Canadian Journal of Rural Medicine
CJRM CMR
Journal canadien de la médecine rurale

# Descriptive Article
# Article descriptif

# Patient advocacy by rural emergency physicians after major service cuts: the case of Nelson, BC

*Richard Fleet, MD, PhD, CCFP(EM)*
*Department of Family and Emergency Medicine, Université Laval, Québec, Que.; Research Centre of the Hôtel-Dieu de Lévis, Lévis, Que.*

*Jeff Plant, MD, FRCPC*
*Faculty of Medicine, University of British Columbia, Vancouver, BC; Department of Emergency Medicine, Penticton Regional Hospital, Penticton, BC*

*Rhonda Ness, MD, FRCPC*
*Department of Emergency Medicine, Foothills Medical Centre, Calgary, Alta.*

*Shiraz Moola, MD, FRCSC*
*Department of Obstetrics and Gynecology, Kootenay Lake Hospital, Nelson, BC*

*Correspondence to:*
*Richard Fleet;*
*rfleet@videotron.ca*

*This article has been peer reviewed.*

Efforts at cost containment through regionalization have led to reduced services in several rural emergency departments (EDs) in Canada. As a result, questions have been raised about patient safety and equitable access to care, compelling physicians to advocate for their patients. Few published reports on physicians' advocacy experiences pertaining to rural EDs exist. We describe our experience of patient advocacy after major service cuts at Kootenay Lake Hospital in Nelson, BC. Despite mixed results, we suggest increased physician involvement in patient advocacy.

Les efforts de compression des coûts par la régionalisation ont abouti à une réduction des services dans plusieurs services d'urgence en milieu rural au Canada. En résultat, on s'est interrogé sur la sécurité des patients et sur l'accès équitable aux soins, ce qui a poussé les médecins à se porter à la défense de leurs patients. Il existe peu de rapports publiés sur les expériences des médecins en représentation des patients dans le contexte des services d'urgence ruraux. Nous décrivons notre expérience en représentation des patients après d'importantes réductions de services à l'Hôpital Kootenay Lake de Nelson (C.-B.). En dépit de résultats mitigés, nous suggérons que les médecins interviennent davantage en représentation des patients.

At 4 am, an elderly patient presented with abdominal pain. I (R.F.) performed bedside ultrasonography in search of an explanation for her pain. She had a large (6.5 cm) abdominal aortic aneurysm and urgently needed vascular surgery — only the service was 400 km away. While I explained the situation to her, she interrupted: "Doctor, by the way, I want to thank you for standing up for us. I have read you and your colleagues' articles in the newspapers about your opposition to the service cuts. We used to have a fabulous hospital here before all the cuts. I understand some of you may leave, and I don't blame you." Surprised and touched, I forged ahead with my explanation of her medical condition and arranged an urgent transfer. At the end of my shift (around 7 am), she told me unequivocally, "Doctor, if I don't see you again, promise me one thing: please continue the fight."

Unfortunately, her transfer did not go well. The plane was delayed several times, and she eventually was transferred by road ambulance — a 5-hour transport. She arrived unacceptably late, at about 6 pm. She died before surgery.

We wish to dedicate this article to the memory of this patient.

## INTRODUCTION

Roughly 20% (6.3 million) of Canadians live in a rural area,[1] and a substantial proportion of emergency visits occur in rural settings.[2,3] Attempts to control spiralling costs of health care have lead several provinces to adopt a model of regionalized care, resulting in substantially reduced local health care

services in many rural areas.[4,5] The challenges of practising emergency medicine in rural settings with limited resources are implicitly acknowledged; yet, few studies on the subject have been published. Media reports of emergency department (ED) closures and service cuts suggest patient safety may be compromised.[6,7] They also point to the increased burden that travel consequently imposes on patients and their families, who often travel for time-sensitive emergency care.[7] Service cuts may contravene the accessibility clause of the Canada Health Act, a key feature of our universal health care system.[8]

In 2002, the BC government closed several rural hospitals and reduced support services to others. At Kootenay Lake Hospital in Nelson, BC, the general surgical program, intensive care unit (ICU) and inpatient mental health unit were eliminated; radiography as well as laboratory services were reduced. Consequently, to obtain these services, patients were required to travel 74 km (1 h 15 min by road) to Trail, BC, where the regional hospital is located. The health authority's decision to accept ICU coverage gaps at the referral hospital was the tipping point in our resolution to further advocate for patients. We had no previous experience or training in patient advocacy. However, we felt patient safety was at risk and that it was our duty to advocate under our code of ethics as physicians.[9]

## METHODS

This is a qualitative case report by former ED physicians and a local obstetrician–gynecologist describing their advocacy experience at Kootenay Lake Hospital between 2006 and 2010. Information on interfacility transfers and specialist referrals was obtained from the hospital's medical records department, Interior Health Authority and BC Ambulance Service. Some information was released subsequent to a formal request under the Freedom of Information and Protection of Privacy Act.

### Study site

Kootenay Lake Hospital is located in Nelson, BC (population 9255).[10] The hospital is a 30-bed acute care facility that serves a regional population of roughly 30 000 people. The ED receives 13 000 visits annually. It is staffed by solo physicians on a continuous basis. Between 2006 and 2009, it was attended by full-time ED physicians 60%–70% of the time, with local family physicians and locums covering the rest. At the time, there were no local specialists continuously on call except for a single obstetrician–gynecologist. A single pediatrician was on call 3 days per week.

## THE PROBLEM

### Need for interfacility transport and travel

Between July 2008 and July 2010, the regional hospital was unable to provide ICU coverage one-third of the time because of a lack of internal medicine specialists. On these days, the closest ICU was in Kelowna, BC (a 447-km distance).

From 2006 to 2009, between 1100 and 1600 interfacility ground or air transfers were required per year, with most occurring on an emergency basis. Most transfers were required for computed tomography (CT), surgical and mental health inpatient services, and ICU care. Most interfacility transfers were conducted by ambulance crews with limited scope of practice (i.e., basic life support). Just one critical care transport team (serving a regional population of 80 000) was available for transport of patients with critical conditions. At the time, air transport of patients was restricted to good weather and daylight via fixed-wing air ambulance from Vancouver, BC.

In addition to ambulance transfers, a substantial number of patients were required to travel by their own means at their expense for elective investigations and consultations. From 2006 to 2010, more than 2000 patients per year travelled for CT, and about 4000 per year travelled for nongynecologic surgical consultations.

Anecdotally and by letter, clinicians reported to the ED chair (R.F.) and to the health authority that patient transfers were increasingly delayed. They also complained of limited staff to care for critically ill patients over extended periods. Adverse events and near misses were reported.

## THE SOLUTION

### Patient advocacy efforts

After several ED meetings, we decided to focus on specific requests to improve patient safety. In the absence of evidence-based standards in rural emergency care, we based our requests on the most common reasons for interfacility transport and what levels of services were offered in similar communities in British Columbia. Most of the ED physicians had previously trained and worked in academic centres, and requests for services were mapped to generally accepted practice patterns in emergency medicine.

## MAIN ADVOCACY OBJECTIVES

### Acquisition of a CT scanner

Considering the high number of referrals and interfacility transfers for CT, in fall 2007, we requested authorization to fundraise for the purchase of a CT scanner. We stated that diagnostic uncertainty without this tool could lead to inappropriate transfers, delayed care and, ultimately, adverse patient outcomes. Physicians and community leaders had been unsuccessful in their requests for a CT scanner for the previous 15 years. The health authority had refused purchase for reasons related to operational and maintenance costs.

### Recruitment of a general surgeon

Kootenay Lake Hospital is the only hospital in BC supporting this size population without a general surgeon. There have also been occasional threats of coverage gaps in surgery at the regional hospital in Trail. We requested that at least one local general surgeon be recruited, and we proposed that the general surgeon share call with surgeons at the regional hospital (as had been the case for 50 years before regionalization). The justification was that this would improve patient safety and minimize interfacility transport. A general surgeon would also support local ED physicians and the obstetrician–gynecologist. Recruitment was not an issue because at least 2 general surgeons lived in the city.

### Addition of high-acuity care beds

We felt that the ED should have at least 2 appropriately staffed high-acuity care beds and that the regional ICU should not authorize coverage gaps. Most of the hospital's ED nurses were former ICU nurses, and certified ED physicians were comfortable with prolonged monitoring of critical care patients under adequate conditions and with the support of local internists. A similar model is used in the province of Quebec.[11] The alternative consisted of a situation of increased pressures on the critical care transport system, and inappropriately lengthy periods of care for unstable patients in inadequately staffed and monitored conditions.

### Independent review

In the absence of evidence-based data on the level of services provided, we called for an independent review of the situation and suggested it be conducted by academic centres in emergency medicine.

## ADVOCACY PROCESS

Based on the aforementioned description of the situation, we proceeded through the following steps to advocate for improved access to services.

### Review the literature

We searched the scientific literature for reports of patient advocacy experiences by emergency physicians. In PubMed, we searched with the terms "patient advocacy" and "emergency medicine" (1990–2009). On a total of 165 articles, only 3 loosely pertained to our situation.[12–14] All called for increased advocacy by emergency physicians.

### Address administrative channels

Throughout the process of service cuts, we wrote multiple letters to our local and regional health administrators (Interior Health Authority, BC) advising them of the risks and challenges. We also held several "emergency" meetings with them and members of the medical staff. We wrote an ED in-house position paper and proposed solutions.[15]

The position paper was widely approved by the hospital's medical staff in an open vote. However, the hospital's medical advisory committee, its highest level of local administrative authority, refused to officially consider the position paper or forward it to the regional medical advisory committee for further debate. The local medical advisory committee consists of representatives of the medical staff (from several departments), local hospital administrators and Interior Health Authority administrators from the region. Medical staff members on this committee are generally unpaid elected representatives (most often by acclamation). These members usually rotate on yearly terms. However, 2 physicians on this committee, the chief of the medical staff and the representatives from the regional medical advisory committee hold Interior Health Authority–paid positions and theoretically have competing interests between the health authority and medical staff. There are no patient or community representatives on these committees.

### Address politicians

We discussed the ED position paper[15] with elected

officials (the mayor, city councillors, members of the legislative assembly, members of parliament), and it was submitted to Nelson City Council and other municipalities in the hospital's catchment area, where it received unanimous votes of support.

**Address patient advocacy groups**

Community advocacy groups were informed of the position paper.[15] These groups recommended that we urgently notify the public and offered to assist in the process. The Nelson and Area Health Task Force later submitted a petition to the BC legislature with more than 3000 signatures in support of the requests for services. Several members of an advocacy group wrote letters to newspapers, senior health authority administrators and the BC Ministry of Health. They held public forums with authors of the position paper and other local physicians. Hundreds of people and several politicians attended these forums.

**Address the College of Physicians and Surgeons of British Columbia**

We contacted the College of Physicians and Surgeons of British Columbia, describing the situation and asking for intervention. The college replied that "the distribution and allocation of healthcare resources are not a College mandate. The College Board will not be drawn into Health Authority and Ministry of Health Services resource allocation disagreements" (Dr. W. Robbert Vroom, senior deputy registrar, College of Physicians and Surgeons of British Columbia: personal communication, 2010).

**Address the media**

At advanced stages in our advocacy efforts and in view of failed discussions with the health authority, we informed the media. *The Globe and Mail* was first to report on Nelson.[7] Other print media and all local radio stations also reported on the situation. A local television production company posted an interview of local doctors on YouTube that earned more than 2000 views.[16]

## RESULTS

We characterize the consequences of our advocacy efforts as having both negative and positive features and impacts on the situation.

**Negative**

Media quotations from the Interior Health Authority questioned the clinical judgment, practice patterns and experience of physicians, and minimized the impact of the level of services on risk to patients. Moreover, after initial media reports, physicians involved in the advocacy efforts perceived that the Interior Health Authority vigorously attempted to dissuade physicians from further public interventions and questioned the rights of physicians to challenge administrative decisions. The response by the health authority instilled fear in fellow physicians. Several physicians were concerned about possible consequences, such as additional service cuts and recruitment issues, and about being further ostracized.

Over a 1-year period following the media events, 5 full-time ED physicians and 1 internal medicine specialist resigned. In total, 4 physicians left BC for other provinces.

For an interval of about 1 year, the ED relied on locums to cover at least 50% of the shifts.

**Positive**

Advocacy efforts contributed to the approval in 2008 from the Ministry of Health and the Interior Health Authority to fundraise $1.5 million for a CT scanner, which became operational in December 2011. However, despite successful community efforts to raise the entire amount, the CT scanner is currently operational only on weekdays, 9 am to 4 pm. The health authority cited a lack of staff and funds to cover continuous operation.

An unexpected positive outcome was the development of a research program dedicated to the study of access to rural emergency care. To date, researchers from 5 Canadian universities have participated in this program that was, in part, inspired by the Nelson case (www.medecineurgence.ca).

## DISCUSSION

To our knowledge, this is the first formal report on the experience of patient advocacy by rural emergency physicians after major service cuts to a hospital. We described how, over a 3-year period, we addressed administrative and political channels, consulted our professional college and, eventually disclosed our clinical concerns to the public. We believe the advocacy efforts raised awareness that resulted in the purchase of a CT scanner and the development of a research program. We were unsuccessful

in obtaining a local general surgeon and critical care beds. Our request for an independent review was also denied. Although the ICU coverage gaps were finally resolved at the regional hospital, the community-purchased CT scanner is functional only on weekdays.

Our initial rationale for requesting more services was based on our collective clinical experience in other rural and academic settings. At the time, we were unaware of any published standards or guidelines for rural ED care. The Canadian Association of Emergency Physicians' position statement on rural emergency care was informative, but it did not include specific guidelines for the provision of better access to advanced imaging services, general surgery and critical care coverage.[3] One article reported on the favourable experience of a rural community after it purchased a CT scanner.[17] Interfacility transfer data were useful to outline the potential costs incurred by the alternative to providing local services. Statistics on the level of services available in other communities with similar demographics were also beneficial. In summary, we perceived that the evidence provided to decision-makers, although limited, was useful in supporting our arguments in favour of the purchase of a CT scanner. Unfortunately, studies have yet to determine what sustainable level of services is required to provide safe care in rural communities.[18] In absence of standards, decisions on service attribution are not evidence-based.

Since the advocacy efforts in Nelson, in 2011, the Fraser Institute published its Hospital Report Card for BC.[19] The study used data from the Discharge Abstract Database and the Canadian Institute for Health Information. Nelson residents fell from fourth place (*4/47* municipalities in 2001/02, before health cuts) to last in the province in 2008/09 with respect to "failure to rescue," which is considered among the most important indicators of health care quality. This indicator describes mortality from complications that arose while a patient was admitted to hospital.[20] It is too early to estimate whether these new data from the Fraser Institute will help health advocates in their efforts to improve access to services.

In the face of equivocal results, a legitimate question is, why bother advocating? Is it the role of doctors to advocate for patients when it contravenes health authority policy? Certainly, the issue does not appear to be isolated to Nelson. Recently, the Canadian Medical Protective Association (CMPA) has commented on the challenging relationship between physicians and hospitals:

> The CMPA is very concerned by efforts to restrict healthcare providers from responsibly fulfilling the role of advocate. In the case of physicians, these restrictions are increasingly being seen in contractual arrangements, appointments or privileges processes or through the institution of physician "codes of conduct." In addition to posing a significant risk to patient safety, such restrictions are contrary to the lessons learned and the improvements adopted in safety-driven industries (such as the nuclear or airline sectors) where employees are encouraged to speak out to identify and correct unsafe practices.[21]

Furthermore, the role of advocate is encouraged by our professional credentialing colleges, and advocating is an obligation under physicians' code of ethics.[9] Community physicians who also hold positions as representatives of the health authority need to be cognizant of the potential risks for conflict of interest that would contravene our code of ethics. Physicians must be cautious, because their actions could be perceived as "rubber-stamping" health authority policy that compromises patient safety. These dual positions may hinder the patient advocacy process.

Finally, we ask, if front-line physicians, with their specific medical knowledge, do not advocate for their patients, who will?

### Limitations

We have reported the experience of patient advocacy by a group of physicians. Recall bias, and professional and personal perspectives may have influenced our interpretation of the impact of the service cuts described herein. Nevertheless, the opinions of the ED physicians were reported in official institutional documents (minutes) and in the media at the time of the events, which would minimize recall bias. Furthermore, the opinions presented here were unanimously supported by the medical staff. The position of the ED physicians was also supported by community groups, politicians and at least the 3000 people in the community who signed the petition. Thus, opinions presented here are likely not only those of the authors.

## CONCLUSION

Patient advocacy can be a complex, time-consuming experience with mixed results, and consequences of such action are to be considered. We still urge physicians to use their expertise to better inform health authorities, as well as the general public, when administrative decisions compromise emergency care. However, we suggest that formal training and support in patient advocacy would be bene-

ficial. Finally, without a continuously operational CT scanner, general surgeon, ICU and efficient critical care transport system, citizens of Nelson and the surrounding area continue to be at risk. Several universities are in the process of investigating issues of sustainable access to quality care in rural communities in Canada with the hope of improving care to rural communities.

**Acknowledgements:** The authors thank Julien Poitras and Julie Villa for their help in revising this manuscript.

**Competing interests:** None declared.

## REFERENCES

1. *Canada's rural population since 1851. Population and dwelling counts, 2011 Census.* Ottawa (ON): Statistics Canada; 2012. Available: www12.statcan.gc.ca/census-recensement/2011/as-sa/98-310-x/98-310-x2011003_2-eng.cfm (accessed 2013 Mar. 10). Cat. no. 98-310-X2011003.

2. Haggerty JL, Pineault R, Beaulieu MD, et al. Room for improvement: patient experience of primary care in Quebec prior to major reforms. *Can Fam Physician* 2007;53:1057, 2001:e.1-6, 1056.

3. Rural & Small Urban Committee of the Canadian Association of Emergency Physicians. *Recommendations for the management of rural, remote and isolated emergency health care facilities in Canada.* Ottawa (ON): Canadian Association of Emergency Physicians; 1997. p. 42.

4. Larsen Soles TM. A strategic plan for eliminating rural hospital services through the process of regionalization. *Can J Rural Med* 2005; 10:107-8.

5. Wong ST, Regan S. Patient perspectives on primary health care in rural communities: effects of geography on access, continuity and efficiency. *Rural Remote Health* 2009;9:1142.

6. Howlett K. Teen's death ignites debate over emergency room closures. *Globe and Mail* 2010 Jan 22. Available: www.theglobeandmail.com/news/national/teens-death-ignites-debate-over-emergency-room-closures/article4311042/ (accessed 2013 Mar. 10).

7. Newman S. Nelson doctors issue emergency aid plea. *Globe and Mail* 2008 Oct 7;S1-2.

8. *Canada Health Act*. R.S.C. 1985, c. C-6, s. 12.

9. *CMA code of ethics*. Ottawa (ON): Canadian Medical Association; 2004. Available: http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf (accessed 2013 Mar. 10).

10. Statistics Canada. 2006 community profiles. Available: www12.statcan.ca/census-recensement/2006/dp-pd/prof/92-591/search-recherche/lst/page.cfm?Lang=E&GeoCode=59 (accessed 2013 Mar. 10).

11. Fleet R, Audette LD, Poitras J. Comparison of rural emergency departments in British Colombia and Quebec: a pilot study. *CJEM* 2012;14:S27.

12. Bandiera G. Emergency medicine health advocacy: foundations for training and practice. *CJEM* 2003;5:336-42.

13. Hemphill RR, Sklar DP, Christopher T, et al. Emergency medicine and political influence. *Acad Emerg Med* 2009;16:1019-24.

14. Hurley KF. Advocacy and activism in emergency medicine: resident issues. *CJEM* 2007;9:282-5.

15. Report to MAC: KLH emergency department position regarding ICU and surgical services. 2008. Available: www.nelsonhealthtaskforce.org/media/MAC-report%20_sept_2008.pdf (accessed 2013 Mar. 5).

16. TMTV News. Nelson BC doctors plea. 2008. Available: www.youtube.com/watch?v=A10bShgP77k (accessed 2013 Mar. 5).

17. Merkens BJ, Mowbray RD, Creeden L, et al. A rural CT scanner: evaluating the effect on local health care. *Can Assoc Radiol J* 2006; 57:224-31.

18. Fleet R, Archambault P, Plant J, et al. Access to emergency care in rural Canada: Should we be concerned? *CJEM*. In press.

19. Barua B, Esmail N. *The Fraser Institute Hospital Report Card: British Columbia 2011*. The Fraser Institute; 2011. Available: www.hospitalreportcards.ca/bc/docs/Complete-Publication.pdf (accessed 2013 Mar. 10).

20. *Patient safety indicators: technical specifications*. Department of Health and Human Services, Agency for Healthcare Research and Quality; 2006. Available: www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V30/psi_technical_specs_v30.pdf (accessed 2013 Mar. 10).

21. *Changing physician-hospital relationships: managing the medico-legal implications of change*. Ottawa (ON): Canadian Medical Protective Association; 2011. Available: www.cmpa-acpm.ca/cmpapd04/docs/submissions_papers/com_2011_changing_physician-e.cfm (accessed 2013 Mar. 10).