades. If a family doctor wishes to hire a Nurse Practitioner as part of his/her practice, the NP salary and benefits come from the doctor's Medicare billings. So why would a family doctor want to do that?

If the same Nurse Practitioner goes to work in an approved position with the health authority or a nursing home, the salary and benefits are paid by "the system". With this latter arrangement, what we continue to perpetuate is the doctor's practice and the Nurse Practitioner's practice, all practicing in the absence of true collegiality.

But the really successful models in which care is consistently superb have physicians, Nurse Practitioners, Physician Assistants, and in some cases Chiropractors and Providers of Natural Medicine advice, nutritionists, social workers all working as a team.

In a progressive Dementia Program in Florida they refer to services provided by non-physicians as "Complementary Medicine", as opposed to competitive with medicine! Dr. Linda Lee discovered that in the care of persons with Dementia, her patients did best when treated by a complete team, not just by the physician. Her success has resulted in over 200 such clinics in Ontario in just 3-4 years.

So why not create an integrated Urgent Care Centre as part of the $200 million expansion? In setting priorities, was that even considered? And if not, how did planning miss that which is so critical to the public?

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