

The Slate

The Newsletter of
The Office of Pediatric Surgical
Evaluation and Innovation



Operation Rainbow Canada - Cambodia





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The Slate is published twice a year by The Office of Pediatric Surgical Evaluation and Innovation. It provides news and information for and about department members, students, staff, colleagues and friends.

Current and back issues of the Newsletter can be found on the Departmental Website: <http://www.opsei.bc.ca>



The Joy of Teaching

By: Dr. Geoffrey Blair
British Columbia Children's Hospital Surgeon-in-Chief

*“AND I HAVE
LEARNED THAT
THE GREATEST
JOY IN TEACHING
IS BECOMING A
STUDENT AGAIN.”*



Amandeep Taggar, Charles Wong, Rupinder Sohal, Callum Baughen, Andrea Human, Katherine Blood, Andrea Lo, Simon Jones, Geoff Blair

I admit it. I was a doubter. Being raised in the old lecture method in medical school I thought that this new-fangled Problem-Based Learning (PBL) was a bunch of new age hooey. So when our UBC Med School years ago followed the trend in medical education to PBL I was both dismayed and in a quandary. You see, I liked teaching and got a charge out of communing with those young minds and – supposedly – passing my hard-earned knowledge and experience onto them. Now that

was to be no more; PBL was going to be the death of all that. The students would try, I was sure unsuccessfully, to teach themselves. Those who I thought were the real teachers would be relegated to the shadowy corners of a seminar room.

So it was actually in a spirit of rebellion that I signed up to be a PBL tutor some years ago. I took the course, sat in on some PBL groups as prescribed and the wisdom of some of UBC's legendary teachers was whispered in my ear. Soon with my rebelliousness on the wane, now supplanted with a new emotion: new PBL – tutor-fright, I was introduced to my first PBL group; a group of eight, new first-year medical and dental students, keener than keen. Our five-week adventure was to explore together the programmed PBL stories of patients suffering from various infections and inflammations. Our 'patients' were examined, talked to, role played, tested and treated – and all except one got better. The students loved it. Heck – I loved it! PBL was working and I was wrong. They really knew Host Defences and Immunity at the end of that block.

Now I can't wait until my PBL time comes around every year. This year our group of eight plus one (me) is doing the second year 'Repro' block – pregnancies, infertility, menopause, and all that stuff. We meet at VGH every Monday, Wednesday and Friday mornings and my colleagues graciously cover my practice while I'm there. Am I that expert passing on my hard-earned knowledge and experience? Nope. I am, as the late Dean Bill Webber said, "The conscience of the group." It's better than the way it used to be. Problem-Based Learning is actually the way we continue to learn throughout our careers. It's how we approach our own patients' problems. PBL teaches teamwork, self-discipline, professionalism and the need to read, read, and read. These students are learning how to become excellent doctors.

And I have learned that the greatest joy in teaching is becoming a student again.

Shriners Gait Lab at Sunny Hill Health Centre for Children

By: Dr. Richard Beauchamp
Shriners Gait lab, BCCH

What is a Gait Lab?

A gait lab is an investigative tool used to assess a person's walking characteristics. It allows one to develop a quantitative measure of gait, implement appropriate treatment options and eventually document the outcome of an intervention in an objective way.

What does it involve?

Conducting a gait analysis involves several stages. Beginning with the referral process, the patients must be a minimum of 5 years old, be able to cooperate for the 2 hours of testing and be a freely independent walker. Some situations do allow us to test subjects with their particular walking aids or braces. A physiotherapy assessment is then conducted to measure range of joint movement, strength of the leg muscles, degree of spasticity, contractures and rotational malalignment. Special retro-reflective markers are then placed on a series of bony landmarks on the trunk, pelvis and upper and lower limbs to serve as identification points for the kinematic (movement) analysis while the patient walks at a self-selected pace. Kinetic (force) analysis is also conducted as the patient walks through the laboratory

over a series of three force plates measuring 3-dimensional forces. Electromyography electrodes are placed over certain leg muscles and the muscular activity during the walking cycles is measured.

The history of Shriners Gait lab.

The gait lab was founded with a capital grant from the Gizeh Shriner Temple of BC and Yukon in 1996. The formation of the lab followed many years of negotiations and planning with myself and Stephen Tredwell, MD, retired head of the Department of Pediatric Orthopaedics. To date we have analyzed over 2500 gait events. When initially established, the Shriners Gait Lab was the only facility in Canada conducting clinical gait analyses. The other labs were primarily research oriented.

Who can be seen at the gait lab?

There has to be a clinical question that needs to be answered in order to justify a gait assessment. This can be a preoperative analysis or request for information, a desire to assess the effect an orthosis may have on a patient's gait, what physiotherapy may be beneficial, or whether a therapeutic intervention was successful. This implies the patient must have a visible gait abnormality

caused by a neurological impairment like spina bifida or cerebral palsy.. Children with various types of amputations and post limb-salvage surgery for malignancies have also been seen.

The Team.

Currently the professionals conducting the analysis consist of a full time lab director, a full time engineer, 2 part time physiotherapists and 2 orthopaedic surgeons. We meet twice a week to interpret the information and generate a report identifying the key issues and recommendations for treatment.(1). We also corroborate to present teaching and educational products to UBC and BCIT students.(2).

References:

1. Lofterod, B., Terjesen, T., et al. *Preoperative Gait Analysis has a Substantial Effect on Orthopedic Decision Making in Children with Cerebral Palsy. Acta Orthop.* 2001;78(1): 74-80.
2. J.D. Maurer, A.H. Black, C.M. Alvarez, V. Ward, K.R. Davies, R.D. Beauchamp. *Can We Classify Mid-foot Break Using a Multi-segment Foot Model? To be Presented at GCMAS Meeting, Denver CO, May 2009.*



Figure. 1. Shriners Gait Lab at Sunny Hill Health Centre

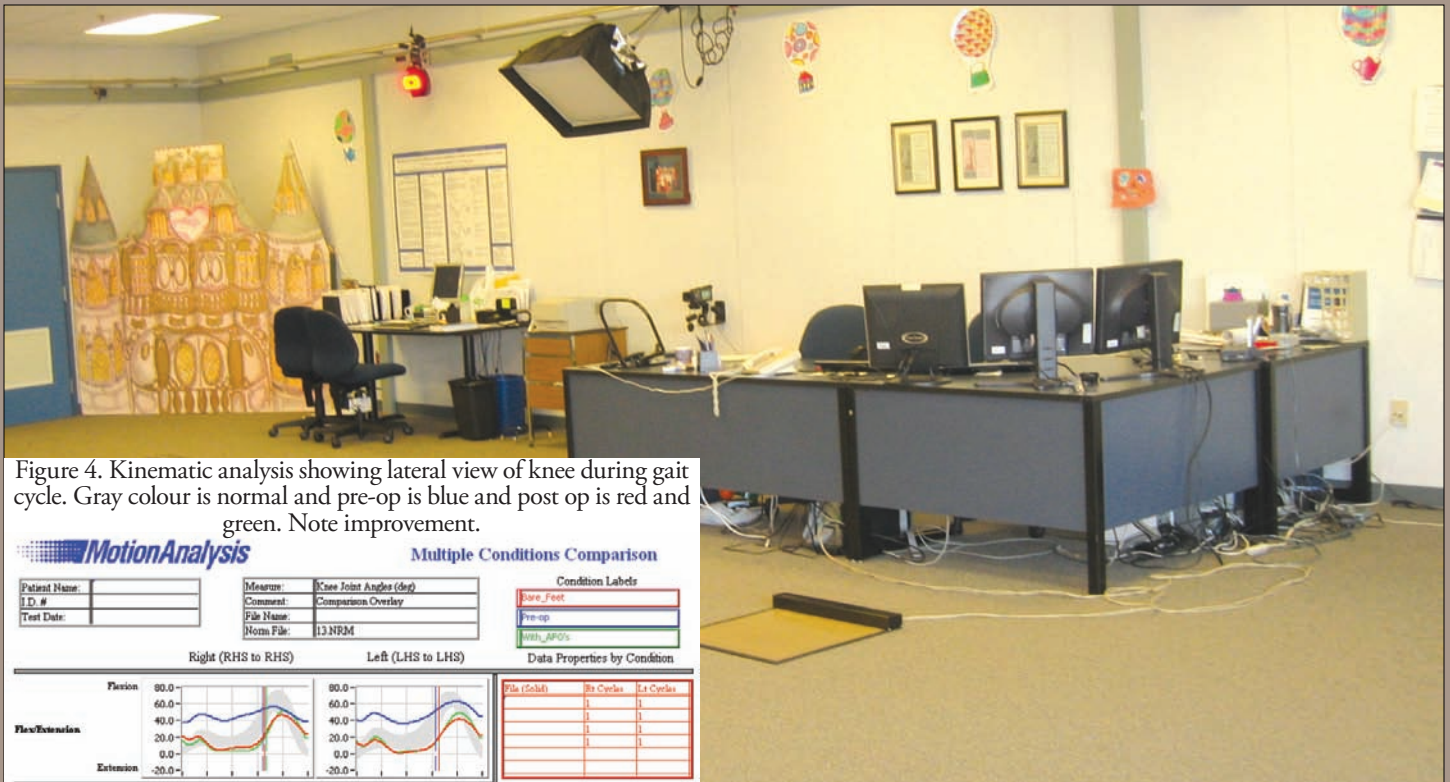
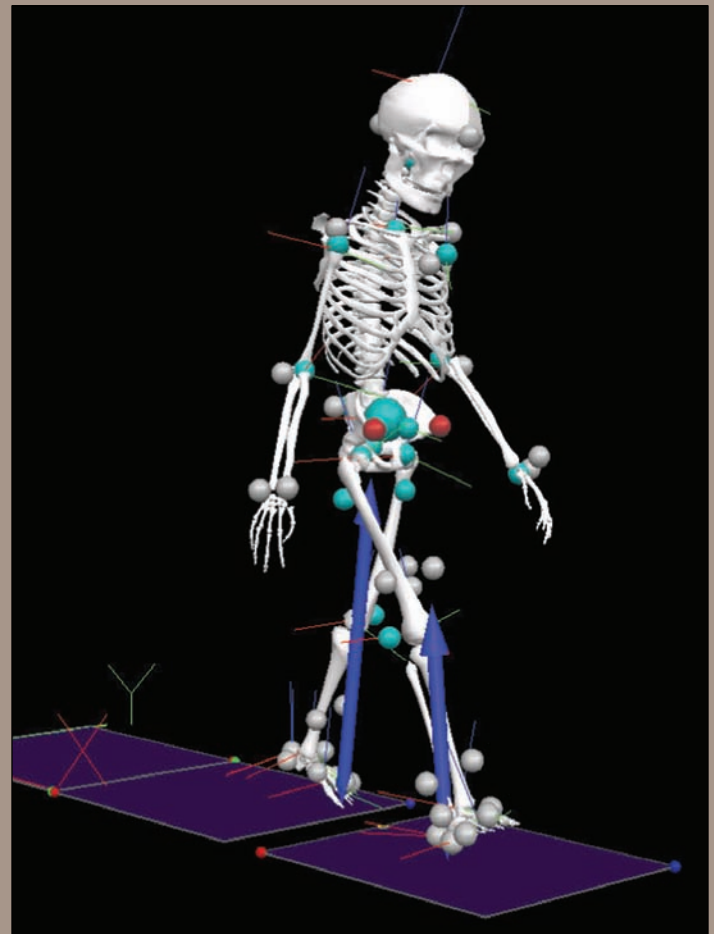


Figure. 2. Patient with retro-reflective markers in place for kinematic analysis while standing on one of the three force plates



Figure 3. Visual 3D of a patient's gait cycle



BC Patient Safety & Quality Council

By: Dr. Doug Cochrane
BC Patient Safety & Quality Council



Last August, as *The Slate* reported, paediatric neurosurgeon Dr. Doug Cochrane resigned from the Provincial Health Services Authority to establish and lead a new provincial organization dedicated to improving patient safety and the quality of patient care in British Columbia.

This organization – the BC Patient Safety & Quality Council – will provide advice and recommendations to the Minister of Health Services on matters related to patient safety and the quality of care.

The Council will also work in collaborative partnership with key stakeholders from across the province in order to promote a provincially coordinated approach to patient safety and quality improvement.

As Council Chair Dr. Cochrane says, *“The stakeholders’ participation and enthusiasm for this important work is crucial to not only the Council’s success, but to the overarching goal of ensuring that patients are receiving the safest care possible.”*

To date, the Council has consulted with 36 key provincial and national stakeholders, including representatives from the Ministry of Health Services, the province’s six health authorities, the College of Physicians and Surgeons of BC, the College of Registered Nurses of BC, the Provincial Infection Control Network, the Healthcare Leaders’ Association of BC, Impact BC, the Canadian Patient Safety Institute, and more.

The Council has recently completed the development of a 3-year Strategic Plan which will be available shortly on its website (www.bcpsqc.ca). Two key first steps within this plan is the establishment of a Health Quality Network for the province – made up of the key stakeholders who participate in the initial consultations with the purpose of providing a forum for ongoing dialogue and to drive provincial improvement priorities. Within the Health Quality Network, the Council is also setting up stakeholder working groups that will explore improvements in key areas such as measurement and evaluation, education and capacity building, and patient/public engagement.

As Dr. Cochrane says, *“We know there is already a lot of work, expertise, and passion for patient safety and quality improvement in BC”.*

“But there is also a clear need and opportunity for the Council to bring this work together – to bring a provincial perspective to patient safety and quality improvement and provide leadership and coordination across the spectrum of care.”

The Council will also be working to develop a BC Health Quality Matrix to provide a common definition and framework for quality. This Matrix will provide the foundation for the development of a quality measurement framework for system, health authority and program level indicators related to the quality and safety of care. For more information on the BC Patient Safety and Quality Council, please visit www.bcpsqc.ca.



Baby Maxtina and her mother Tina Gwee



Ms. Kathleen Ngenda and Dr. Laurence Sherman

To Liberia with Love: Baby Maxtina receives her life-saving surgery thanks to Team Work

By: Mr. Damian J. Duffy
Office of Pediatric Surgical Evaluation and Innovation

Last autumn we received a message from Dr. Stephan Malherbe from the Department of Pediatric Anesthesia. He shared with us that he had been in contact with a physician mission couple who would be traveling to Liberia shortly and were aware of an eight-month old girl named Maxtina in need of a VP Shunt.

Together, with the help of Dr. Jacques Leblanc and Mr. Gavin Marshall from the Operating Room Purchasing Department, we were able to organize the purchase

of the VP shunt for Liberia. Partial funding for this device came through fundraising efforts from the Grassroots Ministry Liberia, who worked together with Dr. Hester Van Wyk from Langley to organize its shipment to Ms. Kathleen Ngenda on the ground in Liberia.

In turn, Ms. Ngenda was able to deliver the device to Dr. Lawrence Sherman a Liberian Surgeon, who worked alongside Dr. Estrada Bernhard a visiting Alaskan Neurosurgeon, to give Maxtina



Dr. Estrada Bernhard

her vital procedure. At this time, Maxtina is doing much better. Dr. Sherman is continuing to provide care for Maxtina and she will be seeing Dr. Bernhard in April for a follow-up appointment. "Although I never met anyone from your team, it is amazing how many people are involved in saving the life of a little girl," said Ms. Ngenda. Warmest thanks to everyone who helped make this procedure possible. This is a wonderful story of the power of team work from three countries to make a difference for a child and her family.



A clinician wearing a tactile belt



tactile belt



A monitor display

Smart Monitors

By: Dr. Mark Ansermino
Department of Anesthesia, BCCH

Pediatric Anesthesia Research Team Lunch



*“WE WOULD LIKE
TO DEVELOP
NEW WAYS OF
CONNECTING
CLINICIANS WITH
THEIR PATIENTS.”*

The Pediatric Anesthesia Research Team has a goal to develop innovative technologies and therapies to improve patient safety. In one aspect of our research, we aim to create Smart Monitors which can help improve the way clinicians work and consequently make our patients safer.

The modern hospital is an arena of continuously competing noises, alarms, physiological signals, and patient information to which the clinician must attend and respond to appropriately. The increasing number of devices that are used to monitor patients has increased enormously the amount of information required to be communicated to the clinician. The visual and auditory senses of the busy clinician are overloaded. It has become too difficult for clinicians in many clinical settings such as the OR, the ICU, emergency department or even the ward to do their work and watch both the patient and the monitors, all at the same time.

The current monitors have become ineffective monitoring systems that amplify demands on human attention and may actually increase the chances of human error (ignore or disable the alarm!). A small fraction of the information collected by the monitor is appreciated by the clinician; the remainder is unused and discarded. We would like to develop new ways of connecting clinicians with their patients. Bridging the gap between monitoring equipment and human attention will reduce the cognitive overload experienced by clinicians and ease the decision-making process in these critical environments.

We have been exploring two avenues for rectifying the current situation:

- (1) presenting monitoring information in a more compact format; and
- (2) exploring new ways to transfer information directly to the attention of the clinician without becoming a further distraction

Our initial efforts were directed to extracting only the key features from the monitored data. We have used the historical trend information combined with our knowledge on how each vital sign changes over time to identify changes in an individual patient. We have combined these features using expert rules. Once we extracted the important new information about a patient, we evaluated two novel and non-obtrusive ways to communicate the results to clinicians:

Enhanced visual displays: Our enhanced visual displays (see) use visual cues to highlight new changes in a single measurement or to show changes in the relationship between two different measurements (e.g. blood pressure and heart rate). These graphical cues represent contextual information regarding the probability of vital sign change. These novel displays provide vital dynamic physiological information in a form that is intuitively useful. In preliminary studies, the enhanced visualization of context-relevant information has led to a significant improvement in event recognition and identification.

Tactile displays: A tactile display (see), harnesses the relatively under-utilized sense of touch, without adding to the already busy streams of auditory and visual information, to convey information from monitors to attending clinicians. Skin, the body's largest sensory organ, responds to stimuli with a high degree of precision. We have attempted to use tactile messages to provide subtle cues, rather than outright alarms. By exploiting the common human interactions of a 'tap on the shoulder' or 'squeeze on the arm', we hope to produce a practical clinical device. The tactile display does not detract from patient observation and will not disturb other individuals in the clinical environment. Our initial experiments suggest that tactile messages compete more successfully for attention than auditory ones and advances in wireless technology mean this device would be lightweight and free from cumbersome cables.

In the future, displays will integrate information from multiple sources and display only information relevant to clinical decisions. The visual display will provide contextual information that could be used as cues to additional detailed information or for navigation to further sources of information. Additional information will be delivered by other sensory pathways such as hearing and touch. Research is needed to deliver the promise of these new smart displays into the hands of the everyday clinician.



Operation Rainbow Canada in Cambodia

By: Dr. Eleanor Reimer, Department of Anesthesia, BCCH
Dr. Cindy Verchere, Division of Plastic Surgery, BCCH



In November 2008, we had the opportunity to travel to Cambodia with Operation Rainbow Canada. The mission of ORC is to provide reconstructive surgery to indigent children in medically underserved areas of the world, to engage in education with physicians and nurses in order to enhance the level of care, and to promote self-sufficiency within the countries served by the organization.

We had both already done missions at Chey Chumnuis Hospital located in a suburb of Phnom Penh, the capital of Cambodia. On this trip we traveled with a team of 22 individuals primarily from BC, approximately half of whom currently work at BC Children's Hospital. Dr. Cindy Verchere and Dr. Kimat Rai, the founder of ORC, were supported by two plastic surgery residents from Calgary. The anesthesia team was comprised of Dr. Bob Purdy, Dr. Eleanor Reimer, and our fellow, Dr. Kawshala Pieris. Ms. Doreen Lore, a nurse currently working in Pediatric Radiology, coordinated the mission. Ms. Jennifer Dunlop was the OR leader. Ms. Cheryl Baldwin, Ms. Caroline Kohlburg, and Ms. Michelle Misse were our PACU team. Ms. Heather Posno assisted Doreen and Bob on the frontline, triaging and preparing the children for their procedures. Dr. Jenny Druker was our amazing team pediatrician.



We had a very successful mission in that we were able to provide surgery and care free of charge to over 100 children and adults who would otherwise not have had access to it in a country with very limited health care. It was also very satisfying to follow-up children who had received operations in our previous trips and provide further stages of their procedures. Some of the patients were reunited with team members who had developed significant emotional connections. We also did some cases that were unforgettable, and future missions will hopefully record their follow-ups with similar feelings. One of the best parts of a mission was developing stronger bonds with our workmates – we established friendships with Cambodian colleagues we might not have otherwise had the opportunity to make if we had stayed in Vancouver.

Education of local physicians and nurses is an important part of our mandate. Cambodia was devastated under the harsh rule of the Khmer Rouge in the 1970s when most of the educated citizens in the country were rounded up and executed. The country is in the process of rebuilding but they lack so much of the infrastructure we take for granted. Through his ORC connections, Dr. Nour Sarom, the only trained plastic surgeon in Cambodia, was able to come to Vancouver for a two-month fellowship in 2008. Surgical techniques that have been brought through our missions are being used routinely in Cambodia now. We are also in the early planning stages of sponsoring an anesthesiologist from Chey Chumnias Hospital for a one-year period of training. His fellowship with us would make him the only pediatric trained anesthesiologist in the country.

It is such a privilege to have the opportunity to share some of our resources with children and their families in these developing countries. We also are grateful for what they bring to us; educationally, ethically, and humanistically. We recognize that our interactions are brief but we truly believe that what we do as a team can make a child's life very different.

Canadian Paediatric Surgical Wait Times Project

By: Ms. Monica Cottafavi
Communications Manager / Writer
Canadian Paediatric Surgical Wait Times Project



Dr. Geoff Blair, Chair of the Paediatric Surgical Chiefs of Canada, Dr. Jim Wright, CPSC President, Right Hon. Stephen Harper, Prime Minister of Canada, Ms. Elaine Orrbine, President of the Canadian Association of Paediatric Health Sciences, Health Minister of Canada, Mr. Jeff Mainland, CPSWT Project Lead

For the past two years, B.C. Children's Hospital has been participating in the Canadian Paediatric Surgical Wait Times (CPSWT) Project, with other Paediatric Academic Health Sciences Centres (PAHSCs) across Canada. The project is led by The Hospital for Sick Children in Toronto and supported by the Paediatric Surgical Chiefs of Canada (currently chaired by Dr. Geoff Blair). **This is the first pan-Canadian project to use national standardized access targets to collect and measure surgical wait times for Canadian children and youth.**

While some jurisdictions were preparing to address paediatric surgical wait times, at the onset of the CPSWT Project, most wait times initiatives focused on adult procedures. At the time, there was a lack of information on paediatric surgical wait times,

"As the Chair of the Paediatric Surgical Chiefs of Canada, I can say that we are enormously proud that the Canadian Paediatric Surgical Wait Times Project was born from our desire to study and improve the access to surgical services for Canadian children".

- DR. GEOFF BLAIR

inconsistent methods of prioritizing paediatric patients, and opportunities for knowledge sharing across Canada's PAHSCs.

Committed to the common goal of improving access to paediatric surgery, the surgical chiefs and administrators from the 16 PAHSCs, the Canadian Child & Youth Health Coalition, the Canadian Association of Paediatric Health Sciences Centres and other interested stakeholders came together in February 2006 and developed a pan-Canadian strategy for addressing the needs of children and youth waiting for surgery.

Following those events, in January 2007 Health Canada funded the CPSWT Project to measure children's wait times in six surgical areas at the 16 PAHSCs across Canada. More recently, the project received funding to expand its wait times monitoring to all surgical subspecialties and extend participation to select community hospitals across the country. The project will also undertake collaborative studies, including the development of surgical indications for one procedure, an analysis of surgical demand and capacity, and a study of best practices in OR performance improvement.

This project is an unprecedented collaborative venture among paediatric healthcare providers across Canada. Participating hospitals (currently 24 serving all Canadian provinces) collect and submit wait time data (from decision to treat date to surgery date for elective cases) to a central database monthly and receive reports they can use to benchmark themselves with their peers.

Participants use the data generated by the Project to actively manage their wait lists (to decrease the number of cases exceeding their access targets), as well as to



CPSWT Project Co-Lead, Ms. Mary Jo Haddad, President & CEO of The Hospital for Sick Children, President & CEO of the Canadian Association of Paediatric Health Centres, Hon. Tony Clement, former Health Minister of Canada, CPSWT Project Director, Ms. Cathy Séguin, CPSWT Project Co-Lead



prompt internal changes, such as addressing internal resource allocations and improving operational efficiencies. Participating hospitals also report benefits from benchmarking themselves with their peers, sharing best practices and learning about common issues across jurisdictions.

To better serve its pan-Canadian approach, this project collects data using national standardized access targets, based on diagnosis. The access targets adopted at the inception of the project were revised and approved by over 100 paediatric surgeons from across Canada in 11 subspecialty expert panels, representing the highest levels of paediatric surgical expertise in this country. The revised list, aptly named the Paediatric Canadian Access Targets for Surgery (P-CATS), currently includes over 800 diagnoses with associated Wait 1 and Wait 2.

By defaulting the priority level to the diagnosis (though the system still allows for individual physician discretion on a case-by-case basis) and using one priority scheme across all surgical subspecialties, the use of P-CATS generate very consistent and comparable data. This in turn enables meaningful analyses, comparisons and benchmarking across hospitals and at national level.

The CPSWT Project does not have a mandate for public reporting, but more information on the project is available through the Canadian Child & Youth Health Coalition Website at <http://www.ccyhc.org/work.html>.

The CPSWT Project successfully represents what an unprecedented national collaborative can achieve for the benefit of children across Canada. Dr. Geoff Blair expressed this sentiment well: “As the Chair of the

Paediatric Surgical Chiefs of Canada, I can say that we are enormously proud that the Canadian Paediatric Surgical Wait Times Project was born from our desire to study and improve the access to surgical services for Canadian children”.



Ms. Julie Chan, CPSWT Project Manager, Hon. Tony Clement, former Health Minister of Canada, Ms. Rena Menaker, CPSWT Project Business Analyst, Dr. Jim Wright, CPSWT Project Co-Lead

Priority Classification Level	Target Time for Surgery
Priority I	Within 24 hours
Priority IIa	Within 1 week
Priority IIb	Within 3 weeks
Priority III	Within 6 weeks
Priority IV	Within 3 months
Priority V	Within 6 months
Priority VI	Within 12 months

Table 1: The priority classification scheme for the Paediatric Canadian Access Targets for Surgery (P-CATS)

The Hearing Health Program in Uganda

By: Dr. Brian D. Westerberg, Otolaryngology & Neurotology,
St. Paul's Rotary Hearing Clinic
On behalf of the Rotary Hearing Health Care Program in
Uganda (CanHEAR) team

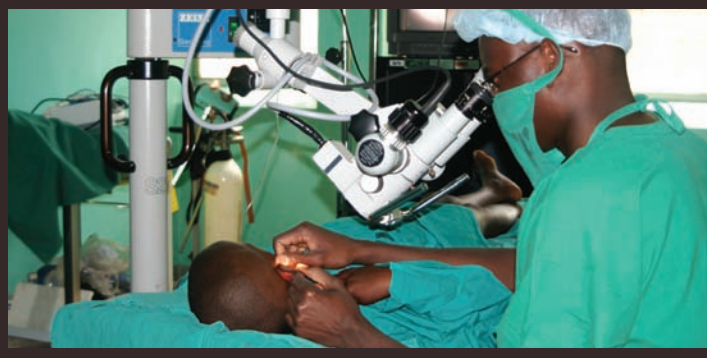
We all have experiences that defined us; a decision that changed our course in life or a moment that changed the way we saw the world.

Such a moment occurs daily in Uganda.

She may have been known as "August" or "Trinity" or "Precious", but her experience is defining. She presented to Arua, an outlying centre in Uganda, with pain in her ear and discharge. The abscess she had at the time was treated the best way possible under the circumstances, by lancing it and draining the pus. But as is want to occur when the underlying cause of the infection is not addressed, she developed relentless often foul-smelling drainage from a persistent fistula behind her ear.

To try to put her at ease, we asked her what grade she was in at school. The question was translated to her. She looked at the floor. Tears welled up in her eyes; she began to cry. It took a while before the translated response came back to us. She didn't go to school. She had enjoyed going to school, though the long walk each way took some 45 minutes. She did well in school. However, when other children teased her about the drainage from her ear, when they teased her about the smell, she stopped going to school.

The surgery to correct her problem took perhaps 2 hours. It was performed in Arua by the local Otolaryngologist, with the guidance and assistance of our team from UBC. The Ugandan surgeon knew what needed to be done, but had never done the surgery before as he didn't have the equipment or training. He now has both.



The surgery treated her infection. We don't know if she ever went back to school as so many in Uganda do not. If she only had access to the treatment originally when she needed it, she may never have left school. What course changed in her life?

Our health care system in Canada is exceptional. We need to appreciate our fortune compared to the misfortune of many in the world when it comes to access to health care. Uganda is one of the misfortunate.

The Rotary Hearing Health Care Program in Uganda, CanHEAR Uganda, has been and will continue to help those people in Uganda with ear disorders who otherwise do not have access to the care they need.



Improving Quality Of Life in Children With Spina Bifida

By: Dr. Kourosh Afshar
Division of Urology, BCCH

Spina bifida is one of the most common congenital spinal anomalies which can have significant effects on a child's health. Different systems in the body may be involved including muscles, bowels and bladder. This disease may have profound effects on the quality of life of these children.

Throughout North America children with spina bifida are managed by multidisciplinary clinics providing highly specialized care. At BC Children's Hospital a weekly spinal cord clinic is the mainstay of the care of these patients. The clinic includes a wide range of health care professionals such as pediatricians, urologists, neurosurgeons, orthopedic surgeons, physiotherapy, occupational therapy and social workers. This setting has provided us with valuable opportunities for clinical research.

Urological issues in children with spina bifida are very common. Urinary tract infections, incontinence and renal dysfunction are among the most important ones. As Pediatric Urologists our aim is to protect the kidneys from any damage and provide a better quality of life by optimizing bladder function. This task may be challenging in many of our patients because of the multitude of other medical, psychological or social issues. It is believed that urinary incontinence may result in lower quality of life because it may cause social isolation, lack of self esteem and hygienic problems. It is also assumed that treatment of urinary incontinence improves the quality of life. This treatment may vary from conservative management with medicines to extensive surgical reconstruction of the lower urinary tract.

We recently presented the results of our prospective study on this topic at the annual meeting of the Section on Urology of The American Academy of Pediatrics in Boston (Oct. 2008). This presentation was awarded the First Prize for Clinical Research, one of the most prestigious prizes in Pediatric Urology. We found that extensive surgical reconstruction of the urinary tract results in improvement in certain domains of quality of life such as self esteem. Nevertheless some areas were not improved. Our results confirm that spina bifida is an extremely complex disease and our best chance to improve the quality of life of these patients lies in a comprehensive approach to all the medical, psychological and social issues.

The New Minimally Invasive Surgical Suite (SMART OR)

Thanks to the generous support of BC's mining industry through the 2006 and 2007 Mining for Miracles campaigns, BC Children's Hospital opened its first operating suite with Surgical, Minimal Access, Radiologic-Telemetric - or SMART - technology in October 2008.

Twice the size of the Hospital's traditional ORs the SMART OR is equipped with the latest surgical and communication technologies, including state-of-the-art laparoscopic equipment, high-definition

flat-panel screens and a voice-activated system. These technologies replace old equipment and greatly enhance the safety level for children undergoing surgery.

The new SMART OR is making a real difference in the quality of surgical care children from across BC receive at Children's Hospital. Thanks to the 2006 and 2007 Mining for Miracles campaigns, children at the Hospital are getting safer, more efficient and less harmful surgeries that let them return home to their loved ones sooner.





The Opening of the New Minimally-Invasive Operating Room at BC Children's Hospital on October 30, 2008





Child life interns: Claire Brown and Bernadette Sanchez

The Canadian Child Life Institute

By: Ms. Diane Hart, Director
Child Life Department
BC Children's Hospital

*"THERE IS HOPE IN DREAMS,
IMAGINATION, AND IN THE
COURAGE OF THOSE WHO WISH
TO MAKE THOSE DREAMS A
REALITY"*

- JONAS SALK

In October 2008, Basile Papaevangelou, Chairman of the Kids' Health Links Foundation (KHLF), spoke at the Canadian Association of Child Life Leaders Meeting in Edmonton, Alberta. In his address, Basile presented a vision for a Canadian Child Life Institute (CCLI), a national institute to enhance care for children, youth, and families through the development of a technology based global network that offers child life best practices, psychosocial research, education, resources, and child and family friendly health information. This endeavour is in-line both globally with the World Health Organization's definition of health as, *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*, and locally with BC Children's vision, *Better health for children and youth, achieved with partners who work together to ensure access to best practices & best care in the best setting*.

The CCLI includes a number of components, several of which are currently being implemented, or soon to be implemented, in hospitals across Canada. One such initiative is called Upopolis™, a private, social community that connects pediatric patients to their peers, family and school networks. Its applications enable children and youth to stay connected through email and online discussions, and to access child-friendly health care information. The Upopolis™ program first began at McMaster Children's Hospital and will be launched at BC Children's Hospital on April 20th, 2009. Other hospitals scheduled to receive Upopolis™ this year include the IWK Health Centre (Halifax), The Children's Hospital of Eastern Ontario (Ottawa), The Hospital for Sick Children (Toronto), and the Stollery Children's Hospital (Edmonton).

A second component of the CCLI is a Child Life Fellowship. Fellowship programs within the profession of child life are prevalent in the United States, however there are currently no established programs in Canada. Following an external program review in January 2007, the child life department at BC Children's Hospital made it a priority to seek funding to create a child life fellowship program.

The goal of a fellowship program is to further the development of students wishing to pursue a career in child life, once a 480-hour child life internship has been completed and the student is eligible for professional certification. We have been met with recent funding success through the KHLF, and the department is

moving forward to implement its first fellowship program in 2009. The child life departments at both BC Children's Hospital and the IWK Health Centre will be involved in the one-year pilot of a fellowship program.

The development of the CCLI provides an unprecedented opportunity to advance child life practice, both clinically and academically. Child life leaders from across Canada are passionate and committed to further enhance the scope of services being offered through the CCLI.

Transforming Clothing into Comfort and Care for Children, Women, and Families

By: Mr. Damian J. Duffy
Office of Pediatric Surgical Evaluation and Innovation

Have you been to the Thrift Shop in the lobby of the Ambulatory Care Building? It's always busy. It's a "going concern" as they say in business circles. Parents and staff alike are in there in search of bargains. Even the good Dr. Rothstein has been observed picking up a snappy new piece of apparel. When the Thrift Shop opened its doors, its annual revenue for 2004 was \$80,000. Their revenue has steadily climbed since and in 2008 the annual revenue topped \$150,000 – and there's no looking back!

The C&W Thrift Shop is a joint venture between the Auxiliary to BC Children's Hospital and the Auxiliary to BC Women's Hospital with the proceeds going directly to supporting the comfort and care of children, women, and families at our site. In addition, this precious source of revenue goes to help frontline clinical staff to stay current with advanced clinical



Ms. Jana Ersoy, Ms. Phyllis Abbott, Ms. Aki Aghily



Mr. Damian Duffy, Ms. Norine Mayede, Ms. Lee Heng, Dr. Cindy Verchere & Ms. Rupinder Parhar

training and continuing professional development.

During the holiday season, we held a clothing drive to help the Thrift Shop restock their shelves. Many staff took the opportunity to reorganize their closets and bring in their lightly-used clothing in support of the Thrift Shop's worthy mission! Ms. Norine Mayede from the Division of Pediatric Plastic Surgery received the Seasonal Basket Prize for the most clothing brought into the shop.

It is springtime now and many of us are putting away our winter clothes and bringing out the spring and summer clothing. As you are rearranging your closets, please have a look and see if there is a piece of clothing that can be transformed into comfort and care for our patients. If you would like to donate some clothes, please bring them directly into the Thrift Shop.



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