

FRONT COVER



The Story of Our Symbol

Our new symbol reflects the scientific and human core of our mission in caring for patients, research and teaching. It is based on the partial double helix DNA strand which, as the basis of life, carries the cell's genetic information and hereditary characteristics. Within this symbol is the link between science and life, science and health. The DNA strand assumes the form of a stylized human figure. The figure's fluid movement and upward motion communicate progress, positive energy, innovation and the dynamic future of health care to which we all contribute and make possible. The human form also places people – patients, physicians, staff, volunteers, donors – at the centre of everything we do.

Our new identity is the result of a process that included people from all parts of the organization. Our goal was to create a strong and meaningful representation of who we are, what we stand for and the value we bring to the people we serve.

On the cover: A young patient enjoys a moment of respite in the Healing Garden at London Health Sciences Centre's Victoria Hospital on Commissioners Road. The Healing Garden was expanded in 2004 through a donation by Clintar Groundskeeping Services.

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Jeff Low, Chair, with Tony Dagnone, CEO and President of the London Health Sciences Centre

Message from the

CEO AND BOARD CHAIR

In this year's Report to the Community, we celebrate "Our Stories." After a year of remarkable change, it is fitting that we pay tribute not only to our accomplishments as an organization, but to the individual contributions of the 8,000 employees, physicians and volunteers who make the London Health Sciences Centre (LHSC) a caring, dynamic, and innovative world-class institution.

Since its inception out of the 1995 amalgamation of University Hospital and Victoria Hospital, LHSC has progressed through a number of milestones to arrive at the organization we see today. Still, over the course of this year, it became apparent to LHSC leadership and the Board of Directors that the promotional, reputational and visual elements of our corporate identity no longer reflected the way in which we see ourselves. The resultant branding project was a three-month initiative, led by Corporate Communications and Public Relations in consultation with the Hospital's key internal and external stakeholders, that assessed our needs as a leading academic health sciences centre and brought forward contemporary possibilities for a new branding strategy that truly told "our story."

This year's Annual General Meeting and Report to the Community feature the new LHSC corporate identity. The new LHSC logo, a partial double helix DNA strand stylized into the form of a human being, represents the link between science and life, and science and health. Our new corporate colours, contemporary shades of blue and gold, reflect our status as a modern, leading health sciences organization. Most importantly, the new brand standardizes the hospital site names as South Street Hospital, Victoria Hospital, and University Hospital. This change supported the tremendous task of Emergency services consolidation that took place in June 2005, during which there could be no confusion in the community around site names.

The consolidation of city-wide Emergency services took place under what the London hospitals have identified as Milestone I, the first of two major planning hurdles they must clear in order to meet the recommendations of the 1997 Health Services Restructuring Commission. At the end of Restructuring, LHSC will have closed the aged South Street Hospital and consolidated its clinical operations at Victoria Hospital and University Hospital.

The first stage of Emergency services consolidation took place in February 2005 with the transfer of the St. Joseph's Health Care, London, Emergency Department to LHSC. Staff and physicians spent the year planning and preparing for that move, as well as the June 12 move that saw the transfer of patients, equipment, and 2,000 staff members from South Street Hospital to Victoria Hospital.

Despite the intensity and pressures of Milestone I, LHSC staff and physicians continued, and excelled at, the work of a leading academic health sciences centre. We celebrated a host of medical breakthroughs, including:

- *Canada's first robotic-assisted prostatectomy, the surgical removal of the prostate for selected patients with prostate cancer;*
- *the first kidney-pancreas transplant for LHSC's Multi-Organ Transplant Program, which is the second site in Ontario for these complex transplant procedures;*
- *the introduction of Helical Tomotherapy, which combines helical CT scanning with conformal radiotherapy, at the London Regional Cancer Program, the second centre to offer this therapy in Canada and one of only 10 in the world;*
- *a North American first for the combined use of minimally invasive robotic-assisted heart bypass surgery and angioplasty with stenting to clear blocked arteries;*
- *a North American first for the robotic-assisted removal of an entire aneurysm.*

LHSC also continued to move forward this year on a key technological initiative: the Electronic Patient Record (EPR). The EPR replaces patients' multiple paper records with a single electronic one. The change offers immediate benefits to both patients and health care providers: for patients, it will help maintain the accuracy and completeness of their patient record and reduce the number of occasions on which they will have to retell their health history; for health care providers, it will deliver instantaneous, up-to-the-minute information about their patients, including digital diagnostic imaging results. The London hospitals were selected by the Government of Ontario in 2003 as the lead site for the EPR initiative because of their outstanding reputation, history of partnership among care providers, and technological expertise. The regional population of 1.5 million and geographically significant location were also factors in the decision.

The move to digital, or filmless, imaging is a key building block to the EPR because it allows a patient's test images, MRIs, X-rays, CT scans, and medical files to be shared electronically among care providers. Over the course of this year, the London hospitals worked with six other regional partners as part of the Thames Valley Hospital Planning Partnership to implement the most extensive shared digital imaging network in Ontario, a project that saw the London hospitals go filmless in March 2005 and will culminate in December 2005 when digital imaging is shared among all eight regional hospitals.

Despite our many successes this year, there have been challenges. Most notably, the London hospitals took the unprecedented step of actively communicating the consequences of a provincial directive to submit a balanced budget. The hospitals continue to work together to address major budget pressures according to the mandated Ministry of Health and Long-Term Care budget planning process.

While the Hospital and community were pleased that the North American Shriners Board of Directors unanimously endorsed London as the future home of the Shriners Hospital for Children in April 2004 and again in April 2005, to our deepest disappointment, this decision was not upheld by the voting delegates at the Shriners Imperial Council Session in July 2005. Nonetheless, the London Bid Committee performed in an extraordinary manner in what was an intense, and at times turbulent, competition. We are extremely proud of the efforts of our Board members, staff, physicians, and many community partners, including London's Mocha Shriners, who are long-time supporters of the Children's Hospital of Western Ontario and the Children's Health Foundation.

Moving forward into the next fiscal year, we will persevere with the work that will enhance the health of our patients and community, improve the continuum of care through technology, and move us towards the completion of Milestone II. We will also be calling on the support of our staff, physicians, volunteers and partners as we outline our strategic directions for the next few years.

The first ten years of "our story" as a leading academic health sciences centre has been exciting, challenging, moving, and inspiring. What a story! What a feat by our valued 8,000 caring performers!

Tony Dagnone
PRESIDENT AND CHIEF EXECUTIVE OFFICER
LONDON HEALTH SCIENCES CENTRE

Jeff Low
CHAIR, BOARD OF DIRECTORS
LONDON HEALTH SCIENCES CENTRE



Dr. Ian Herrick, Chief of Staff

Message from the

CHIEF OF STAFF

The narrative of the past year has touched on so many stories that impact the medical staff at London Health Sciences Centre. Whether it has been as part of a team achieving an exciting medical “first,” or at the bedside caring for an individual patient, LHSC physicians, dentists and midwives continued to provide the high caliber of care for which they are known locally, nationally, and internationally.

A defining chapter in the history of this hospital opened the year with a series of program moves we’ve called Milestone I. Notably, the first stage of consolidating city-wide Emergency services occurred in February 2005 when Emergency services transferred from St. Joseph’s Health Care, London, to LHSC.

Together with the remaining Milestone 1 moves occurring in the summer of 2005, this achievement represents a major component of the city-wide Restructuring project mandated in the mid-1990s. Moves of such magnitude are enormous undertakings and the collaboration among physicians and staff has been tremendous.

A challenge for clinical staff this year has been the bed management pressures our hospital faces. Bed shortages lead to stressful and unacceptable backlogs in Emergency; compromise the scheduling of surgeries; and challenge our ability to meet the health care needs of our community.

There are additional impacts such as those to our regional partners who depend on LHSC for the provision of specialized care, as well as to our capacity to support the government's commitment to addressing unacceptably long waiting lists for selected cancer, surgical and diagnostic imaging procedures.

LHSC, like other hospitals across the province, has implemented a contingency plan to manage beds during periods of critical shortage. However, we cannot adequately address this situation without funding for the approximately 100 hospital beds we are short in this community.

What makes our story such a compelling one is that despite the challenges presented by major clinical moves and bed shortages, our physicians, dentists, midwives and staff members continued to provide compassionate, high quality care to the thousands upon thousands of patients who come through our doors. Our commitment to patients encompasses teaching the next generation of health care providers and championing a spirit of innovation and discovery.

On that front, we have had many exciting stories this past year.

For example, for the first time in Canada, prostate surgery was performed at CSTAR (Canadian Surgical Technologies & Advanced Robotics) with the assistance of the four-armed daVinci® surgical robot system, one of only 11 in the world. CSTAR is also leading an inter-disciplinary medical team in the latest innovation to treat heart disease. The CSTAR team at Lawson Health Research Institute is the first in North America to simultaneously complete two different procedures to clear blocked arteries using minimally invasive robotic-assisted heart bypass surgery and angioplasty with stenting.

Enhancing the precision with which radiation is delivered to the tumor is the concept behind a new cancer treatment technology now available for patients at the London Regional Cancer Program at LHSC. Helical tomotherapy represents another first in cancer treatment for London.

Adding more good news is the Connecting the Continuum of Care (C3) project, which this year moved one major step closer to realizing its motto – Better Information, Better Care, Better Health – when London hospitals announced the achievement of a city-wide filmless diagnostic imaging environment. The project will continue to expand the shared digital imaging network across the Thames Valley hospitals, enhancing efficient and effective consultation among providers and the delivery of health care and services.

This truly has been a year of exciting opportunities and challenges. To the physicians, staff, students and volunteers at LHSC, I extend my sincere thanks for your ongoing and strong commitment to improving health today and to future generations.

Dr. Ian Herrick

CHIEF OF STAFF
LONDON HEALTH SCIENCES CENTRE



Doug Alexander, Finance Committee Chair

Message from the

CHAIR OF FINANCE

The strength of the London hospitals' position continues to be its commitment to partnership and the restructuring process. Where once there were six hospitals, today there are two that are committed to an integrated system. Together, London's two hospitals share management positions, joint ventures, and integrated departments and services. Through perseverance and accomplishment, we've also attracted the investment needed to pursue the major innovations outlined in this annual report.

In 2004/2005, London Health Sciences Centre (LHSC) ended the fiscal year with a deficit of \$17.4 million. Lower than expected Ministry of Health and Long Term Care revenues confirmed late in the year contributed appreciably to this year-end position.

In the previous 2003/04 fiscal year, LHSC had reported a deficit of \$6.6 million, of which \$5.2 million was attributable to unfunded restructuring costs. These results followed an in-depth review of the financial performance of the London hospitals, which was conducted jointly by external consultants with the full cooperation of the hospitals and the Ministry. The study confirmed that London was cost efficient in the delivery of care; identified opportunities for cost savings; and highlighted a shortfall in funding for the services to be delivered to the region. Following funding adjustments received at the end of 2003/2004, the Hospital was able to show a deficit before restructuring of \$1.4 million.

LHSC's financial performance significantly deteriorated in 2004/2005 as measured by its large deficit and declining working capital. Revenue increased by \$46.3 million, or 7.3%. Of this increase, the contribution from the Ministry increased by \$38.5 million, but \$31.2 million of this increase was to reimburse the costs of program transfers to LHSC from Cancer Care Ontario for the London Regional Cancer Centre, and from St. Joseph's Health Care, London. In fact, only \$1.0 million of additional funding was added to the Hospital's base allocation to cover the effects of inflation and to respond to increased patient demands. This represented an increase in base funding of only 0.2%.

Expenses for the year increased by \$62.1 million or 9.8%, including the additional cost of new programs transferred to LHSC. Excluding these new programs, expenses increased by approximately 4.2%. Given the current rates of inflation in health care, we are satisfied with our expense management. Clearly the rate of increases in provincial funding is insufficient to cover our increased costs.

The Ontario Hospital Association (OHA) has estimated that the province's hospitals faced \$30 million in interest payments in this fiscal year because of a combined negative working capital of over \$1.3 billion. Maintaining patient activity and supporting the provincial plan for major redevelopment of our facilities under current funding allocations has significantly depleted our own financial position. LHSC's balance sheet, like that of many hospitals in the province, now reflects inadequate working capital (current ratio of 0.24). Despite this liquidity challenge, our ongoing cash needs continue to be met through provincial support and financing.

In an effort to improve planning and system accountability and avoid a repeat of 2004/05 results, the Provincial Government has made it very clear in 2005/06 that it expects hospitals to eliminate deficits. To this end, a new Ministry hospital planning process has been introduced to provide hospitals and the Ministry the opportunity to coordinate funding, services, and spending levels. Clearly a step in the right direction, and one for which the OHA and its members have been advocating.

However, many of the challenges facing the London hospitals are unique. We are moving forward with a massive, ten-year restructuring plan, with all construction and program transfers estimated to be completed in 2008. We are making major strides in developing electronic patient records and introducing digital imaging to patients in Southwestern Ontario. Study after study has demonstrated our competitive financial performance, but we do not believe we have historically received an appropriate share of funding increases. As a regional centre and as an academic health centre, there are special demands on our services. We are often called on to provide care to patients across our region due to our specialty services or the lack of resources in other hospitals in our region.

At the same time, LHSC continues to face the same cost pressures affecting other Ontario hospitals, including the escalating demand for services from our growing and aging population; increased costs for surgical supplies and equipment, drugs, utilities, insurance, and food; and increases in the wages, salaries and benefits paid to attract and retain health care professionals.

As we move forward under the Ministry's balanced budget mandate, we have relatively few options. We remain committed to achieving high levels of productivity and eliminating any avoidable expenditures. Assuming expenses are managed appropriately, the remaining option is to fit the level of services to the level of funding provided to LHSC. We will continue to advocate for funding to cover our current service levels, but we face the reality that the Ministry may request a reduction in services to meet their funding level.

Although the province's hospitals are operating under significant financial constraints, LHSC's pursuit of operational efficiency and continuous improvement has allowed the hospital to make significant progress towards its goals. We attained three important milestones over the past year: the exterior construction of the new Children's Hospital of Western Ontario and Grace Donnelly Women's Health Pavilion; the implementation of a shared digital imaging network; and the consolidation of city-wide Emergency services at LHSC's Victoria Hospital and University Hospital.

We will continue to voice to the Ministry the need for sustainability in our hospitals, and to work in close collaboration with our government partners to address the challenges we face. We also join the OHA in anticipating an appropriate share of the \$3.2 billion in increased funding available in Ontario as a result of the 2004 Accord and the new Health Care Premium for Ontario hospitals.

In the 2005/2006 fiscal year, we will also begin to understand the scope and extent of influence that the Local Health Integration Networks (LHINs) will have on hospital financial planning. We will also experience the Hospital Accountability Agreement process in its full application, and begin to understand how this Ministry mandate to balance our budget will affect operations.

Although the financial crisis faced by Ontario hospitals continues to bring new challenges, we remain focused on our commitment to serve this community by providing the best care to our patients.

Doug Alexander

CHAIR OF THE FINANCE COMMITTEE
BOARD OF DIRECTORS
LONDON HEALTH SCIENCES CENTRE

Our Story

IN NUMBERS

Working at LHSC

Medical	597
Nursing	2,794
Postgraduate trainees	549
Research	342
Technicians and labs	836
Clerical	1,429
Service	1,079
Management	240
Allied health	464
Other	481
Volunteers	800

Patient Care

	2004-05	2003-04*	2002-03
ER visits	127,202	117,136	119,737
Ambulatory visits	797,430	627,977	540,014
Admissions	38,914	36,954	35,861
Patient days	253,623	247,204	244,585
Average length of stay	6.5	6.7	6.8
One-day stays	29,567	29,576	29,960

*London Regional Cancer Program ambulatory visits included as of January 1, 2004.

Research Activities

Clinical trials started:	2004-05	583*	2003-04	372	2002-03	385
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Lawson Health Research Institute, the joint research arm of LHSC and St. Joseph's, has 1,368 active clinical trials underway across seven hospital sites. The total amount held in research accounts is \$53,315,874, of which \$45,768,224 is for research projects at LHSC.

*Includes the addition of London Regional Cancer Program clinical trials beginning January 2005.

Capital Equipment Expenditures

2004-05	\$41.2 million	2003-04	\$36.2 million	2002-03	\$44.5 million
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New equipment spending at LHSC spans more than 700 categories, including everything from beds and monitors to diagnostic equipment. This year, LHSC opened a \$3.9 million expansion of its radiation treatment program.



Lynne Webb sees the newly arrived and those about to depart through the Emergency doors.

ONE

Emergency Nurse has a

WINDOW ON THE WORLD

Sitting at her workstation, Lynne Webb has a window on the world. Webb's workstation, part of the recently expanded Emergency Department at LHSC's University Hospital, is encased in a large glass dome in the heart of the reception area. From this vantage point she looks out onto the lobby and beyond, to the driveway that winds up to the main entrance, where she sees the newly arrived and those about to depart through the Emergency doors.

As a triage nurse, it is Webb's job to assess patients as they arrive and prioritize their cases according to medical urgency. This is a carefully controlled process designed to connect patients to care in the most appropriate period of time. It is medicine at a rapid pace: high energy, dynamic, always changing. The triage nurse's work area includes the communications infrastructure to track incoming emergency vehicles, computer screens to track the progress of patients in treatment areas, and all the tools and technology needed to organize the process of providing care.

While technology and clinical protocols help tell the story, experience also has a say. A triage nurse must draw upon both her experience and the tools of triage to correctly identify signs or symptoms and mount an appropriate response.

"Intuition and experience are important," says Webb. "You know whose needs are more serious, and whose are less so, by instinct. Always, you need to be able to substantiate your instincts through the triage process."





It is medicine at a rapid pace:
high energy, dynamic, always changing...



Emergency care in our community

Another part of the triage nurse's responsibility is offering emotional support to patients and families experiencing anxiety in emergency situations. "You have to have a calmness about you," says Webb. "You need to reassure patients and families that they are here now, and that you will look after them."

The reasons that bring a person through the Emergency Department's doors are far-reaching, and it's that variety and challenge that keeps her engaged. "I am always surprised. Everyday there is something new, even after 30 years," Webb says.

A different kind of "triage" process is changing the way hospital services are provided in our community. In 1997, Ontario's Health Services Restructuring Commission issued a set of directives intended to minimize duplication and provide more effective care at the London hospitals.

Under the subsequent restructuring plan, it was determined that LHSC would provide all acute inpatient services, including Emergency services, for the City of London, eventually retiring the aging South Street Hospital Emergency Department and expanding Emergency services at University Hospital and Victoria Hospital.



In February 2005, the first phase of Emergency services consolidation was completed when the St. Joseph's Health Care, London, Emergency Department transferred to LHSC. The hospitals collaborated on a public education campaign to ensure the community would "Know Where to Go" when the changes became effective on February 15.

The story of Emergency services consolidation continued to unfold in the next fiscal year, when Emergency services at LHSC's South Street Hospital transferred to the expanded, state-of-the-art Emergency Department at Victoria Hospital at Commissioners Road and Wellington Road in June 2005.

"I am always surprised. Everyday there is something new, even after 30 years."



TWO

A Year of Firsts in

ROBOTIC SURGERY

It's been another year of firsts in robotic-assisted, minimally invasive surgery at CSTAR (Canadian Surgical Technologies & Advanced Robotics). CSTAR, located on the top two floors of the Legacy Research building at LHSC University Hospital, is a collaborative research program of LHSC and Lawson Health Research Institute, and is affiliated with The University of Western Ontario.

In April 2004, CSTAR announced a Canadian first, the surgical removal of a patient's prostate gland with the help of the four-armed daVinci® surgical robot system, one of only 11 in the world. Surgeon Dr. Joseph Chin, assisted by urologists Dr. Patrick Luke and Dr. Stephen Pautler, performed the radical prostatectomy guided by the robot's three-dimensional imaging and robotic arms, which were inserted through small, two-centimetre incisions in the lower abdomen.

“Due to the fact that this surgery is minimally invasive, robotic-assisted surgery offers patients the potential for shorter recovery times, less post-operative pain, and less blood loss,” explains Chin. “For the surgeon, the robot provides superior visualization, magnification and dexterity, all of which translates into greater surgical accuracy.”

CSTAR has pioneered the use of the daVinci® surgical robotic system in Canada. Although the capital costs of the equipment are significant, the benefits are equally significant. A key benefit is the decreased risk of complication for the patient, which leads to lower operating costs for the hospital because of reduced length of stay.

The daVinci® Surgical Robot System



CSTAR announced a Canadian first, the surgical removal of a patient's prostate gland with the help of the four-armed daVinci® surgical robot, one of only 11 in the world.

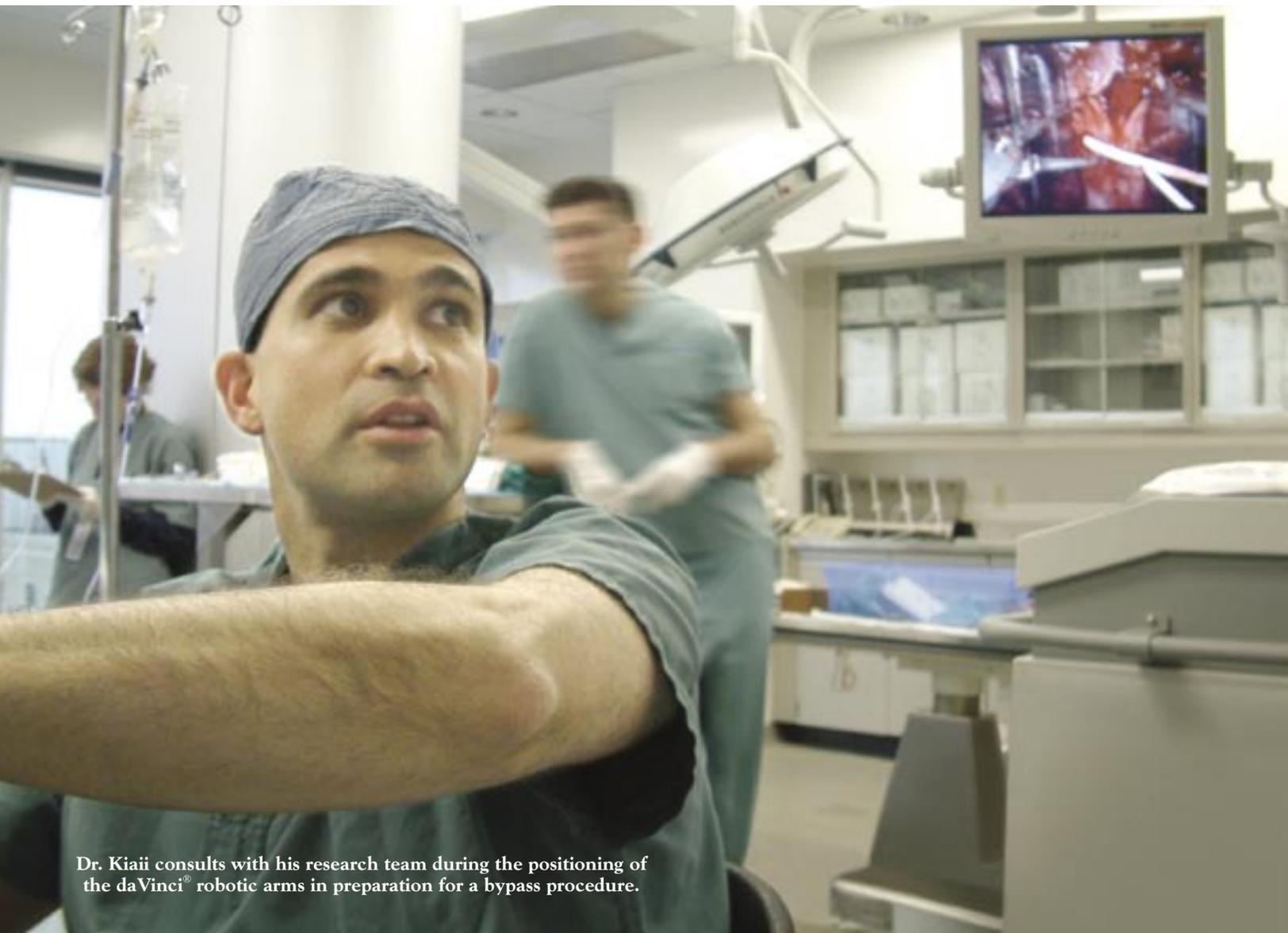


"Study of Hands" Leonardo daVinci, Silverpoint on paper c.1474, from the "Windsor Folio," Royal Library



Dr. Bob Kiaii sits at the console of the da Vinci[®] robotic system during a bypass research procedure in the chronic lab at CSTAR.

“Because it is minimally invasive, robotic-assisted surgery offers patients the potential for shorter recovery times, less post-operative pain, and less blood loss. For the surgeon, the robot provides superior visualization, magnification, and dexterity, all of which translates into greater surgical accuracy.”



Dr. Kiaii consults with his research team during the positioning of the da Vinci[®] robotic arms in preparation for a bypass procedure.



The benefits of robotic surgery were also clear when CSTAR became the first in North America to combine robotic-assisted heart bypass surgery and angioplasty with stenting during one episode of care. These procedures, which are used to clear blocked arteries, are normally performed separately one or two days apart. Combining them resulted in a shorter hospital stay for Karl Ferrier, a 52-year-old contractor from Priceville, Ontario, near Owen Sound.

“I was out of the hospital in three days,” says Ferrier, “and it was almost completely painless. By the third day, I wasn’t even taking pain pills – I didn’t need them.” By all accounts an active person who “can’t sit around,” Ferrier appreciated the faster recovery time and quicker return to work.

“In conventional heart bypass surgery, the patient’s breastbone is cut in half to allow access to the heart,” explains Dr. Bob Kiaii, the LHSC cardiac surgeon who operated on Ferrier. “The heart is stopped and the heart/lung machine is used to circulate the patient’s blood supply. It’s a highly invasive procedure.”

The daVinci[®] surgical robot system allows for heart bypass surgery using only small, keyhole-sized incisions that do not require the patient’s heart to be stopped.



In contrast, the daVinci[®] surgical robotic system allows for heart bypass surgery using only small, keyhole-sized incisions that do not require the patient’s heart to be stopped. Avoiding use of the heart/lung machine is believed to reduce the risk of complications such as increased inflammation, neurological side effects and bleeding. Keeping the breastbone intact reduces trauma to the patient and the length of recovery time. Dr. Bill Kostuk, a cardiologist at LHSC, completed the angioplasty with a stenting procedure on Ferrier immediately following the heart bypass surgery.

In November 2004, CSTAR announced another North American first: the robotic-assisted removal of a renal aneurysm by Dr. Luke, who was assisted by Dr. Anil Kapoor, a urologist at St. Joseph’s Healthcare in Hamilton. Conventional surgery to remove a renal aneurysm is complicated and often dangerous. A rupture can be catastrophic, leading to rapid blood loss, shock and even death. Although the need for renal artery resection is rare, this particular operation showcased the ability of the robot to make a challenging operation a routine procedure. “Without the robot, I would not have attempted to resect this aneurysm laparoscopically,” explains Luke. The patient’s kidney was saved.

CSTAR’s accomplishments over this past fiscal year bring the list of “firsts” to 12 since LSHC began its minimally invasive, robotic-assisted surgery program in 1999.

THREE

Storytelling as

A HEALING ART

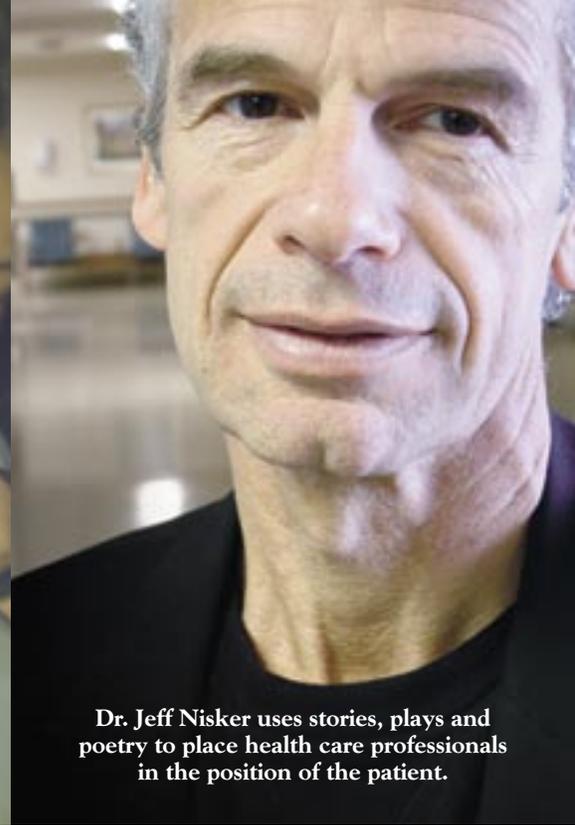


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Storytelling. Poetry. Theatre. Not topics one would typically expect to see highlighted in a workshop for hospital staff, but for more than 15 years, Dr. Jeff Nisker has been using narrative techniques, one of the oldest tools of human communication, to help health care providers explore the meaning of their work.

Nisker, an LHSC physician and professor of Obstetrics, Gynaecology and Oncology, uses stories, plays and poetry to place the health care professional in the position of the patient. “This approach helps the health care student see the person inside the patient,” says Nisker. He encourages health care professionals to write stories to share their experiences with each other and explore their feelings.

An accomplished author and playwright, Nisker holds several grants from the Canadian Institutes of Health Research, one of which is to write a play that will travel across the country to test theatre as a tool for involving the public in health policy development. He is also editing a forthcoming book of stories by London Health Sciences Centre (LHSC) staff members entitled *Stories from an Academic Health Sciences Centre*.



Dr. Jeff Nisker uses stories, plays and poetry to place health care professionals in the position of the patient.

8 DIMENSIONS OF PATIENT CENTERED CARE, *Picker Institute, Inc.©*

1. Access 2. Respect for patient's values, preferences, and expressed needs 3. Coordination and integration of care
4. Information, communication, and education 5. Physical comfort 6. Emotional support and alleviation of fear and anxiety
7. Involvement of family and friends 8. Transition and continuity



“Through storytelling, we come closer to the principles of patient-centred care.”

Storytelling fits well with LHSC's patient-centred approach to care, a system developed by the U.S.-based Picker Institute that uses a set of eight criteria to assess the patient experience. Each year, LHSC presents a Patient-Centred Care Award, sponsored by the Baxter Corporation, to a staff member or physician who submits the most compelling narrative about a patient care experience. In 2004, Janet Orchard's team was a co-recipient of the award with Nancy Lawrence, a communications consultant in the Corporate Communications & Public Relations department.

Orchard, manager of the 4th Floor Medicine Inpatient Unit at LHSC's University Hospital, described how her nursing team granted a dying woman's wish to speak to her grandchildren in the Northwest Territories by arranging a videoconference. Orchard recalls with pride how staff from different departments across the hospital quietly completed each of the tasks required to set up the communications to help meet the needs of this patient and her family.

Sharing that experience with colleagues through the storywriting competition was a therapeutic experience for the team, and a natural extension of what care providers do everyday, says the team's coordinator, Jackie Brindle. "Health care providers cope by talking to each other. Our work can be emotionally trying, and 'getting it out' helps us to reach closure with some of the difficult situations we face.

"It makes us relive what we believe in," adds Brindle, "and it empowers us while acknowledging the positive work that we do. It helps us to continue."

"It really is the relationship that is essential.
That's what people remember and what they talk about."

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Orchard concurs. "Through storytelling, we come closer to the principles of patient-centred care," she says. "Stories remind us that we are here for the patient. They remind us of what we are all about."

Rosemary Kohr, a nurse practitioner and clinical nurse specialist with the Medical Care Program at LHSC's South Street Hospital, has also found a place for narrative in her practice. Kohr's background is in quantitative research, but more recently, she has moved beyond statistics to the story. A Ph.D. candidate, Kohr uses a research technique called interpretive inquiry, or looking at the lived experience, in her work on wound care.

In her study, Kohr found that nurses saw wound care as a visceral, physical activity that fundamentally demonstrated to them that their work made a difference. "I found that nurses care deeply, and that what is important to nurses is the value of the relationship and the value of hands-on actions," she explains.

"It really is the relationship that is essential. That's what people remember and what they talk about. The medical care is important – it's what we're here to do – but the ultimate thing is to relate to one another.

"It is such a privilege to have people talk to you about their lives," adds Kohr. "As health care providers we can become so focused on the medical and technological side of things, when what is really important is the human touch."



Rosemary Kohr, Nurse Practitioner, uses interpretive inquiry in her work on wound care.

“...we can become so focused on the medical and technological side of things, when what is really important is the human touch.”

MRS. M.

By Rosemary Kohr, NP/CNS Medical Care

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It was Mrs. M's last day. For the past two weeks, she had been a patient on our unit, and we had watched her rally with medication and treatment and then start to slide. The doctors, the nurses, everyone knew she was going to die. We moved her to a private room so the family could be there with her whenever they wanted. Without a word being said, everyone seemed to know what was happening. That day, family members kept arriving. She had a lot of children, grandchildren, great-grandchildren. Everyone wanted to say goodbye. The social worker, the nurses and the unit clerk worked together to free up another "quiet room" for the family who were spilling out into the hall. The PSAs and TSAs ran around finding extra chairs to bring into the room. Pastoral Services were called and came to offer their support as well. It was as if there was an unwritten, unspoken message that everyone knew. Meal trolleys didn't clatter, feet walked by on silent shoes, talk was subdued. As Mrs. M's family gathered, we gathered too, watchful for the sign that the final breath had been taken, that she had passed from life to death. The door to her room opened and one of Mrs. M's daughters came out into the hall. Tears were streaming down her face. One of the nurses who had been standing in the hall by the room turned to the daughter. Without words being exchanged, she put her arms around the weeping woman. The genuine understanding demonstrated in that hallway was never recorded as a therapeutic intervention I am sure. But that quiet moment was as if the whole unit had gathered itself together to wrap care and support around Mrs. M and her family to ease her passing.

FOUR

Your Story

GOES WITH YOU

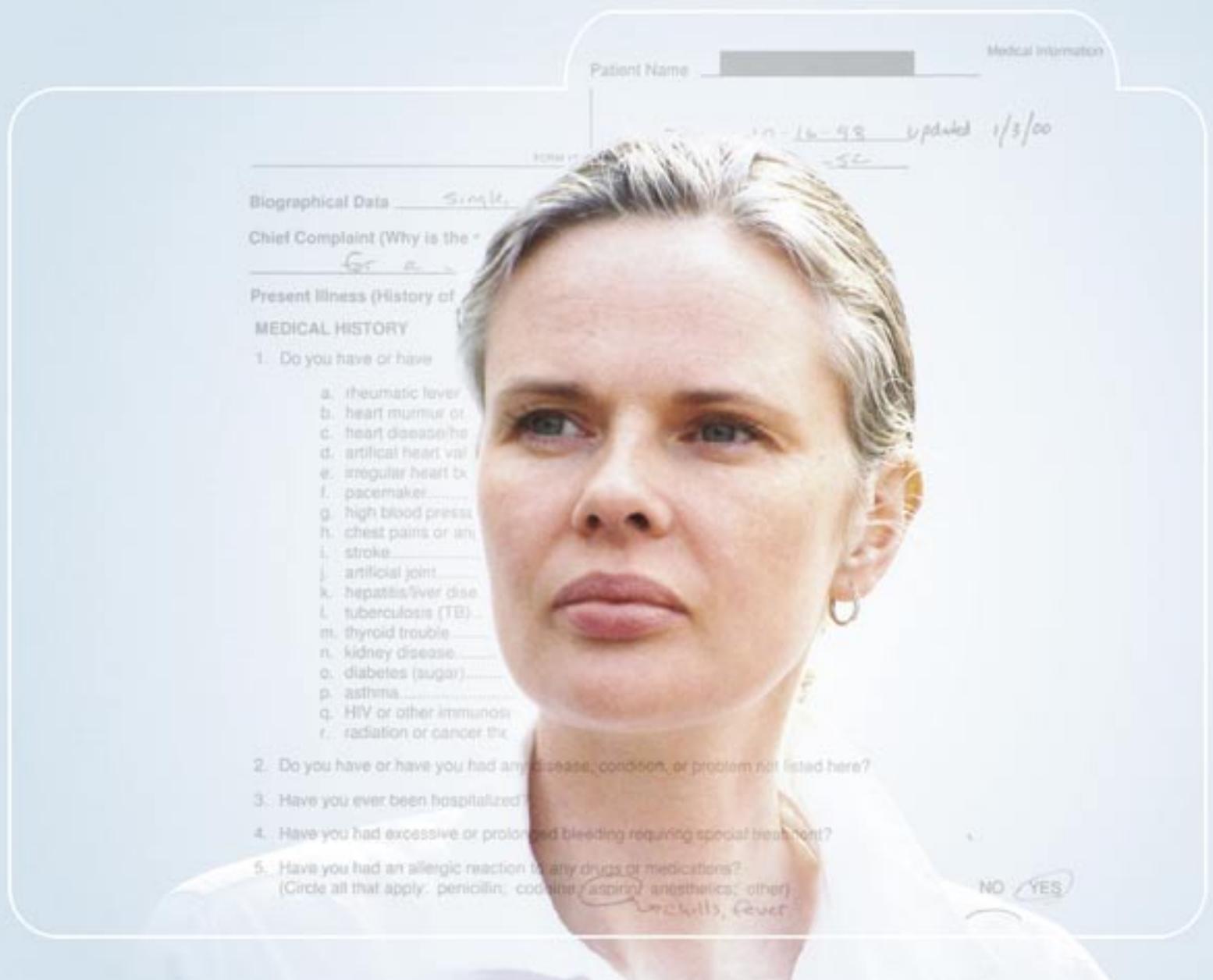
The London hospitals are about to revolutionize the way patient health care information is gathered, stored and retrieved. In the near future, you won't feel like a new patient every time you arrive at the hospital for an emergency or new appointment; your up-to-date "story," or health history, will be instantly accessible to your health care provider on admission.

London Health Sciences Centre (LHSC) and St. Joseph's Health Care, London, are pioneering the development of the Electronic Patient Record, or EPR, a new health care information technology that is expected to become the national standard for medical records in the future.

Once the EPR project is completed, health care providers from all disciplines will have access to a patient's information via computer. They will not need to order a chart from the records office. Nor will it be necessary to send X-ray films across town. Care providers will have seamless access to electronic medical records at their fingertips, everything from test results and medication orders to the full record of a patient's care.

Two or more health care providers who want to discuss a patient's test results will have access to the images on their computer desktop at the same time. An Emergency physician expecting an incoming patient who has experienced a heart attack will be able to consult the patient's chart immediately.





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ELECTRONIC
Patient Record
London

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The EPR initiative is unfolding in steps and stages that vary from site to site. One of the earliest and most significant steps has been the work undertaken by the Thames Valley Digital Imaging Network. Eight area hospitals, including LHSC, are collaborating in a pilot project to move from the use of film to digital technology. Participating sites will have shared access to images such as X-rays and CT scans. The ultimate goal is to expand the network to include 22 regional hospitals. LHSC went "filmless" in February.

For Rob McGuffin, the implementation leader for digital imaging at LHSC, the network includes more than technology: it's people. Staff members at participating hospitals are working together in teams, helping as the need arises at each hospital site, not by affiliation, but by commitment.

"The scope is very large," says McGuffin. "It's a complete change to the way the Hospital and Radiology function. Before, we had one set of images stored in Radiology, and physicians came to our department to request them. Now, there is no "one" set of images – they're digital, and can be viewed anywhere, any time. It makes us more efficient. We're no longer handling a mountain of film."

Pam Weaver, a coordinator in the Paediatric Emergency Department, credits collaboration between the Radiology team and clinical educators for the success of the filmless project in her area. She also appreciates the benefits. "The biggest thing is that there is absolutely no waiting time for films. As soon as the patient returns from X-ray, the film is available on-line. It's available anywhere in the facility, so an orthopaedic surgeon who is working somewhere else in the facility – even the operating room – can take a look. When the patient returns for follow-up at a hospital outpatient clinic, the films are always accessible, on-line."

Pam believes the digital imaging project provides significant benefits across the region. Patients are arriving from small centres with CD-ROMs of their X-rays. "For follow-up care and consistency of care," says Pam, "I think people will see a big change. It's been one of the more exciting and successful projects in our department. We're really seeing the benefits of it."

Another EPR milestone at LHSC this year involved the Pharmacy Network. The stand-alone system that had been meeting the Hospital's dispensing needs had to be replaced



with a newer system that could be integrated into the EPR. Ian McKechnie, manager of Pharmacy Services, says it was no small task.

“Pharmacy staff members had to re-enter some 15,000 active prescriptions into the new system. Behind the scenes, there was an awful lot of planning to help prepare the system for future capabilities, such as allowing physicians to order medications electronically.

“It’s the trend in health care today,” says McKechnie about the project, “and we are one of the early leaders in that area.”

Today, the Pharmacy departments at LHSC and St. Joseph’s are on the same system, thanks to the implementation of the EPR project. “It took planning to meet the patient dispensing needs of the different facilities,” says McKechnie, “but now care providers are able to see a patient’s medication history from previous visits. This benefits the pharmacist, the physician, and nursing staff.” The new Pharmacy Network was completed in February.

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The London Laboratory Services Group (LLSG), a joint venture of LHSC and St. Joseph’s, is implementing a Blood Bank Transfusion Project as part of the EPR. Technical Specialist Kathie Leigh explains why. “With this project, we will have a common blood transfusion medicine database across London hospitals, all operating on the same electronic system. All hospital sites will be able to look at patient information, transfusion records, and each other’s stock of blood and blood products. It will be easier to transfer specimens across the city.” Leigh also expects the ability to cross-match blood electronically for a select group of patients will speed up the blood transfusion process by reducing the need for “wet work.” The project began in March 2004 and is set for completion this year.

As exciting as the opportunities presented by the electronic patient record are, the London hospitals understand that the safeguarding of health care information is vitally important to Canadians. Today, advanced technology is available to ensure personal information remains secure. Privacy is also assured by legislation, the ethical codes binding those in the regulated health care professions, and corporate policies. In 2004, the London hospitals adopted a city-wide Privacy Policy and Confidentiality Policy. All hospital staff and affiliates are bound by these stringent requirements. Provisions such as these – technological, legislative, professional and corporate – have made it amenable to move health care information processes into the electronic age.

Bit by byte, the pieces of London’s electronic patient record system are falling into place. One day soon, our system will tell your story, accurately, securely, and up-to-the-minute. Better information. Better care. Better health.





From left to right: Donors Richard M. and Beryl Ivey, Chief of Cardiology Dr. George Klein, and President and CEO Tony Dagnone attend the opening of the Ivey Heart Centre in January 2005.

FIVE

The Ivey Heart Centre

NEW BEGINNINGS

When the Ivey Heart Centre opened its doors on January 28, 2005, it promised the best minds, in the best place, developing remarkable programs that would have tremendous impact at bedsides in its own clinics and beyond.

“The Ivey Heart Centre will be one of Canada’s premier centres for the treatment of heart disease: a Centre that will drive change and make a difference in the lives of heart patients. This state-of-the-art facility will be more than a London resource, it will be an international resource,” London Health Sciences Centre (LHSC) President and CEO Tony Dagnone told an audience at the opening ceremony.

Poised to take its place among the world’s leading heart institutes, the Ivey Heart Centre was designed as a self-contained unit housing 94 inpatient beds, in addition to specialized areas for coronary care, arrhythmia monitoring, cardiac catheterization, pacemaker implementation and electrophysiology procedures. Located on the fifth and sixth levels of LHSC’s University Hospital, the Centre is part of the London hospitals’ Restructuring initiative to consolidate existing advanced cardiac care services, which were previously spread across three hospital sites.

The Centre is expected to serve more than 5,250 patients annually, providing a seamless continuum of care for cardiac patients and those at high risk for cardiac events. Its services encompass education, ambulatory care, diagnostics, interventional cardiology, surgery and rehabilitation. Construction of the \$31-million facility was generously supported by a gift of \$6.5 million from London’s well-known philanthropists and community leaders, Richard M. Ivey and Beryl Ivey, and The Richard Ivey Foundation.



LONDON REGIONAL CANCER PROGRAM

LRCP is a program of London Health Sciences Centre, and serves a population base of 1.2 million people in nine counties across Southwestern Ontario. LRCP provides radiation therapy and complex chemotherapy, as well as a complete range of support services for cancer patients and their families.



From left to right: Dr. Tomas Kron, PH.D. Physicist at LRCP and program lead on the Tomotherapy Project, explains the advantages of the unit to Margaret Nish, Executive Vice President of Clinical Care and Academic Affairs, and Jim Flett, Executive Vice President of Corporate Services, at the official opening of LRCP's Tomotherapy Program in November 2004.

SIX

London Regional Cancer Program

ADVANCING TECHNOLOGY

Helical Tomotherapy, one of the most exciting advances in radiation therapy, combines the planning abilities of helical CT scanning with conformal radiotherapy. At present, there are only ten centres worldwide that offer this kind of treatment, and on November 5, 2004, LHSC became one of them.

Launched at LHSC's London Regional Cancer Program as part of a prospective clinical trial, Tomotherapy allows for the precise delivery of radiation therapy by conforming to the shape of the tumour, thereby reducing the amount of radiation delivered to nearby healthy tissue. This degree of accuracy is possible through use of the CT scanner, which determines the exact location of the tumour on each treatment day.

The acquisition of the \$2-million Tomotherapy unit was the result of generous financial support from members of the community, including Dr. Olive J. Stewart (in memory), Ila M. Stewart, Great West-London Life, the Plunkett Foundation, Cancer Care Ontario, TomoTherapy Inc. and several other private donors.

A History of Medical

BREAKTHROUGHS

1948 First artificial kidney machine in Canada is developed at Victoria Hospital.

1948 Victoria Hospital physicians first recognize sexual dimorphism in human cells. This discovery leads to knowledge of the relationship of sex chromosome abnormalities to disease.

1951 First “cobalt bomb” in the world is used to deliver radiation therapy to cancer patients at Victoria Hospital.

1956 LRCC and The University of Western Ontario discover the chemotherapy drugs vinca alkaloids.

1958 Dr. Charles Drake pioneers a surgical procedure for aneurysms at the base of the brain, called basilar aneurysms.

1972 Operations begin on cerebral aneurysms using a technique that establishes University Hospital’s worldwide reputation.

1981 University Hospital performs the world’s first heart operation to correct life threatening right ventricular dysplasia.

1985 The University Hospital team announces success in a trial using cyclosporine to arrest the progress of Type 1 diabetes.

1987 The world’s first pacemaker cardioverter defibrillator (PCD) is implanted at University Hospital.

1988 The world’s first successful liver/small bowel transplant is performed at University Hospital.

1989 The first cardiac stent insertion in Canada is performed at Victoria Hospital.

1989 The world’s first invasive inner ear surgery for vertigo in normal hearing ears is conducted at University Hospital.

1990 LRCC is the first in Canada to use the radioactive source Ytterbium for cancer treatment.

1991 Study begins at University Hospital on the safety and efficacy of using detachable platinum coils to treat brain aneurysms.

1993 Victoria and University hospitals collaborate on Canada’s first living-related paediatric liver transplant.

1994 The world’s first 3D ultrasound-guided cryosurgery is performed at University Hospital.

1996 A team of researchers accomplish a world-first when they develop a miniature recording device that monitors the heartbeat during fainting spells.

1997 LHSC’s Multi-Organ Transplant team transplants the liver, bowel, stomach, and pancreas into a five-month-old infant, the world’s youngest recipient of a multi-organ transplant.



1997 LHSC nephrologist performs a world-first in plasma exchange treatment and is credited with saving the life of a man with a severe case of food poisoning.

1997 LHSC cardiac surgeons are the first in Canada to perform a revolutionary method of video-assisted minimally invasive heart surgery designed to make patients' recovery easier.

1998 An LHSC team is the first in Canada to perform voice-activated robotic-assisted minimally invasive cardiac bypass surgery.

1999 LHSC specialists successfully perform the world's first closed-chest, robotic-assisted beating heart coronary artery bypass graft (CABG).

2000 LHSC's transplant team performs the first adult-to-adult living donor partial-liver transplant in Canada.

2000 LHSC's surgical team performs the first minimally-invasive robotic-assisted mitral valve heart surgery in Canada.

2001 LHSC conducts the world's first robotic-assisted surgery using videoconferencing technology where one surgeon assists and mentors another surgeon from a remote site, both able to manipulate the robotic technology in the operating room.

2001 LHSC researchers find strong evidence to support that surgery, not medicine, for temporal lobe epilepsy is key to improved quality of life.

2001 Canada's first artificial disc replacement is performed at LHSC.

2002 LHSC study determines that patients with congestive heart failure have an improved quality of life with a new pacemaker that works on both sides of the heart.

2002 LHSC cardiologists complete a left atrial appendage occlusion, a new procedure for stroke prevention that closes

the area of the heart where the majority of blood clots form.

2002 Neurosurgeons at LHSC complete the first artificial cervical disc replacement in North America. This innovation provides pain relief and maintains mobility for patients with disc herniation in their neck.

2002 LRCC is one of two in Canada and one of three in the world to have a tomotherapy unit, the newest radiation treatment technology.

2003 Urologists at LHSC are the first in Canada to use the three-armed ZEUS™ robot to correct a blockage in the ureter of the kidney.

2003 Results of an international study show that the common high blood pressure drug Ramipril can prevent heart failure in high risk cardiovascular patients.

2003 LHSC is the first in Canada, one of three in the world, to use revolutionary digital technology to produce detailed fluoroscopic images for diagnostic and interventional procedures.

2003 LHSC surgeons are the first in Canada to use a four-armed daVinci® robot, one of 11 in the world, for cardiac surgery.

2004 In a Canadian first in research for CSTAR, the four-armed daVinci® robot was used throughout the surgery to complete a radical prostatectomy.

2004 The CSTAR team is the first in North America to complete two different procedures to clear blocked arteries, minimally invasive robotic-assisted heart bypass surgery and angioplasty with stenting, at the same time in the operating room.

2004 In another North American first, an interdisciplinary team of surgeon/scientists successfully remove a renal artery aneurysm with the help of the daVinci® surgical robot.

London Health Sciences Centre

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