Obstetrics and Gynecology Services

Report Submitted to: Health PEI

Final Report

Hay Group Health Care Consulting
121 King Street West
Suite 700
Toronto, Ontario
M5H 3X7

June 1, 2015

Contents

1.0 INTRODUCTION 1

2.0 PROGRAM OVERVIEW 3

3.0 SIGNIFICANT POSITIVES 9

4.0 PERFORMANCE DATA 11

4.1 PEI Hospital Activity Data 11
4.2 PEI and Peer Hospital Comparisons 17

5.0 OPPORTUNITIES 27

5.1 Leadership 27
5.2 Stress and Burnout 31
5.3 Extra-departmental Relationships 34
5.4 Relationship with Emergency Department 39

6.0 RECRUITMENT 41

7.0 POLYCLINIC 43

8.0 CREATING A BABY FRIENDLY ENVIRONMENT 48

9.0 COLPOSCOPY 49

APPENDIX A: LIST OF RECOMMENDATIONS 50

APPENDIX B: LIST OF RECOMMENDATIONS BY PRIORITY 55

1.0 Introduction

Health PEI contracted with Hay Group Health Care Consulting to provide a comprehensive review of obstetrics and gynecology services. While the initial focus of this review was to be the provision of service in the Charlottetown area, the scope of the project was expanded to include the provision of obstetrics and gynecology services in the entire province.

Specific terms of reference for this project included:

- Completion of a comprehensive national review of similar services in order to gain an understanding of national service standards and service expectations
- Identification of overall provincial goals and objectives for obstetrics and gynecology services
- An analysis of the current and projected demand for the services
- Ensuring an awareness of the support required by family physicians working in Prince Edward Island for obstetrics and gynecology consultations and services
- A comprehensive list of recommendations relating to the actions and activities required to achieve the provincial goal

The report that follows summarizes the outcomes of this process, and will include an overall evaluation of the services provided, the quality of service provided, and identification of opportunities to further improve both access to and the quality of obstetrics and gynecology services in the province of Prince Edward Island.

We wish, at this time, to express our thanks to those who so freely gave of their time and energy to participate in this process, and their candor in providing us with their opinions and evaluations of the services provided.

We are particularly indebted to Ms. Robin Laird for her energy and time commitment in supporting this process.

This process was undertaken as a four phase project. During the project initiation phase, a meeting was conducted with the Wait Times Steering Committee, which also has served as a steering committee for this undertaking. During the initial meeting, our tentative project plan was reviewed, and comments received regarding a variety of items, including, but not limited to, additions to our suggested list of interviewees, the identification of appropriate peer institutions for comparison, and identification of issues associated with the delivery of

obstetrics and gynecologic services in Prince Edward Island that may not have been identified in the original RFP.

In subsequent phases of the undertaking, a data analysis and literature review were undertaken. As will be seen in later sections of this report, a comprehensive array of data elements was reviewed in order to identify current volumes of service, efficiency parameters such as length of stay, and to facilitate peer comparisons.

In addition, we conducted a detailed literature review seeking documents attesting to standards care, current best practice, and other items pertinent to the terms of reference of this process.

A further component of the undertaking was a comprehensive series of interviews, including interviews with administrative and clinical staff as well as patients who had received service from the program.

The penultimate phase of this undertaking is the compilation of this draft report, which is being provided to the steering committee for comment and review.

2.0 Program Overview

Obstetrics and gynecology services are delivered both in Charlottetown (at the Queen Elizabeth Hospital) and Summerside (at the Prince County Hospital). In Summerside, the three obstetricians are supported by anesthetists, who provide 24 hour access to epidural analgesia, and paediatricians who provide 24-hour coverage on an as needed basis for at-risk babies. (Note- the consultants were informed after the review was completed that two anaesthetists have left Summerside). There is also a surgery program, with surgeons available to support the obstetrician/ gynecologists as necessary for complex surgical procedures. The obstetrician/gynecologists in the community provide seamless coverage. Each works independently in his or her own office, and, in the majority of cases, each attempts to attend the delivery of his or her "own" patients although one "signs out" to peers on nights and weekends. Two of the physicians are compensated with a salary, and one works on a fee-for-service basis.

There is more than adequate OR time available (eight days per four-week schedule) to support the program in Summerside.

There is, apparently, equipment available to support a minimally invasive surgery program, although recent data reveals that there are a minimal number of MIS procedures conducted. It is unclear whether this is because of a smaller number of patients who are eligible for minimally invasive surgery, or whether it is related to surgeons in Summerside not having had adequate training in minimally invasive techniques.

Depending on the rationale, providers in Summerside should decide whether it would be prudent to increase their training in minimally invasive techniques, or, alternatively, to consolidate all minimally invasive surgery at the Charlottetown hospital, where it could, in theory, be performed by Summerside obstetricians in partnership with Queen Elizabeth obstetricians. If the latter decision is made, then the equipment to support the program should be transferred to the Charlottetown site to facilitate the expansion of the program in that hospital.

Recommendation:

It is recommended that:

1. **The Medical Directors and Chiefs of Obstetrics of the Prince County and Queen Elizabeth Hospitals should meet and determine both current and anticipated future volumes of**

minimally invasive surgery. If the size of the program will remain small, consideration should be given to conducting all minimally invasive procedures in Charlottetown.

In addition to the obstetricians in practice, there is one family physician in the community who offers prenatal, intrapartum and postpartum care.

Of note, the episiotomy rates at Prince County Hospital are significantly higher than the Queen Elizabeth Hospital. It has been well demonstrated in the literature that episiotomy rates can and should be lower than the current rate at PCH. There is, apparently, a one year trial on the "soothe and stretch" approach that will begin in the new fiscal year designed to lower the episiotomy rate at PCH.

It is also noteworthy that the Caesarean section rate at the Queen Elizabeth Hospital is about 33%, higher than expected although this may reflect that centre's role as the high risk centre for the province.

It may be prudent for Health PEI to purchase or add a dashboard to an existing IT system to create a data base that will allow the tracking of parameters such as episiotomy rates and caesarean section rates for gestations of less than 37, between 37 and 39 and over 39 weeks that will allow individual physicians to track their personal rates and the department chief to track departmental rates.

Recommendations:

It is recommended that:

2. **Health PEI should consider purchasing individual dashboards to track physician performance.**

3. **The Chiefs of obstetrics should regularly review episiotomy and caesarean section rates, and report on them.**

It is also been observed that the length of stay at the Prince County hospital for normal vaginal deliveries approximates three days, almost one full day longer than the peer hospital length of stay for normal vaginal deliveries (2.12 days), and at of the QEH also slightly exceeds the expected length of stay (2.5 versus 2.23 days).

Recommendation:

It is recommended that:

4. **The Chiefs of obstetrics and gynecology at the Prince County and Queen Elizabeth Hospitals should embark on a program**

that will decrease the average length of stay for normal vaginal deliveries to two days.

The gynecology patients are generally housed in a clean surgery unit, and the array of gynecologic services does not include any tertiary or quaternary gyne-oncology. They do consult with colleagues (both pathologists and gyne-oncologists in Halifax) on the management of malignancies to determine whether patients are better treated in Halifax or Charlottetown. There is no obstetrician with sub specialty training in gynecologic endocrinology or maternal-fetal medicine. There is a significant volume of uro-gynecology procedures conducted.

Charlottetown is designated as the "provincial" resource. While it has a designated physician complement of six specialists, currently only four are involved in the delivery of care, and Health PEI is actively engaged in efforts to recruit two more obstetricians. All of the obstetricians are compensated in the province's salary model. During the day, the obstetricians provide in house coverage of the case room, supporting obstetric care, provide inpatient consultations and respond to the emergency department while in the hospital. Again, the obstetricians are well supported by anaesthetists, paediatricians and general surgeons. There is no interventional radiology or vascular surgery available, and as a consequence no fibroid embolizations are conducted in Prince Edward Island and patients are referred to Halifax for this procedure.

There is a very active minimally invasive surgery program, the volume of which is expanding annually.

The provincial program is "designed" so that women in labour at less than 32 weeks gestation (or women previously perceived to be at high obstetrical risk) are preferentially transferred to Halifax. Women presenting in labor at 32 to 34 weeks gestation are, in theory, transferred to Charlottetown, where there are more extensive resources for the support of newborns at that gestational age. Patients over the gestational age of 34 weeks are kept in their home community.

It has, however, been alleged that these standards are not always complied with and that frequently women presenting to the Prince County Hospital at less than 32 weeks gestation, or between 32 and 34 weeks of gestation, are not immediately transferred according to the above protocol. This may, in exceptional circumstances (such as imminent delivery or adverse weather) be necessary. However, it is inappropriate for individual physicians to decide not to comply with protocols that have been written to optimize maternal and fetal safety.

Recommendation:

It is recommended that:

5. **The Medical Director of the Prince County Hospital should monitor compliance with existing maternal transfer guidelines.**

In addition to the support provided for identified high-risk pregnancies, there is an excellent relationship with the IWK hospital in Halifax, which has a neonatal transfer team that, to the perception of those involved, provides excellent support to the obstetricians in Prince Edward Island.

A total of approximately 1,500 deliveries per year occur in Prince Edward Island, divided roughly 2/3 in Charlottetown and one third in Summerside. There is no VBAC protocol in place.

Recommendation:

It is recommended that:

6. **The department of Obstetrics and Gynecology at the QEH (in cooperation with peers at PCH) should formalize and circulate a VBAC protocol.**

Within the obstetrical population, approximately 76% of women are married or in common-law relationships. Of note, 60% of all women delivering in the province at the age of 25 or less are single. Only 42% of teen mothers receive prenatal education.

In looking at obstetrical risk factors in PEI, approximately 45% of pregnant mothers have a BMI greater than 25, putting them at increased risk. This number corresponds with approximately 33% of women having a BMI greater than 25 on a national basis.

The population is further at risk because approximately 25% of expectant mothers are reported to smoke, as opposed to only 8% of the national population of pregnant women. 2.7% of women have babies of high birth weight (compared to a national average of 1.9%), 85% receive folic acid supplementation (versus 90% nationally), 75% breast-feed in the early neonatal period (as opposed 87%), 21% breast-feed exclusively (as opposed to 26% nationally), and the cesarean section rate is approximately 33%, with a national average of 26%.

The above data reveals significant opportunities to enhance the primary care of women of childbearing age, particularly opportunities to engage in birth control counseling for adolescents, obesity and smoking cessation counseling, and support of breast-feeding.

Recommendation:

It is recommended that:

7. **Health PEI, in coordination with Community Health, should develop and deliver a coordinated provincial program focused on the primary care needs of women of child bearing years. This may be integrated with a Women's Health Centre should one be developed.**

Approximately 200 inpatient gynecologic procedures are conducted annually in Summerside, and an additional 170 in Charlottetown. There is abundant time available in the operating room in Charlottetown to support the volume of surgery conducted. In fact, it has been reported that in the 2012/2013 year approximately 17 operating days were cancelled. However, it must be borne in mind that the department is currently short two full-time equivalents, and the need for surgical time may expand at such time as recruitment is completed.

Recommendation:

It is recommended that:

8. **The OR Committee should review operating room utilization by the Department of obstetrics and gynecology and adjust their assigned time accordingly.**

At the current time, all gynecologic procedures are conducted in the main operating room. There are a number of gynecologic surgical procedures, such as laparoscopies, hysteroscopies, D&C's, etc. that lend themselves to being conducted in an ambulatory surgical facility, where the required infrastructure (including human resource supports) is less.

Recommendation:

It is recommended that:

9. **The Department of obstetrics should explore opportunities to decant some of its surgical activity to an ambulatory facility, either in- or outside the current hospital(s).**

While nominally a "program" it is questionable the extent to which obstetrics and gynecology truly operates as a program in the context of the hospitals. In a truly programmatic model, decision-making should be consensual, transparent and collaborative. A program committee should exist, with representation not only from physicians, but also nursing, other health professionals, clerical staff, and others who

contribute to the well-being of the program. Individuals who sit on the program committee should be assigned responsibility for undertaking activities such as quality assurance, recruitment, the development of the standardized order sets, establishing a community advocacy committee that partners with patients, coordination of combined educational opportunities, the development of a centralized referral process, supervising the educational program, etc. While it is recognized that at the current time there is a human resource shortfall, particularly in the Charlottetown area, it would be wise for the program to begin, even at this time, to expand its horizons in order to operate in a more programmatic model, ideally with a "provincial" focus and mandate.

Recommendation:

It is recommended that:

10. **The Chiefs of obstetrics should strike a program advisory committee, with membership to include, at a minimum, the clinical and administrative program directors, and representation from nursing and clerical staff.**

3.0 Significant Positives

Reviews such as this are, by their nature, devoted to focusing on opportunities to improve. We would, however, be remiss in not pointing to a number of significant positives that accrue to the program at this time.

It is clear that there are excellent working relationships between and among obstetricians, surgeons, anaesthetists and paediatricians in each community. The relationship that has evolved between Prince Edward Island and Halifax for the support of complex obstetrics, gynecology and pediatric care is excellent.

As recommended in the surgical literature, the operating rooms at both sites do have surgical checklists which are completed for every case.

It has been reported that the teaching provided (more information regarding the teaching program will follow later in this report) in Charlottetown was traditionally viewed as outstanding.

Obstetricians working in Charlottetown have taken leadership positions with the Canadian Medical Association and the SOGC and have been active participants in bringing technologic and clinical advancement (such as a MIS program) to the province.

The cervical cancer screening guideline published in 2013 is an excellent one, both in terms of the process that was followed and the recommendations that evolved.

The service in both sites is provided with ample OR time, and in Charlottetown the obstetricians have evolved to a model of sharing OR time in the manner that maximizes access to operating room facilities.

The introduction of the minimally invasive surgery program, particularly in Charlottetown, has been a significant innovation and has diminished significantly the need for inpatient beds.

The province has, to a large extent, adhered to national guidelines developed by the SOGC to conduct elective cesarean sections at 39 weeks of gestation, and elective inductions at 41 weeks gestation.

The obstetricians in Charlottetown have committed to working as a group, with offices in a shared location, with shared reception and clerical staff, reflecting modern approaches to the delivery of healthcare.

Members of the program should be complimented on their commitment to patient care, call coverage, and innovation, and nurses and support staff should be particularly complemented on their hard work, patient care, adaptability and open-mindedness to inter-professional care.

4.0 Performance Data

4.1 PEI Hospital Activity Data

4.1.1 Gynaecology

The reported inpatient gynaecology cases dropped from 2012/13 to 2013/14 at both PEI hospitals. In 2012/13, all bladder fixation cases at PCH were done as inpatient procedures.

Exhibit 1: Inpatient Gynaecology by Hospital Site by Fiscal Year by Case Mix Group

Case Mix Group	Prince County Hospital		Queen Elizabeth Hospital	
	2012-13	2013-14	2012-13	2013-14
501 - Hysterectomy with Malignancy	5	8	14	12
502 - Hysterectomy w Non Mal Dx	100	104	89	77
503 - Fix/Ocl/RemInt FmRpSy excTb/Ov	2	3	10	-
504 - Ov/Fallop Tube Intv Mal exc EA	-	-	-	2
505 - Ov/FalTb Int w NonMalDx exc EA	12	7	11	2
506 - Bladder Fixation	56	20	4	1
507 - Rep/Bra/OthInt FmRpSy excTb/Ov	21	17	6	5
508 - Other Intv w Fem Reprod Sys Dx	4	3	3	-
509 - Ther Intv Female Reprod Sys LA	1	3	12	11
510 - Diagnostic Laparoscopy w/wo Bx	-	-	2	-
511 - Vulva/Perineum Intervention	-	-	3	-
512 - D&C/Other Minor Intv Uterus	1	-	1	1
520 - Mal Neo Female Reprod System	2	-	3	5
521 - Fibroid/Prolap/Fist/Oth Disord	-	-	-	3
522 - Inflam Dis Female Reprod Sys	3	2	3	4
524 - Dis Menstr/Endomet/Noninfl FRS	3	3	11	10
525 - Malig Neo Fem Rep Sys exc Ovry	1	1	8	6
Grand Total	211	171	180	139

There was little change in the number of day surgery gynaecology cases at the PEI hospitals from 2012/13 to 2013/14. Day surgery cases for CMG 521, Fibroid/Prolapse/Fistula/Other Disorder were concentrated at QEH.

Exhibit 2: Day Surgery by Hospital Site by Fiscal Year by Case Mix Group

Case Mix Group	Prince County Hospital		Queen Elizabeth Hospital	
	2012-13	2013-14	2012-13	2013-14
502 - Hysterectomy w Non Mal Dx	-	3	2	1
505 - Ov/FalTb Int w NonMalDx exc EA	4	3	5	4
506 - Bladder Fixation	-	21	76	43
507 - Rep/Bra/OthInt FmRpSy excTb/Ov	39	38	63	80
508 - Other Intv w Fem Reprod Sys Dx	2	1	6	4
509 - Ther Intv Female Reprod Sys LA	91	63	82	86
510 - Diagnostic Laparoscopy w/wo Bx	11	4	18	5
511 - Vulva/Perineum Intervention	12	17	9	16
512 - D&C/Other Minor Intv Uterus	93	101	105	115
521 - Fibroid/Prolap/Fist/Oth Disord	-	-	26	24
522 - Inflam Dis Female Reprod Sys	-	-	-	1
524 - Dis Menstr/Endomet/Noninfl FRS	7	4	8	12
525 - Malig Neo Fem Rep Sys exc Ovry	-	-	1	1
556 - Antepart Dx w Surg/Non-Maj Int	-	1	-	-
557 - Antepartum Disord tx Medically	-	2	-	-
Grand Total	259	258	401	392

The day surgery cases above include all cases categorized by CIHI as gynaecology cases, irrespective of the specialty of the surgeon performing the procedure. At PCH, almost all of the day surgery gynaecology cases were done by a gynecologist, whereas at QEH the fibroid cases and some of the bladder fixation cases are, according to available records, done by urologists. However, this appears to be a coding error that should be addressed by the health record staff at the QEH.

Exhibit 3: Distribution of 2013/14 Gynaecology Day Surgery Cases by Doctor Service

Hospital	Doctor Service Name	Day Surgery Cases
Prince County Hospital	General Surgery	2
	Obstetrics and Gynecology	256
	Total	258
Queen Elizabeth Hospital	Family/General Practitioner	1
	General Surgery	3
	Obstetrics and Gynecology	335
	Urology	53
	Total	392
Grand Total		650

4.1.1.1 Gynaecology "Market Share" and Utilization

In 2013/14, 87% of gynaecology surgery cases for residents of Queens and Kings Counties were done at QEH, and 13% at PCH. For residents of Prince County, 95% of cases were done at PCH, and only 5% at QEH.

Exhibit 4: 2013/13 Gynaecology Surgery Cases by Patient Residence and Hospital

Modality	Patient Residence	Cases by Hospital		% of Cases for Residents	
		PCH	QEH	PCH	QEH
IP	Queens Kings	29	128	18%	82%
	Prince County	142	10	93%	7%
Day Surgery	Queens Kings	33	283	10%	90%
	Prince County	195	8	96%	4%
All Gyn	Queens Kings	62	411	13%	87%
	Prince County	337	18	95%	5%

As shown in Exhibit 5 below, comparing gynaecology surgery activity by county with the estimated female population of the county, the rate of use of gynaecology surgery per 1,000 female residents of 18.7 cases for Prince County is 66% higher than the rate for the residents of Queens and Kings Counties. This discrepancy may be attributed to many phenomena:

- Significant differences in socio- demographics
- A lack of primary care contributing to conditions worsening to the point of needing surgery
- Lack of access to surgical resources in the QEH
- A "preference" for surgical treatment among Summerside practitioners

The differences are, however, striking and should be further explored.

Recommendation:

It is recommended that:

11. **The Executive Director Medical Affairs and DI should investigate the cause(s) of the differences in rates of surgical intervention in the PCH and QEH.**

Exhibit 5: 2013/14 Gynaecology Surgery Cases per 1,000 Female Population by County

	Patient County	
	Queens and Kings	Prince
Inpatient	157	153
Day Surgery	316	203
Total	473	356
2011 Females 15 and Older	42,186	19,079
Gyn. Surgery Cases per 1,000 Females Age 15 & Older	11.2	18.7

4.1.2 Obstetrics

The inpatient obstetrical activity for each hospital by CMG for fiscal years 2012/13 and 2013/14 is shown below. In 2013/14, the C-section rate was 26.6% at PCH and 33.3% at QEH.

Exhibit 6: Inpatient Obstetrical Activity by Hospital Site by Fiscal Year by Case Mix Group

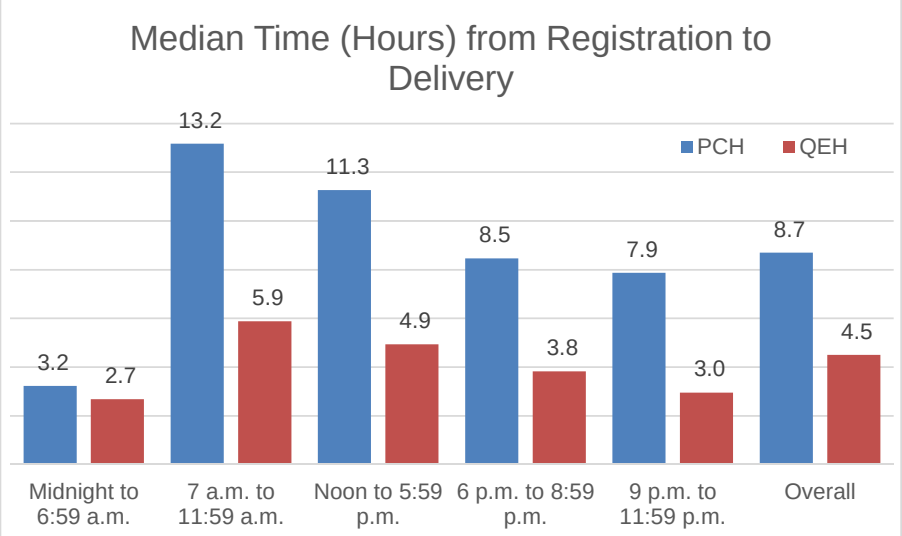
Case Mix Group	Prince County Hospital		Queen Elizabeth Hospital	
	2012-13	2013-14	2012-13	2013-14
531 - Major Intv not related Obs Dx	-	-	2	-
556 - Antepart Dx w Surg/Non-Maj Int	-	2	2	1
557 - Antepartum Disord tx Medically	65	71	61	77
558 - Primary C-Sect with induction	18	22	60	54
559 - Primary C-Sect no induction	35	43	94	96
560 - C-Sect w uter scar no induct	51	62	124	118
561 - C-Sect w uter scar & induct	2	1	-	-
562 - Vag Brth w An Non-Maj Ob/Gyn	32	59	133	118
563 - Vag Brth w An wo Non-Maj int	15	46	167	135
564 - Vag Brth wo An w Non-Maj Int	89	100	65	79
565 - Vag Brth wo An wo Non-Maj Int	171	149	223	205
674 - Puerperal Disorder	-	2	1	2
Grand Total	478	557	932	885
Total Deliveries	413	482	866	805
Vaginal Deliveries	307	354	588	537
Caesarean Section Deliveries	106	128	278	268
Percent Caesarean Section	25.7%	26.6%	32.1%	33.3%
C-Section with Induction	20	23	60	54
% of C-Sections with Induction	18.9%	18.0%	21.6%	20.1%
Vaginal Delivery without Anaesthetic	260	249	288	284
% Vaginal Delivery w/o Anaesthetic	84.7%	70.3%	49.0%	52.9%

The percent of C-sections that had induction was slightly higher at QEH than at PCH. Just over half of vaginal deliveries at QEH did not have anaesthetic, compared to 70% at PCH.

4.1.2.1 Time from Admission to Delivery

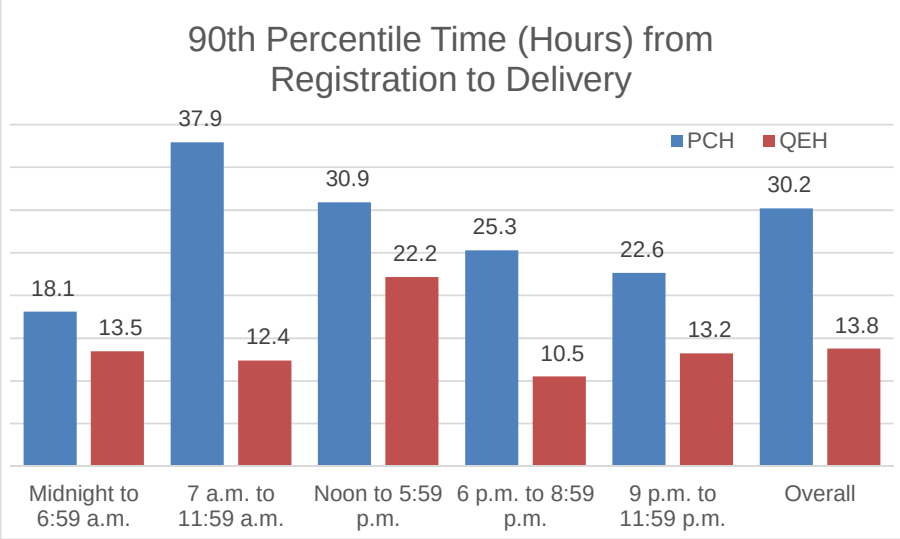
The 2013/14 CIHI data for the two PEI hospitals was used to examine the typical times for mothers from registration at the hospital to the delivery. The median time from registration to delivery was 4.5 hours at the QEH and 8.7 hours at PCH. Times were longer at the PCH site than at the QEH site for all arrival times at the hospital. Times were longest for mothers arriving between 7 a.m. and noon, and shortest for mothers arriving between midnight and 7 a.m. It has been suggested that the time intervals from arrival to delivery may be influenced by the lack of an Ob "focused" EMR, resulting in a long paper process that often culminates in obstetrical patients "registering" in early labour, then going home and returning when labour is well established.

Exhibit 7: 2013/14 Median Time from Registration to Delivery by PEI Hospital Site



The chart below shows the 90th percentile times (i.e. the time where 90% of mothers had a shorter wait, and 10% had longer). 90th percentile times were longer at PCH than at QEH for all arrival shifts, with the overall 90th percentile times of 13.8 hours at QEH and 30.2 hours at PCH.

Exhibit 8: 2013/14 Median Time from Registration to Delivery by PEI Hospital Site



4.1.3 Neonate/Newborn

The distribution of births at both PEI hospitals by neonate/newborn Case Mix Group is shown in the following table. Just over half of the births at both hospitals were categorized as normal newborns.

Exhibit 9: Inpatient Newborn/Neonate Activity by Hospital Site by Fiscal Year by Case Mix Group

Case Mix Group	Prince County Hospital		Queen Elizabeth Hospital	
	2012-13	2013-14	2012-13	2013-14
576 - Normal Newborn Sing Vag Deliv	166	217	370	321
577 - Normal NB Mult/C-Sect Deliv	58	63	127	132
578 - NB/Neo <750 grams	2	-	1	-
579 - NB/Neo 750-999 grams <29 Wks	-	-	2	-
581 - NB/Neo 1000-1499 gm <29 Wks	2	-	-	1
582 - NB/Neo 1000-1499 gm 29+ Wks	-	1	2	9
583 - NB/Neo 1500-1999 gm <32 Wks	1	1	2	3
584 - NB/Neo 1500-1999 gm 32-34 Wks	-	3	5	9
585 - NB/Neo 1500-1999 gm 35+ Wks	2	-	3	2
586 - NB/Neo 2000-2499 gm <35 Wks	2	4	7	8
587 - NB/Neo 2000-2499 gm 35-36 Wks	1	4	13	9
588 - NB/Neo 2000-2499 gm 37+ Wks	8	9	11	11
589 - NB/Neo 2500+ gm Maj Resp Comp	45	48	25	39
590 - NB/Neo 2500+ Asp Syn/Fet Asph	4	2	11	11
591 - NB/Neo 2500+ Oth Resp Prob	9	19	64	59

Case Mix Group	Prince County Hospital		Queen Elizabeth Hospital	
	2012-13	2013-14	2012-13	2013-14
592 - NB/Neo 2500+ Sept/Oth Neo Inf	5	4	6	3
593 - NB/Neo 2500+ Shrt Gest/Low BW	7	8	19	22
594 - NB/Neo 2500+ gm Jaundice	19	23	33	18
595 - NB/Neo 2500+ Anom Nrv/Resp/GI	1	1	1	-
596 - NB/Neo 2500+ Chrom/Mult Anom	-	1	1	-
597 - NB/Neo 2500+ Cardiovasc Anom	2	1	7	2
598 - NB/Neo 2500+ Oth Congen Anom	10	9	18	14
600 - NB/Neo 2500+ Oth Mod Prob	8	13	26	20
601 - NB/Neo 2500+ Oth Min Prob	84	86	147	174
602 - NB/Neo 2500+ Haemolytic Dis	2	-	4	2
Grand Total	438	517	905	869
Normal Newborn	224	280	497	453
Percent Normal Newborn	51.1%	54.2%	54.9%	52.1%

The distribution of 2013/14 births at both hospitals by birth weight category is shown below. QEH had a higher percent of babies (2.8% of births) under 2,000 grams compared to PCH (1.0%), as would be expected given its role as the high risk centre.

Exhibit 10: Distribution of 2013/14 Births by Birthweight Category

Birthweight Category	Queen Elizabeth Hospital	Prince County Hospital	Grand Total	Queen Elizabeth Hospital	Prince County Hospital
< 1,500	10	1	11	1.2%	0.2%
1,500 to 1,999	14	4	18	1.6%	0.8%
2,000 to 2,499	28	17	45	3.2%	3.3%
2,500 to 2,999	120	80	200	13.8%	15.5%
3,000 to 3,499	303	169	472	34.9%	32.7%
3,500 to 3,999	267	172	439	30.7%	33.3%
4,000 +	127	74	201	14.6%	14.3%
Total	869	517	1,386	100.0%	100.0%

4.2 PEI and Peer Hospital Comparisons

2013/14 CIHI discharge data for gynaecology, obstetrics, and newborn/neonates was acquired for 4 Ontario and 4 Atlantic peer hospitals. Both inpatient and day surgery data was acquired, but the Ontario day surgery data is categorized using "CACS" rather than CMGs, and is not directly comparable with the PEI day surgery data.

4.2.1 Obstetrics

All of the peer hospitals had more than 900 deliveries in 2013/14. QEH had the highest C-section rate (33.2%) and PCH had the highest percent of vaginal deliveries without anaesthetic.

Exhibit 11: 2013/14 PEI and Peer Hospital Obstetrical Inpatient Activity

Activity Measure	Bluewater	Cape Breton	Chatham Kent	Everett Chalmers	Halton	Saint John	Sault Ste. Marie	Moncton	Queen Elizabeth	Prince County	Peer Total
Total Deliveries	943	925	905	1,557	1,002	1,474	946	1,359	882	482	10,475
Vaginal Deliveries	725	633	668	1,077	751	1,161	673	1,007	589	354	7,638
C-Section Deliveries	218	292	237	480	251	313	273	352	293	128	2,837
Percent C-Section	23.1%	31.6%	26.2%	30.8%	25.0%	21.2%	28.9%	25.9%	33.2%	26.6%	27.1%
C-Section with Induction	82	58	64	101	24	74	48	56	58	23	588
% of C-Sections w/ Induction	37.6%	19.9%	27.0%	21.0%	9.6%	23.6%	17.6%	15.9%	19.8%	18.0%	20.7%
Vaginal Delivery w/o Anaesthetic	422	345	329	530	299	472	306	411	311	249	3,674
% Vaginal Delivery w/o Anaesthetic	58.2%	54.5%	49.3%	49.2%	39.8%	40.7%	45.5%	40.8%	52.8%	70.3%	48.1%

All four of the Ontario hospitals had family physicians involved in obstetrical care, but, of note, they only perform 3-13% of the deliveries.

Exhibit 12: Distribution of Obstetrical Cases by Most Responsible Provider

Hospital	Obstetrical Cases	Percent Distribution of Cases by "Most Responsible Provider Service"			
		Obstetrics and Gynecology	Midwife	Family Practitioner	Other
Bluewater Health	1,023	87.5%	7.6%	2.9%	2.0%
Chatham Kent HA- Chatham	1,016	72.2%	13.8%	13.3%	0.7%
Halton Healthcare	1,059	97.4%	0.0%	2.5%	0.1%
Prince County Hospital	557	92.6%	0.0%	7.4%	0.0%
Queen Elizabeth Hospital	885	97.7%	0.0%	1.7%	0.6%
Sault Area Hospital	1,039	86.3%	12.6%	0.3%	0.8%
Grand Total	5,579	88.5%	6.3%	4.5%	0.7%

CIHI establishes expected lengths of stay (ELOS) for “Typical” cases (i.e. those not transfers, deaths, sign-outs or long stay outliers) based on national length of stay patterns. For obstetrical cases, all of the Ontario hospitals had average lengths of stay shorter than the CIHI ELOS, and all of the Atlantic peer hospitals had lengths of stay longer than the CIHI LOS. PCH had the longest LOS at 41% longer than

expected, with QEH the second highest ratio of actual to expected LOS at 13.6% above.

Exhibit 13: 2013/14 Length of Stay Performance versus CIHI ELOS for Obstetrical "Typical" Cases

Hospital	IP Cases	Avg. Acute LOS	Avg. ELOS	Actual as % of ELOS
Bluewater	933	2.0	2.2	90.9%
Cape Breton	888	2.6	2.3	113.0%
Chatham Kent	896	2.1	2.2	95.5%
Everett Chalmers	1,435	2.3	2.3	100%
Halton	995	1.9	2.1	90.5%
Moncton	1,295	2.3	2.2	104.5%
Prince County	435	3.1	2.2	140.9%
Queen Elizabeth	860	2.5	2.2	113.6%
Saint John	1,384	2.4	2.2	109.1%
Sault Ste. Marie	933	2.0	2.1	95.2%

Data Source: CIHI Portal reports run by HPEI HIU based on Obstetrical Service code.

4.2.2 Newborn/Neonate

The PEI hospitals were less likely to have a pediatrician as most responsible provider for newborn care (except for Halton Healthcare, where family practitioners are MRP for newborns). PCH was the only hospital where obstetricians/gynecologists were frequently recorded as MRP for the babies.

Exhibit 14: Distribution of Newborn/Neonate Cases by Most Responsible Provider

Hospital	Neonatology Cases	Percent Distribution of Cases by "Most Responsible Provider Service"			
		Family Practitioner	Pediatrics	Midwife	Other
Bluewater Health	994	14.0%	74.6%	11.2%	0.2%
Chatham Kent HA- Chatham	956	31.2%	51.9%	16.8%	0.1%
Halton Healthcare	1,002	99.2%	0.8%	0.0%	0.0%
Prince County Hospital	517	36.8%	46.4%	0.0%	16.8%
Queen Elizabeth Hospital	869	81.8%	17.7%	0.0%	0.5%
Sault Area Hospital	1,012	67.8%	16.7%	15.1%	0.4%
Grand Total	5,350	56.4%	33.8%	7.9%	1.8%

The PEI hospitals (and Saint John) had the longest actual LOS for typical newborns/neonates compared to the CIHI ELOS. As with maternal (see Recommendation 4) length of stay, there are opportunities to shorten newborn length of stay that should be pursued.

Exhibit 15: 2013/14 Length of Stay Performance versus CIHI ELOS for Newborn/Neonate "Typical" Cases

Hospital	IP Cases	Avg. Acute LOS	Avg. ELOS	Actual as % of ELOS
Bluewater	921	2.4	2.5	96.0%
Cape Breton	923	3.3	2.7	122.2%
Chatham Kent	884	2.2	2.2	100.0%
Everett Chalmers	1,535	3.1	2.9	106.9%
Halton	965	1.7	1.9	89.5%
Moncton	1,357	3.1	3.3	93.9%
Prince County	465	3.1	2.3	134.8%
Queen Elizabeth	855	3.2	2.6	123.1%
Saint John	1,428	3.5	2.8	125.0%
Sault Ste. Marie	945	2.7	2.8	96.4%

Data Source: CIHI Portal reports run by HPEI HIU based on Newborn Service code.

4.2.3 Early Caesarean Section Delivery

In the United States, the Centre for Medicare Services (CMS) has identified rates of early elective induction or caesarean section as a routinely monitored indicator of quality of care. "Choosing Wisely" has reported that:

"Carrying an infant the full 39 weeks has important health benefits for the baby and the mother. For example, during weeks 37 and 38, the baby's lungs and brain are still developing. The baby's body also gains fat during this time, which helps the baby keep a healthy body temperature. Babies induced or delivered by C-section before 39 weeks are more likely to have problems breathing and feeding, have severe jaundice, and need intensive care after birth. They also have a higher chance of having cerebral palsy, which can affect movement, hearing, seeing, thinking, and learning. And, while the overall risk of infant death is low, it is higher for babies who are delivered before 39 weeks.

Women who carry their baby at least 39 weeks also have less postpartum depression. This may be because their infants are less likely to have problems than those born early."

We used 2013/14 CIHI hospital delivery data to examine the rates of early caesarean section (not inductions for vaginal delivery) in the PEI and peer hospitals. Deliveries were identified as early caesarean sections if all of the following conditions applied:

- Delivery via caesarean section
- Gestational age at delivery less than 39 weeks

- Mother's admission to hospital reported as elective
- No significant obstetrical comorbidities (i.e. as identified in the CIHI comorbidity categorization) reported

In Ontario in 2013/14, 9.2% of the 135,000 deliveries were "early elective caesarean section". For the peer hospitals in the table below, PCH had the lowest rate at 5.2%.

Exhibit 16: 2013/14 Percent of All Deliveries Categorized as "Early Elective C-Sections" for PEI and Peer Hospitals

Hospital	Deliveries	% Early Elective Deliveries
Bluewater Health	943	5.4%
Chatham Kent HA- Chatham	905	6.5%
Halton Healthcare	1,002	7.7%
Prince County Hospital	482	5.2%
Queen Elizabeth Hospital	805	7.6%
Sault Area Hospital	946	8.1%
Grand Total	5,083	6.9%

While some "elective " caesarean sections were reported as occurring on weekends, upon further inquiry it appears that they occur only when patients booked for elective repeats present to the case room in labour prior to their "booked" date and are thus not truly "elective".

4.2.4 Off-Island Obstetrical and Newborn/Neonate Activity

In 2013/14, there were 174 inpatient obstetrics patients at the IWK Health Centre who were residents of PEI. These patients stayed an average of 10 days, and 65 of these mothers were admitted for antepartum care.

Exhibit 17: Inpatient Obstetrical Cases at IWK for PEI Residents in 2013/14

Case Mix Group	IP Cases	IP Days	Avg. LOS
556 Antepart Dx w Non-Maj Interv	3	5	2
557 Antepartum Diagnosis treated Medically	62	745	12
558 Primary Caesarean Section, with induction	1	5	5
559 Primary Caesarean Section, no induction	15	276	18
560 Caes. Section w uterine scar, no induction	19	104	5
562 Vag Birth w Anaes. and Non-Major Interv	36	263	7
563 Vag Birth w Anaes. w/o Non-Major Interv	16	264	17
564 Vag Birth w/o Anaes w Non-Maj Interv	18	102	6
565 Vag Birth w/o Anaes w/o Non-Maj Interv	4	7	2
Grand Total	174	1,771	10

There were 148 babies from PEI hospitalized at the IWK Health Centre, for an average stay of 15 days. Only 4 of the PEI babies hospitalized in Halifax were considered to be normal newborns.

Exhibit 18: Inpatient Newborn/Neonate Cases at IWK for PEI Residents in 2013/14

Case Mix Group	IP Cases	IP Days	Avg. LOS
570-NB/Neo 1500+ w Maj GI/Dphm Int	6	60	10
571-NB/Neo 1500+ w Maj Cardiov Int	22	471	21
576-Normal Newborn Sing Vag Deliv	2	3	2
577-Normal NB Mult/C-Sect Deliv	2	5	3
578-NB/Neo <750 grams	1	50	50
581-NB/Neo 1000-1499 gm, <29 Wks	8	173	22
582-NB/Neo 1000-1499 gm, 29+ Wks	20	626	31
583-NB/Neo 1500-1999 gm, <32 Wks	8	129	16
584-NB/Neo 1500-1999 gm, 32-34 Wks	9	128	14
586-NB/Neo 2000-2499 gm, <35 Wks	5	69	14
587-NB/Neo 2000-2499 gm, 35-36 Wks	6	22	4
589-NB/Neo 2500+ gm, Maj Resp Comp	1	11	11
590-NB/Neo 2500+, Asp Syn/Fet Asph	5	55	11
591-NB/Neo 2500+, Oth Resp Prob	3	9	3
592-NB/Neo 2500+, Sept/Oth Neo Inf	6	78	13
593 NB/Neo 2500+ grams, Short Gestation	8	45	6
594-NB/Neo 2500+ gm, Jaundice	1	4	3
596-NB/Neo 2500+, Chrom/Mult Anom	5	45	9
597-NB/Neo 2500+, Cardiovasc Anom	3	13	4
598-NB/Neo 2500+, Oth Congen Anom	2	3	2
600-NB/Neo 2500+, Oth Mod Prob	6	99	17
601-NB/Neo 2500+, Oth Min Prob	18	128	7
602 NB/Neo 2500+, Haemolytic Dis	1	3	3
Grand Total	148	2,228	15

4.2.5 Inpatient Gynaecology

Most inpatient gynaecology patients have an obstetrician/gynecologist as MRP, but almost 15% of QEH patients have their inpatient stay managed by other physicians according to data submitted by Health PEI. This may reflect the MRP role being served by a hospitalist.

Exhibit 19: Distribution of Gynaecology Inpatient Cases by Most Responsible Provider

Hospital	Gynaecology Cases	Percent Distribution of Cases by "Most Responsible Provider Service"			
		Obstetrics and Gynecology	Family Practitioner	Urology	Other
Bluewater Health	215	88.8%	0.5%	8.8%	1.9%
Chatham Kent HA- Chatham	181	95.0%	2.8%	0.0%	2.2%
Halton Healthcare	134	93.3%	6.7%	0.0%	0.0%
Prince County Hospital	171	98.2%	1.2%	0.0%	0.6%
Queen Elizabeth Hospital	139	85.6%	9.4%	0.7%	4.3%
Sault Area Hospital	210	96.2%	1.4%	0.0%	2.4%

Both PEI hospitals had lengths of stay shorter than the CIHI ELOS for inpatient gynaecology cases.

Exhibit 20: 2013/14 Length of Stay Performance versus CIHI ELOS for Gynaecology "Typical" Cases

Hospital	IP Cases	Avg. Acute LOS	Avg. ELOS	Actual as % of ELOS
Bluewater	203	2.4	2.4	100.0%
Cape Breton	283	2.6	2.6	100.0%
Chatham Kent	203	2.5	2.7	92.6%
Everett Chalmers	317	2.3	2.6	88.5%
Halton	129	1.9	2.6	73.1%
Moncton	273	2.3	2.6	88.4%
Prince County	172	2.4	2.5	96.0%
Queen Elizabeth	141	2.2	2.6	84.6%
Saint John	472	2.3	2.7	85.2%
Sault Ste. Marie	219	2.4	2.6	92.3%

Data Source: CIHI Portal reports run by HPEI HIU by Gynecology Service (55 & 56).

4.2.6 Gynaecology Day Surgery

The Cape Breton Hospital and the 4 Ontario hospitals do not report their day surgery activity to CIHI using the same classification system (i.e. Case Mix Groups) as do the PEI and other Atlantic hospitals. The following table shows the 2013/14 day surgery cases by CMG for the hospitals for which data is available.

Exhibit 21: 2013/14 Day Surgery Cases by CMG for PEI and Peer Hospitals

CMG # and Name	Everett Chalmers	Moncton	Prince County	Queen Elizabeth	Saint John	Grand Total
502-Hysterectomy w Non Mal Dx	2		3	1		6
505-Ov/FalTb Int w NonMalDx exc EA	9	2	3	4	70	88
506-Bladder Fixation	57	20	21	43	38	179
507-Rep/Bra/OthInt FmRpSy excTb/Ov	37	28	38	80	22	205
508-Other Intv w Fem Reprod Sys Dx	6		1	4	2	13
509-Ther Intv Female Reprod Sys LA	123	110	63	86	77	459
510-Diagnostic Laparoscopy w/wo Bx	31	12	4	5	24	76
511-Vulva/Perineum Intervention	16	9	17	16	11	69
512-D&C/Other Minor Intv Uterus	273	90	101	115	398	977
521-Fibroid/Prolap/Fist/Oth Disord	5			24		29
522-Inflam Dis Female Reprod Sys		1		1		2
523-Disorder of Fertility	1					1
524-Dis Menstr/Endomet/Noninfl FRS	18	7	4	12	65	106
525 Mal. Neo Fem. Reprod. Sys., exc Ovary	4			1	22	27
556 Antepart Dx w Non-Maj Interv	1	1	1			3
557 Antepartum Diagnosis treated Medically			2			2
912-MCC 12 Unrelated Intervention	3	1			2	6
Grand Total	586	281	258	392	731	2,248

There is substantial variation across hospitals with respect to the percent of time that individual procedures are performed on an inpatient versus day surgery basis. The QEH has consistently high rates of use of day surgery for gynaecology compared to most peer hospitals. Examples of high volume CMGs, often done via day surgery, are shown below.

Exhibit 22: 2013/14 Comparison of Inpatient vs. Day Surgery Cases for CMG 506 Bladder Fixation

Hospital	CMG: 506-Bladder Fixation			
	IP Cases	Day Surg	Total	% Day Surg
Everett Chalmers	14	57	71	80%
Moncton	22	20	42	48%
Prince County Hospital	20	21	41	51%
Queen Elizabeth Hospital	1	43	44	98%
Saint John	16	38	54	70%
Grand Total	73	179	252	71%

Exhibit 23: 2013/14 Comparison of Inpatient vs. Day Surgery Cases for CMG 507 Repair/Brachytherapy/Other Intervention on Female Reproductive System except Tube/Ovary

Hospital	CMG: 507-Rep/Bra/OthInt FmRpSy excTb/Ov			
	IP Cases	Day Surg	Total	% Day Surg
Everett Chalmers	32	37	69	54%
Moncton	29	28	57	49%
Prince County Hospital	17	38	55	69%
Queen Elizabeth Hospital	5	80	85	94%
Saint John	31	22	53	42%
Grand Total	114	205	319	64%

Exhibit 24: 2013/14 Comparison of Inpatient vs. Day Surgery Cases for CMG 509 Therapeutic Intervention on Female Reproductive System, Laparoscopic Approach

Hospital	CMG: 509-Ther Intv Female Reprod Sys LA			
	IP Cases	Day Surg	Total	% Day Surg
Everett Chalmers	29	123	152	81%
Moncton	35	110	145	76%
Prince County Hospital	3	63	66	95%
Queen Elizabeth Hospital	11	86	97	89%
Saint John	7	77	84	92%
Grand Total	85	459	544	84%

These data likely reflect the greater use of MIS techniques in QEH, but as the MIS approaches are associated with lower use of inpatient resources (and hence costs), more rapid recovery and, at a minimum, equivalent outcomes, they are further evidence of the need to consider offering patients a "choice" of procedure, expanding the PCH skill set in MIS, or creating a provincial MIS program at the QEH.

While a detailed review of the program's operational characteristics and was not in the terms of reference for this process, it is noteworthy that the Queen Elizabeth Hospital assigns two RN's and two LPNs to staff the operating room on a daily basis. We believe that there may be an opportunity for cost reduction by decreasing the total allotment of nursing staff assigned to the room to three, as opposed to the current four.

Recommendation:

It is recommended that:

12. **The nurse manager of the operating room should review the staffing requirements for the obstetrics and gynecology operating room and adjust it accordingly.**

At the current time, the department does not collect and distribute data that attest to program quality, volumes of activity, rates of infection, re-admission rates, etc.

Recommendation:

It is recommended that:

13. **The program should convene a quality assurance subcommittee. This committee should be interdisciplinary, and, at a minimum, develop quality management process including the collation and distribution of program specific data to all program members on a monthly basis, as well as the development of an audit system based on peer review using generally accepted and published statements.**

5.0 Opportunities

In this section of the report, we review of a number of areas in which we believe the obstetrics and gynecology program has opportunities to improve even further. The areas for improvement have not been triaged to reflect an order of priority or magnitude of importance. In this section we provide not only our observations, but suggestions for opportunities for improvement, and suggest that Health PEI discuss each of these suggestions and determine which, if any, it wishes to pursue. We emphasize our willingness to support the implementation of any change processes, should you wish our assistance.

5.1 Leadership

While, in theory, the obstetrics and gynecology program is a "provincial" program, it essentially operates as two independent programs operating at two sites with distinct leadership. As a consequence, opportunities for, for instance, common quality assurance programming, common morbidity and mortality reviews, conjoint strategic thinking and planning for the program, etc. have been lost.

Given the relatively small size of the program, the relatively small total number of FTE positions allocated to the program, and the proximity of the two centres it is suggested that a single leader be appointed with administrative responsibility for both sites. This may be accomplished by continuing the current co-leadership model for period of time (one year is suggested) and then converting to a single leader.

Recommendation:

It is recommended that:

14. Health PEI should appoint a single leader for the provincial obstetrics and gynecology program.

The leadership of the obstetrics and gynecology program is determined, in keeping with Health PEI's bylaws and medical staff rules and regulations, by a departmental selection process. Chiefs are appointed for two years. There is, in theory, a model of mentorship of Chiefs. The chief stipend is currently $15,000 per year. There is a lack of comprehensive, explicit documentation of the roles and responsibilities and job and role descriptions for program/department chiefs. While Health PEI has provided opportunities for physician leaders to attend PMI training either locally or elsewhere, there is a lack of explicit

expectations of and support for physician leaders in the organization to gain advanced management training.

Given the considerable challenges currently facing the program (the details of which will be outlined in later sections of this report), the time that will be necessary to devote to physician recruitment, the desire, as part of the department's planning, to increase its menu of services to include maternal-fetal medicine and uro-gynecology, and other strategic imperatives, the leader of the department will need a minimum of 1 to 2 days per week of "protected" time for administrative activity. In the absence of adequate compensation for lost clinical time, it is both unrealistic and impractical to expect the department's chief to achieve the administrative objectives necessary to rejuvenate the program.

Therefore, the compensation model for the chief should be modified to reflect the time that will be necessary to devote to achieve important strategic and operational objectives.

Rates of compensation in similarly sized organizations, based on a 2010 survey in Ontario, reveal that chiefs of departments of obstetrics and gynecology in similarly sized organizations were receiving $40,000 per day for administrative activity on average. Therefore, we suggest, that for at least the next two years, the chief of the department should be compensated for 1.5 days administrative time, and receive an annual stipend of $60,000. In addition, the chief should be provided with part-time secretarial support, a fax machine, a computer to be used for his or her administrative tasks, and a small budget ($5000 per annum is suggested) to support continuing professional development activities focused on his or her need to enhance their administrative skills.

Recommendation:

It is recommended that:

15. **The Medical Director of Health PEI should review the compensation package for the chief of obstetrics and gynecology and adjust it upwards.**

Members of the department have expressed the belief that emerging from the current state will be greatly facilitated by having an experienced leader with particular skills in administration, strategic planning and strategic communication. While not the traditional practice of Health PEI, we believe that organizations benefit greatly from open search processes for department leaders. Such processes allow for the incorporation of experience from other geographic

venues, significantly increase the array of potential candidates, and create the potential to recruit chiefs with, perhaps, significantly more experience and skill than local candidates. Furthermore, we believe that formal search processes should be convened for Chiefs, and that "selection "processes in which members of departments are "appointed" or "voted on" by peers do not ensure the organization's interests will be optimally served.

Furthermore, we believe that a two-year term is of insufficient duration to allow a chief to articulate and enact a vision.

Recommendations:

It is recommended that:

16. **Health PEI should consider a change to the Medical Staff By-laws to allow for the recruitment of Chiefs after nationally conducted search processes.**

17. **Health PEI should consider changing the term of appointment of Department Chiefs from two years to 3-5 years, with one renewal possible with no external search.**

The current department leader at the QEH feels, not inappropriately, overwhelmed by the current state of affairs. It is evident that he, along with other members of his department, are feeling considerably stressed owing to difficulties in recruiting a sufficiently large cadre of providers, and issues associated with their office practice that will be delineated later. While there is no doubt that his level of commitment to the program is high, and that he is willing to work with Health PEI, his colleagues, and the Queen Elizabeth Hospital to improve the current state of affairs he will need considerable support and mentorship for at least the next year.

This mentorship should, ideally, be provided by an individual or organization experienced in working with and coaching physician leaders. The Department Chief should be able to access his mentor or coach to discuss "political" issues as they arise, gain observation and comments on how department or other meetings are conducted, review correspondence before it is distributed, and have an individual to rely on for guidance in administrative issues.

Recommendation:

It is recommended that:

18. **The Medical Director of Health PEI should contract with a mentor for the Chief of obstetrics and gynecology at QEH for at least a one year.**

One of the key responsibilities of a department chief is the mentorship of other members of his or her department. The current performance appraisal model is insufficiently developed to ensure that department members are appropriately mentored and monitored. For instance, although they may have obtained some professional development over the past year, at least two physicians in the department did not actually list any professional education on their reapplication form, notwithstanding which they were reappointed. In addition, there is no evidence of a "procedure specific" credentialing tool. Individual physicians apply for and are granted privileges either as "active obstetrics" or "active gynecology", but there is no opportunity for individuals to indicate, for instance, whether they have the requisite skills to conduct minimally invasive procedures, major cancer procedures, or other surgical techniques. Thus, in theory, in the current model it will be possible for an individual physician to decide that he or she wishes, with no evidence of appropriate training, to commence offering a surgical procedure for which they may or may not have received adequate training.

Recommendations:

It is recommended that:

19. **The Chief of obstetrics and gynecology should be vested with responsibility for developing a formal career mentorship program for members of the department, as well as a performance appraisal process.**

20. **Health PEI should review its re-credentialing model, and ensure that those applying or reapplying for privileges have, in fact, that the minimum requirements for appointment.**

For departments to develop, it is essential, at a minimum, that they conduct strategic planning processes at least every three years, revisit the plan annually to ensure that it aligns with the corporate plan, and engage in department wide planning exercises. The department of obstetrics and gynecology has not created a strategic plan for approximately 20 years. While the QEH does have interdisciplinary perinatal and reproductive care committees, there have been no

program wide retreats, nor are there interdisciplinary educational events. There are no fora in which the medical and nursing and other health professional staff meet to conduct morbidity and mortality reviews, present new or emerging technologies, or plan for the future of the program. While it is acknowledged that these deficiencies almost certainly are reflective of a chief compensation model that is deficient, limiting his or her ability to engage in the planning of such activities, these deficiencies should be addressed.

Recommendations:

It is recommended that:

21. **Once a policy decision is made regarding the compensation of the department chief, he or she should be expected to arrange annual strategic planning exercises and department retreats.**

22. **The department should refine its quality assurance and educational programs to ensure that there are interdisciplinary morbidity and mortality rounds, as well as joint continuing professional development activities.**

23. **The department chief should ensure that annual retreats are conducted.**

The program does not operate in a truly "programmatic" model. There is no program steering committee with representation from the broad array of providers involved in the program (such as nursing, dietary, housecleaning, clerical etc.) thus limiting its potential for truly interdisciplinary planning and service delivery.

Recommendation:

It is recommended that:

24. **The chief should create a program management committee which is multidisciplinary in nature and meets, at a minimum, four times per year.**

5.2 Stress and Burnout

In the course of the conducted interviews, it became apparent that the department of obstetrics and gynecology providers, particularly at the Charlottetown site, are suffering from stress and incipient burnout. This is evidenced not only by the fact that they verbally acknowledge this phenomenon, but also in some of the anecdotal comments regarding "near misses" that have occurred in the recent past. There is ample evidence that physicians suffering from stress and burnout are at

significant risk for developing adverse personal health outcomes that may include, among others, hypertension, ischemic heart disease, the resumption of smoking, and depression.

Furthermore, it has been well demonstrated that physicians suffering from stress and burnout are more prone to medical error, becoming confrontational and adversarial with patients, and making ill - considered clinical decisions.

It is clearly in the interests of Health PEI to have strategies in place to prevent, recognize, and remediate physician stress and burnout before adverse outcomes occur.

Recommendation:

It is recommended that:

25. **Health PEI should contract an individual or firm with experience in the domain in physician stress and burnout to support the Department of obstetrics and gynecology for a period of 6 to 12 months in order to work both with the department and individual physicians on identifying issues related to stress and burnout and provide them with remediation.**

A major component of the stress being experienced by the obstetricians is, apparently, related to a sense of frustration with the growing waitlists, large volumes of patient visits, and the inability to practice medicine in a manner which the group purports to desire. To a certain extent, the workload has been determined by the failure to successfully recruit and retain two additional obstetrician/gynecologists which will, inevitably, significantly improve the current situation.

The reviewers question whether it is necessary for the obstetricians to be on site in an uninterrupted manner from morning to evening when on-call based on the practice pattern seen in other sites with similar obstetric volumes. The concerns regarding workload are made worse still by virtue of the fact that office practice is not conducted on Friday afternoons because office staff have already accumulated their designated 37.5 hour work week. The obstetricians and the obstetrics clinic manager should consider adjusting the assigned staff hours to accommodate a Friday afternoon clinic.

While there are nominally four obstetricians, given that one will be absent from the office on any given day owing to being on-call, and none of them are present on Friday afternoons, the amount of clinical time available is closer to that of two rather than four full time

equivalents. Clearly, with the arrival of two more obstetricians, and the potential recruitment of family physicians or other primary care providers to undertake a significant portion of the prenatal and postnatal workload, the stress related to office practice may be significantly diminished.

The average number of deliveries conducted in any given day is three. The volume of activity conducted in the hospital for a 24 hour period is augmented by conducting some (generally minor) operative procedures, performing in patient or emergency department consultations, bedside ultrasounds, fetal assessments etc. We believe that having the on-call obstetrician work a one half booked office on the days he or she is on call will significantly decrease the backlog of consultations, increase the amount of time obstetricians have available to spend with patients, and shorten the wait list. Not being in the case room would allow the obstetricians to continue to comply with the (now deemed outdated by the SOGC) Society of Obstetricians and Gynecologists of Canada recommendation that they be available in 30 minutes to perform a cesarean section on an emergency basis. At this time there is no distinctly Canadian "policy" recommendation regarding on site response times, but when the SOGC next considers this issue, the QEH and PCH should ensure that their policies are aligned with it. In the interim we point out the recently published Obstetric Care Consensus published by the American College of Obstetricians and Gynecologists (Obstetric Care Consensus Number2 February 2015) that calls for Obstetricians in Level 2 centres (the equivalent of QEH) to be "available" at all times but NOT necessarily on site (as is the case, for instance , for level 3 centres).

In addition, we support the obstetrician/gynecologists decision to conduct an office part of the day following their on-call day.

As an alternative, consideration may be given to creating two 12 hour on call shifts- a "day" and a "night" shift with the "night " obstetrician takin the following morning off. If all four obstetricians were willing to adjust their schedules accordingly, and perhaps two of the group were willing to work on alternate Friday afternoons, it would significantly improve the availability of gynecologic services, while not exacerbating the physician stress issue.

Recommendations:

It is recommended that:

26. The Departments of obstetrics and gynecology should ensure their policies with regard to on site response time reflect the policy of the SOGC, and in the interim consider the

recommendation of the American College of Obstetricians and Gynecologists.

27. **The Department of obstetrics and gynecology should continue its policy with regard to the day after call, with some clinical service being provided the day after call.**

28. **The obstetricians and the obstetrics clinic manager should consider adjusting the assigned staff hours in the clinic to accommodate a Friday afternoon clinic.**

While the obstetricians feel that they are fairly remunerated, it is acknowledged that a different financial arrangement might provide enhanced opportunities for stress and burnout remediation. While the "principle" of the salary arrangements may be similar, each of the obstetricians has, apparently, an individual arrangement for billing. Many physician groups have shifted from individual salaries or fee-for-service to group billing arrangements. Such arrangements allow the group to not only determine the value of the total work provided in the course of a given year, but also provide opportunities for physician groups to incent or reward behaviours that they value. For instance, some groups provide for a percentage of the gross annual income to be set aside and provide financial support to individual members who conduct research, present papers, serve on national committees, or devote time to teaching. Yet others set aside larger percentages of the annual incomes in order to provide "financing" for sabbaticals of individuals who wish to take periods of 3 to 6 months off every 4 to 6 years while maintaining an income.

Recommendation:

It is recommended that:

29. **The obstetricians and gynecologists should consider negotiating an annual lump sum payment with Health PEI and establishing a model in which this income will be distributed, including specific behaviours or activities that they may wish to incentivize or reward.**

5.3 Extra-departmental Relationships

While the nature of the relationship between the obstetricians and gynecologists and their specialist colleagues is, as reported above, excellent, there is, at the current time, a particularly fractious relationship with the province's community of family physicians. This is particularly true with regard to the relationship between the obstetricians located in Charlottetown and family physicians, and

significantly less so between the family physicians and the obstetricians working in Summerside.

The conflict appears to have arisen because of workload issues encountered by the obstetrician/ gynecologists in Charlottetown that has, at this time, contributed to a delay in obtaining consultations that may reach up to two years. Recently, in response to the prolonged wait for access to consultation, family physicians have been asked or cajoled into referring patients to the Summerside community.

The extended wait times for access to consultations was reported by former patients of the program who were interviewed as being most vexatious. In addition, both physicians practicing and women living on the east side of the island are upset by the extra distance to Summerside to access service.

The obstetricians' perspective is that given the fact that there are only four individuals working in Charlottetown currently, they have insufficient resources to accommodate the large volume of requests and need for antenatal, intrapartum, postpartum, and gynecology services.

Conversely, family physicians note that they, in some measure, are or have been "excluded" from the provision of obstetrical care. They also admit that this is because of a lack of willingness to undertake responsibility for obstetrical care owing to the time commitment, the risks involved, the lack of sufficient training, and a variety of other factors.

In addition, however, family physicians note that oftentimes when they were providing antenatal care and transferring patients at the latter stages of pregnancy that the investigations they conducted and the documentation they compiled was repeated by the obstetricians, making them feel either neglected or that the standard of care they offered was inadequate.

The combination of the perceived "exclusion" of family physicians from obstetrical care and the lack of timely availability of gynecology consultation has contributed to an adversarial and contentious atmosphere that must be addressed.

Further complicating this issue is the withdrawal the obstetricians and gynecologists from clerkship teaching in the province's family medicine program. The quality of teaching provided in the past was reported to be excellent, and this was a most sought after rotation.

This issue is complex, and a variety of factors must be considered in attempting to bring about a solution. They include consideration of

whether family physicians are the sole alternative to obstetrician delivered antenatal care, the importance of a family medicine residency experience in obstetrics and gynecology that is not only educationally rewarding, but portends, at a minimum, an opportunity for family physicians in training to determine whether or not, when in practice, they will provide obstetrical care, a difficult history between family physicians and obstetricians, and opportunities for obstetricians to change their work model in order to provide more hours service per week. In addition, consideration needs to be given to opportunities to streamline care, and perhaps create integrated models of care for obstetricians and family physicians to work collaboratively.

A variety of models may be considered to address all of the above concerns.

5.3.1 Re-integrating Family Physicians

Re-integrating antenatal care into family physicians' practice is an important consideration. This may require any or all of:

- Opportunities for family physicians who have not recently provided prenatal care to be updated in their skills. This would necessitate the cooperation and collaboration of obstetricians, particularly allowing family physicians to participate in care in the obstetricians' offices until such time as the FP's felt confident in their skills. Of particular note, we would recommend teaching and mentoring family physicians in their pursuit of the knowledge of how to safely conduct endometrial biopsies as an office procedure.
- Creating opportunities for family physicians to offer not only prenatal, but intra-partum care. This would require capitalizing on the skills and knowledge of the family physician in Summerside that currently provides comprehensive care along with the support of obstetricians and gynecologists to provide the education and skill updates to family physicians who wish to resume obstetrical care. Once a core group of family physicians have resumed obstetrical activity, it will increase the likelihood future graduates of the province's family medicine program will also participate in obstetrical care, while concomitantly decreasing the number of consultations sought, and increasing the skill with which family physicians provide antenatal care.
- An alternative model would create a program that facilitates the entry of recent family medicine graduates into obstetrical care by combining brief periods of mentorship with support (both philosophical and clinical) for the resumption of obstetrical care. It has been identified, for instance, that one of the factors that

discourages family physicians from renewing or continuing to practice antenatal (and by extension obstetrical) care is the fact that obstetricians regularly repeat the histories, physicals and investigations family physicians conduct on their pregnant patients.

- A further idea for consideration is the creation of an interdisciplinary women's healthcare centre, which could be created either in Charlottetown or in Summerside, or, with the benefit of experience, in both centres. In such a facility family physicians, nurse practitioners, obstetrician/ gynecologists and others could come together and conjointly plan for and deliver an integrated program of women's health services including, among other "product lines", treatment for sexually transmitted diseases, menopausal issues, osteoporosis, breast disease etc. Such a facility is in keeping with innovative models of care in many centres, and will provide an ideal training facility for family medicine residents, while concomitantly decreasing wait times. Such a facility can also be used as a "centre" in which family physicians from disparate practices who wish to practice obstetrics can work in a collaborative model in a single physical plant supported by nursing and other staff all of whom will work with care maps and protocols that will be common across all providers. This concept received strong endorsement from many of the interviewees contacted during the process.
- The obstetricians and gynecologists may also wish to consider whether it will be possible to "leverage" their ability to attract senior obstetrical residents from Halifax to Charlottetown based on their participation in family medicine teaching and their support of the family medicine community. For instance, if the perks accrued to obstetricians for teaching family medicine residents included not only an academic appointment, but an opportunity for academic advancement based on teaching performance, the presence of appointees at the Assistant or Associate Professor level might facilitate further teaching opportunities for core obstetrics residents in Prince Edward Island.

5.3.2 Incorporating Non-Physician Providers

Many interviewees suggested that the incorporation of non-physician providers, such as nurse practitioners, midwives, or physician assistants could assist greatly with the workload issues facing the obstetricians. Each of these options was explored with interviewees, and a variety of models of care delivery in other constituencies were also explored.

Physician Assistants are not recommended because it is not a credentialed profession in the province of Prince Edward Island, and physician assistants are not well trained in the delivery of obstetric or gynecology care. Furthermore, the model requires direct supervision by a physician, as it is not an independent health profession, thus limiting the ability of physician assistant to lessen to the obstetricians' workload.

While not yet recognized as an independent health profession in Prince Edward Island, midwifery would be a consideration. Midwives command a significant salary (approximately $100,000 per year), and practice in other provinces dictates that they are required to work, at a minimum, in a group of 4. In general, the midwives' commitment is limited to 40 deliveries per year (in addition to the requisite ante- and post-natal care for these women). Thus, the incorporation of midwives would only offload 160 deliveries and the associated pre and post natal care, less than the volume of activity offered by an obstetrician at approximately the same cost. The lack of experience with the midwifery model would require the development of protocols, policies and procedures as well as the creation of a work atmosphere that was seen by the midwives is being supportive. As many midwives and their clients may be committed to home births, this might be an additional challenge.

We do, however, recommend the incorporation of nurse practitioners into the delivery of obstetrical and gynecologic services. Primary care nurse practitioners are trained in the delivery of ante and post-natal care, as well as in the delivery of primary care services for women. Thus, not only could they participate in antenatal and postnatal examinations, but they can also undertake the treatment of sexually transmitted diseases, menopause and osteoporosis. They may also do the comprehensive pre-operative histories and physicals necessary for admission to hospital. In some Canadian provinces (e.g. Ontario), nurse practitioners can be credentialed to be the "most responsible provider" and can serve as the MRP during the patient's stay, taking responsibility for admit and discharge decisions.

The successful incorporation of nurse practitioners will, however, require the obstetricians to be supportive, facilitating, and encouraging. In addition to providing consultations upon request from nurse practitioners, the obstetricians and gynecologists will have to commit to supporting their education and ongoing professional development, and to practicing in what is perceived by both parties to be a collegial manner.

Recommendation:

It is recommended that:

30. **Health PEI, in conjunction with the obstetricians and gynecologists in Charlottetown, should recruit, at a minimum, two full-time nurse practitioners to work in the same physical location as the obstetricians.**

5.4 Relationship with Emergency Department

The relationship between the Department of obstetrics and the emergency department is regarded as excellent. However, owing to the delays encountered in the community obtaining access to gynecologic consultation, it has been reported that some family physicians' patients may arrive in the emergency department in anticipation of obtaining earlier access to gynecologic consultation. The community of family physicians should, wherever possible, advise patients that it is inappropriate to attempt to "short circuit" the system by presenting to the emergency department.

Conversely, should an emergency physician encounter a patient who has attempted to short-circuit the system but does, in his or her opinion, have a medical or surgical condition that warrants immediate or urgent consultation the obstetricians and gynecologists should be open to receiving such requests.

At the current time, patients with first trimester bleeding are, in general, referred to their family physicians for follow-up evaluation, ultrasound if necessary, and gynecologic referral if necessary. Yet others are discharged from the emergency department, return to the emergency department for follow-up ultrasound, and are then triaged to an obstetrician.

In either case the process is unnecessarily slow, requires repeat visits, and places a burden of care on the emergency department. Many centres (such as Winnipeg Health Sciences, North York General Hospital, and others) have developed first trimester bleeding clinics. In these venues, patients seen in the preceding 24-48 hours in the emergency department are reviewed by an obstetrician, and decisions made regarding further follow-up and treatment.

Recommendation:

It is recommended that:

31. **Health PEI, in conjunction with the Departments of obstetrics and gynecology and Family Medicine, should explore opportunities to develop a first trimester bleeding clinic.**

6.0 Recruitment

The department has experienced difficulty recruiting its full-time complement of six obstetricians. On occasion, they have been able to recruit an obstetrician, or have arranged for extra coverage by locums on an intermittent basis. Clearly, given that previous reviews have confirmed the need for six full-time obstetrician gynecologists to meet the service needs of patients in the Charlottetown area, recruitment of two additional obstetricians is an important aspect of the Department's future. The recruitment of more obstetricians will greatly facilitate shortening of the wait list, minimize problems alluded to elsewhere with regards the efficiency of utilization of the operating room facilities, and considerably decrease the stress currently experienced by the obstetricians in Charlottetown.

In order to successfully recruit, however, the Department will need to think strategically. The desire has been expressed to recruit obstetricians with extra training or experience in the domains of uro-gynecology and maternal fetal medicine. It will be essential for the Queen Elizabeth Hospital to ensure that it has infrastructure in place to support these the subspecialty undertakings.

It will also behoove the Department of pediatrics to ensure that the pediatricians are aligned with and support an enhanced maternal fetal medicine program.

In order to facilitate recruitment, many of the areas of concerns addressed in other sections of this report will need to be addressed. Issues such as the physical layout and management of office space, decisions regarding the on-site presence of an obstetrician during the 24-hour call and the relationship with the community of family physicians will need to be addressed.

We suggest, based on a much appreciated and highly evaluated past record of supporting the province's teaching program, that continuing involvement in the teaching program will, in fact, facilitate recruitment. We further believe that efforts to review and/or revise the remuneration model, including consideration of an APP with a new model of distribution of income, may also help facilitate recruitment.

It is important, in the current era, to recognize that recruitment of physicians is not simply the recruitment of one professional, but the recruitment of a "family". Thus, Health PEI, or other organizations (such as the Chamber of Commerce) should ensure that opportunities for spousal employment, children's education, and registration in

recreational activities are aggressively advertised to potential candidates.

Recommendations:

It is recommended that:

32. **The Health PEI recruiter should develop a comprehensive plan for Obstetrician recruitment.**

33. **As the recruitment process proceeds, the Queen Elizabeth Hospital should ensure that it has the infrastructure necessary to support the new recruits' specialized practices.**

7.0 Polyclinic

Many of the observations and recommendations that follow may be redundant if suggestions made regarding the establishment of a "women's health centre" above are acted upon, as the centre could easily house all of the obstetricians' practices and offer an additional menu of services.

Considerable concern was expressed regarding the operation of the obstetrician/gynecologists' office practice in the polyclinic building in downtown Charlottetown. By virtue of a negotiation between the obstetricians and Health PEI at the time the obstetricians formed a group, Health PEI undertook to rent square footage of sufficient size in the polyclinic building to house six obstetricians. The agreement results in Health PEI paying the rent and an administrative charge to the owners of the Polyclinic that covers not only rent, but the provision of staff and a number of infrastructure supports such as specimen processing and shadow billing.

However, this arrangement has proven to be extremely difficult. At least two external reviews of the function of the polyclinic have been conducted in the past, and neither has resulted in a revised arrangement perceived as satisfactory by the obstetricians. In particular, because the staffing of the clinic is controlled by the polyclinic, and not by either of Health PEI for the obstetricians themselves, any human resource issues that arise are extremely difficult to resolve. The obstetricians do not have direct control over the employees that report to them, or the ability to hire, fire, provide performance assessments or negotiate compensation arrangements with their support staff. This relationship has proven to be untenable for a variety of other reasons, not the least of which is been the inability to recruit and retain an office manager.

The polyclinic is currently staffed with three secretaries, five LPNs, and one 0.6 full-time equivalent registered nurse who was reported to be leaving the clinic at the end of 2014.

The office space consists of five offices, 8 examining rooms, and an additional examining room which also contains a colposcope but can be used as an additional exam space. In addition, there is adjacent space, currently not occupied, but which could be (and has been) used at times when the complement of obstetricians is greater than four.

The obstetricians currently dictate their consultation notes, and subsequently they are transcribed.

Paper charts are in use in the office.

In reviewing the office function, and briefly reviewing patient flow, a number of observations can be made. While a detailed review of staffing, work processes, and patient flow were not conducted as part of this exercise, we have observed:

- There is no EMR used in the office, notwithstanding multiple previous recommendations that one be purchased.
- Blood is drawn from patients by the LPN accompanying a specific obstetrician. The specimen is then transferred to the polyclinic lab facility approximately twice per day. This is an inefficient process, and results in patients' blood being drawn in hallways, which are of limited size and provide opportunities for other patients to observe their co-patients' blood being drawn.
- There is a lack of a full-time manager with the appropriate skills, knowledge, experience or mandate working in the clinic, and it is essential that a full-time manager with appropriate background and skills be hired directly by and reporting to the obstetricians, who should conduct their performance management.
- Currently, each of the LPN's is assigned a one-to-one relationship with a particular obstetrician. While this may be an effective system at times when all the obstetricians are in the office, and working at peak capacity, it is essential that the staff of the clinic be capable of working in support of any obstetrician who happens to be in the office at any time. This will help with cross coverage during times of vacation, sick leave and meal breaks, and contribute to the standardization of care, including the way individual exam rooms are laid out.
- There is an extended wait time to see an obstetrician for a gynecologic consultation. Part of this may be decreased or eliminated by moving to an electronic booking system. Many such systems are available in the commercial marketplace, and would greatly increase efficiency of appointment booking, and identify opportunities to process consultations sooner.

Recommendations:

It is recommended that:

34. **Health PEI should purchase an electronic booking system for the obstetricians.**

35. **The obstetricians and staff working in the Polyclinic should review and where appropriate, revise, their work flow.**

There has been extended discussion conducted regarding continuing occupancy of the space. The initial ten-year lease will, apparently, expire in approximately 15 months. The obstetricians may choose to continue occupying the same space or, alternatively, seek alternative space.

If occupying the same space, then significant renovations should be made to ensure that all the available space is integrated, and that a portion of it is not separated from the main body of space so that opportunities for ad hoc consultation are improved, and patient flow is enhanced.

If, as an alternative, other space is rented on behalf of the obstetricians, it should be designed so that each of the obstetricians has an office and two exam rooms, a bleeding station in which a single employee can take blood, and the most efficient possible flow.

Ideally (see 9.0) the province will create a provincial colposcopy program. At that time, the colposcopes should be located in an outpatient setting, perhaps in the hospital(s). Should that recommendation not proceed, it may be appropriate to ensure there is sufficient space in either the polyclinic (or its replacement) or the women's health centre for two colposcopy rooms.

In the current situation, while the obstetricians work as a "group", they essentially function as four solo physicians with a shared waiting room. Efforts should be made to make the practice a true "group practice" with standardized approaches, for instance, to charting, layout of the rooms, equipment, etc.

The current office space has an insufficient number of washrooms, bearing in mind that the vast majority of patient visits are pregnant women, all of whom are asked to produce urine specimens at each visit.

Recommendations:

It is recommended that:

36. The office space the obstetricians occupy should have at least three patient washrooms.

37. The province's obstetricians should explore opportunities to create true "group" practices.

Notwithstanding the fact that the obstetricians all work together, there is no policy or procedure manual that is required reading on the part of all employees. This makes the standardization of practices, decisions

regarding vacation time, performance management, and a number of other important bureaucratic functions difficult.

Recommendation:

It is recommended that:

38. The obstetricians and gynecologists, in conjunction with the office manager, should write and distribute a policy and procedure manual for all staff working in their office.

The obstetrician/ gynecologists expressed a desire to move to a location that has better layout, and in which they can "manage" their own staff. Three options have thus far been identified.

One is to move to new space somewhere in the Charlottetown area that may require negotiation of a lease, renovation etc.

Another is to move to unoccupied space in the ambulatory care wing in the Queen Elizabeth Hospital. The reviewers have examined that space and find, for a variety of reasons, it would be a totally unacceptable for the conduct of an office practice.

A third identified alternative would be to occupy a portion of the current emergency department (the area currently identified as an "isolation" area plus one of the current "ICU" rooms and some adjacent areas) to serve as an obstetrics and gynecology clinic. Doing so would, in theory, be possible, with many caveats. The space which the obstetricians have identified is currently used for housing admitted patients who have no bed available in the hospital. In order to be able to use the space, an array of hospital policies to ensure the timely transfer of admitted patients from the emergency department to inpatient beds would be required.

Even with the changes, the space is insufficient. The space could be made acceptable by combining some of the functions currently taking place in two areas of the department. This will require minor renovations and changes to the care process and flow of the emergency department.

Recommendation:

It is recommended that:

39. The Chief of obstetrics and gynecology, the Chief of emergency medicine and the newly arriving Medical Director of the Queen Elizabeth Hospital should meet, review the potential space available in the emergency department, and determine whether

or not it will be feasible to create office space for the Department of obstetrics and gynecology in the current emergency department.

It was reported that during the normal course of daily operations, the male obstetricians do not routinely request the presence of a female in the examining room when they are conducting Pap smears or other gynecologic examinations. In all other constituencies the provincial colleges have strongly recommended that no gynecologic examinations be conducted in the absence of a female chaperone.

Recommendation:

It is recommended that:

40. **The Chief of obstetrics should consult with the College of Physicians and Surgeons of Prince Edward Island, determine whether the College has a standard regarding the presence of chaperones for pelvic examinations and ensure office practices comply with the recommendation.**

The clinic does not function optimally because of a lack of collegiality and consensus building in planning for patient flow, human resources, etc. While each of the staff values the relationship that she has with an obstetrician, the group of physicians, office staff, and nursing staff do not meet on a regular basis to discuss issues, plan improvements, or respond to the concerns that may arise in the day-to-day running of the office. At a minimum, the entire office should meet at least once a month to discuss issues, and, ideally, should consider conducting an annual retreat, the first of which should take place as soon as possible.

Recommendation:

It is recommended that:

41. **One obstetrician (chosen by the group) and the newly appointed office manager should schedule, plan the agenda, and plan for action items emanating from monthly department meetings.**

8.0 Creating a Baby Friendly Environment

A recent accreditation report indicated that the obstetrics service has not yet reached its maximum capacity to be "baby friendly". While we are unaware of efforts that may have been made to improve the hospitals' profile in this domain, we remind the practitioners of both obstetrics and gynecology and paediatrics that this important recommendation should be complied with.

Recommendation:

It is recommended that:

42. The obstetrics and pediatric services at both the Prince County and Queen Elizabeth Hospitals should work towards creating a baby friendly environment as outlined in the recent accreditation report.

9.0 Colposcopy

At the current time, colposcopy is carried out primarily in physicians' offices. There is, however, no truly organized, standardized colposcopy program in the province, addressing issues such as the indications for biopsy and models to ensure pathology reports are not only written consistently, but read and interpreted appropriately. The process may be hastened by "borrowing" regional guidelines from neighbouring provinces.

Recommendation:

It is recommended that:

43. The obstetricians at the Prince County and Queen Elizabeth Hospitals, in cooperation with the provincial cancer screening program, should cooperate in developing a provincial colposcopy program.

Appendix A:

List of Recommendations

1. **The Medical Directors and Chiefs of Obstetrics of the Prince County and Queen Elizabeth Hospitals should meet and determine both current and anticipated future volumes of minimally invasive surgery. If the size of the program will remain small, consideration should be given to conducting all minimally invasive procedures in Charlottetown.**

2. **Health PEI should consider purchasing individual dashboards to track physician performance.**

3. **The Chiefs of obstetrics should regularly review episiotomy and caesarean section rates, and report on them.**

4. **The Chiefs of obstetrics and gynecology at the Prince County and Queen Elizabeth Hospitals should embark on a program that will decrease the average length of stay for normal vaginal deliveries to two days.**

5. **The Medical Director of the Prince County Hospital should monitor compliance with existing maternal transfer guidelines.**

6. **The department of Obstetrics and Gynecology at the QEH (in cooperation with peers at PCH) should formalize and circulate a VBAC protocol.**

7. **Health PEI, in coordination with Community Health, should develop and deliver a coordinated provincial program focused on the primary care needs of women of child bearing years. This may be integrated with a Women's Health Centre should one be developed.**

8. **The OR Committee should review operating room utilization by the Department of obstetrics and gynecology and adjust their assigned time accordingly.**

9. **The Department of obstetrics should explore opportunities to decant some of its surgical activity to an ambulatory facility, either in- or outside the current hospital(s).**

10. **The Chiefs of obstetrics should strike a program advisory committee, with membership to include, at a minimum, the clinical and administrative program directors, and representation from nursing and clerical staff.**

11. **The Executive Director Medical Affairs and DI should investigate the cause(s) of the differences in rates of surgical intervention in the PCH and QEH.**

12. **The nurse manager of the operating room should review the staffing requirements for the obstetrics and gynecology operating room and adjust it accordingly.**

13. **The program should convene a quality assurance subcommittee. This committee should be interdisciplinary, and, at a minimum, develop quality management process including the collation and distribution of program specific data to all program members on a monthly basis, as well as the development of an audit system based on peer review using generally accepted and published statements.**

14. **Health PEI should appoint a single leader for the provincial obstetrics and gynecology program.**

15. **The Medical Director of Health PEI should review the compensation package for the chief of obstetrics and gynecology and adjust it upwards.**

16. **Health PEI should consider a change to the Medical Staff By-laws to allow for the recruitment of Chiefs after nationally conducted search processes.**

17. **Health PEI should consider changing the term of appointment of Department Chiefs from two years to 3-5 years, with one renewal possible with no external search.**

18. **The Medical Director of Health PEI should contract with a mentor for the Chief of obstetrics and gynecology at QEH for at least a one year.**

19. **The Chief of obstetrics and gynecology should be vested with responsibility for developing a formal career mentorship program for members of the department, as well as a performance appraisal process.**

20. **Health PEI should review its re-credentialing model, and ensure that those applying or reapplying for privileges have, in fact, that the minimum requirements for appointment.**

21. **Once a policy decision is made regarding the compensation of the department chief, he or she should be expected to arrange annual strategic planning exercises and department retreats.**

22. **The department should refine its quality assurance and educational programs to ensure that there are interdisciplinary morbidity and mortality rounds, as well as joint continuing professional development activities.**

23. **The department chief should ensure that annual retreats are conducted.**

24. **The chief should create a program management committee which is multidisciplinary in nature and meets, at a minimum, four times per year.**

25. **Health PEI should contract an individual or firm with experience in the domain in physician stress and burnout to support the Department of obstetrics and gynecology for a period of 6 to 12 months in order to work both with the department and individual physicians on identifying issues related to stress and burnout and provide them with remediation.**

26. **The Departments of obstetrics and gynecology should ensure their policies with regard to on site response time reflect the policy of the SOGC, and in the interim consider the recommendation of the American College of Obstetricians and Gynecologists.**

27. **The Department of obstetrics and gynecology should continue its policy with regard to the day after call, with some clinical service being provided the day after call.**

28. **The obstetricians and the obstetrics clinic manager should consider adjusting the assigned staff hours in the clinic to accommodate a Friday afternoon clinic.**

29. **The obstetricians and gynecologists should consider negotiating an annual lump sum payment with Health PEI and establishing a model in which this income will be distributed, including specific behaviours or activities that they may wish to incentivize or reward.**

30. **Health PEI, in conjunction with the obstetricians and gynecologists in Charlottetown, should recruit, at a minimum, two full-time nurse practitioners to work in the same physical location as the obstetricians.**

31. **Health PEI, in conjunction with the Departments of obstetrics and gynecology and Family Medicine, should explore opportunities to develop a first trimester bleeding clinic.**

32. **The Health PEI recruiter should develop a comprehensive plan for Obstetrician recruitment.**

33. **As the recruitment process proceeds, the Queen Elizabeth Hospital should ensure that it has the infrastructure necessary to support the new recruits' specialized practices.**

34. **Health PEI should purchase an electronic booking system for the obstetricians.**

35. **The obstetricians and staff working in the Polyclinic should review and where appropriate, revise, their work flow.**

36. **The office space the obstetricians occupy should have at least three patient washrooms.**

37. **The province's obstetricians should explore opportunities to create true "group" practices.**

38. **The obstetricians and gynecologists, in conjunction with the office manager, should write and distribute a policy and procedure manual for all staff working in their office.**

39. **The Chief of obstetrics and gynecology, the Chief of emergency medicine and the newly arriving Medical Director of the Queen Elizabeth Hospital should meet, review the potential space available in the emergency department, and determine whether or not it will be feasible to create office space for the Department of obstetrics and gynecology in the current emergency department.**

40. **The Chief of obstetrics should consult with the College of Physicians and Surgeons of Prince Edward Island, determine whether the College has a standard regarding the presence of chaperones for pelvic examinations and ensure office practices comply with the recommendation.**

41. **One obstetrician (chosen by the group) and the newly appointed office manager should schedule, plan the agenda, and plan for action items emanating from monthly department meetings.**

42. **The obstetrics and pediatric services at both the Prince County and Queen Elizabeth Hospitals should work towards creating a baby friendly environment as outlined in the recent accreditation report.**

43. **The obstetricians at the Prince County and Queen Elizabeth Hospitals, in cooperation with the provincial cancer screening program, should cooperate in developing a provincial colposcopy program.**

Appendix B:

List of Recommendations by Priority

The Steering committee for this undertaking requested assistance in "triaging" the recommendations. We have categorized the recommendations into "urgent" (should be begun in less than 6 months), less urgent (should begin in 6 to 12 months) and "elective" (should begin in the next 2 years) categories. The order in which the recommendations are listed in each category is NOT intended to reflect specific ordering within the categories.

Urgent

The Chiefs of obstetrics and gynecology at the Prince County and Queen Elizabeth Hospitals should embark on a program that will decrease the average length of stay for normal vaginal deliveries to two days.

The department of Obstetrics and Gynecology at the QEH (in cooperation with peers at PCH) should formalize and circulate a VBAC protocol.

The Chiefs of obstetrics should strike a program advisory committee, with membership to include, at a minimum, the clinical and administrative program directors, and representation from nursing and clerical staff.

The Executive Director Medical Affairs and DI should investigate the cause(s) of the differences in rates of surgical intervention in the PCH and QEH.

Health PEI should appoint a single leader for the provincial obstetrics and gynecology program.

The Medical Director of Health PEI should review the compensation package for the chief of obstetrics and gynecology and adjust it upwards.

The Medical Director of Health PEI should contract with a mentor for the Chief of obstetrics and gynecology at QEH for at least a one year.

Health PEI should contract an individual or firm with experience in the domain in physician stress and burnout to support the Department of obstetrics and gynecology for a period of 6 to 12 months in order to work both with the department and individual physicians on identifying issues related to stress and burnout and provide them with remediation.

The Departments of obstetrics and gynecology should ensure their policies with regard to on site response time reflect the policy of the SOGC, and in the interim consider the recommendation of the American College of Obstetricians and Gynecologists.

The Department of obstetrics and gynecology should continue its policy with regard to the day after call, with some clinical service being provided the day after call.

The obstetricians and the obstetrics clinic manager should consider adjusting the assigned staff hours in the clinic to accommodate a Friday afternoon clinic.

Health PEI, in conjunction with the obstetricians and gynecologists in Charlottetown, should recruit, at a minimum, two full-time nurse practitioners to work in the same physical location as the obstetricians.

The Health PEI recruiter should develop a comprehensive plan for Obstetrician recruitment.

As the recruitment process proceeds, the Queen Elizabeth Hospital should ensure that it has the infrastructure necessary to support the new recruits' specialized practices.

The Chief of obstetrics should consult with the College of Physicians and Surgeons of Prince Edward Island, determine whether the College has a standard regarding the presence of chaperones for pelvic examinations and ensure office practices comply with the recommendation.

Less Urgent

The Medical Directors and Chiefs of Obstetrics of the Prince County and Queen Elizabeth Hospitals should meet and determine both current and anticipated future volumes of minimally invasive surgery. If the size of the program will remain small, consideration should be given to conducting all minimally invasive procedures in Charlottetown.

The Chiefs of obstetrics should regularly review episiotomy and caesarean section rates, and report on them.

The Medical Director the Prince County Hospital should monitor compliance with existing maternal transfer guidelines.

The OR Committee should review operating room utilization by the Department of obstetrics and gynecology and adjust their assigned time accordingly.

The nurse manager of the operating room should review the staffing requirements for the obstetrics and gynecology operating room and adjust it accordingly.

The program should convene a quality assurance subcommittee. This committee should be interdisciplinary, and, at a minimum, develop quality management process including the collation and distribution of program specific data to all program members on a monthly basis, as well as the development of an audit system based on peer review using generally accepted and published statements.

Health PEI should consider a change to the Medical Staff By-laws to allow for the recruitment of Chiefs after nationally conducted search processes.

Health PEI should consider changing the term of appointment of Department Chiefs from two years to 3-5 years, with one renewal possible with no external search.

Once a policy decision is made regarding the compensation of the department chief, he or she should be expected to arrange annual strategic planning exercises and department retreats.

The department should refine its quality assurance and educational programs to ensure that there are interdisciplinary morbidity and mortality rounds, as well as joint continuing professional development activities.

The department chief should ensure that annual retreats are conducted.

The chief should create a program management committee which is multidisciplinary in nature and meets, at a minimum, four times per year.

The obstetricians and staff working in the Polyclinic should review and where appropriate, revise, their work flow.

The obstetricians and gynecologists, in conjunction with the office manager, should write and distribute a policy and procedure manual for all staff working in their office.

The Chief of obstetrics and gynecology, the Chief of emergency medicine and the newly arriving Medical Director of the Queen

Elizabeth Hospital should meet, review the potential space available in the emergency department, and determine whether or not it will be feasible to create office space for the Department of obstetrics and gynecology in the current emergency department.

Elective

Health PEI should consider purchasing individual dashboards to track physician performance.

Health PEI, in coordination with Community Health, should develop and deliver a coordinated provincial program focused on the primary care needs of women of child bearing years. This may be integrated with a Women's Health Centre should one be developed.

The Department of obstetrics should explore opportunities to decant some of its surgical activity to an ambulatory facility, either in- or outside the current hospital(s).

The Chief of obstetrics and gynecology should be vested with responsibility for developing a formal career mentorship program for members of the department, as well as a performance appraisal process.

Health PEI should review its re-credentialing model, and ensure that those applying or reapplying for privileges have, in fact, that the minimum requirements for appointment.

The obstetricians and gynecologists should consider negotiating an annual lump sum payment with Health PEI and establishing a model in which this income will be distributed, including specific behaviours or activities that they may wish to incentivize or reward.

Health PEI, in conjunction with the Departments of obstetrics and gynecology and Family Medicine, should explore opportunities to develop a first trimester bleeding clinic.

Health PEI should purchase an electronic booking system for the obstetricians.

The office space the obstetricians occupy should have at least three patient washrooms.

The province's obstetricians should explore opportunities to create true "group" practices.

One obstetrician (chosen by the group) and the newly appointed office manager should schedule, plan the agenda, and plan for action items emanating from monthly department meetings.

The obstetrics and pediatric services at both the Prince County and Queen Elizabeth Hospitals should work towards creating a baby friendly environment as outlined in the recent accreditation report.

The obstetricians at the Prince County and Queen Elizabeth Hospitals, in cooperation with the provincial cancer screening program, should cooperate in developing a provincial colposcopy program.