

## **PRESENTATIONS TO THE MEDICAL ADVISORY COMMITTEE**

***Please note that in the Question/Answer section of the Report, questions or comments from MAC members are italicized***

### **1.0 Chair's Remarks:**

Dr. Sischek called the meeting to order and thanked the Medical Advisory Committee members for their presence at this precedent-setting, daylong meeting. The members of the MAC committed to this meeting to ensure presentations were heard and that all new or different information was brought forward to everyone's satisfaction.

Subsequently, Dr. Sischek highlighted the background events leading up to today's meeting. During 2000/2001, the London Health Sciences Centre engaged in a comprehensive review of the clinical and academic enterprise. This initiative, commonly known as "Scoping and Sizing" arose from the recommendations of the Operational Review of 1999/2000. The review indicated that LHSC could not continue to "be all things to all people" and that difficult choices needed to be made. In the Fall of 2000, a Steering Committee was struck to oversee the Scoping and Sizing initiative and the final recommendations were presented to the Board of Directors on September 4, 2001. On October 2, 2001, the Board approved those Scoping Recommendations.

Subsequently, issues were raised regarding the information available to the Board of Directors on September 4<sup>th</sup> and the Board directed the Medical Advisory Committee to receive and assess new information on their behalf.

Dr. Sischek reminded the membership that the Board was relying on the broad-based insight and professional knowledge of the members of MAC to provide objective and unbiased advice in assessing the information presented as being new or different from that which the Board received with the Scoping recommendations on September 4<sup>th</sup>. He also commented that a report, summarizing the day's work, would be drafted and circulated to all members for review and comment, prior to the report being provided to the Board of Directors for the December 18<sup>th</sup> Board meeting.

Dr. Sischek reminded the members that following the presentations and question/answer period, the MAC would enter into its decision process regarding the content of the presentation. The first issue to be addressed was:

Is the information presented substantially new or different than that which was presented to the Board of Directors in the Scoping Recommendations?

A vote would then be taken and recorded regarding this decision. Should it be decided that the information was new or different, the MAC would need to make a recommendation regarding the information. Dr. Sischek highlighted the three possible recommendations:

1. The Scoping recommendation should continue to the implementation phase of discussions. Issues of medical safety or quality of care will need to be visited again there.

2. The new or different information impacts to a significant extent on the Academic mandate and should be reviewed in conjunction with the Office of the Dean of Medicine.
3. The new or different information is significant enough that it should cause the Board to more fully reconsider this Scoping recommendation. We would advise against going to implementation planning until this has happened.

Dr. Sischek reminded the members that all information regarding the MAC deliberations prior to the vote, results of the votes and recommendations to the Board were to be considered privileged information. The release of the information was at the discretion of the Board of Directors.

Dr. Rorabeck expressed his concern with respect to the inability of sharing the outcomes of the day with his department members. Lengthy discussion ensued and members were respectful of the process outlined and agreed that outcomes, votes and decisions could not be shared with others until the information had been presented to the Board. It was agreed that the content of the discussions and decisions would be privileged information for use by the Board of Directors.

It was suggested that a communiqué be drafted by the group at the end of the meeting that could be shared with all physicians on December 6<sup>th</sup>.

**ACTION:**  
*A communique will be written for distribution to all physicians on December 6, 2001.....Dr. Sischek*

Dr. Sischek also made the Committee aware of a late change in the agenda. Dr. Colby had decided not to present on the Travel Clinic. There was however a late request from Dr. Bourne to present to the MAC on issues pertaining to the Division of Orthopedic Surgery. In his capacity as Chair Dr. Sischek had informed Dr. Bourne that, time permitting, he would be able to present to the MAC. Details would be discussed later in the day.

**2.0 Presentations:**

**2.1 Adult Cardiac Transplantation:**

Dr. Wall, Director of the Multi-Organ Transplant Program, Dr. Klein, Division Chief, Department of Cardiology, and Dr. Chow, Site Chief of Cardiology, University Campus presented regarding the Scoping decision on Adult Cardiac Transplantation (Appendix 1).

The following summarizes subsequent discussion with the presenters in attendance:

- *Is cardiac transplantation a "standard of care"?*  
 Cardiac transplantation is accepted treatment. It is recognized and cost-effective. The longest survivor now is twenty-eight years post surgery. Transplantation is not an end-stage procedure; the procedure results in improved quality of life.

- *With respect to the aging population, will transplantation increase?*  
The age of patients receiving transplantation is increasing; sixty years of age is common, as survival of an older patient is good. More patients in the future will require cardiac transplantation, regardless of other innovations in the management of cardiac failure.
- *What are your thoughts with respect to artificial hearts and Left Ventricular Assist Devices?*  
We could not do these procedures without the funding.
- *The Program is funded by the Ministry for twenty (20) heart transplants per annum regardless of whether the number of twenty is reached and we are doing approximately fifteen (15). What happens to the formula if the volumes were to increase?*  
Administration will need to negotiate another agreement with the Ministry.
- *It is clear to me that the academic integrity of the London Health Sciences Centre and the University of Western Ontario are affected with this scoping decision. What would be the effect on postgraduate education (ie. Anaesthesia, Cardiology, ICU)?*  
There is not a service that is not affected. Pathology has an interest in xenotransplant, Infectious Diseases does consults, Nephrology/Dialysis consult on patients with end stage cardiac disease, just to name a few.
- *There would be an impact on research. Small bowel transplant was of interest to Pathology, and with this clinical program gone, we will not do the research. I worry that if this Transplant Program is gone, research on xenotransplantation will stop. This may have negative repercussions on retention.*
- *With respect to referral patterns, how many heart transplants are from Southwestern Ontario?*  
20% are from Southwestern Ontario.
- *In view of the increased trend in heart failure, does it make sense for three centres (London, Toronto, Ottawa) to continue performing the surgery, or should they consolidate in London?*  
If one were to design the system today, it would make sense to have one centre doing all the procedures rather than three centres doing lower volumes. It has evolved differently. The service could be in fact be consolidated in London. The government recently announced the Trillium Gift of Life Network, a priority of the Provincial government. I would strongly support rationalization of heart transplant services, through the Trillium Foundation.
- *This is a key point. This program has clinical and academic excellence. We should not cut the program but rather create a provincial system.*

Dr. Sischek thanked the presenters, who then left the room.

Dr. Sischek introduced the question to the membership, “*Is this new or different information?*”

The following summarizes the discussion:

- This is new information. This is an integral piece of the clinical and academic model for Heart Failure and Transplantation.
- Heart transplantation is the standard of care and there are quality of life implications.
- I am not sure that I heard “new”. The Steering Committee was aware of the budget and the clinical issues. However, I am not sure they understood the academic program; the academic impact is new.
- I heard that transplant would increase because it would be more aligned and improve lifestyle. This is new to me; we were assuming that transplants would decrease before. We were told today that if there were an unlimited supply of organs, transplant would be at different volumes.
- I was on the Steering Committee. Today’s presentation brought more emphasis to two areas: academics and interdependencies. We have the Trillium Foundation now to look at rationalization and London Health Sciences Centre should not lose this opportunity.

**THE MEDICAL ADVISORY COMMITTEE RECOMMENDS TO THE BOARD OF DIRECTORS THAT THE INFORMATION PRESENTED RELATED TO ADULT CARDIAC TRANSPLANTATION IS “NEW” INFORMATION.** (CARRIED: 19 agreed; 2 disagreed; 1 abstention).

Subsequently, the Medical Advisory Committee voted on the three possible recommendations regarding the new information.

**VOTE #1:**

| RECOMMENDATION  | VOTE |
|---|------|
| 1.0 The scoping recommendation should continue to the implementation phase of discussions. Issues of medical safety or quality of care will need to be visited again there.   | 3    |
| 2.0 The new or different information impacts to a significant extent on the Academic mandate and should be reviewed in conjunction with the Office of the Dean of Medicine.   | 9    |
| 3.0 The new or different information is significant enough that it should cause the Board to more fully reconsider this Scoping recommendation. We would advise against going to implementation planning until this has happened. | 8    |

Discussion:

- There are now external discussions (Trillium Foundation) being initiated that are key to the decision. I would strongly support rationalization of the Transplant Program.
- We need to distinguish between implementation and implementation planning. With respect to implementation planning, the Board wants to see plans in place which meet certain criteria. We need to consider the impact on the academic mission.
- We cannot make an academic decision. We have not been given the academic data to look at teaching and research implications.

- We cannot lose the potential opportunities with the Trillium Foundation.

**FINAL VOTE:**

| RECOMMENDATION  | VOTE |
|---|------|
| 1.0 <del>The scoping recommendation should continue to the implementation phase of discussions. Issues of medical safety or quality of care will need to be visited again there.</del>  | n/a  |
| 2.0 The new or different information impacts to a significant extent on the Academic mandate and should be reviewed in conjunction with the Office of the Dean of Medicine.   | 8    |
| 3.0 The new or different information is significant enough that it should cause the Board to more fully reconsider this Scoping recommendation. We would advise against going to implementation planning until this has happened. | 12   |

**RECOMMENDATIONS:**

**THE MEDICAL ADVISORY COMMITTEE RECOMMENDS THAT THE NEW INFORMATION IS SIGNIFICANT ENOUGH THAT IT SHOULD CAUSE THE BOARD TO MORE FULLY RECONSIDER THIS SCOPING RECOMMENDATION. THE MEDICAL ADVISORY COMMITTEE ADVISES AGAINST GOING TO IMPLEMENTATION PLANNING UNTIL THIS HAS HAPPENED.**

**THE MEDICAL ADVISORY COMMITTEE STRONGLY SUPPORTS A PROVINCIAL APPROACH, THROUGH THE TRILLIUM GIFT OF LIFE NETWORK, FOR THE RATIONALIZATION OF HEART TRANSPLANT SERVICES IN LONDON. (CARRIED. 12 agreed; 8 disagreed; 1 abstention)**

**2.2 Radionuclide Systemic Therapies:**

Dr. Driedger, Acting Chief, Department of Nuclear Medicine and Dr. Rankin, Chief of Radiology presented regarding the Scoping decision on Radionuclide Systemic Therapies (Appendix 2).

The following summarizes subsequent discussion with the presenters in attendance:

- *If this treatment is unavailable to patients, what do patients do?*  
Patients would have to go to Edmonton for treatment; however, we are in receipt of a letter from Edmonton indicating that they cannot take any more patients.
- *The presentation covered radionuclides. The scoping document is confusing - is the scoping recommendation for all radionuclides or just Samarium?*  
Please refer to page 115 of the document. The focus is Samarium. There is no intention to scope out other radionuclides.

- *The Cluster Team considered Samarium and acknowledged the financial pressure on LHSC. Oncology is a multi-faceted program from standard of care to research, curative to palliative, existing dollars to incremental dollars.*  
These treatments are competitive with other treatments. The “upfront” costs are higher; however, the treatment outcome has a longer-term efficacy.
- *Can you please explain why this treatment is offered only in London and Edmonton?*  
I suspect it is because we have a strong academic base. Other centres are different; there are not many centres with specific Nuclear Medicine physicians.
- *What about the costs – who pays for treatment?*  
London Health Sciences Centre pays for the isotopes. In parts of Canada there is funding and some Ontario Cancer Care Centres have dollars. There is a team working diligently to obtain funding.
- *If a patient comes from outside the Region, is there a mechanism for LHSC to be reimbursed for the costs?*  
No. For instance all thyroid patients from Thunder Bay and Sault St. Marie are sent to London and we do not receive the funding.

Dr. Sischek thanked the presenters who then left the room.

Dr. Sischek introduced the question to the membership, *“Is this new or different information?”*

The following summarizes the discussion:

- If we assume the scoping recommendation was only for Samarium, then nothing is new.
- Why would we treat patients from all over the Province and Eastern Canada; we cannot be an Eastern treatment centre, Southwest Ontario perhaps.
- Mr. Byrne made a presentation to the ELT and the Steering Committee that recognized the industry relationship was stopping, resulting in a significant financial impact.
- This is a financial issue.

**THE MEDICAL ADVISORY COMMITTEE RECOMMENDS TO THE BOARD OF DIRECTORS THAT INFORMATION PRESENTED RELATED TO RADIONUCLIDE THERAPY IS NOT NEW OR DIFFERENT INFORMATION.** (CARRIED: 13 agreed; 7 disagreed; 2 abstentions).

**RECOMMENDATION:**

**THE MEDICAL ADVISORY COMMITTEE RECOMMENDS THAT THE SCOPING RECOMMENDATION REGARDING SAMARIUM SHOULD CONTINUE TO THE IMPLEMENTATION PHASE OF DISCUSSIONS. ISSUES OF MEDICAL SAFETY OR QUALITY OF CARE WILL NEED TO BE VISITED AGAIN.**

It was further MOVED BY: Dr. Lampe; SECONDED BY: Dr. Frewen

**THE MEDICAL ADVISORY COMMITTEE FURTHER ADVISES THE BOARD THAT THE DOCUMENTATION WAS CONFUSING, AS PRESENTED IN THE SCOPING DOCUMENT, AND THE MEDICAL ADVISORY COMMITTEE HAS ONLY DEALT WITH THE SAMARIUM ISSUE. CARRIED.** 13 agreed; 7 disagreed; 2 abstentions).

### **2.3 The Impact of Paediatric Scoping on the High Risk Perinatology Program:**

Dr. Han, Division Chair of Neonatal/Perinatal Medicine, Dr. Natale, Associate Chief of Obstetrics, and Dr. Gagnon, Chair, Division of Maternal/Fetal Medicine presented regarding the impact of the Paediatrics Scoping decision on the High Risk Pregnancy Program (Appendix 3).

The following summarizes subsequent discussion with the presenters in attendance:

- *To date we have not seen the resources to allow the Children's Hospital to expand to the level of its expressed vision. If it were to expand, it would potentially draw resources away from everything else we do. Given that, what does an NICU truly need to "get by"?*

The NICU needs tertiary level Paediatrics. We need a program funded similarly to the one funded in Ottawa.

- *You say that these proposed changes mean the end of Neonatology in London. What is the difference between a Level III and a modified Level III NICU?*

There are no academic tertiary NICUs in Canada that are not associated with a comprehensive Paediatric program.

- *How does the loss of Paediatric Cardiac Surgery and its subsequent impact on Paediatric Cardiology cause the demise of Perinatology?*

We need to be able to provide full care for women with babies with severe congenital heart disease. If we cannot, this results in the fragmentation of care and separation of families. Additionally, the fetal echocardiography program may not be sustainable, meaning the referral of approximately 300 women a year to another centre.

- *How does the Shared Care Model negatively impact on the NICU?*

The loss of any Paediatric subspecialty service will mean the antenatal or postnatal transfer of subsets of babies with congenital anomalies.

Dr. Sischek thanked the presenters, who then left the room.

Dr. Sischek introduced the question to the membership, *"Given that this presentation is directly related to the following two presentations, should we deliberate now or incorporate the deliberations into the following presentations?"*

It was: MOVED BY: Dr. Lampe; SECONDED BY: Dr. Hollomby

**THAT the deliberations regarding the Impact of Paediatric Scoping on the High Risk Perinatology Program be deferred until presentations from the Department of Paediatrics and Paediatric Cardiac Surgery are heard. CARRIED.**

## 2.4 Department of Paediatrics Response to the Scoping and Sizing Recommendations:

Dr. Frewen, Chair/Chief, Department of Paediatrics, Dr. Singh, Director, Paediatric Critical Care Unit and Ms. Ellen Rosen, Manager, Childrens Care presented the Department of Paediatrics response to the Scoping and Sizing Recommendations (Appendix 4).

The following summarizes subsequent discussion with the presenters in attendance:

- *Could you please elaborate with respect to Paediatric Critical Care Units (PCCU's)? Hamilton is similar to London, and they do not have a Paediatric Cardiac surgeon. Is it a high level PCCU?*  
Hamilton differs from London; they have a designated number of ICU beds (4) at the McMaster site, a transport service and clinical linkages with Toronto.
- *You presented new information with respect to the alternate funding agreement. Is the funding for Paediatrics only or Paediatric Surgery as well?*  
The agreement begins with Paediatric Medicine. However, the Ministry had committed to an AFA for Paediatric Heart Surgery for John Lee and I would think that if the Board supported the Program, the Ministry would honour the commitment.
- *Given your arguments, why do we not have a freestanding Children's Hospital of Western Ontario?*  
The Paediatric Services at LHSC are excellent. The cost to this community is less than CHEO for example, because we have all of the services as part of LHSC. We now have the opportunity as a result of the Provincial Review of Paediatrics to sit with other providers and put forward our case to the government- that LHSC's needs be recognized.
- *You presented on the release of the report from Dr. Camfield and Dr. Gauthier. Why is this new?*  
This was an external review of the Department of Paediatrics as part of the Selection Process for Chair/Chief. It was released in September and was unavailable to the Steering Committee.
- *If we set aside NICU and PCCU, what is there about the "shared model of care" which does not include specialists currently in the community as well.*  
There is for example a Paediatric Respiriologist in the community. He does provide valuable service to the community. However, he is outside the hospital and timely consults are difficult.
- *In the PCCU, what services can an Intensivist not offer which mandates specialized Paediatric Respirologists?*  
The Paediatric Respirologists specialize and look after other patients as well, such as our cystic fibrosis patients. Most of that work is outside the PCCU.
- *What is the role of a Paediatric Cardiac Surgeon in performing PDA ligation?*

Over time, other surgical services have provided this service. The most recent was Dr John Lee, the Paediatric Cardiac surgeon. While we are currently relying on itinerant General surgeons from Hamilton, this is not a sustainable long-term solution. We need to have people in London trained to do this procedure.

I want to assure you that we realize we are not asking for what we had before. A robust Paediatric Cardiac surgery program here is dependent on the support of others. We want a surgery program here, but modified.

- *It is easy to say “Go to the Ministry for additional funding”. What is your advice if we do not receive additional funding?*  
Paediatric tertiary care is a “package deal” – the Department of Paediatrics, the Medical School and the Hospital as full partners. With respect to hospital resources, we will need to tell London’s story at the Provincial Review.
- *At what stage is the Paediatric Provincial Review?*  
The first meeting is scheduled for December 20<sup>th</sup>. The Ministry of Health has asked each participant to sign a “confidentiality agreement”. It is important for all stakeholders that the discussions are tabled until decisions are made.
- *With respect to the “Shared Model” you talked about adult. Could Paediatric specialists not share in providing some subspecialty care?*

Some are doing that now. For example, Dr. Salvadori is a Paediatric Infectious Disease specialist, and she is providing care in the Clinical Teaching Unit. In order for adult caregivers to provide this “shared model” of care, there would be a need to either train or recruit individuals with those skills.

## **2.5 Paediatric Cardiac Surgery:**

Dr. Richard Novick, Chief of Cardiac Surgery, presented regarding the scoping decision on Paediatric Cardiac Surgery (Appendix 5).

The following summarizes subsequent discussion with the presenters in attendance:

- *It has been suggested that we move to a “lower complexity” model of Paediatric Cardiac Surgery. Could we recruit a Paediatric Cardiac surgeon here under those circumstances?*  
Most Paediatric Cardiac surgeons would want an unrestricted practice. Given the limited number of trained Paediatric Cardiac surgeons available to be recruited, the likelihood is low but not impossible.
- *Given the discussions on requiring a two surgeon Paediatric Cardiac service, what are your comments?*  
The ability to recruit to this type of service would be lower still though a two-surgeon service might be more attractive from the perspective of recruitment.

- *With respect to the role of Paediatric cardiac catheterization linked to cardiac surgery, if there were to be Paediatric Cardiology Interventionalists, why can't Adult Cardiac surgeons support Paediatrics?*  
This was discussed at length in our Department. Despite the fact that we currently have two Cardiac surgeons who previously did Paediatric Cardiac surgery, the Division does not feel it has the necessary expertise and is not prepared to provide the necessary emergency backup for the procedures.
- *If we do not have a Paediatric Cardiac Surgery program, could we maintain a Level I Paediatric Trauma Unit?*  
Cardiac Surgery would not affect the Paediatric Trauma Program so long as the critical mass of professionals for the care of the critically ill child were still available in London.
- *What are the issues relating to the Hospital for Sick Children in Toronto?*  
Ms. Rosen recently went to Toronto and there is a severe nursing shortage at HSC. Because of the human resource shortage, the 44 bed ICU is staffed at only 23 beds. Additionally there are 6-7 vacancies on the nursing inpatient unit and this is causing pressures. There is a waiting list of 100-110 cases and the echo waiting list is approximately four months. London's caseload would need to be added to this.
- *What if we demand additional funding and the Ministry says no? What then – is this truly the collapse of Paediatrics? I understand your vision but I do not understand why the absence of one cardiac surgeon could cause Paediatrics to collapse.*  
The status quo is not sustainable. The government has responded by announcing the Provincial Paediatric Services Review. Given the current human resource shortages the loss of the patients associated with the cardiac surgical program may impact our ability to retain and recruit other subspecialties.
- *With respect to your recommendation #4, "The members of the Department of Paediatrics recommend that the MAC ask the Board to instruct its executive team to work with members of the Paediatric Cardiovascular Program to ensure Paediatric cardiac catheterization continues at LHSC during the provincial specialized review process" I do not understand what is required.*  
We are trying to get a surgeon to come and support this.

Dr. Sischek thanked the presenters, who then left the room.

Dr. Sischek introduced the question to the membership, *"Is this new or different information?"*

The following summarizes the discussion:

- There is significant new information if Toronto cannot help us.
- With respect to the new information regarding HSC, this is information that is being collected for implementation planning. The Board made a proviso to address implementation issues and this new information is appropriate to the implementation phase.
- I am struggling with the domino effect, NICU, Maternal Fetal Medicine, etc. To me, this needs to go through implementation planning.

- Either the government funds us or they do not. If we are not funded for the vision, we cannot do the work. The Board knows that.
- The information is not new. We do, however, need to see where the Province goes with the Paediatric Review.
- I was impressed with the intensity of feelings. How can a department be so strong, yet so fragile? It is clear to me that the psychological effects on the department would be profound.
- Ottawa is struggling with 140 cases. They want to partner with us and have suggested they want to help with interventional care. They are hesitant because we have begun dialogue with HSC.
- There are two new pieces of information: 1. the MOH Paediatric Task Force was initiated after Scoping; and 2. the reaction of the public in Southwestern Ontario. The Shared Adult Model could work; we need to recruit unique individuals. There are models of shared Adult Paediatric care in General Internal Medicine and Infectious Diseases. They are based on unique individuals that would be difficult to replace without seeking specific dually trained individuals.
- Discussions have occurred with HSC. Their urgent cases are being done within twenty-four hours. The challenge for them is elective cases and we have offered help with diagnostics, catheterizations and echoes. We need to build bridges.
- We must ensure that the Board is aware of the PDA issue.

A motion was tabled BY: Dr. Lampe; SECONDED BY: Dr. Rorabeck

**THAT THE MEDICAL ADVISORY COMMITTEE HAS DETERMINED THAT THERE IS SIGNIFICANT NEW INFORMATION, HOWEVER, WITH THE MINISTRY'S RECENTLY ANNOUNCED PROVINCIAL TASK FORCE TO REVIEW PAEDIATRICS, NO FURTHER DECISIONS SHOULD OCCUR UNTIL THE RESULTS OF THE REVIEW ARE RECEIVED.**

Further discussion ensued:

- We are trying to be decisive and our medical community is relying on us. I am not sure this is new information.
- A government task force should not derail all current processes. There is some new information, however, it is important to pursue the PDA issue and the Alternate Funding Agreement. The Board needs to be aware of this.
- I support the intent of the motion. Putting things "on hold" does not mean we are supporting the hiring of a cardiac surgeon. An implementation plan needs to be developed.

An amendment to the motion was proposed and accepted, adding the following to the motion (Moved by: Dr. Bocking; Seconded by: Dr. Hollomby):

**THAT THE BOARD OF DIRECTORS RECOGNIZES THE IMMEDIATE NEEDS TO BE ADDRESSED IN THE DEPARTMENT OF PAEDIATRICS:**

- **PROVISIONS FOR ADDRESSING THE SERVICE NEEDS FOR PDA'S**
- **PROVISIONS FOR ADDRESSING THE SERVICE NEEDS OF PAEDIATRIC HEART CATHETERIZATION**

- **CONTINUATION OF THE PURSUIT FOR AN ALTERNATE FUNDING AGREEMENT FOR PAEDIATRICS.** CARRIED. (13 agreed; 4 disagreed; 2 abstentions)

## 2.6 Division of Plastic Surgery:

Dr. Hurst, Chair/Chief, Division of Plastic Surgery, Dr. Roth, Director, Hand and Upper Limb Centre (HULC), and Dr. Ross, Program Director, Plastic Surgery presented regarding the effects of the scoping decision on Plastic Surgery (Appendix 6).

The following summarizes subsequent discussion with the presenters in attendance:

- *With respect to the loss of the Plastics Residency Program, how many centres in Canada do not have a Plastics Program?*  
Ottawa and Kingston do not. There was an initiative to develop Plastics Programs in those centres, however, the Ministry of Health resisted.
- *What would be the effect on the HULC of the loss of the Plastic Surgery Residency Program?*  
HULC is an integrated orthopaedic/plastic surgery program with three full-time academic plastic surgeons. I anticipate they would not stay if the plastic surgery residency program were lost. If the three plastic surgeons leave, the HULC will dissolve with a significant negative academic impact on the Department of Surgery and the University of Western Ontario.
- *You have suggested a solution to perform cosmetic (aesthetic) surgery at St. Joseph's Health Care, London on Saturdays. How does that effect SJHC?*  
At St. Joseph's we have a business plan and we profit share with the Hospital. Dollars to the hospital go toward the Hand and Upper Limb Centre operating rooms to buy equipment, etc. Dollars that go to the HULC physicians are expended on research.
- *With respect to Paediatric Craniofacial cases, the data indicates that there were 5 to 6 cases per year. With respect to recruiting a Plastic Surgeon, how important are these cases?*  
That is a recent snapshot in time of the cases in London. Historically there were as many as 20 cases per year. The recent pattern of practice reflects the level of engagement of a neurosurgeon who is no longer a member of staff.

Often when one chooses a subspecialty there are 5% of cases that are important to that surgeon. They are the cases that are "the cream" of their practice. These cases reflect that part of a Maxillofacial Plastic surgeon's practice and can result in innovation and research.

There are also critical interdependencies with Paediatrics. The Thames Valley Childrens' Centre, in conjunction with the CHWO, has been conducting a cleft lip and palate clinic and dental funding program for children for over 20 years.

- *Why do you want to reverse the scoping recommendation on Paediatric Craniofacial Surgery?*

We need to be able to recruit to replace Dr. Lacey. As I reported before, the total savings from this recommendation for craniofacial surgery at this volume is approximately \$23,000 per year. If LHSC cannot resolve the loss of this scope out of funds, Mr. Nordal has agreed to accept \$23,000 worth of plastic hand surgery or breast cases from LHSC to do the cases at SJHC.

- *Regarding the Burn Unit, the Emergency Department of LHSC sees very few extensive burns annually. This is problematic for residents' exposure to this training.* I would agree that the incidence of major burns is down here as it is nationally. This reflects increasing safety standards in Canada. However, one needs to be aware that beds in the system to look after these patients have also decreased.

Another major issue for burn care in Ontario is nursing manpower. That is the advantage in London, the Burn Team here is a group of exemplary and dedicated members.

- *Burns were recommended by the original Plastic Surgery Cluster Group to be scoped out. Why are you now recommending reversal of that recommendation?*

We were looking at burns in isolation and trying to re-group. There were concerns about a separate Burn Unit at Westminster Campus without an ICU and the lack of cardiac arrest coverage at WC. Given the cumulative impact of the Scoping recommendations on the academic Plastic Surgery program, we believe we now need to better service burn patients.

The Department of Plastic Surgery has since unanimously committed to treat any burns referred by centres in Southwestern Ontario. There is also talk of a Shriner's Hospital locating in London and the issue of the Burn Unit might be resolved. A surgeon who is retiring staffs the Burn Unit in Windsor and perhaps we should approach the Ministry of Health to see if those funds could be transferred to London. A task force should be struck to look at burn care in Ontario.

Dr. Sischek thanked the presenters, who then left the room.

Dr. Sischek introduced the question to the membership, *"Is this new or different information?"*

The following summarizes the discussion:

- There is great concern with respect to the threat to academics and the viability of the HULC Unit. The threats to the academic issues of Plastic Surgery were presented by the Steering Committee; the threat to the viability of the HULC Unit was not appreciated.
- The HULC Unit is the "crown jewel" of the Department of Surgery.
- Without the HULC Unit, other programs at St. Joseph's will be adversely affected.
- With respect to cardiac arrest coverage at WC and the Burn Unit, the Trauma Team leaders have always offered to assist in resuscitation and provided Trauma beds if required.

- The Oral-maxillofacial service is interested in developing a multi-discipline service to help service the needs of the patient population.
- I can summarize ... develop a provincial task force for Burns; perform craniaofacial trauma in partnership; there is an excellent solution for cosmetics, develop a business plan similar to SJHC or transfer aesthetic surgery there.
- We must emphasize the academic issues to the Board.
- The Hand and Upper Limb Centre is very important to SJHC and has made recruitment to other departments there much easier.

**THE MEDICAL ADVISORY COMMITTEE RECOMMENDS TO THE BOARD OF DIRECTORS THAT THE INFORMATION PRESENTED RELATED TO PLASTIC SURGERY IS “NEW” INFORMATION.** (CARRIED: 18 agreed; 0 disagreed; 1 abstention).

Subsequently, the Medical Advisory Committee recommended:

**THE MEDICAL ADVISORY COMMITTEE RECOMMENDS THAT THE NEW INFORMATION IMPACTS TO A SIGNIFICANT EXTENT ON THE ACADEMIC MANDATE AND SHOULD BE REVIEWED IN CONJUNCTION WITH THE OFFICE OF THE DEAN OF MEDICINE. CARRIED.** (CARRIED: 18 agreed; 0 disagreed; 1 abstention).

## **2.7 Endovascular Aneurysm Surgery:**

Dr. DeRose, Division Vascular Surgery, Dr. Harris, Chair, Department of Surgery, Dr. Forbes, Program Director, Vascular Surgery and Dr. Rankin, Chief, Department of Radiology presented regarding the effects of the scoping decision on Endovascular Aneurysm Surgery (Appendix 7).

The following summarizes subsequent discussion with the presenters in attendance:

- *Can you expand on the statement that this procedure is standard of care?*  
This is not experimental surgery. We are the most experienced program in the country. LHSC is a national training centre for endovascular aneurysm surgery and surgeons from other centres come here to train.
- *Can you expand on the future of this procedure if 25% of cases are amenable to having the procedure now?*  
25-30% of our cases are being treated this way now, and if we limit the procedure to “high risk” the numbers will stay at 25-30%.
- *Ottawa, Sudbury and Toronto have limited numbers with respect to this procedure because of funding. This Program at LHSC is unfunded; year-to-date LHSC has spent \$580,000. We urged the Team to work with us and give priority to Southwestern Ontario Patients. We need to plead our case to the Ministry of Health.*  
The Team is willing to participate with LHSC in obtaining funding from the Ministry. 80% of our patients are from our Southwest region. The programs in the other three centres are similarly unfunded.

- *Have you performed a cost analysis? We are focusing on the cost of the device here; are there savings elsewhere?*

The difference in the cost analysis is that the endovascular aneurysm procedure results in both a decreased length of stay and ICU utilization. The bottom line however is that the endovascular stent patients cost \$5,000 to \$6,000 more per case because of the cost of the stent.

- *What are the interdependencies with Radiology?*

LHSC is recognized as a national leader in endovascular stent-grafting. Elimination of this will adversely affect the quality of vascular surgical and radiology training. Also lost will be any research opportunities.

Dr. Sischek thanked the presenters, who then left the room.

Dr. Sischek introduced the question to the membership, *“Is this new or different information?”*

The following summarizes the discussion:

- How did this “go off the rails”; it is not an experimental procedure.
- I cannot accept being told all information on Endovascular grafts in the Scoping Report was wrong. This is a new and evolving procedure.
- When the Steering Committee looked at the procedure we went to the literature. In an Editorial in the June/July ‘01 issue of the Journal of Vascular Surgery, the President reported that this is an experimental procedure, as the long-term outcomes are not yet known.
- *If it was not for the cost of the procedure, shouldn’t we be doing it?*
- I talked to Dr. Wayne Johnson in Toronto who praised the Program. He suggested that British Columbia and Quebec were perhaps ahead of London and suggested we go to the Ministry and demand funding.

Dr. Sischek introduced the question to the membership, *“Is this new or different information?”*

The following summarizes the further discussion:

- The new information for me is that it is standard of care. However, the issue is how do you add \$1M into the budget. They need to develop a Business Plan. We cannot say “here is another million” – to me this is a “sizing” issue.
- To me, I have not heard much in the presentation that is new or different.
- I would agree it is an outstanding program, however it is a \$1M unfunded Program.
- There is some merit. It is an important program and London is well positioned to be leaders but we require funding.
- There are 1,600 Vascular cases requiring surgery in Ontario each year and we are told 25% of the cases in Ontario are now to be done this way. Toronto has only a \$200,000 to \$500,000 commitment in the budget; Sudbury and Ottawa have also capped the number of procedures because of limited funding.
- I did not hear anything new. We need to let the Board know that the procedure is innovative, but it requires funding.

Subsequently, a vote was taken as to whether or not the information was new or different, resulting in a split vote, as follows:

- 9 agreed
- 9 disagreed
- 1 abstention.

Prior to casting a deciding vote, Dr. Sischek inquired if further discussion was in order. Consequently a motion was tabled by: Dr. Rorabeck; SECONDED by: Dr. Joubert:

**THE MEDICAL ADVISORY COMMITTEE RECOMMENDS THAT THE ENDOVASCULAR ANEURYSM SURGERY PROGRAM CONTINUES AT LONDON HEALTH SCIENCES CENTRE SUBJECT TO OBTAINING A SECURE SOURCE OF FUNDING FROM THE MINISTRY OF HEALTH.**

Further discussion ensued:

- In 1997 when Administration supported the procedure (financially), the commitment was for 10 procedures per year. The numbers have increased and 46 procedures were funded for this year. Fiscal year-to-date, 50 procedures have been performed.
- Without additional funding, other programs will be jeopardized.

An amendment to the motion was tabled BY: Dr. Lampe; SECONDED BY: Dr. Bocking:

**THAT IN THE INTERIM THE MEDICAL ADVISORY COMMITTEE RECOMMENDS THAT THE BOARD OF DIRECTORS CONSIDER LIMITING ENDOVASCULAR ANEURYSM SURGERY TO PATIENTS FROM SOUTHWESTERN ONTARIO. CARRIED.** (17 agreed; 1 opposed).

## **2.8 Other Business:**

Dr. Sischek reminded the membership of the process for those wishing to bring forward new or different information to the MAC. The agenda for December 5, 2001 was set on Monday, November 26 and communicated to all involved individuals that day. This included the time of day for a given Scoping recommendation discussion. Additionally written materials, charts, overheads etc. pertaining to new or different information were to be provided no later than November 28, 2001 to allow for distribution to the MAC by Friday November 30, 2001.

Dr. Sischek reported that he had been contacted after working hours on Monday, November 26<sup>th</sup> by Dr. Bourne, who had been out of the country, to request a presentation on behalf of Orthopaedic Surgery to the MAC. Given Dr. Colby's cancellation of his presentation, Dr. Sischek contacted Dr. Bourne and suggested he might present in that time slot. Dr. Sischek asked the membership if they were in agreement with this decision and they subsequently concurred; Dr. Bourne was then invited into the Boardroom to present.

## 2.9 Department of Orthopaedic Surgery:

Dr. Bourne, Chair, Division of Orthopaedic Surgery presented regarding the effects of the Scoping decision on Orthopaedic Surgery (Appendix 8).

The following summarizes subsequent discussion with the presenter in attendance:

- *You state that the scoping of the complex foot and ankle makes recruitment problematic. We can no longer “be everything to everyone”; therefore, if there were no more funding, what would Orthopaedics cut?*  
Ankles and feet are very important. There is no other centre that performs this surgery, only Dr. Daniels in Toronto.
- The most complaints I hear from Family doctors is that no one can help them with foot and ankle problems in London.
- The Scoping recommendation was to scope out complex foot and ankle procedures. We need to address the issue of “simple”.

Dr. Sischek thanked the presenter, who then left the room.

Dr. Sischek introduced the question to the membership, *“Is this new or different information?”*

The following summarizes the discussion:

- This was a very brief presentation and I do not think new information was presented. We did not have any facts precirculated for our review.
- I hear the issues around process, however, in all fairness to Dr. Bourne it is not fair for us to make any decisions. Foot and ankle surgery is a huge issue and a proper discussion needs to occur.
- In the Scoping document, it indicates that the key physician for this program has left LHSC. It further states that an upper extremity surgeon replaced this physician. If this surgeon has been replaced, it may be that there is no replacement position in Orthopaedics. The Joint Medical Human Resources Committee has not approved any new positions in Orthopaedics. We do not have the facts; therefore, we will need to hear another presentation.
- The Steering Committee understood that there was still a means and need to perform simple ankle procedures.
- The new information is the academic impact.
- I would summarize the new information as follows: 1. there is no other referral centre; 2. there is no surgeon in London; and 3. there is no ability to recruit.

Subsequently, Dr. Sischek re-introduced the question to the membership, *“Is this new or different information?”*

It was recommended that:

**THE MEDICAL ADVISORY COMMITTEE RECOMMENDS TO THE BOARD OF DIRECTORS THAT THE INFORMATION PRESENTED RELATED TO ORTHOPEDIC**

**SURGERY IS “NEW” INFORMATION.** (CARRIED: 13 agreed; 0 disagreed; 3 abstentions).

Further discussion ensued:

- We need more delineation of the academic piece. I have a problem with process here; there was no cluster leader present today.
- We are unsure if they even have a position to address the simple ankle procedures. We need to work with the JMHR Committee.
- Unfortunately there are too many unknowns and we cannot make a recommendation to the Board. We need another presentation to the MAC before we can make any recommendations.

It was the general consensus of the MAC that these issues required further discussion and consideration. In light of the issues tabled but not fully addressed, it was decided to invite Dr. Bourne to come before the MAC at a subsequent date.

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| <p><b>ACTION:</b></p> <ol style="list-style-type: none"><li>1. <b><i>Dr. Bourne will be asked to present further information related to Orthopaedics – Complex Ankle Procedures to the Medical Advisory Committee on January 16, 2002.....Dr. Sischek</i></b></li><li>2. <b><i>Any consequent recommendation will be forwarded to the Board of Directors from the Medical Advisory Committee.....Dr. Sischek</i></b></li></ol> |
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**2.10 Communiqué to Physicians:**

Dr. Sischek reminded the membership that a communiqué would be drafted for distribution to all physicians on December 6<sup>th</sup> that would identify:

- that the full Medical Advisory Committee (MAC) of LHSC met for a day-long meeting ;
- the Programs which presented;
- whether the MAC received adequate input
- that thoughtful discussion and deliberations occurred
- that a full report will be drafted for the December 18<sup>th</sup> Board meeting.

All members present were in agreement with this approach.

Dr. Sischek thanked the membership for making time for this special MAC meeting and expressed his appreciation for the members’ active participation, thoughtful comments and insightful recommendations.

There being no further business, the meeting was adjourned.

Respectfully submitted,

William Sischek, MD, FRCPC  
Chair, Medical Advisory Committee