

## SOS Committee

### A. Comments on material obtained through FIPPA application

### B. Comments on VIHA Salt Spring Island Health Review 24 May 2010

#### A.

1. The budget for the Lady Minto Hospital (LMH) operating room is listed from 2004 - 2009. In 2004 it was \$192000, and in 2009 it was \$318900. Interestingly they had no surgeon in 2009 ( Dr Preshaw was forced out in June 2008), yet the budget that year was the highest of the years listed.

2. The minuted material from administrative meetings starts by promoting maintenance of surgical services on Salt Spring, and slowly loses enthusiasm.

In February 2008, a Lady Minto Hospital OR Review Committee was formed with Dr Barclay (Chief of Staff) in the chair. The other members were de Kock (a family practitioner) Relph (Manager Rural Health and Clinical Coordinator LMH) Ian Drost (a community representative), Schulz (president LMH Foundation) and Jones (retired Clinical Coordinator). This committee was formed by unanimous vote at the monthly medical staff meeting.

At this time the minutes noted that Barclay had stated publicly on 6 Sept 2007 that "it was of no concern to him whether surgical services at LMH continued or not." He responded to this by stating that he had been quoted out of context, but he did not deny making this remark. This did not prevent him from chairing this Committee.

3. The LMH OR Review Committee appeared to struggle with the problem of gaining a commitment from VIHA to support the surgical services.

Material presented to this OR Review Committee by Grant Hollett in March 2008 included the projection that the population of Salt Spring Island would reach 18000 by 2017 (this was not included in the May 2010 VIHA report). No projection was made for the population of the Gulf Island Health Area at this Committee presentation but was included in the May 2010 VIHA report (see below).

Data were presented by Hollett in the form of a Powerpoint presentation with reproduction of small graphs. It appears he said the number of **general** surgical cases in 2006/2007 in Gulf Islands residents was 163, with 106 carried out on Vancouver Island and 56 at Lady Minto. The next table summarised **all** the surgical cases at LMH in 2006/2007: there were 108 cases. These were broken down into 62 general surgery cases (this means there were six cases who travelled from elsewhere to get surgery on LMH): 15 gynecology cases (carried out by the visiting gynecologist): 1 ENT case: 9 plastic surgery cases: and 18 other cases. Since there were no other surgeons besides Dr Preshaw and the gynecologist, these 28 cases were done by the general surgeon for a total, in 2006-2007 of 95 cases. This is surgery only and excludes endoscopy, for which he presented no data.

4. The meetings of the OR Review Committee continued.

At a meeting on 10 March 2008, six general practitioners expressed support for the surgical service.

In April 2008, the OR Review Committee issued a three page report: conclusion - ***“surgical services continue to be supported at LMH. VIHA should be asked to explore possible extended surgical services in the form of day care procedures that could be done at LMH***

***Physicians including the GPs, psychiatrists and internist from LMH strongly support having a surgeon and maintaining surgical services at LMH.”***

5. On 4 Sept 2008, a motion was approved at a Medical Staff meeting

***“Medical staff unanimously approves the document entitled LMH OR Review Committee Report April 2008”***

6. Oct 7 2008 medical staff meeting notes problems with “Ministry mandated CSR (central sterilisation room) audit” has meant that endoscopy was on hold. At this time that there was no endoscopy being carried out.

7. Nov 4 2008 medical staff meeting.

***“OR - nothing defined. At a minimum we would like to retain Endoscopy Services”***

8. Apr 1 2009 VIHA Board of Directors meeting (minutes)

***“It is the Board’s intention and desire to continue to provide surgical services in Salt Spring island.”***

9. 15 Apr 2009 letter from Waldner to Crichton (president Medical Staff LMH).

***“VIHA is committed to surgical services at Lady Minto Hospital”***

10. However, a change occurs over the summer of 2009. On 20 Aug 2009 Wm Relph (Manager VIHA Rural Health services LMH and Southern Gulf Islands) e-mails to Shannon Marshall

***“Would you please review the last two Driftwood publications ? The SOS Committee is still active and looking for ways to continue with surgical services. This is not the direction we want to go in. The foundation President has come to me expressing concern that VIHA is not refuting the claims put forth by the SOS Committee. It would sure be nice if they would float away.”***

On 18 Sept 2009, the Honourable Murray Coell wrote to Mr Harold Page ***“I do understand the issue and have been actively working with the SOS Committee, the Minister of Health and the CEO of VIHA. I personally feel that a study is a good idea and I have been assured that it will be completed before December. I am also fully supportive of the efforts of the community to obtain a surgeon for their state of the art surgery and do not believe that the study prevents this from happening.”***

12. In an e-mail Knype states to Allison Cutler on 24th Sept 2009

***“Plans are in place to temporarily remove \$150,000 from LMH’s surgical services budget in 2009/2010 to address the fiscal challenges VIHA is facing.”***

13. On 24th Dec 2009, Dr Richard Crow wrote to Harold Page ***“VIHA understands the community concerns about surgical procedures at Lady Minto Hospital and continues to explore options to provide surgical services on Salt Spring Island..... Please contact [Grant.Hollett@viha.ca](mailto:Grant.Hollett@viha.ca) if you would like to provide any additional concerns or suggestions for the review...”***

14. At the VIHA meeting on 14th June 2010 on Salt Spring Island, the presentation in-

cluded the statement that the VIHA proposals of May 2010 to delete the surgical service had the “unanimous support of the family physicians at Lady Minto Hospital.”

This is a remarkable 180 degree change from

a. April 2008 LMH OR Review Committee Report

***“Physicians including the GPs, psychiatrists and internist from LMH strongly support having a surgeon and maintaining surgical services at LMH “***

b. Sept 2008, minutes of Medical Staff LMH

***“Medical staff unanimously approves the document entitled LMH OR Review Committee Report April 2008”***

General practitioners, psychiatrists, and the internist at LMH are about 12 in number.

For all of them to change their opinion in such a remarkable fashion in such a short period suggests that more than moral suasion was involved. Each physician with “privileges” to admit patients to Lady Minto Hospital has to have an annual review approved by the Chief of the Medical Staff, that is, Dr Barclay.

## **B**

The Salt Spring Island Health Review (24 May 2010) is introduced with the statement

***“In the summer of 2009, VIHA determined that a health services review was required for Salt Spring Island.”***

See comments 10 and 12 above: in the summer of 2009, VIHA administrators at LMH had decided to terminate the surgical services and remove its funding.

15. Another reason given was

***“The lack of any previous needs assessments on Salt Spring island”***

This conflicts with evidence given by Gary Holman, past director CRD, on 14 June 2010 at the public meeting: there was an extensive needs assessment carried out in 2002 before the new operating room facility was budgeted. This has been confirmed by Karen Davies (previous Rural Health Manager LMH) and Wendy Shea (previous president LMH Foundation). This needs assessment was not provided under FIPPA. Ms Davies believes it may be in the files of the Ministry of Health, as the process was started before VIHA was formed.

These two distinguished ladies are appalled that the same data (demographic and surgical) which they used to gain funding for the operating room are now blissfully used to shut it down (personal communication from each 24th June 2010).

16. Section on geography. Salt Spring Island is part of local health area 64 (Southern Gulf Islands) and this health area is shown in Fig 1.

***“The 2009 population estimate for the Gulf Islands LHA (Local Health Area) is roughly 15,600 and is projected to grow by 8% by 2014 and by almost 35% by 2030”***

This estimate means that the population of the Gulf Islands LHA is projected to reach 21060 by 2030. This number is important because each general surgeon in Canada serves a population base of about 20,000.

The surgical service at Lady Minto was designed to serve local health area 64, with a

combined population of some 16,000. There is very little said in the report about the local health area, apart from one estimate of its population. Nothing is said about where the population of the other islands get their surgery.

17. Demographics and Mental Health Sections.

One explanation for the favorable health indicators on Salt Spring Island is the overall average income, which has not been considered here.

18. Operating Room, Surgery and Endoscopy (page 16).

***“Lower volumes make it more difficult for general surgeons and operating room staff to maintain the skills required for high quality and low risk surgery.”***

This general statement depends on some 160 scientific publications. A recent Canadian metaanalysis of the relationship between surgical volume and outcome found a positive association in 68% of studies, and no association in 32%. The authors stated that this relationship is only true for certain procedures and noted that extensive cancer surgery and major vascular procedures were most often studied. (CIHI Surgery: volumes and outcomes for surgical services in Canada. Tracey & Zainer Health Care Quarterly 8: 29, 2005).

In laparoscopic hysterectomy, there was no relationship between surgical volume and serious complications (Does Surgical Volume influence Short Term Outcomes? Am J Obstet Gyn 27 Apr 2010, preprint).

Some procedures such as cholecystectomy show no relationship between volume and mortality (The empirical relationship between surgical volume and mortality. Luft et al NEJM 30, 1364, 1979).

There was no relationship between surgical volume and outcome in a very large Veterans Administration study (Relation of surgical volume to outcome in eight common operations: results from the VA National Surgical Quality Improvement Program. Khuri et al Ann Surg 230: 414, 1999).

The statement in the review is probably correct when it refers to complex surgery, but is difficult to prove when applied to the kind of small scale surgery done on Salt Spring in the last 20-30 years.

These facts were also known in 2002 when the previous means assessment was conducted before the decision was made to rebuild the operating room.

19. One commonly used method of assessing the quality of intermediate or minor surgery is to examine the wound infection rates, especially in so-called clean cases. No attempt was made in the review to look at this feature of surgery at LMH, which would reflect concerns outlined in the statement quoted above about “low volumes making it more difficult... to maintain... high quality ... surgery.” Dr Preshaw reports that the clean wound infection rate from 2002-2008 was similar to that reported from major hospitals in Victoria.

20. On page 16-17 the report states

***“Stakeholders identified a wealth of potential alternate uses for the current operating room and post-anesthetic recovery room. These included expanding the***

**emergency room, using the space for psychiatric care, creating a transitional care space to help people transition from hospital to home, increasing laboratory space, and increasing medical imaging space, among others.”**

What is carefully avoided is recognition of the expensive specialised and fixed equipment present in the current operating room: this includes two automatic sliding doors, a specialised positive pressure ventilation system, three built in expensive overhead operating room light fixtures, specialised video equipment on built in arms swinging out from the wall, and specialised sterilisation equipment with access from a dirty room used for cleaning and a clean room used for storage. None of this equipment is of the slightest value for the alternate uses identified above.

It is true that some of this equipment can be used elsewhere, but this is not likely: after it has been ripped out of the wall, it will not be acceptable for new operating room construction elsewhere, and will likely be donated to the third world.

The review contains no estimate of the costs likely if these alternative proposals are adopted. An intelligent guess is that the costs would be between \$250,000 and \$500,000.

21. Fig 8 shows the number of surgical cases carried out at LMH from 1991-2009. The statement is made that the average number of cases is 150/year.

The graph does not take into account that for periods during these years there was no surgeon (1995-96, 2001-2002, 2008-2009). A better measure would be the mean number of cases for the last six years when there was a full time surgeon present: the mean number is 177/year. The numbers given in this graph are different from the numbers presented by Hollett to the OR Review Committee in April 2008 (section 3 above).

This graph does not include endoscopy cases, and does not make that clear.

22. The last paragraph on page 17 recognises that

***“In the last two fiscal years in which Lady Minto Hospital had a general surgeon for the entire year (2006-07 and 2007-08) there were an average of just over 220 endoscopies per year. ...”***

This statement conflicts with Fig 10, page 18. This figure identifies about 55 endoscopies at LMH from 2007-2009. This should have been at least 330 rather than 50, and should have recognised that the surgeon left in mid 2008: if the surgeon had continued at this rate until the end of 2009, the number of endoscopies would have reached 660. To claim that the number is 17% (55/330) of the correct number is hardly incompetence, and to claim that it is 8% (55/660) of the potential number if the surgeon had not been fired is a deliberate attempt to deceive.

*(Dr Preshaw confirms billing data to the Medical Services Plan for 330 endoscopies from 2007-mid 2008).*

Fig 9 “Surgery as Percent of all cases, 19 year average, 1991-2009 (various hospitals within VIHA)” is also erroneous, and again suggests manipulation. Firstly, Lady Minto Hospital did not have a full time surgeon throughout this identified period. All of the other hospitals listed never had periods without any surgery.

Secondly, all of the other hospitals, without exception, have other surgical subspecialties besides general surgery. Lady Minto Hospital only has had one general surgeon at

a time since 1991.

We don't have accurate data on how many of the cases at the other hospital were general surgery only, but in 2008 there were 12 general surgeons in Victoria and 95 other specialised surgeons. Assuming that all specialties have roughly the same number of cases per year (very roughly true but not accurate), then the number of cases in, for example, the Royal Jubilee Hospital due to general surgery should be 12/95 of the total. Absolute numbers are not given on this graph, but this would indicate that the percentage of cases admitted by general surgeons to the Royal Jubilee Hospital during this period would be 12/95 of 52%, or 7%. During this period general surgery accounted for 14% of cases at Lady Minto Hospital !

24. Maintaining endoscopy services at Lady Minto Hospital.

At the moment (June 2010) a visiting specialist from Duncan performs endoscopy twice a month. He also performs endoscopy in Duncan (number of days per month unknown) but presumably this is sufficient for him to maintain his skill.

However the skill and training of the staff associated with endoscopy at Lady Minto Hospital is not likely to be maintained with only two days/month (see argument in VIHA report about difficulty maintain surgical and nursing skill for a low volume general surgical practice). In fact, Lady Minto Hospital will have difficulty maintaining accreditation as a site for endoscopy with such low volumes of cases.

25. Throughout the report, concern is expressed that the number of cases (both surgical and endoscopic) at Lady Minto Hospital is likely insufficient to attract a surgeon (hinted to be a financial problem) or to maintain his/her competence (due to insufficient cases to maintain surgical skills).

Yet in the VIHA report, it is identified (Fig 9) that a considerable number of cases which could have been done at Lady Minto Hospital are referred off-island (for example, about half of the endoscopy cases in their erroneous numbers). The report of the OR Review Committee (Apr 2008) makes it clear that

***“The declining surgical cases noted were felt to be due to a number of factors, including potential patient preference and GP referral patterns. It is felt that a number of surgical cases that have been referred off island could likely be repatriated should a new surgeon come on staff.”***

The GPs, psychiatrist and internist who are identified elsewhere in this report to ***“strongly support maintaining surgical services at LMH”*** cannot have their cake and eat it too. If they do not support a surgical service at LMH by referring patients off-island, the numbers of surgical cases will decline, and the administration will have an argument against maintaining a surgical service at LMH.

26. Nowhere in the report is acknowledgment that previous administrators came to exactly opposite conclusions by building a \$3 million surgical facility at LMH. At the public meeting of 14th June 2010, the speakers somewhat awkwardly tried to distance themselves from the previous decision and decision-makers.

We believe that it is the duty of current administrators, whether in Victoria or at LMH, to acknowledge and respect the decisions of previous administrators. When they accepted their positions and responsibilities, new administrators must have known a sur-

gical facility had been built with an expected lifetime of some 30-40 years. If they had felt strongly about the surgical facility, they should not have accepted the appointment. The arguments advanced in the VIHA Review document of 23 May 2010 were all present when other administrators came to an opposite decision in 2002. In fact the data presented in the review suggest that, in 2008, the surgical service was more viable than in 2002.