Reduced Access to Higher-Acuity (Specialized) Care at South Muskoka Memorial Hospital in the "Made-in-Muskoka" Model

Prepared by
Save South Muskoka Hospital Committee

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The Save South Muskoka Hospital Committee (SSMHC) has concluded that the Muskoka Algonquin Healthcare (MAHC) Stage 1.3 Functional Program, entitled "Made-in-Muskoka", will result in a reduction in the future South Muskoka Memorial Hospital's (SMMH) ability to provide higher-acuity care. This assessment is based on our review of the Stage 1.3 Functional Program received through a formal Freedom of Information process (available at ssmh.ca) and consultations with local healthcare practitioners to incorporate insights from those with direct clinical experience.

Acuity refers to the severity and complexity of a patient's condition and the level of care required to treat it safely and effectively. Acuity levels assist healthcare providers in prioritizing care, allocating resources, and determining staffing requirements, ensuring that patients receive appropriate attention based on their condition. The clinical capability of hospitals to address higher-acuity conditions varies based on several factors, including provincial classification, the availability of specialized services, and the range of programs offered. Additional factors include hospital administration, operational practices, physician and nursing resources, and the ability to sustain specialized expertise.

The Stage 1.3 Functional Program reduces or eliminates services at SMMH, including a reduction in acute care beds, restrictions on inpatient admissions based on patient condition, and the elimination of both rehabilitation/recovery and dedicated obstetrical services. These changes will create sustainability pressures and strain medical practice, with a resulting erosion of SMMH's ability to provide higher-acuity care, as further described below.

Obstetrical Services and Emergency Care

Obstetrical services have been closed at SMMH since March 2025 and only limited birthing support will be offered at the future SMMH site. This situation will result in reduced acuity capability at SMMH. For example, as elective C-sections will no longer be performed at SMMH, surgeons on-call will not maintain routine exposure in the same way they would in an active

obstetrical program. That creates a concern about whether SMMH can continue to respond to the same level of obstetrical urgency as before, particularly where immediate on-site specialized support is no longer available.

Similarly, centralizing obstetrics to the Huntsville site increases the burden on the SMMH emergency department, because obstetrical emergencies do not disappear even when the supporting obstetrical unit is removed. These patients will instead present first to the SMMH emergency department, where physicians must stabilize patients in high-stakes situations while relying on specialist support based in Huntsville. However, obstetrics requires specialized training and ongoing support to maintain skills and a current level of practice; emergency room physicians are not necessarily trained or credentialed to provide obstetrical care.

These changes matter because the resulting strain on the Emergency Department directly affects the hospital's ability to sustain higher-acuity care. A model that expects emergency physicians at SMMH to shoulder greater obstetrical risk without the support of a local dedicated obstetrical program will make physician recruitment and retention more challenging. If emergency physicians are reluctant to practice in an environment where they may face obstetrical emergencies without onsite specialist support, SMMH becomes harder to staff. Once staffing becomes more difficult, the effect is not limited to OB care - it affects the hospital's ability to manage acute presentations safely and consistently across all areas of emergency medicine.

This concern also extends to NOSM University medical students seeking broad clinical exposure, including obstetrical practice. NOSM represents one of MAHC's best opportunities to recruit and retain physicians in South Muskoka. A model that provides only limited exposure to obstetrical practice will reduce the attractiveness of SMMH as a teaching and recruitment site.

Internal Medicine and Other Specialist Care

Internal medicine as a specialist practice will be pressured under the Stage 1.3 Functional Program and, if not addressed, will risk SMMH's acuity response capability. Notwithstanding the significant questions regarding the ability of a 46-bed hospital to recruit and sustain internal medicine specialists, the proposed constrained admissions approach creates an additional challenge by limiting the continuity-of-care opportunities that are an important component of an attractive and sustainable internal medicine practice environment. If inpatients can be stabilized in SMMH but then are administratively transferred to Huntsville due to length of stay, the specialist coverage at SMMH is, by design, insufficient to carry the patient through the full admission. This disruption is not a benign, neutral handoff for patient care. It disrupts the treating physician relationship, interrupts evolving clinical judgment, and risks delays or fragmentation in specialist input at exactly the stage when more complex patients often require careful reassessment, coordination of diagnostics, and adjustment of treatment plans. As a result, the acuity capability of the hospital is reduced, both by design and through the pressure placed on its ability to attract specialists and support related care.

Nursing Workforce and Service Sustainability

Nursing represents another key pressure point within the Stage 1.3 Functional Program, as the proposed service model may affect SMMH's ability to recruit, retain, and sustain the nursing resources required to support higher-acuity care. Concerns have already been raised publicly about nurses being shifted between sites to fill schedule gaps, particularly toward the Huntsville site. A future model centered on a much larger hospital in Huntsville raises a practical question: if staffing shortages persist, will the larger, regional site receive priority, leaving SMMH increasingly exposed to coverage shortfalls? If so, then SMMH may retain services on paper while losing the staffing stability needed to keep beds open, sustain inpatient complexity, and support higher-acuity care on a reliable basis.

Implications for Town of Bracebridge and South Muskoka

Even if the formal service description for SMMH remains acute care, the Made-in-Muskoka model will predictably erode several of the conditions that make higher-acuity local care possible: active procedural practice, specialist support, physician recruitment, inpatient capability and depth, and stable nursing coverage. Once those conditions weaken, the kinds of cases that can be handled locally will narrow, transfers will increase, and care provider and community confidence in the site will decline.

For the Town of Bracebridge, the planning question should not simply be whether SMMH will continue to be called a hospital, but whether it will remain capable of safely managing the same level of urgent and complex care that a growing community reasonably requires. Based on the information currently available, including the Stage 1.3 Functional Program and consultations with the local medical community, SSMHC has concluded that there is a clear and reasonable basis to expect that the Stage 1.3 Functional Program will reduce the acuity response capability of the future SMMH.