

## The Domino Effect on Windsor-Essex County Health Care

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Over the last twenty years of working in Emergency Medicine in Windsor, I've witnessed and experienced a remarkable change in the provision of Health Care in our community. In the early to mid eighties 60% of emergency room visits were non-essential, meaning almost two-thirds of the approximately 40,000 visits to hospital could have and should have been seen by the patient's family doctors. However in the last two decades with the loss of family physicians and specialist, at least 60% of the now over 60,000 ER visits is categorized as essential. Why the change? What happened? First and foremost we lost physicians without being able to replenish the doctor pool. Some left us prematurely, others retired, few went on to the USA and some GPs closed practice to work in walk-in-clinics. Many of these physicians's had over 5,000 patients in their practices. If you do the math you realize that suddenly over 50,000 patients and hundreds of families are left with no primary care giver. Secondly, we baby boomers are unfortunately getting older. Though our minds may at times deny it, our bodies let us know that we are getting older. Now, neither your parents nor you have a family doctor. Where do we go to get treatment? Who's going to refill my mother's medication? My children need their immunizations. Who's going to do my physicals, check my cholesterol, blood pressure or answer my one hundred and one health care concerns? Etc... Etc... etc.... Who is going to be my primary care giver? The answer: clinics, urgent care centers, and emergency rooms. In the last few years clinics are becoming as common as Tim Horton's. Are they bad? No. These facilities are providing a band aide solution to a large open wound. The problem lies in the fact that Windsor-Essex County lacks at least fifty family physicians and an equal number of specialists. In fact our community is one of the most under serviced areas in Canada!

The clinics, urgent care centers and emergency rooms are now acting as primary care centers. That's not their area of expertise. Health care is a patient-doctor relationship based on trust, comfort, communication and continuity. Continuity of care is in my opinion, especially important. When the patient travels from one health care facility to another and yet another, it denies both the doctor and patient the opportunity to get to know each other. Even if clients visit the same clinic, they are experiencing the style or method of practice by a number of different physicians. These facilities by design exist solely for the purpose of caring for the patient's immediate problem. They look and respond to only one frame of the total picture.

Contributing largely to that aforementioned increase number of critical patients admitted the emergency departments, is this lack of primary care physicians. Suddenly our aging patient community with diabetes, depression, hypertension, emphysema, high cholesterol and coronary artery disease, just to name a few, are without a family doctor. There is no one to provide ongoing care, to do routine examinations, monitoring, teaching

and prevention. Prevention of future health problems through routine blood testing, Pap smears, PSA testing, colon exams etc., cannot be stressed enough. The result is the 'Domino Effect'. The consequence of leaving many of these illnesses uncontrolled, unchecked without the safety net of the family physician has resulted in significant mortality and morbidity in patients. Diabetics are presenting with high sugars and its complications. Hypertension left uncontrolled leads to cerebral haemorrhages, which are strokes. Chest pains uninvestigated can result in heart attacks. The end result is that patients are presenting to hospital sicker, with critical health problems, requiring longer length of stay in hospital and increased convalescent care, escalating the cost to the health care system. Within the last two months I've diagnosed two patients with invasive cancers of the rectum. The truly unfortunate part of this is that early detection could have meant a cure rather than palliative care and a poor prognosis. An ounce of prevention is worth several times its weight in gold and could mean the difference between life and death.

However, the saga doesn't end once the patient passes through the hospital doors. What happens to the patient requiring hospitalisation that has no family doctor or has one that doesn't admit to hospital? These unattached patients are then admitted under a specialist or hospitalist-physicians hired by the hospital to care for in house (hospital) patients. These physicians must become familiar with the patient and redevelop a trusting, working relationship during the few days or weeks of the admission. The problem lies in who, if anyone, continues the care and follow-up once the patients are released. Again, the care is spotty and lacks continuity. There are simply not enough primary care givers to oversee total patient care and the ones that are in practice are overwhelmed with the ever increasing patient workload, which will lead only to physician burn out and a further GP shortage.

The solutions are as inadequate as the system itself.

1. Increase the number of spots for medical students and residents. However, it will take a minimum of five years and more like ten years, before this added influx will be felt in the community.
2. Foreign trained physicians should be able to apply for licensure providing they have completed Canadian Speciality Exams and one to two years of residency at an approved facility that can monitor their clinical skills, thereby assuring they meet with Canadian Standards of Practice.
3. Limit the number of clinics in any one community dependent upon need and population. More clinics only add to the cost of health care and not to continuity of patient care.
4. Physicians practising in Ontario must be affiliated with a hospital in order to acquire a billing number. This will maintain continuity of care thus alleviating the workload on hospitalists and specialist.
5. If you implement solution 4, there must also be proper remuneration for physicians caring for their in house patients. A physician spending one and a half-hours plus transit time to care for six patients in hospital, can easily see twice that number of patients in his or her office. It is for this reason many physicians relinquish their

hospital privileges. This year a large number of family practice residency positions in the teaching centers, were not filled in the first round. The reasons are two fold: first, the work load is demanding and overwhelming; second. it doesn't pay to become a family physician. That's another reason why clinics are so popular. You can see far more people at a reduced stress level.

6. Medical graduates should be required to practise in Canada for a minimum of ten years before being able to exodus.
7. Physicians like lawyers should be allowed to bill patients when providing phone advice.
8. Patients need to be charged a fee when using the Health Care System. This can be based on illness severity, age and income. This would then be an allowable Medical expense that would be appear on your tax return. Anything given for nothing is abused and not appreciated. Even better would be to change the GST to a Health Care Tax (HCT) so that the revenues generated would give the 'illusion' that they were actually earmarked for the Health System.
9. The Ontario Government must increase health teaching and prevention.