



## **MUHC Department of Medicine Retreat**

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On the afternoon of Monday, February 5, 2007, about 100 members of the MUHC Department of Medicine, MUHC officials and colleagues from the JGH and St. Mary's gathered at the New McGill Residences for a retreat aimed at preparing the way for the upcoming planning process for the MUHC Redevelopment Plan. In addition to our many distinguished speakers, the incoming Scientific Director of the MUHC Research Institute, Dr. Vassiolos Papadopoulos and our new Dean, Dr. Richard Levin, were both able to participate.

The afternoon began with a brief address by MUHC Chief Executive Officer Dr. Arthur Porter, who reported on the state of negotiations with the government. It is clear that we are close to a final okay for the project and that many of the key elements for success, including the architectural team, are in place. Work is currently focusing on getting final approval for the functional and technical plan and finalizing the public-private partnership that will be needed to finance the project.

Our own Dr. Tim Meagher then followed with a review of the project, emphasizing the issues that are being finalized with the government. Dr. Meagher described a very arduous process involving repeated meetings with government officials and tough negotiations. It is clear that the final approved project will include not more than 832 beds, although the government has conceded to make available at least 30 additional beds in other institutions for alternate level of care for patients at the MUHC. Negotiations over the ambulatory care part of the project are very difficult, since the government has called for us to give up many thousands of patient visits. To help address this issue, the hospital has purchased a major property on de Maisonneuve Blvd. that will help to provide space for at least some of the ambulatory care that is to be displaced into the "community". While the government at first rejected this solution, the *Agence de Montreal* has come to realize that this will be essential for the success of the project. Nevertheless, full approval for this idea is still to be obtained. Dr. Meagher also discussed some of the issues surrounding the Mountain site, which will involve new construction and renovation on the MGH campus, with most of neurosciences moving to a new structure where the current Travencore Pavilion is located.

In the question and answer period that followed, the clinical viability of the proposed cuts to bed numbers was called into question. Dr. Meagher reported that this initiative is based on the government's assumption that a significant proportion of our primary and secondary activities will be carried out by institutions located in the 450 region. Dr. Meagher acknowledged that everyone involved is skeptical about the estimates that the government has made but this appears to be the best deal possible at present.

Dr. David Eidelman answered a question on research planning by saying that there is an active planning process being led by the new Director of the MUHC Research Institute, Dr. Vassilios Papadopoulos. A preliminary functional and technical program has been forwarded to the government for approval, which is expected in the near future. The plan is to build two major research structures at the Glen. The Centre for Innovative Medicine will house dedicated clinical research space in a facility adjacent to both the Pediatric and Adult hospitals. A separate basic science pavilion will be built to house more than 100 principal investigators. At this time, four major research themes are slated to go to the Glen: genetics and development, infection and immunity, respiratory, and cancer. Endocrinology, metabolism, bone and calcium research are proposed to the MGH site. In addition, there are active committees working on developing applications to the upcoming CFI Research Hospital Fund competition.

The next major speaker was Mr. Jacques Hendlisz, the Director General of the Douglas Hospital, who presented an overview of the ongoing reform of Quebec's health care system. The heart of Mr. Hendlisz's message was that the Ministry of Health is taking a population-based view to its decision making. This means maximizing the availability of good care for the largest number of people close to where they live. The government favors expansion of primary and secondary care in the "community", while downplaying the role of teaching hospitals, particularly CHU's like the MUHC. The result of this way of thinking is more recruitment slots in the regions, downsizing of all university hospital centres, which are to focus their work on tertiary care to a greater degree than in the past. Although the MUHC has a role to play as one of the secondary care institutions for the CSSS de la Montagne and CSSS Cavendish, it will not play this role for the West Island, the Montérégie or Laval.

Before breaking into working groups, we heard reports from Dr. Tom Maniatis, who led a task force on Education, Dr. Dick Menzies who headed up a task force on the risks of the redevelopment project and Dr. Louise Pilote who chaired a task force on opportunities created by the project. A key element in Dr. Maniatis' report was that changes in the vocation of the MUHC leading to out migration of clinical activity would result in the movement of teachers and students to follow the patients. Dr. Pilote and Dr. Menzies entertained everyone with a well coordinated point/counter-point discussion of the problems and opportunities presented by the redevelopment plan. A key aspect of their discussions was to investigate the potential reorganization of the department and the hospital along the lines of centres of excellence, which would be multidisciplinary organizations built around a single theme (e.g. respiratory, cardiovascular, diabetes) that would be responsible for clinical care, research and teaching. The Chest and the Neuro were mentioned as models. Another approach would be to create free standing MUHC clinics, using the idea of an off campus "Institute of Endocrine Disorders". Finally, a franchise model, based on the Cleveland Clinic model was also discussed, in which the MUHC would "own" a network of feeder institutions. The risks of the redevelopment plan and of all of these proposals were discussed by Dr. Menzies, including threats to income, to availability of teaching material, to clinical research and most importantly to the ability of patients to access needed services.

These presentations served as an entry point to the small groups, which dealt with four major questions, each with two sub-sections. At the end of the discussion each of the eight groups reported back to the plenary session. Here is a summary, organized by question, of the group deliberations as reported back to the plenary session.

Question 1. Should we move to a model built around centres of excellence for our future development?

1.1 How do we identify the best programs? How do we measure excellence? What are the criteria in each of the missions (research, clinical and education)?

This group explored the centres of excellence approach, citing its advantages for improving quality and promoting research excellence. However, they raised concerns about a “Darwinian” process that could harm those programs deemed less than excellent. This is a particular problem given the lack of adequate markers of excellence. Moreover a top-down approach is not always a guarantee of success.

1.2 What are the alternatives to the “Centres” model? What happens to programs that are not considered to be “flagship”?

This group emphasized the importance of using bottom-up approaches to developing clinical programs. We need to promote a culture of excellence and rather than building silos, we need more collaboration. While we may already have developed some research flagship programs, we need to grow links to the basic science departments and look for opportunities to share expensive platforms.

Question 2: What models should we develop to expand our referral network and serve the RUIS?

2.1 Should we adopt a “consultative model” in which we export our expertise to other institutions through consultation and collaboration? If so, then what are the advantages and disadvantages to the Department and the MUHC?

This group commented on the need to balance benefits such as access to patient populations for education and research, with the problem of dividing people too thinly. Travel time between sites was emphasized as an important issue. Other important problems include lack of intramural manpower to address our current load, let alone additional consultative work. This approach would depend on the ability to recruit more GPs, and would greatly benefit from more telehealth infrastructure. A major problem is that the RAMQ system does not reward this type of activity.

2.2 Should we adopt a “franchise model” in which the MUHC creates branch operations across the RUIS? If so, then what are the advantages and disadvantages to the Department and the MUHC?

This group cited the importance of an academic presence in the community as necessary for the success of this approach. There would need to be a careful assessment of needs and resources before any such approach could be considered, as we do not have the staff to send out to “franchises” in the community. The best way to address this would be to recruit specialists in the community to join the faculty while being based in the community.

Question 3. How do we preserve excellence in clinical care, teaching and research in a two-site model?

3.1 What resources are needed to ensure good quality care in this model? How will the emergency room and the other services at each site shape the way the department carries out its clinical, research and educational missions?

This group focused on the need to improve communication between sites, and for that matter within the RUIS. Electronic medical records would be essential to the success of this enterprise. Continuity of care is a major problem already and will be exacerbated by the greater geographic distance between sites, not to mention the shift of primary and secondary care out of the MUHC. Ideally, management of patients needs someone in charge, like a clinical nurse specialist who could act as a coordinator.

3.2 What modifications to the organization of the department are needed to support the Glen/Mountain split? How should our educational programs be modified to account for the different patient mix at each site? How can clinical research be done at the Mountain campus if the Centre for Innovative Medicine is located at the Glen?

This group spoke of the need for infrastructure, particularly in the realm of clinical informatics agreeing that an electronic medical record is needed now. Transport issues need to be addressed and the use of video conferencing needs to be expanded. We need to match better physical infrastructure with more consistent procedures and processes. Standard MUHC protocols for care need to be established.

Question 4. How do we promote academic excellence in a redeveloped MUHC?

4.1 How do we build a career path for clinical educators? What is the role of non-researcher clinicians in the new MUHC? How do we promote clinical innovation?

This group emphasized the need to provide rewards and resources and to ensure access to appropriate and plentiful space for teaching as well as clinical care and research. They did not like the “Institute” approach since it limits interactions and they felt strongly that for innovation to take place we need to streamline the decision making process in the MUHC and make it less bureaucratic.

4.2 How do we promote links between research and clinical activities? What is needed for the development and maintenance of successful translational research programs in the Department?

This group was very concerned about the loss of primary and secondary care patients to the community since it creates a big risk not only for teaching, but also for clinical research. In regard to planning they asked that faculty members have more input into decision making, and that physical planning needs to include research needs everywhere including the clinical milieu. A robust clinical informatics system would be helpful. In considering how to engage the community, they proposed using a consultative model as a precursor to a franchise model.