

M U H C

MCGILL UNIVERSITY HEALTH CENTRE

HEALTH

PERSPECTIVES



In this issue: Interview: Dr. Arthur T. Porter **1** A Passion for Prevention **4**
A Slice of Life in the Department of Surgery **6** Portraits in Time **8** Laparoscopic Ultrasound **8**

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a clear vision

Dr. Arthur Porter was named Director General and CEO of the McGill University Health Centre (MUHC) last March. Since then he has brought focus to the MUHC's redevelopment project and provided it with a roadmap to a successful conclusion. We spoke with Dr. Porter in late April.



On behalf of the MUHC Foundation, welcome to Montreal. Your arrival coincides with a period of dramatic change to the health-care network and to this institution. What are your thoughts regarding the challenges and opportunities the MUHC is facing?

There is probably no better or more exciting time to come to the MUHC than this. It is very rare to find a situation like the one we have in Quebec at the moment, where all of the natural paradigms of health care are being challenged, from networks to academic enterprises to how hospital facilities are put together. This gives us the unique opportunity to create what can truly be a new health-care system based on the principles and practices of world-class patient care.

An important part of this system will be what we are referring to as the redeveloped MUHC, which includes a refurbished Montreal General and a new facility on the Glen site. By the time this newsletter has gone to press the MUHC will have identified what services each of these two sites will be providing.

I want to emphasize as strongly as I can that, even with a two-site plan, there is only one MUHC. This will be a single facility on two sites. There won't be one university part and one non-university part or anything else that suggests two

(continued on page 2)





(A clear vision continued from page 1)

classes of service or citizenry. Ultimately we will be able to say that we have a strong site at the Montreal General and a strong site at the Glen Yards, and we have an MUHC that expands across them all.

Now, some people have expressed anxieties about how we will be able to deliver care on two sites. First, to the greatest extent possible, entire services or program lines should not be split. So for example on one site you would have an oncology program with radiation therapy, chemotherapy and surgical oncology services all in one place. And on another site you'd have trauma and all of the ancillary surgical services that support it. The thing that you shouldn't do, and the situation that to some extent exists at the moment, is to have bits and pieces of these programs split up in different places.

Second, it is absolutely imperative to have the input of physicians as you make these determinations. I think one of our great assets at the MUHC is that we have tremendously knowledgeable physicians who have a great interest in what goes where. I intend to listen to those physicians and to use their expertise to delegate services in the manner that will allow us to serve patients as well as we can.

Q. Are physicians and other professionals and staff being brought into the planning process already?

A. Absolutely. For example, I've spent the better part of my time here meeting with physicians to make sure that they are involved — integrally involved — with the planning process. Whether it's the elected physician bodies, the physician leadership such as department chairs or simply individual doctors that have a large patient practice, a long history with the organization and a commitment and desire to be involved, I'm making sure that physicians' opinions and those of other professionals and staff are being heard and acted upon as we move forward.

Q. Can you summarize the status of the project and the redevelopment plans?

M U H C HEALTH PERSPECTIVES

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Editor: Sami Antaki
Assistant Editor: Dianne Fagan
Copy Editor: Jane Pavanel
Designer: Shari Blaukopf
Photographer: Christian Fleury
Translators: Andrée Michon, Joelle Bernier

For information, comments or to make a donation, please call (514) 931-5656
www.muhcfoundation.com

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A. I think this can be summarized in terms of six areas where we are making truly substantial steps forward.

First, and maybe most important, I want to get

Fourth, as I mentioned before, physicians are heavily involved with the project, which is different from how things have been done in the past and which they've been lobbying for actively.



There is only one MUHC.

There won't be one university part and one non-university part or anything else that suggests two classes of service or citizenry. Ultimately we will be able to say that we have a strong site at the mountain and a strong site at the Glen, and we have an MUHC that expands across them both.

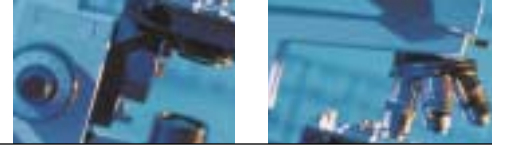
started with the project as quickly as possible. Because I'm a terribly impatient person, I'd like to see a shovel in the ground by the end of the year. I don't know that this will be possible, but I will do everything in my power to get started by year's end.

Second, we now have made an absolute commitment to being on two sites. There is no question any more. In think in the last little while there has been some lingering hope or desire from some people that we would be on a single site, but that's off the table as far as I'm concerned.

Third, and related to the first point, is that not everything needs to be done at once on the site. I'm perfectly happy with a phased-in approach, with a master plan that calls for certain services or pavilions in place before others. This is a massive undertaking, like building a health city. A phased-in approach is sensible, and might allow us to be more responsive in our plans to changes in health-care over the coming years.

Fifth, I think we have some other partners who might look at sharing the site with us. There may not only be the MUHC at the Glen, but also other institutions that will use the site in a sort of condominium arrangement. For example, we will be working very hard over the next few months to persuade the Shriners to stay.

Finally, we have created a strategic plan that tells everyone, from the physician to the staff member working in the laundry, what our goal is and how we will set out achieving it. One of the things that has bothered me, I'll be very honest, has been the level of uncertainty within the MUHC. This has included everything from whether their job was secure to questions about the future of the Children's Hospital to where an individual's office was going to be located. The strategic plan will provide answers to these questions, will give us clarity, and will give everyone a chance to get on board this train.



Our goal

is to provide the right health care to the citizenry of Montreal.



Q. The Technical Review Committee emphasized that practice plans must be an integral part of the MUHC's redevelopment planning. What are practice plans, and how will you go about implementing them?

A. A practice plan is no more than a way for the distribution of fees and other moneys generated by physicians to sensibly and fairly follow the mission of the institution. In our case, this is the mission of an academic health centre, which includes not only seeing patients for billable services, but writing papers, travelling and giving talks, teaching, and so on.

It is important to note that practice plans already exist at the MUHC. Many departments, including surgery and several medical specialties, currently operate under practice plans, where the physicians within the department pool their income and mechanisms are in place to distribute that income according to the doctors' varied workloads. In order to conform to the Technical Review Committee's recommendations, the next step is to take these separate departmental practice plans and to integrate them into an MUHC-wide overarching plan.

Now, this sounds very simple. But like all major projects, especially those that touch on income, the devil is in the details. As we go through this process, we will need to look very carefully at all of the various means by which physicians generate income, to develop an appropriate distribution formula, and to test it methodically. Because this formula will have to reflect not only the clinical activities that bring in the money, but also the teaching and research that don't generate income so directly, it is possible that more funds will have to be injected into the system. The Mulroney-Johnson report alluded to this very possibility.

Q. How would you address concerns that the new MUHC will have fewer patient beds than it does today?

A. It is interesting how people focus on the numbers. From my perspective, far more important than the number of beds is how they are managed medically, and how well they accommodate the services for which they are required. The incredible increase in ambulatory care in recent years has reduced the number of beds required by all health-care institu-

tions, as have strategies to manage the length of time patients must stay in hospital by maximizing the efficiency of tests and other medical resources.

In terms of the MUHC's redevelopment, I want to emphasize that the Technical Review Committee didn't actually reduce the total number of beds, they just suggested we move them around a bit. At the end of the day we need to have the appropriate number of beds at each site for the services we configure. And so, based on our calculations and the government's, the way I plan on doing things is not starting with an arbitrary number of beds and working backwards. We'll start with what we have to do to provide the best care to our patients, how that optimally can be organized, and then determine how any beds we need to achieve it.

Q. There has been a lot of debate about the government's suggestion that the MUHC examine Public Private Partnerships (PPPs). How do you see the role of PPPs in the MUHC's redevelopment plans?

A. As with many things, PPPs can be either good or bad depending on how they're implemented. They can take many different forms, from engaging a private company to take on the capital risk and the risk in terms of construction times, to forming some kind of joint venture with a clinical facility. This might mean engaging a private company to run the laundry or the parking facilities. What people must understand, however, is that we are not in any way looking at privatizing the delivery of care at the MUHC. Patient care will always be delivered by us and controlled by us.

What is crucial in the end is that we look very carefully at why we are engaging in these partnerships, how they will be organized, and whether or not they will enhance our ability to care for patients. The government has floated this idea of PPPs and asked us to consider it, but no decisions have been made and whatever we do will be cautious, considered, and in the best interests of our patients.

Q. The Mulroney-Johnson Commission made suggestions for the Centre hospitalier de l'Université de Montréal (CHUM) that are

quite different from what they recommended for the MUHC. How do you see the relationship between the two institutions and their redevelopment projects?

A. From my perception, health care has no linguistic or geographic barriers. Our goal, and the goal of the CHUM, is to provide the right health care to the citizenry of Montreal. In order to do that, we need to work together to ensure that our projects are successful in the long term, whether or not they start or finish at the same time. I don't know that the timing of their project and ours should necessarily be linked, as I think each institution needs to proceed in whatever way works best for the community. We will continue to support the CHUM fully and to work together on the complementarity initiatives that we need to implement.

Q. Finally, when do you think we're going to see the new MUHC up and running?

A. The MUHC is up and running. However, its redevelopment is a major project that will take a long time to fully complete. But, as I've said, I would like to see a shovel in the ground by the end of this year, whether it's to begin decontamination, to build some ambulatory care facilities, or something else. Once you have a project that is visibly underway, you will find that everything runs more smoothly and that more and more people will get excited about what the MUHC can become. And what that will end up being, I cannot say because I cannot predict to any great extent what will be the new innovations of health care in the next ten years. What I do know is that they will be different from what they are today and we must plan flexibility into our project.

In my specialty there has been a decoding of the human genome. Every year there is an exponential increase in the number of genes for cancer that are found. There were four two years ago; there were 160 last year; there will be about 1,000 this year. Once you have a rate of explosion like that, what about genetic therapy? We don't have it in the plan, but it's going to be there because it's going to be part of medicine. Our plan is flexible enough to meet our needs today and to accommodate the future of health care. ❄



Cervical cancer meets its match

It is something every doctor dreams of but very few are lucky enough to experience: playing a part in eradicating a widespread and deadly disease. The last century saw the development of inoculations against devastating infectious illnesses like polio, typhoid fever and smallpox. Now, thanks to the efforts of McGill University Health Centre (MUHC) gynecological oncologist Dr. Lucy Gilbert and a team of international collaborators, cervical cancer may soon be added to that list.



both genital warts and malignant changes in the cells of the cervix and lower genital tract. “Between 30 and 50 percent of young people have been exposed to HPV, which is transmitted sexually,” Gilbert explains. “Most people have an immune reaction that effectively fights off the virus, but the rest experience what we call a clinical response, which can be genital warts, precancerous conditions or cancer itself.”

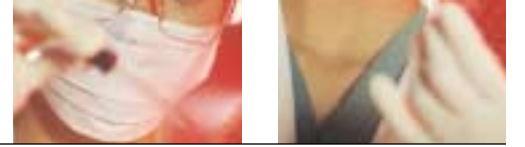
There are around 100 different strains of HPV varying in frequency and virulence. Although not all HPV infections lead to cervical cancer, every case of cervical cancer is the result of HPV. “We’ve made a certain amount of progress with cervical cancer by aggressively treating it in its precancerous stages,” Gilbert says, noting that in Canada, where early diagnosis and treatment is prevalent, cervical cancer is the eleventh-deadliest cancer in women. “Clearly, though, we’d prefer to get to the disease even earlier. Our goal is to prevent it from developing in the first place. That’s why vaccination is so attractive and why so much international effort has been invested in this project.”

Although the relationship between HPV and cervical cancer has been understood for many years, American scientists only began testing a vaccine in the late 1990s. The vaccine synthetically mimics a part of the HPV virus, tricking the body into mounting a powerful immune response. The results of early trials, which were published in the fall of 2002 in the prestigious *New England Journal of Medicine*, showed that the vaccine is 100 percent effective against HPV-related diseases, including cancer.

Dr. Gilbert and her colleagues began conducting the phase III clinical trials in July of 2003. These trials are an integral step in gaining government approval of the vaccine and making it available to the public. “It’s a great honour to be a part of such an important study, and a credit to the MUHC’s reputation for scientific rigor and integrity that they were asked to participate by the study’s principle

“**I** predict that cervical cancer will be eliminated in ten years,” says Gilbert, who is part of a global team conducting trials on a new vaccine that prevents the infection that leads to the disease. “We’re talking about the second leading cause of cancer deaths in women worldwide, so this is really overwhelmingly exciting news.”

The new vaccine targets human papilloma virus (HPV), a common infection that causes



researchers, who are based at the University of Washington in Seattle,” Gilbert says. The four-year project, which involves 53 patients at the MUHC and many more at hospital centres around the world, is designed to provide detailed information about the efficacy of the vaccine over time, as well as comprehensive proof that the vaccine works in a wide range of clinical environments. “The vaccine is being studied in London, Hong Kong, Brazil, the United States and Canada,” Gilbert says. “The more diverse the populations that are tested, the more convincing the results are.”

For Gilbert, working in an international context is nothing new. “I’m really something of a gypsy,” she says with a smile, describing her peripatetic past. Born in Singapore to Indian parents, Gilbert moved to the Mysore region of India to attend medical school. She then travelled to England to undertake a fellowship in oncology. She completed her studies at the National Institutes of Health in Bethesda, Maryland, where she first became interested in HPV and the conditions under which it develops into cancer. Gilbert then returned to England to work as a gynecological oncologist, eventually becoming chief of two medical districts in the north of England.

In 2001, Gilbert was approached by the MUHC, which was keen to recruit specialists with her particular expertise. “I really had given no thought to moving to Canada,” she recalls. “But they were clever enough to invite me to visit in the summer when everything is so beautiful. I really was seduced by Montreal, and am delighted to be working with such a fine group of colleagues.”

Gilbert was invited to oversee the MUHC’s participation in the HPV vaccine trials, in large part because of her own well-regarded work in the area. Another reason why the study’s researchers chose the MUHC was the particularly stringent ethical standards it applies to clinical trials. “Because we’re dealing with sexuality and young people, it’s particularly crucial that the highest ethical standards are upheld,” says Gilbert, explaining that the MUHC’s trial group includes women between the ages of 16 and 21, many of them students at McGill and Concordia. “The study leaders were confident that the MUHC would respect the particular consent issues of this population.”

Another difficulty presented by this demographic is their tendency to move away, making the four-year follow-up required by the study challenging. “We’ve been very fortunate that the girls have been absolutely excellent. Our rate of successful follow-up has so far been 95 percent, in large part due to the commitment of the young women we’ve recruited. In many of the cases where people have moved away we’ve been able to make arrangements with local health centres to perform the necessary tests.”

For Gilbert, the satisfactions of being involved in the groundbreaking study are personal as well as professional. “One thing that’s really been a delight is dealing with healthy young women,”

The results of early trials, which were published in the fall of 2002 in the prestigious *New England Journal of Medicine*, showed that the vaccine is 100 percent effective against HPV-related diseases, including cancer.

she says. “As a cancer specialist so much of my practice involves tragedy. This is a very welcome change. I also have a teenage daughter, so I guess there is a special significance in this work for me as well.”

So once you have helped eliminate cervical cancer, what do you do next? If you are Gilbert, you turn your attention to lower-profile but equally crucial research into preventive measures for cancers where a cure isn’t yet on the horizon. “Ovarian cancer is particularly problematic because its symptoms are so vague,” Gilbert explains. “In many cases neither patients nor doctors identify the disease early on. As a result 70 percent of ovarian cancer patients are only diagnosed in stage III, meaning the cancer has already spread to other abdominal organs. The challenge, therefore, is to find ways of diagnosing the disease earlier, when treatment will be more effective.”

According to Gilbert, symptoms such as pain and bloating are common to so many women that researchers have more or less given up on finding ways to identify when they might be signalling something more serious. She is convinced, however, that a program of sensitization

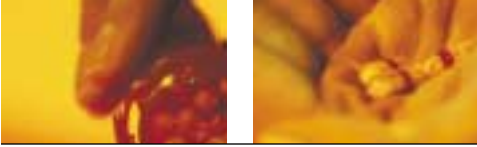
among both women and physicians, as well as a rigorously tested set of clinical guidelines for doctors, can make a difference. “One difficulty is that the gynecologists providing front-line care don’t generally have a specialized expertise in oncology. Typically only three to four percent of a gynecologist’s practice involves cancer patients, so it’s hard for them to keep their skill level high.”

Gilbert hopes to develop a finely tuned set of guidelines for both general practitioners and gynecologists that will let them know exactly when a patient’s symptoms require further investigation. “Preliminary work has shown that when postmenopausal women develop pain and bloating they haven’t experienced before, this should be taken

very seriously. They need to be referred to the right physician and the most effective treatments have to be offered as quickly as possible.”

Ovarian cancer provides just one example of how a low-tech but evidence-based approach to early detection and treatment has the potential to reduce mortality. Unfortunately, Gilbert explains, it is much more difficult to attract funding for such projects than for more glamorous and sensational research. “The HPV vaccine is an incredible triumph and is deservedly very well funded. The challenge is in finding donors who are willing to support work that won’t produce a miracle cure but will improve the prognosis for a wide range of cancer patients.” One tool Gilbert hopes to acquire that will improve her patients’ recovery rate is a universal database of gynecological cancer patients that is capable of tracking which treatments work under what conditions.

Even as she looks ahead to future projects, Gilbert can take pleasure in knowing that, thanks in part to her work and that of her MUHC colleagues, the battle against cervical cancer has almost certainly been won. For women worldwide, that is a victory worth celebrating. ❁



a cut above

If you don't like superlatives, you had better avoid asking Dr. Mostafa Elhilali, the McGill University Health Centre (MUHC)'s newly appointed Director of Surgical Services, to describe what the MUHC's surgeons, surgical nurses, professionals and staff are up to. That's because even the soft-spoken Elhilali can't help but use phrases such as, "biggest in Canada," "busiest in Quebec," and "first in the world" when talking about the myriad achievements of the MUHC's world-renowned surgical mission.

“It’s hard to know where to start,” says Elhilali, taking a few

moments to consider the scope of the mission which he now directs. A former Chief of Urology, Elhilali took over as Interim Director of Surgical Services in November of 2002 and was named Director in April of this year. At the same time, Elhilali became Professor and Chair of the Department of Surgery at McGill University. “We have about 70 surgeons working in our divisions of cardiac surgery, general surgery, orthopedics, plastic surgery, thoracic surgery, and vascular surgery, and even more working in independent departments like urology. Surgical Services at the MUHC also encompasses every department that has a surgical component, including things like anaesthesiology, otolaryngology (ear, nose and throat procedures) and ophthalmology. Overall, we see more than 18,000 patients a year. From heart transplants to cataract surgery, from hip replacements to limb re-implantation, if it takes place in an operating room, we are responsible for it.”

If medicine is like the backbone of a hospital, then surgery can perhaps be seen as its musculature: dynamic, powerful, and responsible for some of the great leaps forward that both save lives and make headlines. In 1958 surgeons at the MUHC stunned the world by performing the first kidney transplant. In 2002, the innovative use of a mechanical heart to save the life of little Émile Jutras captured the imaginations of the medical establishment and the public alike. A look at developments across the MUHC's surgical divisions reveals that, far from being the exception, such breakthroughs are all in a day's work for the MUHC's surgeons.



I'm certain the day will come when conventional, large-incision operations will be a thing of the past. I'm proud to be able to say that the MUHC has been instrumental in this transformation.”

“Take trauma, for example,” Elhilali says. “The MUHC is one of only two level one trauma centres on the island, meaning we're equipped to handle even the most complex and difficult cases.” These adjectives certainly describe the remarkable surgery performed last fall on Louis Côté, who was brought to the MUHC from Rivière-du-Loup when his arm was severed in a

sawmill accident. A multidisciplinary team of plastic and orthopedic surgeons spent 11 grueling hours in the operating room repairing and reattaching the bones, vessels, tendons and nerves in Côté's arm, which is expected to regain almost full function in about a year. Although incredible, limb reattachments are now commonplace for the MUHC's trauma specialists, who deal with the most trauma cases



of any hospital centre in the province.

Surgeons at the MUHC are also on the front lines of the fight against Canada's biggest medical killer: cardiovascular disease. The MUHC has long been a leader in cardiac surgery and, following on the success of Émile Jutras's procedure, today performs the largest number of transplants involving mechanical hearts in the province. In 2002, one of Émile's surgeons, Dr. Renzo Cecere, for the first time in Canada fitted a patient who was unable to have a heart transplant with a permanent mechanical heart pump. These pumps promise new hope to people suffering from end-stage heart failure, which kills more than 78,000 Canadians a year.

Many of us are old enough to remember a time when nightmarish braces and painful traction were the only treatment options for that most feared childhood affliction: scoliosis. Fortunately, recent decades have seen great advances in the surgical correction of even the most extreme curvatures of the spine. The Montreal Children's Hospital of the MUHC is a recognized centre of excellence in spine surgery, receiving referrals from across Quebec and the Maritimes to correct severe cases of scoliosis. The program's director, Dr. Vincent Arlet, recently designed an electronic database of 150 successful Canadian scoliosis surgeries that can be consulted by surgeons to choose the best procedures for their own patients. A multicentre clinical trial is currently testing the efficacy of the database.

Other areas in which the MUHC's surgeons shine include transplants, bariatric surgery (used to reduce the stomach capacity of morbidly obese patients), and laser prostate surgery, for which the MUHC is one of only four major centres in the world. "There are so many surgical disciplines where we stand out," Elhilali says. "This is really only a sampling of what we're doing."

For many patients facing surgery, the greatest anxiety derives not from the specialized work taking place inside the body, but from the idea of the incision itself and the post-operative discomfort that accompanies it. That's why one of the areas Dr. Elhilali describes with the most enthusiasm, and one which cuts across nearly all surgical divisions, is minimally invasive surgery (MIS). MIS, also called laparoscopic surgery, is a technique that has truly revolutionized the surgical experience for both patients and physicians. Instead of making a large incision, surgeons make small holes in the patient's body through which they introduce surgical instruments and perform the procedure with the aid of a video screen. Dr. Gerald Fried, a recognized leader in the field, was one of the first surgeons in Canada to perform laparoscopic gall bladder surgery. Along with Dr. Liane Feldman, Dr. Fried developed and directs

an MIS training program for surgeons and surgical residents that serves as a model across North America. Recently, the Society of American Gastrointestinal and Endoscopic Surgery adapted this MUHC training program as part of its own competency certification in MIS (see sidebar on McGill's new \$6 million surgical skills lab).

"Right now, 70 per cent of the surgeries we perform at the MUHC are minimally invasive," Elhilali explains. "The patient comes in the morning of the surgery, has the procedure in the afternoon, and is often able to resume normal activities after only a week or two. New laparoscopic procedures are being perfected all the time, and I'm certain the day will come when conventional, large-incision operations will be a thing of the past. I'm proud to be able to say that the MUHC

The MUHC's Department of surgery will soon be able to benefit from a new \$6 million surgical skills lab being built by McGill University. This elaborate facility will feature a variety of physical and computerized simulators that will allow both students and surgeons to hone their skills outside of the operating theatre. As the MUHC's Director of Surgical Services, Dr. Mostafa Elhilali, explains, "surgical techniques are changing all the time, and the rise in laparoscopic surgeries in particular has put a strain on surgeons' skill sets. It is one thing to develop the dexterity to perform conventional surgery, and quite another to master the tiny movements of the laparoscope while looking not at a surgical field but at a TV screen." Although many of these methods are already being used to train the MUHC's surgeons, the new lab will offer more equipment, better facilities, and the capacity to train an even greater number of students, ensuring that McGill and the MUHC remain centres of excellence in surgical teaching. ✨



has been instrumental in this transformation."

Elhilali takes the long view when it comes to maintaining and improving the department through a sound recruitment strategy. The Department of Surgery has acquired nine new surgeons in the last two years, and currently has search committees in place to hire division heads in cardiac surgery and trauma. "Finding excellent, experienced candidates to fill these key roles will help us build on our strengths and sustain academic growth in the future," Elhilali says. "In the coming years we plan to target our recruitment very carefully so that the surgeons we hire have precisely the skills we need to fill gaps in our various divisions. To that end, we're going to be focussing on five areas of priority: trauma, cardiac surgery, surgical oncology, transplantation and minimally invasive surgery."

In addition to patient care and teaching, research is also front and centre in the Department of Surgery. "We have researchers working on pancreatic islet transplantation, a potentially life-saving procedure for diabetics. Outcomes research gives us important data about just how our patients are doing after traumas and other surgeries. Orthopedic researchers are exploring what factors influence bone healing, and we've just hired four full-time clinician researchers and two new scientists to the team working on prostate cancer," Elhilali says, naming just a few of the promising research projects taking place across the department.

With such a venerable past and a vibrant present, what does Elhilali see in the future of the department? First and foremost, he is enthusiastic about the opportunities presented by the MUHC's redevelopment at a refurbished Montreal General site and the new facilities at the Glen Yards. "Although we have done as much development as we can on the current sites, most of the facilities we're using weren't built to accommodate the large and sophisticated equipment needed for today's surgical procedures," says Elhilali. Laparoscopy, for example, requires TV monitors, X-ray machines, lasers, and other equipment that was unheard of in an operating room even thirty years ago. "Robotics is another important area of surgical development right now, and we haven't been able to begin working seriously in this field because we just don't have rooms large enough to house the equipment."

As currently planned, in the redeveloped MUHC the General will be the so-called 'hot site,' where trauma will be located along with the surgical services, such as orthopedics and neurosurgery, needed to support it. The Glen site will specialize in day surgery, elective procedures and other non-urgent surgical services, with 18 adult and 6 pediatric operating rooms. The General will have a total of 10 operating rooms, of which three will be specially designed MIS suites.

Even though new construction may be required to accommodate some of the most cutting-edge surgical disciplines, Elhilali is adamant that both the General and the Glen will be centres of surgical excellence. "While we want to make sure that individual surgical divisions aren't split up, we are committed to ensuring that both sites are equal in terms of their importance to our mission of teaching, research and patient care."

Rest assured that you can look forward to big things from the MUHC's Department of Surgery — even if they're happening inside tiny incisions. ✨



Portraits in Time

Thousands of individuals have helped advance the development of the McGill University Health Centre, and in every issue of *MUHC Health Perspectives*, we feature one or more of these significant contributors.

MABEL FRANCES HERSEY (1872-1943)



During her 30-year tenure as Superintendent of Nursing at the Royal Victoria Hospital, Mabel Hersey was instrumental in bringing nursing education at McGill into the modern era. By the time of her retirement in 1938, the training of nurses had evolved from an ad-hoc affair involving only a few weeks of practical instruction to a formal academic discipline, culminating in Hersey's crowning achievement: the establishment of the McGill Graduate School of Nursing in 1920.

Born in 1872 in Lucan, Ontario, Hersey received her training in nursing at the Royal Victoria Hospital, graduating in 1905. She accepted a post in the Royal Vic's operating room, where she worked until 1908 when the Superintendent of Nursing resigned and the hospital requested that Hersey

take her place.

By 1917, Hersey and Grace Fairley, the head of the nursing program at the Alexandra Hospital, had conceived of a rigorous and academic standard of training that would offer nurses the chance to extend their education beyond the RN degree. The McGill Graduate School of Nursing was an immediate success, and its graduating classes continued to expand until the school was formally absorbed by the Faculty of Medicine in 1940.

Hersey's efforts resulted in numerous awards and honours, including the Order of the British Empire in 1935 and the Canadian Nurses' Association's Mary Agnes Snively Memorial Medal for outstanding contributions to nursing, which she received the following year. In a fitting tribute to such an eloquent advocate of the merits of higher education, Hersey was awarded an honorary doctorate by McGill in 1938.

JONATHAN CAMPBELL MEAKINS (1882-1959)



At today's MUHC, major medical discoveries almost always emerge from close collaborations between laboratory scientists and clinical practitioners. This integration of scientific inquiry into the practice of medicine was the passion and major achievement of Jonathan Campbell Meakins, Physician-in-Chief at the Royal Victoria Hospital and Director of its University Medical Clinic.

Meakins was born in Hamilton, Ontario, and received his medical degree from McGill University in 1904.

After graduation he was employed as a resident physician at the Royal Victoria Hospital for two years before moving briefly to the United States. In 1910, he returned to Montreal to join the staff of the Royal Victoria Hospital and to become a Lecturer in Clinical Medicine at McGill.

Meakins's career in Montreal was interrupted in 1914 when he enlisted in the Canadian Army Medical Corps following the outbreak of World War I. After the war Meakins remained overseas, accepting an appointment in Scotland as Professor of Therapeutics and Clinical Medicine at Edinburgh University and Physician to the Royal Infirmary. In 1924, Meakins was persuaded to return to the Royal Vic to set up the University Medical Clinic. There, for the first time at a McGill hospital, basic medical scientists worked alongside clinicians, inaugurating a formula that has since become a hallmark of the institution. At the same time Meakins became Professor of Medicine at McGill, embarking on an academic career that would eventually see him serve as Dean of the Faculty of Medicine from 1941 to 1948.

In addition to his services at McGill and the Royal Victoria Hospital, Meakins played an important role in the formation of the Royal College of Physicians and Surgeons of Canada and was elected its first President. Perhaps most remarkably, Meakins's son Jonathan Fayette and grandson Jonathan Larmonth both had distinguished careers at McGill, creating an extraordinary medical dynasty spanning almost a century. *

Equipping Excellence

To the benefit of patients of all ages, surgeons at the McGill University Health Centre (MUHC) are increasingly replacing conventional surgical procedures with minimally invasive surgery (MIS), also called laparoscopy. By inserting a tube-like instrument containing tiny surgical instruments and a miniature camera into a one-centimetre incision, surgeons can perform even complex procedures on an out-patient basis, saving time, money and, of course, patient suffering.

Despite its advantages, this relatively recent technology has some limitations. Unlike during conventional surgery, surgeons performing MIS don't have access to necessary tactile information and can't see below the surface of tissue and organs. This is why the **laparoscopic ultrasound**, which is specially designed for use during MIS, is so important. Inserted through the same tube as the other laparoscopic instruments, the laparoscopic ultrasound uses sound waves to generate detailed, three-dimensional images of tumours, organs and other anatomical structures. This allows surgeons to make quick and informed diagnostic decisions and to operate with confidence in even the most delicate areas.

The MUHC plans to purchase one laparoscopic ultrasound at a cost of around \$250,000. From oncology to urology, this innovative device will allow the hospital centre's renowned MIS surgeons to perform a greater range of laparoscopic procedures than ever before, saving even more patients the risk and discomfort of large-incision surgery. *

This series is intended to be informative; the McGill University Health Centre Foundation does not endorse any particular manufacturer or model of the equipment shown and described here.

