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Challenges in Ontario Health Care: A Personal Reflection

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Recently I had the occasion to witness challenges in Ontario health care in a personal way. My friend, G, who was diagnosed with pancreatic cancer, had lived eighteen more or less good months since the diagnosis. But, with much of her family away to attend to another health crisis, G fell ill with what turned out to be a large blood clot in her lung. It was not unexpected but it signalled what was likely to be the beginning of the end. When I got the call from her, she was in the emergency department (ED) of our local hospital.

Before describing what happened next, I want to be very clear that despite the very challenging circumstances that hospital staff faced, G and her family received excellent care—absolutely excellent care.

With the need to discover what was causing her to feel suddenly weak and short of breath, G came into the ED and eventually had the scans that identified the presence of the blood clot and the inevitable and deadly spread of the cancer. She had a do-not-resuscitate order in place and had registered with Palliative Care some months earlier. The time had come for her to be admitted to the unit. Unfortunately no beds were available in Palliative Care—or, as it turned out, anywhere else in the hospital. Ultimately, my dying friend spent four days in a cubicle in the ED.

Again, I cannot emphasise enough the excellent quality of the care she received. Once it became clear that she was not going anywhere else quickly, she was treated as an admission. Staff had the ED gurney on which she was lying replaced with a hospital bed. Nurses were aware that G was palliative; as soon as they were able, they moved her to a cubicle in a (relatively) quiet section of the unit. My friend was not the only admission in the ED. I understand that one evening there were more than ten cubicles occupied by admissions waiting to go upstairs to med-surg units.

THE CONSEQUENCES OF HAVING ADMISSIONS IN EDS

Originally emergency departments were meant to treat sudden-onset, life-threatening events: heart attacks, traumatic effects of accidents and assaults, poisonings, overdoses and so on. Today people also present themselves at EDs for after-hours care and worrisome symptoms. In 2017-2018, there were 5.9 million visits to EDs in Ontario hospitals and the 2018 Health Care Experience survey found that in 41% of cases, patients "received care for a condition that could have been treated by their primary care provider."[1] Despite the expansion of usage, the basic dynamic of EDs remains the same: assess and then treat and/or transfer. The ED is meant to be a way station for patients rather than a destination for ongoing patient care.

The obvious consequence of having patients occupy ED beds as admissions is that those spaces are then not available for other emergency room patients. The ED gets backed up, which can have serious negative effects for patients who desperately require care. But there are additional difficulties.

Again, emphasizing the very good care that my friend received, G nevertheless had to contend with the realities of being in the ED—the noise of the machines, the distress of other patients and their families, the lights that were always on. Furthermore, staff had to contend with a patient who did not fit the ED profile—a patient who required palliation.

There was only one occasion during which G had to wait over an hour to receive pain medication. That it was only one occasion was remarkable, given the triage that drives patient care in such a setting. For instance, a person in cardiac arrest may require all of the resources available, meaning that other patients simply have to wait, including a palliative patient overdue for her pain meds. This is obviously hard for the patient but health care professionals can also find it frustrating, even heartbreaking, not to be able to provide the care that patients require.

But having admitted patients occupying ED beds can have further implications as other patients requiring emergency care must either wait or be treated in settings not normally used for patient care, such as hallways. The practice of "hallway medicine" is, according to one expert quoted in a recent *Toronto Star* article, '"associated with greater complications, medical error, delayed treatment and higher death rates... There are other issues—increased risk of delirium, violence, costs to the health care system, ambulance off-load delays leading to inadequate ambulance response times and system gridlock so rural hospitals cannot transfer their patients to university hospitals for advanced care....'"[2]

HOW DID THIS CRISIS COME ABOUT?

This type of crisis in the ED occurs when there is nowhere to send patients because there are no beds available anywhere in the hospital. This can happen when there is a flu outbreak, for instance, or in towns where the summer population swells because of tourism. In cases like these, admission surges occur. But the term "surge" implies a situation that is temporary, where a wave comes forward and recedes again. However, what many hospitals in Ontario are currently experiencing is something more like climate change, where water levels are on the rise in a permanent way. The question is: what is causing this sea change in acute care settings? The short answer, as many people see it, is the increasing number of Alternate Level of Care (ALC) patients.[3]

I have written about ALC patients in an earlier volume of *Bioethics Matters*.[4]These are patients, usually elderly, who present in hospital with an acute condition requiring hospitalization. Once the condition is treated successfully, or as well as it can be, the patients may display other conditions—confusion, for instance, or loss of mobility—which do not require the resources of an acute care hospital but which nevertheless make it unsafe for them to return to their homes. Unfortunately the shortage of beds in appropriate care settings means that there is nowhere for these patients to go and so they continue to occupy beds in acute care hospitals for days, weeks, even months at a time. According to the Ontario Hospital Association, "In October 2018, there were 4,635 alternate level of care (ALC) patients ...occupying one in six beds…[which is] equivalent to more than 10 large hospitals, filled each day by patients who should be cared for elsewhere."[5]

During G's stay, our middle-sized hospital in a southern Ontario town had almost one-third of its beds upstairs occupied by patients waiting for placement in appropriate care settings outside of the hospital. And so G had to stay in the ED.

As a Health Quality Ontario report notes, patients waiting in the ED and patients waiting for placement outside the hospital may both "receive care that is less that optimal."[6] In the case of ALC patients, once the acute event has been resolved, they continue to have care needs that may not be given priority—and may even be

overlooked—in the acute care setting. These needs include "Personal care (activities of daily living, assistance with meals) and comfort."[7] Informal caregivers—family members usually—may step in to help with meals and hygiene; even so, this may come at a cost to them as they must juggle these tasks with caring for other family members including children, working outside the home, attending school and so on.[8] It can be a frustrating and stressful situation as, in many cases, informal caregivers of ALC patients may witness what they consider to be the de-personalization of their loved ones by staff. For them, an acute care setting can be a place where "the *person* tends to be overlooked within an environment geared to the *patient*."[9]

ALC PATIENTS AND THE HEALTH OF THE HEALTH CARE SYSTEM:

There can be a tendency to blame ALC patients and identify them as, if not the root of, at least a significant contributing factor in the current health care crisis. Unfortunately, it is easy to see how this might happen. In a society that values youth and vitality and which goes to great lengths to hang onto them as long as humanly (and surgically) possible, persons who are older are often the victims of deeply held prejudice. Older persons who may present as frail, confused, immobile and perhaps incontinent may be regarded—and treated—as less than human. They may be identified by their infirmity, exist as perpetually nameless "Sweetie" and "Dear," or they may simply be invisible. As one author puts it, "the oldest old remain objects of care often spoken and written about in 'post-human' terms."[10] This makes it easy to objectify this particular patient population further, labelling them as "bed blockers" and as the problem that will ultimately lead to the demise of the health care system.

Clearly, to do this is to overlook the inherent dignity and value of every human person, value and dignity that are always present no matter what the person's condition or stage of life. In a 2015 General Audience, Pope Francis addresses the prejudices faced by persons who are older. He states that, "The Church cannot and does not want to conform to a mentality of impatience and much less of indifference and contempt, towards old age. We must reawaken the *collective sense of gratitude*, of appreciation, of hospitality, which makes the elder feel like a living part of his community."[11]

More to the point, how we treat older people not only affects them but says a great deal about us as a society. As Pope Francis notes, "The care given to the elderly, like that of children, is an indicator of the quality of a community."[12] The question, of course, is: what sort of a community to we aspire to be? Governments know the numbers: "Ontario's senior population ... is expected to almost double from 2.4 million, or almost 17% of the population in 2017 to 4.6 million, or almost 25% by 2041."[13] Furthermore, at this time, Ontario's six hundred and twenty-seven long-term care facilities are "at 98% capacity"[14] while there are over 34,000 people waiting for placement in long-term care facilities.[15] Meanwhile, the Ontario government has plans to add 15,000 beds over the next five years with just over 7,000 coming in the next one to two years.[16] Of course not all seniors who require care are destined for long-term care facilities. In 76% of cases, those over 75 years of age who receive care are in fact receiving home-based care. However, given the projected numbers, to "maintain that ratio, the system would need to provide home care services to 97,194 more clients." [17]

If we go by these numbers, it seems that seniors who require care in Ontario are at grave risk of neglect and harm, and will be for some time to come. By failing our seniors in this way, our "economically advanced society" stands in direct contradiction to what John Paul II calls a "fully human civilization" that "shows respect and love for the elderly".[18]

Furthermore, the numbers indicate that the "problem" of ALC patients is not going away any time soon and blaming this vulnerable patient population for the woes of the health care system may simply be much easier than admitting that our health care system is rapidly losing its way. In this sense, the ALC patient population—far from being useless or without worth—has been given a prophetic role. As one health care administrator put it to me, the ALC patients are the canaries in the coal mine—and they are suffocating.

As for my friend G, after four days in the ED she was sent upstairs to a med-surg ward where she continued to receive care as a palliative patient. A bed in the small palliative care unit became available and she died there very peacefully a few weeks later. ■

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[2] Theresa Boyle, "Waitlist for long-term care hits record high", *Toronto Star*, September 16, 2019, p. A5.

[3] See, for instance, Ontario Hospital Association, "A Balanced Approach: The Path to Ending Hallway Medicine for Ontario Patients and Families. Pre-Budget Submission 2019 Ontario Budget" https://www.oha.com/Bulletins/A%20Balanced%20Approach%20-%202019%20Pre-Budget%20Submission.pdf ; Health Quality Ontario, "Measuring Up 2018", p. 21 https://hqontario.ca/Portals/0/Documents/pr/measuring-up-2018-en.pdf

[4] Bridget Campion, "The Plight of ALC Patients: A Call to a 'Revolution of Tenderness'" *Bioethics Matters/Enjeux Bioéthiques* (2014) 12(5), pp. 1-4.

[5] OHA, "A Balanced Approach"

[6] HQ Ontario, "Measuring Up", p. 21.

[7] Kerry Kuluski, Jennifer Im, Mary McGeown, "'It's a waiting game' a qualitative study of the experience of carers of patients who require an alternate level of care", *BMC Health Services Research* (2017) 17: 318 , doi: 10.1186/s12913-017-2272-6

[8] Ibid.

[9] Ibid., italics in original.

[10] Silke van Dyk, "The othering of old age: Insights from Postcolonial Studies" *Journal of Aging Studies* (2016) doi: 10.1016/j.jaging.2016.06.005

[11] Pope Francis, "General Audience, Saint Peter's Square, Wednesday, 4 March 2015" https://w2.vatican.va/content/francesco/en/audiences/2015/documents/papa-francesco_20150304_udienza-generale.html. Italics in original.

[12] Pope Francis, "Address of Pope Francis to the Sant'Egidio Community, Basilica of 'Santa Maria in Trastevere' Sunday, 15 June 2014" http://w2.vatican.va/content/francesco/en/speeches/2014/june/documents/papa-francesco_20140615_comunita-sant-egidio.html

[13] "Hallway health care"

[14] Ibid.

[15] News Ontario, "Ontario investing in new long-term care beds in Brampton" https://news.ontario.ca/mltc/en/2019/07/ontario-investing-in-new-long-term-care-beds-in-brampton.html

[16] The Canadian Press, "Health ministry to add 1,157 long-term beds across province" https://www.cbc.ca/news/canada/toronto/moh-announces-1157-more-longterm-care-beds-1.5067857

[17] "Hallway health care"

[18] John Paul II, "Letter of His Holiness Pope John Paul II to the Elderly, 1999" https://w2.vatican.va/content/john-paul-ii/en/letters/1999/documents/hf_jp-ii_let_01101999_elderly.html