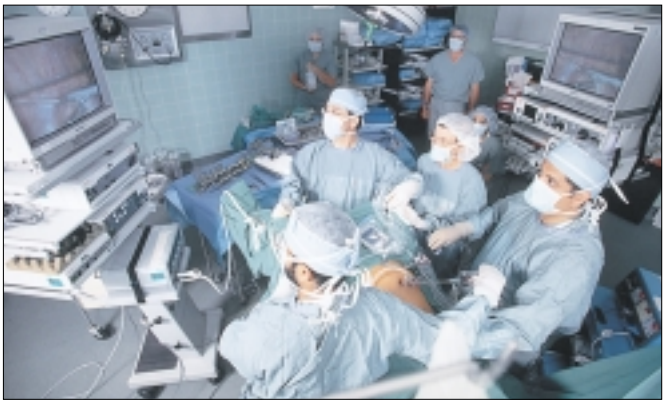
New surgery training centre sets big goals

A new centre for minimal access surgery training at St. Joseph's Hospital in Hamilton is designed to provide residents, surgeons and nurses from across Canada with the latest state-of-the-art techniques.

Minimal access (keyhole) surgery is winning converts because it is less invasive and reduces pain and recovery time. The latter result brings a smile to the face of hospital administrators because it helps clear badly needed beds quicker. The new centre opened in January after being launched in October. The multidisciplinary centre is located at St. Joseph's because it is a teaching hospital and its surgeons are among the most experienced when it comes to the relatively new technique.



Dr. Mehran Anvari performs a bowel resection

Dr. Mehran Anvari, an associate professor with the Department of Surgery at McMaster University, will direct the centre. "It will provide an opportunity to practise telesurgical techniques in a computer-simulated environment," he said. "The computerized patient simulators and other equipment will allow surgeons to refine and master the visual and motor skills required in a specific procedure. With additional research, patients will be able to have all sorts of operations without the need for a long hospital stay or recovery period."

The centre will cooperate with the Royal College to standardize new techniques and monitor their developments in Canadian hospitals. As well, information on a wide range of keyhole surgical and diagnostic techniques will be available to the public through a Web site and information line.

The centre's highlights include an integrated video-conferencing system, with rapid transfer of surgical proceedings from the operating room to a classroom, as well as a 2-way audio connection that allows for immediate interaction between students and surgeons. As well, simulations allow students to practise operative procedures in a more realistic environment. The centre is also designed to facilitate learning by physicians in remote and international locations. — *Ken Kilpatrick*, Hamilton

Is 79 too old for a heart transplant?

The University of Alberta Hospital has set off an ethical storm by performing a heart transplant on a 79-year-old man. A transplant team did the surgery Dec. 27 after lengthy debate and following a secret vote taken by members of the transplant unit. Dr. Arvind Koshal, director of cardiac sciences for Edmonton's regional health authority, said the hospital came to a compromise of sorts by transplanting a donor heart that would not have been used by another patient. The patient received a 55-year-old heart.

Usually, a heart that old would be reserved for patients facing death within hours or days without a transplant. But with no one on the waiting list qualified to accept the older heart, U of A staff transplanted it to the older patient. Causing a further wrinkle is the fact that the patient and Dr. Dennis Modry, who heads the U of A transplant centre, are friends. Although Modry was excluded from the decision-making process, Koshal agreed the transplant was considered because Modry argued in favour of the procedure. The patient was in excellent physical condition and Modry was against ruling the patient out simply because of his age.

But ethicists argue that, if the patient was deemed fit enough to receive a transplant, he shouldn't have received a "second-rate heart." The decision sets a dangerous precedent, according to Dr. Douglas Kinsella, a professor of medicine with the University of Calgary and past director of the medical faculty's Office of Medical Bioethics. "This could create a slippery slope where you use the poorer organs for the 'less good' persons, and the interpretation of who might be less good or less worthy could prove to be a very dangerous slope on which to start sliding."

Glen Griner, a philosopher and member of the John Dossetor Health Ethics Centre at the U of A, agrees. "Using less-good organs is like saying, 'Yes, you can ride on the bus but you have to ride at the back of the bus.' The first decision they make is that we will not discriminate on the basis of age and, having made that de-

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Hospital mergers leaving many Ottawa doctors riled

Although hospital restructuring is well under way across Ontario, some of the transitions are proving to be anything but smooth. In Ottawa, for instance, the merger of the Civic and General hospitals into the Ottawa Hospital has created bitter professional disputes. "We are all very disappointed, but we were expecting it," Dr. Alan Guberman, senior neurologist at the General site, said following the Dec. 13 decision by the Ottawa Hospital board to move all neurology, neurosurgery, trauma services and related programs from its General campus to the Civic campus.

"We are all very angry, not only that this was done but at how it was done," added Guberman. "It was a top-down decision that was railroaded through. Everyone who supported the plan and pushed it had [his or her] own agenda. It was a political decision [with] economic and fund-raising implications."

General campus neurologist Mark Freedman was blunter: "The board and CEO [David Levine] say patient care is at the root of this decision, which is absolutely not true. They want to reinvent the wheel by uprooting a successful program and moving it to the Civic in order to save the political face of that institution."

Freedman said that when the restructuring commission determined that the Civic would be transformed from a full-fledged teaching facility into a community hospital, the leaders there "turned their face and said, 'No, we will just figure out how to turn this decision around.' When the new Ottawa Hospital board was planning restructuring, it hired its own people and stacked the deck so that it could get whatever it wanted. But there is no logical reason for this move."

Levine, whose appointment to the CEO's position was itself controversial because of his political background, knows all the arguments against moving the program but stands by the decision. "Yes, they have a service that functions very well. But it has 115 people and it exists in a physical location. The Ottawa Hospital is 9000 people, and we are looking at its development over the next 3, 10 and 15 years."

Effectively killing any notion about the Civic becoming a community facility, Levine described the need to balance programs at both sites. He said the Civic is better suited for overall emergency care, the General for "elective surgery, academic and tertiary care. It was agreed by everyone that we had to concentrate the neurosciences activities in one place, but if we had decided to do it at the General the facility would have been overloaded. It has 560 to 600 beds and would never have been able to grow."

He emphasized that oncology is one of the fastest growing disciplines today, and it was recently moved to and concentrated at the General. "We have been cancelling elective surgery in oncology because there is too much activity at that campus. If we had moved neurosurgery over there as well, the impact on our elective surgery would have been terrible."

In the future, he adds, the big technological strides and expansions will be in the areas of oncology and transplantation, both programs primarily located at the General site, where they will need room to grow. The Civic, however, has a new ICU and 16 new operating rooms, and is considered suited to handling the city's emergencies, including neurological trauma.

Neuroscience staff at the General were not in a very cooperative mood following the hospital's decision — there were threats to quit and move — but Levine hopes tempers will soon cool and that the transfer will go smoothly. — *Lynn Cohen*, Ottawa

Transplant controversy

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cision, he is then in fact treated differently than the other people on that waiting list. That looks curious and needs some explanation."

But Eike Henner-Kluge, chair of philosophy at the University of Victoria and a former director of ethics at the CMA, thinks the hospital made the appropriate decision. "If there is a difference between hearts at all, one would try to match a heart to a recipient. If you are looking at lifetime expectancy, you shouldn't give a heart with 70 years on the ticker to someone with 20 years left to live," he said. "It is a relevant difference. You want to make sure you get the appropriate use of the appropriate resources. That is ethically not questionable at all. We do this rationalization of resources in health care every day."

Dr. Koshal said that this is precisely the line of thought the hospital used. In fact, the patient, hospitalized since September following complications from a bypass operation, wouldn't have accepted a younger heart that a younger recipient might have received. The move to break the age barrier for transplant recipients, which is now 65, will force other changes in transplant protocols, Koshal insists. "Ultimately what I think will happen is we'll say, 'He is on the list and he gets whatever is available.' Criteria are going to be expanded more, but you need to be practical. Would you give a 55-year-old heart to 16-year-old patient? We face these decisions from time to time."

The heart transplant was 1 of 32 performed in the province in 1999. — *Richard Cairney*, Devon, Alta.