COMHAIRLE NA N-OSPIDÉAL

REVIEW OF PAEDIATRIC SURGERY SERVICES

DECEMBER 1998

Report of the Committee adopted as policy by Comhairle na n-Ospidéal on 18th December 1998
REVIEW OF PAEDIATRIC SURGERY SERVICES

INTRODUCTION

The Committee to review Paediatric Surgery Services was established by Comhairle na n-Ospidéal at its meeting on the 21st March, 1997. The need for the committee arose from the absence of agreement among the three hospital authorities concerned - Our Lady’s, Crumlin, the Children’s Hospital, Temple Street and the FDVH/MANCH (Tallaght) - on the nature and structure of a permanent post of Paediatric Surgeon in replacement of Professor E. Guiney who had retired. The following members in addition to Comhairle officials (Mr. Tommie Martin and Ms. Colette Vincent) were nominated to the committee:

Mr. Denis Doherty (Chairman)
Professor Gerard Loftus
Dr. John F. Murphy
Mr. Maurice Neligan
Mr. Vincent Barton, Principal Officer, Department of Health & Children, deputised for Mr. Frank Ahern.

DESCRIPTION OF EXISTING SITUATION

Paediatric surgery services in Dublin are currently provided by four consultant paediatric surgeons (including one vacant post - Professor Guiney) in three hospitals - Our Lady’s Hospital, Crumlin, the Children’s Hospital, Temple Street and Tallaght Hospital. Outside of Dublin, consultant general surgeons perform non-specialist paediatric surgery and almost all neonatal surgery and specialist paediatric surgery is referred to the paediatric surgeons in Dublin. Paediatric urology in Our Lady’s Hospital, Crumlin is provided by the four paediatric surgeons who have commitments to the hospital. In Temple Street Hospital, paediatric urology services are provided by two consultant adult urologists with an interest in paediatric urology. In Tallaght Hospital, paediatric urology services are predominantly provided by one of the paediatric surgeons and to a lesser extent by one of the adult urologists who has a designated special interest in paediatric urology. The three separate paediatric surgery units each producing an on-call service are supported by a complement of 20 junior doctors. Due to the fragmented nature of the service, recognition for higher specialist training has been limited in the past. The committee has been informed by the Irish paediatric surgeons group that “the Specialist Advisory Committee (Paediatric Surgery) in two visitations to Dublin recently have criticised the division of specialist paediatric surgery in terms of training of paediatric surgeons”. While a review of these matters is outside the remit of this committee, its recommendations if implemented should lead to improved training.
The committee sought relevant workload data information from the three hospitals in respect of 1996. The information was received and analysed. It was noted that virtually all of the specialist paediatric and neonatal surgery took place in Our Lady's Hospital, Crumlin. An analysis of the figures is attached at Appendix 1 to this report.

LITERATURE REVIEW

The committee studied in detail the available data and reviewed the literature on paediatric surgical services. The documentation which was considered by the committee is listed in Appendix 2 to this report. The literature suggests concentration of expertise and workload in specialist centres to give sufficient critical mass for clinical effectiveness. The committee had particular regard to the report of the British Association of Paediatric Surgeons (BAPS) entitled “A guide for Purchasers of Paediatric Surgical Services” (August 1994). This report recommended that “there should be one specialist paediatric surgeon per 500,000 population” and that “it is unacceptable to plan a department with fewer than four paediatric surgeons and one paediatric urologist. Thus 2.5 million will be the minimum population needed to ensure that there is sufficient critical mass of workload to ensure the clinical viability and effectiveness of a specialised service”. The BAPS report indicated that, for geographical reasons, exceptions should be made for Northern Ireland and parts of Scotland and Wales. Applying these recommendations to Ireland would indicate a need for one specialist paediatric unit based in Dublin to serve the Republic of Ireland’s population of 3.5 million.

The BAPS report states that “Paediatric surgery comprises specialist paediatric surgery and non-specialist paediatric surgery” and distinguishes between both as follows:-

Specialist paediatric surgery consists of four clinical categories:-
- neonatal surgery
- the surgical management of infants and children with conditions requiring special expertise
- the management of infants and children with relatively straight-forward surgical conditions who have an associated disorder which in itself requires management in a specialist centre. An example would be a child with an inguinal hernia and cardiac disease
- paediatric urology, a sub-speciality of paediatric surgery.

The report from the British Association of Paediatric Surgeons states that "specialist paediatric surgery must be provided in a specialist paediatric surgical unit". Their report lists the following as the requirements for specialist paediatric surgery
- Trained and accredited paediatric surgeons and paediatric anaesthetists.
- A full range of specialist services for children including paediatrics, neonatology, paediatric intensive care, radiology, neurosurgery, nephrology, cardiology and oncology.
Nursing staff trained in paediatric nursing and paediatric critical care nursing.
- Support services catering for the specific needs of children, including dieticians, social workers, play leaders and teachers.
- Facilities designed for children, including the accident and emergency, out-patient department wards, operating theatres, day care unit, radiology suite and laboratory services.
- Accommodation for parents who should have unrestricted access to their children.

The report states that **non-specialist paediatric surgery** is "the surgical treatment of relatively common disorders which usually do not require a major or complex operation or peri-operative care. These include:

**Elective procedures:** herniotomy for congenital inguinal hernia and congenital hydrocele, circumcision, orchidopexy, repair of umbilical hernia.

**Emergency procedures:** appendicectomy, correction of torsion of the testis, repair of incarcerated inguinal hernia and less complex trauma".

In addition to these emergency procedures, the BAPS report goes on to acknowledge that infantile hypertrophic pyloric stenosis and intussusception are dealt with in some non-specialist paediatric surgery units which have the appropriate facilities and staff with the appropriate training and continuing experience in children’s surgery.

**CONSULTATIVE PROCESS**

The Comhairle Committee met with representatives of the three hospital authorities concerned in May 1997. The hospitals indicated their hope of arriving at an agreed proposal by the middle of June 1997 without the assistance of the Comhairle committee. The committee met with the group of three paediatric surgeons in September 1997. They reiterated what they saw as some of the main requirements for specialist paediatric surgery as set out in their letter to the committee dated 21st August, 1997. In their letter, they had stated that "Specialist paediatric surgery must be provided in a specialist paediatric surgical unit....... In the context of the Irish and Dublin situation it would seem logical to place specialist paediatric surgery in one major unit in the city of Dublin and preferably in a children’s hospital with a full range of specialist paediatric services. It would be cost effective and also professionally desirable to provide for the non-specialist paediatric surgical requirements in the city with the full-time and fully trained paediatric surgeons appointed again ideally in one centre". They had finished by stating that "The paediatric surgeons are agreed that there should be one paediatric surgical centre in Dublin...... [an additional post] should not be used to prop up the current system of three paediatric surgical centres in the city of Dublin".

The unanimous view of the paediatric surgeons at the meetings was that in order to achieve quality of surgical care, training and research, the ideal would
be one paediatric surgical centre in Dublin staffed by four paediatric surgeons and a paediatric urologist providing a specialist paediatric surgical service for the whole country and also a non-specialist paediatric service to the children of the Eastern Health Board area. In the absence of a green-field situation and given the existing network of three paediatric hospitals in Dublin city and their institutional aspirations, the paediatric surgeons regarded the following as being a reasonable compromise - three paediatric secondary care centres in Dublin, one of which would also be a tertiary care centre incorporating all of the paediatric specialist units in one location as recommended by the Faculty of Paediatrics in their document entitled "Recommendations for Dublin Paediatric Services". The paediatric surgeons stated that less complex surgery will continue in the other hospitals.

Following concerns expressed to them by Comhairle na n-Ospidéal at their lack of progress in reaching an agreed position as promised by June 1997, a letter dated 26th May, 1998 signed by the three childrens hospitals indicating their agreement on a number of issues was received. The hospitals agreed that

"(i) Five posts are needed to serve the City's needs.
(ii) Ideally no consultant should work at more than two hospitals.
(iii) That Professor Guiney's post and the fifth post be recruited simultaneously.
(iv) That the paediatric surgeons will, as one group, organise themselves to be responsible for providing on-call commitments to each of the three paediatric hospitals to the satisfaction of the boards of management".

While the hospitals were also in agreement as to how the posts should be structured, it was the view of the committee that the structure of the five posts as proposed by the hospitals would perpetuate the current situation of three separate paediatric surgical centres in Dublin and did not adequately address the issue of the location of specialist paediatric and neonatal surgery. The committee had been hoping that sufficient consensus among the paediatric institutions would have been achieved to form the basis on which it could devise and recommend an agreed plan for the future organisation of paediatric surgery services in Ireland. It became apparent that consensus agreement could not be reached. The committee met again with the paediatric surgeons group in October 1998. They reiterated the views they expressed at the meeting held in September 1997 and advised the committee that they had accepted that there would be five surgeons, all of whom would work in the tertiary referral unit and one other institution. Furthermore, in view of Mr. Puri's interest in urology, one of the new appointees should have a particular expertise in reconstructive paediatric urology.

**RECOMMENDATIONS**

The committee has reviewed the literature and taken account of the position of the paediatric surgeons as conveyed orally and in writing and has borne in
mind the Comhairle aim for high quality and safe hospital services generally. Specialist paediatric surgery and neonatal surgery because of the relatively small volume of cases and the high level of expertise required, can best be provided on a national basis in one unit. To achieve this aim, it is the committee’s considered and unanimous opinion that all specialist paediatric surgery and neonatal surgery, as defined in the BAPS report should be concentrated in Our Lady’s Hospital, Crumlin.

The service should be provided by a complement of four paediatric surgeons and one paediatric urologist. All five posts should be structured with the majority of the sessions (6 sessions per week) to Our Lady’s Hospital, Crumlin with three of the posts linked to Temple Street (5 sessions per week) [Professor Fitzgerald and the vacant post of paediatric surgeon (replacement for Professor Guiney) and the new post of paediatric urologist] and two of the posts linked to Tallaght [Mr. Puri and Mr. Corbally]. Non-specialist paediatric surgery and less complex urology will continue to be provided at Temple Street and Tallaght Hospitals. The three existing paediatric surgeons have indicated their agreement to restructuring their posts as set out above. The proposed structure of each post in terms of sessional commitments are set out hereunder for clarity.

<table>
<thead>
<tr>
<th>CONSULTANT POST</th>
<th>OUR LADY’S HOSPITAL CRUMLIN</th>
<th>THE CHILDREN’S HOSPITAL TEMPLE STREET</th>
<th>TALLAGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor R. Fitzgerald</td>
<td>6</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>Vacant Post (Prof. E. Guiney)</td>
<td>6</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>New post-Paediatric Urologist *</td>
<td>6</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>Mr. P. Puri</td>
<td>6</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Mr. M. Corbally</td>
<td>6</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL SESSIONS</td>
<td>30</td>
<td>15</td>
<td>10</td>
</tr>
</tbody>
</table>

* Recognising that paediatric urology services are already provided in the children’s hospitals by paediatric surgeons with an interest in paediatric urology and urologists with an interest in paediatric urology, the committee recommends the creation of a wholetime post with a major commitment to paediatric urological surgery shared as indicated above between Our Lady’s Hospital, Crumlin and the Children’s Hospital, Temple Street, to provide a highly specialised paediatric urological service e.g. major reconstructive surgery.
While the appointee’s broad training and experience will be in both paediatric surgery and urology, he/she must have special training and expertise in paediatric urological surgery.

The committee acknowledges that its recommendations will have some implications for some consultant neonatologists in terms of a small portion of their current referrals. The necessary changes can and should be made without difficulty in the interests of patient care.

The committee believes that its recommendations although not the ideal, represent a significant step forward, in relation to the provision of specialist paediatric surgery services for the benefit of the children of Ireland. The provision of high quality and safe services must take priority over other considerations.

The committee urges the Department of Health and the hospitals concerned to accept its recommendations as the most viable means for providing specialist paediatric surgery services of the highest quality and safety to the children who require such services. It suggests that the necessary funding and administrative processes be carried out without delay to enable this plan to be implemented quickly.

DECEMBER 1998
ANALYSIS OF PAEDIATRIC SURGERY/UROLOGY WORKLOAD DATA - 1996

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CRUMLIN</th>
<th>TEMPLE ST.</th>
<th>NATIONAL CHILDRENS' HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pyloromyotomy</td>
<td>29</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>Appendicectomy</td>
<td>174</td>
<td>138</td>
<td>138</td>
</tr>
<tr>
<td>Inguinal Hernia Repair</td>
<td>218</td>
<td>97</td>
<td>129</td>
</tr>
<tr>
<td>Orchidopexy</td>
<td>177</td>
<td>94</td>
<td>55</td>
</tr>
<tr>
<td>Cystoscopy</td>
<td>176</td>
<td>126</td>
<td>204</td>
</tr>
<tr>
<td>Repair Myelomeningocele</td>
<td>6</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Tracheo-Oesophageal Fistula</td>
<td>8</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>&quot;STING&quot;</td>
<td>210</td>
<td>93</td>
<td>158</td>
</tr>
</tbody>
</table>

COMMENT

It appears that little surgery in infants under 2 months is carried out in Harcourt Street. Presumably infants are still nominally under the care of the maternity hospitals at this stage and their referral patterns would be to Temple Street or Crumlin. Virtually all the "major" neonatal surgery takes place in Crumlin. There is a relatively large amount of paediatric urology practised at Harcourt Street. The surgical workload at Temple Street is predominantly "non specialist" paediatric surgery.
DOCUMENTATION STUDIED BY THE COMMITTEE


