Implementing an Advanced Surgery Program at a Tertiary Care Regional Medical Center: Leading Change and the Liabilities of Newness

This case was written by Dr. Neri Cohen, Fellow of the Brandeis Health Leader’s Program under the supervision of Dr. Sarita Bhalotra and Professor Jon A. Chilingerian Ph.D. of Brandeis University. It is intended to be used as a basis for class discussion rather than to illustrate either effective or ineffective handling of a managerial situation. The events are real, though the names, location, and some information have been disguised.

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A Patient Needs Help

James, a 61 year old male patient, had been having serious problems with acid reflux. His primary care physician was concerned when the symptoms of burning and pain weren’t relieved by simple medications. He referred James to Dr. Sallie, a gastroenterologist, who performed an endoscopy. The endoscopy went well and Dr Sallie explained to James that he saw a lot of inflammation in his esophagus and after a series of biopsies, Dr Sallie told James that he had something called Barrett’s esophagus. He said that the lining of his esophagus was abnormal from acid backwashing from his stomach. The condition could progress to cancer and therefore it was very important to stop the acid reflux with medicines and keep a close eye on the changes in the lining of the esophagus. He put him on medications and a special diet and asked him to come back in three months to check if the esophagus was healing alright.

Three months later, James reported that he felt much better and he claimed to have been very compliant with his regimen. However, when the patient came in for his follow-up endoscopy, the biopsies revealed invasive esophageal cancer. Dr. Sallie referred him to Dr. Colon, a board-certified thoracic surgeon.

A Referral for Dr. Colon

Dr. Colon had been recruited by Tertiary Medical Center (TMC) two years earlier. Colon was a top general thoracic surgeon with a special interest in applying minimally invasive surgical techniques to benign and malignant diseases of the chest. He had already greatly increased the size and scope of the Thoracic Surgery practice, and had made impressive gains in improving patient flow and revenue through Thoracic Surgery. His reputation and affable style had gained the trust of referring Primary care physicians. The medical oncologists and radiation therapists considered him an invaluable part of the award winning TMC Cancer Center team. Dr. Colon had brought several high-profile clinical trials to the hospital as well.

In general, his practice was going very well. However, one aspect of his practice needed more development. He wanted to help patients with esophageal disease. Though Dr Colon had tried repeatedly to get the gastroenterologists to use him as a resource for both benign and malignant disease, for some reason, neither he nor the other general and thoracic surgeons were seeing many cases from the Digestive Diseases Center.

Perhaps the GI docs felt that they could handle all the cases. Benign disease could be managed by medications or endoscopic procedures. Most of the malignant diseases were managed by the medical oncologists and radiotherapists at the Cancer Center because most patients needed chemotherapy and radiation therapy anyway.

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1. The primary care physicians sent all their GI business to the award winning gastroenterologists at the Digestive Diseases Center.
The cases that were referred to the surgeons were for disease or treatment complications; these patients could rarely be cured. The surgeons assumed that the GI doctors failed to see them as partners in the care of complex patients, but rather, as an admission of their failure.

Dr. Colon was very pleased that James’ was an esophageal cancer referral. Finally all the talking seemed to have paid off.

When Dr. Colon reviewed James chart, he realized that this might really be a patient he could really help. Clearly, Dr Sallie had done everything right. As Dr. Colon reviewed the case, he thought to himself:

“This patient has reflux. Following the endoscopy they find Barrett’s. The physician puts James on acid suppression and brings him back in three months for a re-scope after medical treatment and finds invasive adenocarcinoma at the distal esophagus. CT of the chest and abdomen does not show any evidence of advanced disease. He’s scheduled for PET scan later this week. James’ medical history is only significant for well-controlled mild bipolar disorder; he hadn’t had an operation. Hmmm, this looks great. James might even be a candidate for minimally invasive esophagectomy (MIE)!”

Dr. Colon had been trained and was skilled in minimally invasive surgery. He had been waiting for a chance to start doing minimally invasive foregut surgery in his new setting. When Dr Colon reviewed James’ test results, he was pleased. Finally, he had a perfect candidate for his first MIE at the Cancer Center. The patient has a localized tumor. His heart and lungs were in excellent shape. He had no previous surgeries. And the patient James was not obese. This was the type of case that Dr. Colon had been seeking for two years.

After a thorough evaluation, Dr. Colon spent a long time communicating with James and his family. Dr. Colon explained the problem. He explained reflux disease and discussed the different options for treatment. He also went over the additional tests that James would need to better determine the stage of the cancer, which would ultimately dictate the best treatment strategy. Even if James was a good candidate, he would have to want to undergo this procedure.

**Tertiary Medical Center**

The Tertiary Medical Center (TMC) is the flagship hospital of a highly integrated network TMC Health Care. The medical center provides health care to the region as well as the province of New Brunswick through active involvement in teaching, research and patient care in secondary and highly specialized tertiary services. TMC, located in Kingston in the Province of New Brunswick in Canada, is a non-profit health care organization, licensed and accredited by the International Joint Commission on Accreditation for Health Care Organizations (JCI).

With a total of 300 licensed acute care beds, TMC is the region's primary centre for acute care, and is one of only two accredited tertiary trauma centers in Atlantic Canada. TMC houses expertise in areas such as: Medicine, Otolaryngology- Head and Neck Surgery, Ophthalmology, Obstetrics and Gynecology, Colo-Rectal Surgery, General Surgery, Bariatric Surgery, Family Practice, Pediatrics, Psychiatry, Oncology, Breast Surgery, Minimally
Invasive Surgery, Cochlear Implants, and Infertility. TMC has residency programs in Medicine, Ophthalmology, Otolaryngology- Head and Neck Surgery, Obstetrics/Gynecology, Podiatry and Colorectal and fellowships in Urogynecology. Exhibit 1 displays the TMC organization chart.

TMC is a twenty minute drive from downtown Bolton, the medical center is located on a beautiful suburban campus, serves nearly 22,000 inpatient admissions, 75,000 patient days, 40,000 inpatient and outpatient surgeries and nearly 50,000 emergency room visits. The staff includes 1200 physicians with admitting privileges, 2600 clinical and non-clinical employees (excluding physicians), and more than 1000 volunteers. TMC has National Recognition Award for their Cancer Center and is ranked among the top 50 Medical Centers in both Cancer Care and Digestive Diseases in North America (for more information, see appendix).

Building a New Minimally Invasive Esophagectomy Team

Dr. Colon began to plan for the possibility of the first minimally invasive esophagectomy (MIE) at the Cancer Center. He approached Dr. Kellogg, the thoracic anesthesiologist. Dr. Kellogg said he was excited about doing more chest cases. Over the past two years he had steadily increased the amount of work he did with Dr Colon, and admired the surgeon’s precision and superior technique.

Dr. Kellogg wished, however, that most of Dr. Colon’s patients weren’t on Canadian Medicare, with the very low Anesthesia reimbursement that was associated with that! It really was a lot of work taking care of these sick patients – epidural, a-line, double lumen tube, one lung ventilation, post-op pain management.

Kellogg and Colon were a good team. In general, Dr. Colon was very receptive to Kellogg’s ideas for managing pain; and they worked well together in the OR. Dr. Colon’s programs were growing and getting great results. Dr. Colon had even been successful in recruiting another thoracic anesthesiologist to help with the growing number of cases. He also wasn’t too thrilled about being chided by the OR team, that included Davida, the team scrub nurse and Lucy, the team circulating nurse, for slowing down the schedule when anesthesiologists weren’t available.

Dr. Colon had kept his laparoscopy skills honed by helping his colleague Dr. Valley develop the minimally invasive Bariatric surgery program over the past year. He was committed to helping Dr Valley both to see Bariatrics grow and to not let his laparoscopy skills wane. They had worked together on several challenging upper abdominal cases and both wanted to expand their practices. He now called Dr Valley and asked him to assist him. Dr. Valley was more than willing to help with a MIE, especially since the abdominal part was very similar to the mirror image of a laparoscopic gastric bypass. They tentatively agreed on the Monday in two weeks to do the case.

Scheduling a New Procedure

When James came back to see Dr Colon after a staging esophageal endoscopic ultrasound and other tests, he was pleased to find out that indeed he was a candidate for MIE. He had had a
chance to do some research on the Cancer Center and Dr Colon and reassure himself that he was in good hands. Now Dr. Colon once again explained the specifics of the operation to James. He described how Dr. Valley and he would make tiny incisions, and use a video camera and instruments to free-up the entire esophagus through James’ right chest. They would then make some more small incisions in the abdomen, free up the stomach, fashion it into a narrow tube to replace the part of the esophagus with the tumor that would be cut out, open the outlet valve from the stomach and put in a feeding tube in the small bowel. Lastly, they would make a small incision in the base of James’ neck, free up the esophagus there, and using the esophagus like a fishing line, they would tip the new stomach on end and deliver the diseased section of the esophagus out through the cervical incision and connect the new stomach to the good esophagus up in his neck.

Dr Colon explained that the operation would take all day, and that James would stay overnight in the ICU to recover from the surgery. He would be on the ventilator until he was strong enough to breath on his own. He would have a tube in his nose which would keep the anastomosis open and dry, and a tube in his chest to drain any residual fluid or air left after the operation. Lastly, he would have a feeding tube in his abdomen so that he could get maximal nutrition to heal from the surgery before he could start eating again. The tubes in his nose, chest and belly would stay until he had an esophagram to study the anastomosis about a five days after the surgery. Dr Colon explained that Dr Valley and he would work together to do the operation and that they both were available in two weeks.

The surgery would still be very extensive and very dangerous, but that cutting out the cancer was James’ best chance for cure and long term survival. Dr Colon said that if he could remove all the cancer, that he would be able to eat again – small frequent meals – and that his chance of beating the cancer would be around 60-70%. The risks of something bad happening during the surgery were around 25-30%. James felt confident that this was the right choice and signed the papers to go ahead with surgery in 2 weeks. Dr Colon’s assistant sat down with him and went through everything again to make sure that everything was clear to James.

At the end of the day Dr Colon got out his atlases and papers on MIE. He had done the operation many times before moving to the Cancer Center and was very comfortable with the procedure. He knew, however, that it was a complex case and would take exquisite coordination of the entire team. He went back over his notes from when he started the program at the previous hospital and copied the diagrams of the operation, the lists of equipment they would need and outlined the special input they would need from nursing, anesthesia and the pain service.

During the next two weeks, most of his usual team were in the OR for a normal schedule:

- Monday a few routine thoracic cases with Dr Colon
- Tuesday a couple of bariatric cases with Dr. Valley
- Wednesday a few more minimally invasive thoracic cases with Dr Colon
- Thursday 2 more laparoscopic gastric bypasses with Dr Valley and Dr Colon.

The Thursday before James’ case, Dr Colon was in the OR with Dr Valley. Davida and Lucy were in the room as well, and Dr. Kellogg was the anesthesiologist. He told Dr. Kellogg, Davida, Lucy and the others about the scheduled operation, and they were very supportive.
They asked questions about specific logistical issues which Dr Colon answered. Both Davida and Lucy worked with Dr Valley on Bariatric cases on days opposite Dr Colon, and Dr Kellogg had worked with them on Bariatric cases too. In between and after the second case, Dr Colon reviewed the plans with everyone for Monday’s case. He gave each team member a copy of the description of the operation, the expected conduct and flow of the surgery, what each team member would be expected to do and everyone was sure of their role. Davida had already collected most of the special equipment and supplies they would need and had hidden it in the closet in the OR. At the end of the day, they all talked through a dry run and they all felt ready for Monday. Davida pulled Dr Colon aside just as they were all getting ready to leave to tell him that she had straightened everything out.

Davida: Dr. Colon, I’ve straightened everything out.

Dr Colon: What do you mean?

Davida: I was supposed to be on vacation next week, but I’m going to come in on Monday to do James’ case with you.

Dr. Colon: That’s great, I can’t thank you enough, because I really need you to be here to do this case.

Davida: I know; that’s why I’m coming in.

Overall, Dr Colon was very pleased with the coordination, team spirit and prior preparations.

The Surgical Team Goes to Work

It was Monday morning, and Dr Colon, Dr Valley, Davida, Lucy and Dr Kellogg were all ready and waiting for James. Dr Kellogg had made a special effort and was there early so the operation could start on time at 7:30 a.m. James went to sleep without any trouble but Dr Kellogg could not get the double lumen endotracheal tube to seat properly. Dr Colon and he spent a long time with the bronchoscope and finally were able to insert it into the left mainstem bronchus. They worked together to put in the rest of the monitoring lines, turned James on his side and were finally able to start the operation around 9:30 AM. By noontime, the first part of the operation was done – the esophagus was completely freed up from the chest. Dr Colon proceeded to put in a chest tube and removed all the other instruments from the chest, and Dr Kellogg reinflated James’ right lung.

Dr Valley took a break while Davida pushed back the sterile field, and Dr Colon and Dr Kellogg turned James onto his back. While Lucy prepped James’ abdomen and neck, Dr Colon took a break too. When he came back, Davida and he draped the belly and neck for the second stage of the operation. Dr Valley came back, and they dissected out the stomach and fashioned it into a tube to replace the esophagus. Dr Kellogg got relief and went to get some lunch. By the time Dr Kellogg came back to the OR, Dr Colon and Dr Valley were working on the pyloropasty and Dr Kellogg knew that they would then proceed to insert the feeding tube into James’s small bowel.
Dr Kellogg: I’m going to go check to see who’s going to take my room at 3 o’clock
Dr Colon: What do you mean? Where are you going? We still have a lot more surgery to do!
Dr Kellogg: It’s my day to leave early. Hey, you seem to be doing fine; any one of the other anesthesiologists can finish the case.
Dr. Colon: Dr. Valley and I have just hit a tough part of the operation; we really need to concentrate on putting in the feeding tube and finish freeing up the esophagus from the belly. I can’t deal with anesthesia personnel issues right now!
Dr Kellogg: Dr Alexis is going to come in after I leave, don’t worry, I’ve told him all about James’ history and signed out all the things that he needs to know.

At this point, Dr Colon realized that persuading Dr. Kellogg stay was futile. He overheard Dr. Kellogg talking on the phone about how he would meet his trainer at the gym in 40 minutes and how he was sorry that they didn’t have a chance to hook up over the weekend. Things really were going along as planned, after all. Dr Alexis came in to replace Dr Kellogg, and Dr Colon explained the plan to finish the operation: first he and Dr Valley would free up the esophagus in the neck, and then they would transpose the stomach on end up to the neck to replace the diseased esophagus. Dr Colon and Dr Valley proceeded to free up the rest of the stomach and esophagus from the hiatus.

Dr Alexis: Dr. Colon, it’s 4:00 p.m. and I’m leaving now. Dr. Rohit will come in to replace me.
Dr. Colon: But I’ve never worked with Dr. Rohit before. I’m coming up to a part of the operation where I’m going to need close coordination with anesthesia in order to finish the resection and construct the anastomosis.
Dr. Alexis: I’m sure Dr. Rohit can handle it with you.
Dr. Colon: Well alright...let’s get this esophagus out and transpose the stomach up to the neck.
Dr. Valley: This stomach tube’s reaching easily...looks like it’ll work nicely...oh hello, Dr. Rohit.
Dr. Colon: Dr. Rohit, would you pull back the nasogastric tube into the mouth so I can resect the esophagus?
Dr. Rohit: Aren’t you going to want to keep that in through the anastomosis?
Dr. Colon: Yes, but I need you to pull it back so I can cut the esophagus and construct the anastomosis.
Dr. Rohit: It’s going to be a pain putting the nasogastric tube back in after eight hours of surgery.
Dr. Colon: So don’t pull it all the way out; just back into the mouth.
Dr. Rohit: Okay
Dr. Valley: Done with the resection? Fine, let’s reconnect the stomach and cervical esophagus in the neck
Dr. Colon: Dr. Rohit, you advance the nasogastric tube across the anastomosis, while I guide the tube down into the abdomen and secure it? We’ll sew it at the end of the case.
Dr. Valley: Davida, let’s get the equipment out, Dr. Colon and I are closing now.
Dr. Colon: My first MIE took 15 hours; looks like we’ll be done in about nine this time! Dr. Rohit, we’ll need to change out the double lumen tube at the end of the case.

Dr. Rohit: Why would we do that?

Dr. Colon: Well, after such a long case, especially with part of it on one lung ventilation and being on his side and all, I expect he’s developed lots of secretions.

Dr. Rohit: I’ve suctioned the tube a couple of times and I’m not getting much out. There must not be much mucus down there.

Dr. Colon: Trust me, I’ve done this before. James needs a toilet bronchoscopy before he spends overnight on the ventilator.

Dr. Rohit: It’s a difficult airway, I’m not comfortable extubating and then re-intubating him.

Dr. Colon: What makes you think James’ is a difficult airway?

Dr. Rohit: That’s what the other anesthesiologist passed on to me.

Dr. Colon: Actually, there was no difficulty intubating James; it was the positioning of the double lumen tube that was a challenge.

Dr. Rohit: Well, that’s not what I was told...

Dr. Colon: OK, I’ll be happy to help you change it.

Dr. Rohit: That’s okay; I’ll get someone who knows something about the airway to help me.

Dr. Valley: Look guys, it’s 5:30 p.m. and all the wounds are closed; okay if I take off to make rounds?

Dr. Colon: Sure! all that’s left to do is changing the endotracheal tube and the bronchoscopy.

Dr. Valley: Congratulations; great job, team!

Wrapping-up

Davida helped Dr. Colon put on sterile dressings, connected the tubes and catheters and pushed back the sterile field. Lucy set up the bronchoscope for Dr. Colon to clean out the airway after the endotracheal tube was changed. Dr. Rohit called for another anesthesiologist from the Labor and Delivery suite to come help him change the tube. Dr. Markus came in to the OR. Dr. Colon had never worked with Dr. Markus in the OR and had only little interaction with him through the pain service. Dr. Markus and Dr. Rohit conferred about their strategy for changing the endotracheal tube. Dr. Colon stood by ready to help. Dr. Markus looked at Dr. Colon and told him that James was a difficult airway and that he would go ahead and change the tube.

Once again, Dr. Colon tried to explain to the anesthesiologists that the difficult part was at the carina not at the cords but they were dismissive in their focus on changing the tube. Dr. Markus deflated the balloons and removed the double lumen tube. He looked in the back of James’ mouth and pronounced that he couldn’t see anything. Dr. Colon offered to assist him but he turned to Dr. Rohit who gave him a different laryngoscope blade. He looked again and said that he could see a little of the cords but not enough to place the tube. He replaced the mask as James started to desaturate.

Dr. Markus: You’ll have to get a surgical airway.
Dr Colon: What do you mean! You refuse to accept my help and now you want me to trach him after an esophagectomy!! Look, the airway should be intubateable; let me have a try.

Dr Markus: No thanks...I think I know more about the airway than you do...let me have another look...ahh, I see it now.

Dr. Markus inserted the endotracheal tube. As they were hooking up the tube to the ventilator circuit, Dr Colon passed the bronchoscope down the tube and they saw that the tube was in the esophagus and not the trachea.

Dr. Markus: How far down is the anastomosis?
Dr Colon: Right there, where you put the tube, don’t you know what operation we did?
Dr Markus: No, I just came up to help change the tube.

Dr Colon turned back to James, pulled out the endotracheal tube and together with Dr. Rohit, intubated James’ trachea without difficulty. He then completed the toilet bronchoscopy, washing and suctioning the airway of copious thick secretions. They secured the tube and proceeded to transport James to the ICU.

Once in the ICU, while Dr. Rohit gave report to the nurses, Dr. Colon went to talk to the family. He explained to James’ father that the operation went well. Dr. Valley and he were able to remove the tumor, it did not appear that there was any spread to the surrounding lymph nodes and indeed they had completed the operation using the minimally invasive approach. James’ father asked where Dr. Kellogg was since he met him in the morning and expected to see him at the end of the operation, and Dr. Colon explained that the operation went longer than Dr. Kellogg expected and that his partners had finished for him. Dr. Colon also explained that there was a little difficulty at the very end of the procedure with changing the endotracheal tube, and that he planned on leaving James on the ventilator to rest overnight. As long as there were no unexpected problems, they would be able to let James wake up un the morning and take the breathing tube out then. Dr. Colon went over the case with the ICU nurse, wrote the orders, looked at the post-operative CXR, dictated the operative note and left.

Post-op

Overnight, James woke up as expected, and was weaned off the ventilator and was ready for extubation in the morning. The next morning, Dr. Colon came in and was at the bedside as the respiratory therapist extubated James. Dr. Colon explained to James what they found and what had happened the day before. During the course of the day, James progressed as expected. His pain was minimal and was controlled with IV narcotics. He was able to be weaned off supplemental oxygen and be started on tube feedings via the jejunostomy feeding tube. He was up in the chair at the side of the bed chatting with the nurses when Dr. Colon came to round again in the afternoon.

That night, James dropped his blood pressure a little but responded as expected to an IV fluid bolus. In the morning, Dr. Colon came to make rounds and noticed the color of the chest tube
drainage to be darker and thicker than he expected. The quantity was also higher than he expected at that point. He decided to study the anastomosis that day instead of waiting until later in the week. He thought about the difficulty with changing the endotracheal tube and was concerned that the anastomosis that he and Dr. Valley had so meticulously constructed may have been disrupted. Dr. Colon explained his plan to James and his ICU nurse and went off to the OR to start his usual schedule of surgeries.

In the OR, Dr. Kellogg was just starting to put the epidural in the first case. Dr. Colon went out to the OR control desk, and added James on to his OR schedule at the end of the day, to reserve time just in case the esophagram showed a problem. Between cases, while the OR was turning over for the next case, Dr. Colon ran down to radiology to check in the results of the esophagram. It showed his worst nightmare; the anastomosis was leaking into the chest. Dr. Colon called the ICU and informed James’ nurse of the results and that they were going to have to take James back to the OR. Dr. Colon then called Dr. Valley, and asked him to help try and fix the leaking anastomosis. Dr. Valley agreed. Dr. Colon returned to the OR, confirmed with the control desk that he would need to bring James back and went to finish his other case. Once the second case was asleep, Dr. Colon explained to Dr. Kellogg what was going on with James and that he needed to come back to the OR. Dr. Kellogg suggested that they go together up to the ICU once this case was done, to talk to James and bring him back to the OR.

In the ICU, Dr. Colon first spoke with James. He explained that the anastomosis was leaking and that they needed to go back and try to fix it. He explained that Dr. Valley and he were going to try to fix the hole from the neck incision, and then they would make a small incision on his chest near the shoulder blade in order to clean out the contaminated fluid from the right chest. James said that he understood and Dr. Colon went out to call James’ family and inform them as well. Dr. Colon and Dr. Kellogg transported James back to the OR.

James: Dr. Kellogg, Dr. Colon, I need you to get me through this…stay with me please...

Dr. Colon: Davida, what are you doing here? I thought you were on vacation.

Davida: They called and told me you were bringing James back to the OR. You need my help. I came in to help you.

Dr. Colon and Dr. Valley opened the neck incision and were able to get to the cervical esophagus and the anastomosis without too much trouble. Once they got everything exposed, however, they realized that this was much more than a little hole in the anastomosis. When Dr. Markus put the endotracheal tube in the esophagus, it was pushed down far enough that the back of the stomach came off the anastomosis and the staple line used to create the gastric tube had been disrupted. For all they knew, the entire stomach was avulsed and pushed down into the chest. That certainly explained why the leak drained into the chest and not out the neck like Dr. Colon would have expected.

Dr. Colon and Dr. Valley looked at each other and realized that there was no way that they would be able to fix the anastomosis. They weren’t worried about how James would eat now, they were trying to figure out how to prevent him from dying from uncontrolled sepsis. They agreed that the best course of action was esophageal diversion; save James’ life and come
back another day to hook him up. They disconnected what was left of the anastomosis and sewed the end of the esophagus to the skin at the edge of the neck incision.

*Dr. Kellogg:* It’s 5:00 p.m. and time for me to leave. Dr. Arthur, you know him, he’s one of the other thoracic anesthesiologists that you’ve worked with, is coming in to replace me.

*Dr Colon:* Oh come on! You heard James, he’s counting on you!

*Dr Kellogg:* Yes I heard him, but it’s my turn to go home and Dr. Arthur certainly can handle finishing the case; you can, can’t you, Dr. Arthur?

*Dr Arthur:* Sure thing!

*Dr Colon:* Here, take a look at this

*Dr. Arthur:* Wow! Looks like someone jammed something right through the staple line.

Dr. Colon: Well, as Dr. Valley and I repair the stomach and return it to the abdomen, let me tell you what went on during the first surgery…

*Dr. Arthur:* You know, Dr Kellogg feels that he has been in the practice 18 years and as a senior partner his personal time is his time and that he doesn’t have to give more than is required. As a senior member of the group, he’s hired most of the other anesthesiologists, and feels that he should be able to depend on them.

Dr. Colon washed out James’ chest thoroughly and closed the chest. Dr. Valley and Dr. Colon proceeded to open James’ abdomen and put in a drainage tube in James’ stomach so that the stomach would be drained and he could get nutrition and medications in addition to the feeding tube in the small bowel. Dr. Colon and Dr. Arthur worked together to exchange James’ endotracheal tube from a double lumen to a standard single lumen without any difficulty, Dr. Colon cleaned out James’ airway again with the bronchoscope and they proceeded to transport James back to the ICU.

The rest of James’ post-op course was stormy, prolonged, and protracted. He required several return trips to the operating room and interventional radiology procedures to manage other complications, such as drainage of abscesses, placement of tubes to control fistulae, release of trapped lung, replacement of dislodged tubes. The final pathology on the esophageal specimen revealed a stage IA completely resected adenocarcinoma, all margins and lymph nodes were negative for tumor. Though James survived, and his operation cured the esophageal cancer, James certainly wasn’t better off now than before his surgery.
Exhibit 1
PATIENTS AND COMMUNITY
TERTIARY MEDICAL CENTER STAFF

Organizational Chart: Tertiary Medical Center (TMC)
Appendix

Tertiary Medical Center Health Care is a private, not-for-profit corporation that owns and operates Tertiary Medical Center (TMC), a regional hospital in Kingston, two miles north of Bolton in the province of New Brunswick, Canada. TMC HealthCare also owns Hospice of Bolton and the Filenes Center for Hospice Care, the largest, not-for-profit hospice organization in Canada. The organization also includes the TMC Foundation, which supports the TMC mission by managing fundraising efforts.

Incorporated in 1960, TMC HealthCare consolidated the operations of two specialty hospitals located in Bolton, the Canadian Women’s Hospital in Bolton (“Women’s Hospital”), and Eye and Ear Hospital. The services were relocated to serve the growing population. Tertiary Medical Center opened its door in 1960 as a regional medical center providing general acute and specific specialized services to the populations of New Brunswick. Founded in 1880, the Canadian Women’s Hospital in Bolton was the second women’s hospital in the country. The Eye and Hospital had nearly 100 years of excellence in ophthalmology and otolaryngology, originating as a clinic in 1887.

The Mission of TMC HealthCare is to provide medical care and service of the highest quality to each patient with a Vision to be the leading community medical center in Canada, committed to medical, professional and community education, and dedicated to the Values of Respect, Excellence, Accountability, Teamwork, Ethical Behavior and Results.

Located on approximately 106 acres on Prince Charles Street, TMC's main buildings contain more than 1 million square feet. In addition to the main hospital building, the campus includes three medical office buildings; additional support buildings; parking garages/ lots for 3,800 vehicles; and the Hospice of Bolton and the Filene Center for Hospice Care. TMC operates satellite patient care facilities and physician practices in New Brunswick. Hospice of Bolton, the largest not-for-profit hospice in Canada, has provided care to more than 14,300 terminally ill individuals since 1994. The Filene Center for Hospice Care is a 24-bed inpatient facility located on the TMC campus.