ANESTHESIA NEWS

PRESIDENT'S MESSAGE

Dear Colleagues:

Since my last communication in the July issue of *Anesthesia News*, I am pleased to report that the CAS office and Executive are continuing to manage all issues that have arisen in follow-up from the 2013 Annual Meeting. In particular, I would like to thank all delegates, exhibitors, suppliers and others who were affected in any way – your patience and understanding are much appreciated.

CAS Annual Business Meeting Held by Electronic Means

Each year at the Annual Business Meeting, members vote to admit new members, elect Divisional Representatives of the Board of Directors and appoint the auditors. This year, in lieu of the cancelled meeting in Calgary, CAS conducted an electronic vote of members on August 27, 2013 and I'm pleased to report that the Active members voted in favour of all motions.

Recognizing Our Award Winners

High priority has been given to choosing and recognizing as many award winners as possible over the past two months. Because some awards are adjudicated at the meeting, the challenge was to find a work-around and, thanks to technology through teleconference meetings and email communications, committees were able to deliberate and select the winners.

It is important to note that unlike most Best Paper awards that are selected based on the abstract alone, the oral competitions are based on the abstract score *plus* the presentation score. Given that no presentations could take place this year, the *Canadian Journal of Anesthesia* Editorial Board had to determine a winner for the Richard Knill Competition, ACUDA had to determine a winner for the Residents' Oral Competition, and the Education and Simulation in Anesthesia (SESA) and the Cardiovascular and Thoracic (CVT) Sections had to determine a winner for the Best Papers. In this issue, you will find the winners of these remaining awards. Congratulations to all!

Reimbursement of Fees

As of September 5, CAS has processed 529 refunds, which have been forwarded to 394 members, 117 non-members and 18 exhibitors. Refunds to non-members were processed automatically by CAS. As a reminder, members who have not yet advised CAS of their reimbursement preferences can view the form on the Member Portal here.

I want to thank the 60 members to date who have left their registration fees with the CAS and would encourage the 188 members who have not advised CAS either way to also consider leaving their registration fees with the CAS. The monies will be used to offset the costs of the 2013 meeting not associated with registration. Should there be any overage, these dollars will be donated to the Alberta relief fund.

Sponsors

I am pleased to advise that the majority of sponsors have agreed to roll their 2013 sponsorship support to 2014 in St John's. We thank them for their generosity.

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Editor-in-Chief	Dr Salvatore Spadafora
Managing Editor	Andrea Szametz
Design and Production	Marco Luciani

2014
CAS ANNUAL MEETING
ST JOHN'S, NEWFOUNDLAND
JUNE 13 – 16
St John's Convention Centre
and Mile One Centre

Looking Ahead to St John's

And now our attention is focused on 2014 and St John's!

If you have not yet visited Newfoundland and Labrador, I urge you to make plans to join us for the 2014 Annual Meeting. CAS is planning a huge celebration and the Annual Meeting Committee promises a superb technical program, a fun-filled and adventurous social program and a unique travelling experience in Maritime Canada. I trust the dates – June 13–16 – are etched in all members' minds.

Watch for updates and details – and remember that the CAS web-site is always a valuable resource.

Dr Patricia Houston, FRCPC
CAS President

"Newfoundland and Labrador has a long and colourful history. In fact, there isn't a rock, cliff, tree or cave around here without a legend attached."

Extract from the Newfoundland Labrador tourism website

CALL FOR NOMINATIONS: CAS VICE-PRESIDENT

By December 31, 2013, the Nominating Committee, chaired by Past President Dr Richard Chisholm, is required to present the Board of Directors with a nominee for a new CAS Vice-President to take office September 1, 2014. In normal circumstances, the Vice-President will move to become President in two years.

Under the CAS bylaw, the nominee must have been a member of the CAS Board of Directors or a committee Chair within the past three years. A list of eligible members is available upon request; please forward a request to: anesthesia@cas.ca.

CAS members are invited to propose nominees by contacting Executive Director, Stan Mandarich, via email at director@cas.ca.

A recipient of the 2011 Royal College Accredited CPD Provider Innovation Award

ANNUAL MEETING COMPETITIONS AND AWARDS

BEST PAPER AWARDS

CVT Raymond Martineau Prize — *$1,000*

Dr Jean Bussières

Institut universitaire de cardiologie et de pneumologie de Québec, Quebec City, QC

Isolated Lung Collapse in Two Stages with Bronchial Blocker: Equivalent to Double-Lumen Tube?

Award for Best Paper in Education and Simulation in Anesthesia — *$500*

Dr Tobias Everett

The Hospital for Sick Children and University of Toronto, Toronto, ON

Managing Emergencies in Pediatric Anesthesia (MEPA) Global Rating Scale is a Reliable Tool for Assessment in Pediatric Anesthesia Crisis Management: A Pilot Study

Please note: All other Best Papers were announced in the July 2013 issue of Anesthesia News.

Richard Knill Oral Competition

Dr José Carvalho

Mount Sinai Hospital, University of Toronto, Toronto, ON

Carbetocin at Elective Cesarean Delivery: A Randomized Controlled Trial to Determine the Effective Dose, Part 3 - Final

Residents' Oral Competition

First place:

Dr Kimberly Macala

Memorial University of Newfoundland, St John's, NL

Fatty emulsion: Rats Survive Clonidine and Propranolol Overdose

Second place:

Dr Roshan Raban

University of Manitoba, Winnipeg, MB

Cerebral Desaturation in Cardiac Surgery: The importance of the ICU

Third place:

Dr Andrew John Heikkila

McMaster University, Hamilton, ON

Transversus Abdominis Plane Block: Does Volume Make a Difference?

WINNER OF THE 2012 MEMBERSHIP SURVEY INCENTIVE PRIZE

Congratulations to Dr Dagmar Moulton, who won an iPad mini! CAS appreciates the efforts of Dr Moulton and all respondents who took the time to complete the survey. The survey results will be shared in a future newsletter.

"Thank you so much! I'm so excited that I won and I am much looking forward to using it!"

2013 GOLD MEDAL AWARD WINNER: DR PATRICIA MORLEY-FORSTER

Dr Patricia Morley-Forster (Western University, London, ON) is the CAS Gold Medal award winner in 2013. Following the cancellation of the Annual Meeting, Dr Morley-Forster agreed to share the text of her acceptance speech, which is reproduced below. In addition, Dr Morley-Forster will be making a video to inform those interested in learning more about the Pain Medicine curriculum or becoming certified in Pain Medicine through the practice-eligible route.

I am Dr Pat Morley-Forster from Western University in London. This year, the Canadian Anesthesiologists Society honoured me by awarding me the Gold Medal for contributions to the profession and especially for leadership in the development of Pain Medicine as a subspecialty. I am deeply honoured and humbled to stand among distinguished winners of this award who have contributed so much to anesthesiology in Canada.

The devastating floods in Calgary prevented the Annual Meeting and the Award Ceremony, thus depriving me of the chance to thank the many who contributed to Pain Medicine, and my role in it.

Dr Patricia Houston and the Executive kindly offered me the opportunity to post a video on our website to express my gratitude.

Thank you to Dr Davy Cheng, Chair of the Department of Anesthesia at Western University for nominating me for this award and, back in 2001, for suggesting I apply for the position of Earl Russell Chair in Pain Management and Research at the University of Western Ontario.

Dr Earl Russell and his family generously donated over $2.1 million to Western University in 1999 to create this Chair, unique in Canada at the time. During my tenure as Chair, I had the time and freedom from clinical duties to lay the groundwork for the Pain Program at Western, and to make the initial application to the Royal College in 2006 to establish Pain Medicine as a subspecialty.

My co-applicants on that Phase I application were Dr Roman Jovey, Dr Norm Buckley, Dr Anita Chakrvarti, and Dr Eldon Tunks. I owe this group thanks for their courage in taking that first step.

My two chief mentors when training in chronic pain in 2000 were Dr Allan Gordon, University of Toronto, and Dr Dwight Moulin at Western, both neurologists. From them, I learned the value of an interdisciplinary approach to pain and will be forever grateful.

I am enormously indebted to all of the members of the Working Group in Pain Medicine 2008 – 2011 and the subsequent Specialty Committee in Pain Medicine 2012-2014.

Each of them has made a unique and important contribution. Their passion and commitment to the creation of a subspecialty has been extraordinary. I would like to especially thank Dr Dan Gray from the University of Alberta, my vice-chair. At our first formal meeting of the Working group held at the Royal College in 2011, he was the only member who understood what the College meant by OTR, SSA, STR and FITER, the documents we needed to prepare.

The first Residents in Pain Medicine, we hope, will start their training in July 2014. For those of you interested in learning more about the curriculum or in becoming certified in Pain Medicine through the practice-eligible route, I will be posting another presentation on the CAS website.

Last but not least, I must thank my husband, Professor Ben Forster, and our two sons, Eric and Graham Forster. They had to survive on their own when I went to Toronto in 2000 to do my Chronic Pain Fellowship training, and they have always been there for me. Thank you.

To view a video of Dr Morley-Forster's acceptance speech, please go to: http://cas.ca/English/Morley-Forster-acceptance-speech

Royal College Specialty Committee in October 2012

DR DEVEN CHANDRA RECEIVES JOHN BRADLEY YOUNG EDUCATOR AWARD

Dr Deven Chandra (St Michael's Hospital/University of Toronto, Toronto, ON) expressed his appreciation for the honour of receiving the John Bradley Young Educator Award in correspondence to CAS President Patricia Houston.

While the flooding in and around Calgary resulted in the cancellation of our Annual Meeting and thus did not allow me to receive this award in person, it was a potent reminder of what is truly important. Professional life, awards, and meetings pale in comparison to events such as natural disasters, which can adversely affect the lives of thousands.

Nevertheless, it is my honour to accept this award even in the absence of an actual award ceremony. The John Bradley Young Educator Award honours effectiveness in Anesthesia Education and significant contribution to students and Residents in Anesthesia in Canada – such achievements are impossible without the support of many organizations and individuals.

I would like to thank the Department of Anesthesia at St Michael's Hospital and the University of Toronto, with special thanks to Drs Megan Hayter and John Laffey. They have provided both moral and financial support to my educational activities for the past eight years. I would also like to thank my mentors in the field of Administration, Education, Simulation, and Evaluation: Drs Viren Naik and, of course, yourself, Dr Patricia Houston. I would like to thank the students, Residents, and fellows in the Department of Anesthesia at the University of Toronto. And finally, I would like to thank my wife, Deborah, and my son, William, for allowing me the time to pursue my interests in Anesthesia Education.

2013 RESEARCH RECOGNITION AWARD RECIPIENT: DR ANDREW BAKER

Honoured to receive the Research Recognition Award, Dr Andrew Baker (St Michael's Hospital, Toronto, ON) expressed his appreciation to his mentors and colleagues.

Firstly, I want to express my gratitude to the Society. It is a remarkable organization that has supported our specialty in Canada to excel in all domains. I am very proud of it. Supporting research is one of the domains that our Society has made a priority. Our Society helps us all take pride in our collective accomplishments.

Participating in, and sharing research, elevates our specialty. It is indeed a group effort. It is abundantly clear to me that my success in receiving this award is a shared one. Not only do I share it with the members of our Society, but there are many people at my local institution that have made my scientific endeavours possible. Early mentors for me included Drs Byrick and Mazer. It has been a gift to work closely with colleagues such as David Mazer and Greg Hare. The Chiefs of the Department at St Michael's have created such a supportive atmosphere it is remarkable. These include Drs Byrick, Rose, Houston and now Laffey. The Department Chairs at the University of Toronto have also been a major part of my career – in particular, Drs Byrick and Kavanagh. I am grateful for the students who keep us on our toes and teach us more than we teach them. Many turn into close research colleagues such as my research partner, Eugene Park. Dr Houston deserves so much credit for continuing to build our St Michael's Department and solidifying the great culture of support here – then handing the Department leadership over to Dr Laffey who is continuing a great tradition. Dr Houston deserves credit for her leadership and her share of this – without her this would not have been possible. Dr Mazer is a tireless man of incredible intellect and humanity – his support for any research I have done has been invaluable. Finally, and of course, the anesthesiologists at St Michael's are a marvelous group of professionals and individuals who are indeed the foundation for the success in this award.

AND THE NOMINATIONS FOR LEADERSHIP AND EXCELLENCE ARE...

Each year, CAS is proud to recognize the outstanding work and achievements of its members. The diverse range of expertise and talent that abounds in our membership is well reflected in our awards program such as the Membership Honour Awards (Gold Medal Award and Clinical Teacher Award) and other awards (Medical Student Prize, John Bradley Young Educator Award, Emeritus Membership).

There are many tangible examples worthy of recognition. From innovative research projects that have widespread implications for patients and outstanding leadership "above and beyond the call of duty" to the creation of new anesthesia tools and protocols, there's plenty to celebrate.

Please think about the members you know who have made important contributions to anesthesia and consider nominating someone. Let's make it a special awards ceremony in St John's in 2014. For more information, go to: http://www.cas.ca/English/CAS-Honour-Awards.

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Where to find Knowledge Direct

Instructions to access the Knowledge Direct site can be found on the Canadian Anesthesiologists' Society website at: http://www.cas.ca/Members/CPD-Online

On the same page, there is a user's manual, showing how to go through the modules.

Username and password have been sent via email. For assistance, contact anesthesia@cas.ca

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- Ultrasound-guided regional anesthesia for upper limb surgery **(March 2013)**
- Massive transfusion in the trauma patient **(December 2012)**
- Competency-based professionalism in anesthesiology **(September 2012)**
- Fluid and vasopressor management for Caesarean delivery under spinal anesthesia **(June 2012)**
- Postoperative delirium: risk factors and management (**March 2012**)
- Airway management in the patient with potential cervical spine instability (**December 2011**)

HOW TO ACCESS THE MODULES

Instructions can be found on the Canadian Anesthesiologists' Society website at: http://cas.ca/Members/CPD-Online

Successful completion of each module of the self-assessment program will entitle readers to claim four hours of continuing professional development (CPD) under section 3 of CPD options, for a total of 12 maintenance of certification credits. Section 3 hours are not limited to a maximum number of credits per five-year period.

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Lethal Injection: A Deadly Paradox

By: Jayden Cowan

Physician involvement in organized death has been, and continues to be, an issue of great debate within the medical community. Euthanasia, physician-assisted suicide, and capital punishment represent dilemmas that push against the pillars of medical ethics and call upon professional scrutiny for resolution. Discussion on organized death often includes the principle of *primum non nocere* —'above all, do no harm'— with its implications extending to the physician, patient, and society at large. In general practice, this precept offers limited clinical guidance as myriad interventions are beneficial despite harmful risks and side effects; however, in the context of organized death, nonmaleficence fuels debate on physician desensitization, death as a positive outcome, and the slippery slope phenomenon.[17] In terms of capital punishment, a historical synopsis of lethal injection reveals that although the medical community is generally opposed to its participation in the procedure, competing ethical perspectives struggle to find excellence in this dimension of patient-centered care.

For example, a turning point on February 20, 2006, exposed a gulf between law and medicine when two American anesthesiologists resigned from the Michael Morales execution, citing ethical responsibilities as a barrier to their involvement.[18,23] Six days prior, a federal ruling stated that Morales' execution required either anesthesiologist participation or an updated single-drug regimen that reduced the risk of undue suffering.[7,8] The Morales case uncovered a controversial paradox: anesthesiologists, while most educated in the drug delivery of the lethal injection process, are commonly reluctant to participate in the act.[7] This dilemma initiated an ongoing suspension of Morales' execution, a continued moratorium on capital punishment in California, and an in-depth analysis of lethal injection protocol and efficacy. [7,23]

The first interaction between medicine and capital punishment occurred years earlier in 1789, when Dr. Guillotine suggested a device to painlessly behead criminals.[7,23] However, the advent of lethal injection was not until the 19th century – nearly 100 years after it was initially contemplated as a means of execution.[7,23] In 1888, lethal injection was considered in the United States but was rejected because physicians believed associating with organized death would precipitate the mistrust of society.[7] Lethal injection was researched six decades later by Great Britain; counsel from the British Medical Association and the Association of Anaesthetists determined the procedure would require medical skill and, to account for vascular variation, should be standardized as an intramuscular injection.[7] This protocol would deliver an inappropriately painful and prolonged death, thus, lethal injection remained theoretical.[7]

The United States re-evaluated lethal injection in 1976 and, despite previous concerns, approved the procedure on the basis of cost-effectiveness and appearing more humane than other methods of capital punishment.[7,23] One year later, Oklahoma became the first state to adopt lethal injection.[13,18] Execution protocol was largely developed by legislators, with medical counsel limited to two physicians: the Chief Medical Examiner of Oklahoma and the Anesthesiology Department Head of Oklahoma Medical School.[7,8] Their statute described the intravenous administration of an ultrashort-acting barbiturate to induce general anesthesia (sodium thiopental), followed by a neuromuscular blocker to induce painless death (pancuronium bromide).[7,24] This statute passed without any medical or scientific evidence, and it was not endorsed by the Oklahoma Medical Association.[16,23] Dr Chapman, one of the two medical contributors to the statute, maintained that physician involvement in execution was ethical; he envisioned lethal injection would be performed by a person skilled in drug injection, predicting that improper administration would result in severe muscle pain rather than death.[7,13] The surfacing of such cases led him to update the statute in 1981 with the addition of a third drug to induce cardiac asystole (potassium chloride), thus finalizing the conventional three-drug regimen of lethal injection.[4,7] However, a succeeding history of multiple procedural errors and debate over physician participation in execution has held lethal injection under increasing scrutiny.[20,22] The following discussion focuses on the ethical perspectives of anesthesiologist involvement in lethal injection.

Multiple ethical boards ban anesthesiologist involvement in lethal injection, save certifying death: American Society of Anesthesiologists, American Public Health Association, American College of Physicians, American Medical Association, Standing Committee of European Doctors, and the World Medical Association.[1] This prohibition is founded upon preserving the ethical and moral integrity of medicine, with frequent reference to the Hippocratic Oath – "I will prescribe regimens for the good of my patients according to my ability and my judgment and never harm anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death."[9,23] While one may empathize with those maintaining that participation in lethal injection is justified by minimizing inmate suffering, committing what is perceived to be an immoral act to 'do no harm' remains impermissible; thus, herein lies the void between law and medicine.[4,5,19]

Anesthesiology was exploited by the legal system to the extent of understanding lethal injection, but suffering due to poor execution protocol cannot supersede potential ethical constraints regarding physician participation.[3,22] Generally, lethal injection is not considered to be a medical procedure because it lacks beneficence and does not promote health; consequently, no physician-patient relationship exists, thus, anesthesiologists hold no moral obligation to relieve inmate

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suffering.[11,13,14] Further argument suggests anesthesiologist participation is justified by ameliorating the torment of co-victims[1], however, this notion may be proved invalid in that committing what is perceived to be an immoral act to 'do no harm' is impermissible, and co-victims receive equal closure from execution with or without anesthesiologist participation.[3,5,15,19] Finally, anesthesiologist participation in lethal injection may have compounding consequences, including the emotional desensitization of physicians, the erosion of public trust and a slippery slope towards further organized death (e.g., assisted suicide).[4,22]

Contrary to the aforementioned perspective, recent years have seen an increased movement towards anesthesiologist participation in lethal injection. It is indisputable that execution is a legal process; thus, any immorality must belong exclusively to the judicial system, dissociating physicians from the moral plane.[14,22] This dissociation is cardinal in defining lethal injection as a medical *procedure* albeit its conjunction with a controversial legal *process*.[11,18] Therefore, in light of reported procedural errors, some physicians interpret 'do no harm' as replacing or training the current non-medical workers who lack expertise in medical equipment, procedures, and pharmacodynamics.[13,20,22]

Perhaps the most discussed error in lethal injection is the failure to induce appropriate anesthetic depth (using sodium thiopental) before administering the subsequent drugs; one study, although contentious, used post-mortem toxicology reports to claim 43% of inmates (n=49) had serum sodium thiopental concentrations consistent with consciousness at the time of death.[8,10,16,22] In this situation, pancuronium bromide subjects the inmate to conscious paralysis and asphyxiation, and potassium chloride subjects the inmate to muscle cramping with severe burning pain on infusion.[11,20] Unsuccessful executions have attributed this error to 1) the absence of monitoring anesthetic depth[2], 2) failed intravascular access with subcutaneous injection, 3) simultaneous infusion of the drugs causing precipitation and intravascular catheter blockage, 4) an arm restraint acting as a tourniquet, and 5) improperly connecting the intravenous lines.[8,22] Beyond harm reduction, advocates of anesthesiologist participation posit that fears of compounding consequences are speculative and exaggerated, arguing: physicians are resilient to desensitization because they consider their actions beneficent; public trust is protected against erosion because physicians' long participation in gas chamber execution has not yielded any apparent societal consequences; and the medical profession is protected against sequential perversion because physicians who have participated in capital punishment exhibit no progression towards indiscriminate killing.[20,22]

Since Oklahoma accepted lethal injection in 1977, arguments weighted on the Hippocratic Oath, physician-patient relationship, and definition of *medical procedure* have propelled both perspectives along the debate of physician participation. Although profound, this discussion represents only a fraction of the moral conversation on the death penalty. Currently, movement for an international moratorium on capital punishment is gaining momentum, with organizations such as the United Nations and Amnesty International leading the charge.[2,21] Similar movement has manifested within the drug industry, as indicated by the indefinite suspension on sodium thiopental manufacturing for North America.[12] Therefore, although Canada eradicated capital punishment in 1998, understanding the historical and ethical implications of lethal injection is helpful in addressing its impact on anesthesiology and healthcare.[6] Anesthesiologists are welcome to personal opinions regarding the morality of capital punishment, and structured debate surrounding participating in lethal injection holds the specialty to scrupulous peer review. However, the aforementioned synopsis reveals a challenge to all physicians: protecting professional and ethical values of medicine from external pressures. As an aspiring anesthesiologist, this contextual disconnect between law and medicine exemplifies that physicians' relationships with self, patients, and society are an obligation to moral conduct, and not necessarily civic duty. This awareness will hopefully assist in preserving the integrity of anesthesiology for years to come, and foster growth in the specialty as leaders in healthcare.

1 Keane coined 'co-victims' in reference to family, friends, and partners of murder victims.[15]

2 Anesthetic depth is assumed due to the large dose of sodium thiopental (generally 2g, compared to the typical induction dose of 3-5 mg/kg).16

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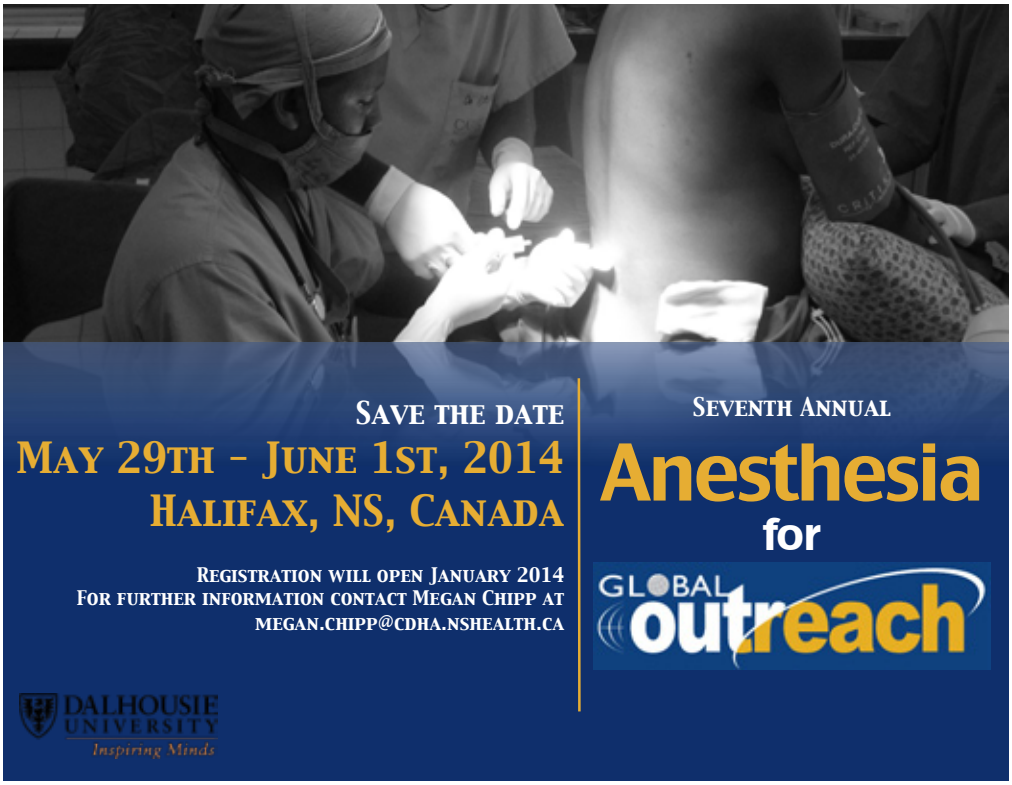

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For information: general - contact: margorie.fraticelli@mountsinnai.org; abstract: ian.sampson@mounsinai.org; industrial ehibits contact: bob.williams@mountsinai.org.

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NEWS FROM RESEARCH: FINAL REPORT

2012 Dr R A Gordon Award

Dr Alain Deschamps, FRCPC
University of Montreal,
Montreal Heart Institute
Montreal, QC

Feasibility Trial to Maintain Normal Cerebral Oxygen Saturation (rSO2) in High-Risk Cardiac Surgery (NORMOSAT Trial)

Summary of Progress

For this multicentre, parallel-arm RCT study with a 30-day follow-up, a sample size of 200 patients was determined to confirm the feasibility of enrolling patients, implementing measures, based on a physiological algorithm, to reverse decreases in cerebral oxygen saturation, measured using near infrared-reflected spectroscopy (NIRS) during high-risk cardiac surgery and obtaining a follow-up of patients for 30 days.

After one year, all of the 200 patients have been recruited in eight University Center Hospitals. To date, we have a 100% follow-up of patients at 30 days. The analysis of the data from the study on implementations of measures to reverse decreases in cerebral saturation during cardiac surgery will be done in the next few months and I hope to be able to submit the manuscript before the New Year.

2012 Abbott Laboratories New Investigator Award in Anesthesia

Dr Stephen Choi, FRCPC
Sunnybrook Health Sciences Centre
Toronto, ON

Optimizing Pain and Rehabilitation After Knee Arthroplasty (OPRA)

Final Report

Summary of Progress to Date

There has been significant progress since July. With respect to enrollment, we have assessed 209 patients for eligibility, of which 86 have been approached since recruitment was initiated in March 2013. To date, 43 patients have been consented and enrolled.

Our second site for enrolment, St Joseph's Healthcare of Hamilton Health Sciences Centre, was approved to enroll patients in July 2013. The legal contracts between Sunnybrook Health Sciences Centre, St Joseph's and, the Applied Health Research Centre (our administrative/database support) were recently approved by the respective research institutes and legal departments. St Joseph's Healthcare has assessed 12 patients for eligibility, of which 6 were approached but did not enroll.

Other Comments

Our enrolment to date has been unfortunately slower than anticipated. We have had turnover in our research staff that resulted in a two-month period in which we encountered difficulty enrolling patients. This situation has been rectified and we expect that recruitment will proceed more rapidly.

2013 EARL WYNANDS LECTURE NOW ONLINE

The 2013 Earl Wynands Lecture by Dr James Ramsay is available for viewing online. The Lecture was presented at the Society of Cardiovascular Anesthesiologists (SCA) Foundation on Sunday, April 7 at the SCA Annual Meeting in Miami and is supported through a gift from the CAS Cardiovascular and Thoracic (CVT) Section's Earl Wynands Fund.

To view Dr Ramsay's presentation – Cardiac Critical Care Anesthesiology Moving Forward: Why Dual Training is Beneficial – go to: http://scahqgive.org/2013-earl-wynands-lecture/

"With your help we can keep CARF flying high. CARF is one of my causes. Please make it one of yours."

Can you guess the identity of the pilot? Hint - he maneuvers at great heights to keep CARF "straight and level".

Our profession deserves a firm foundation.

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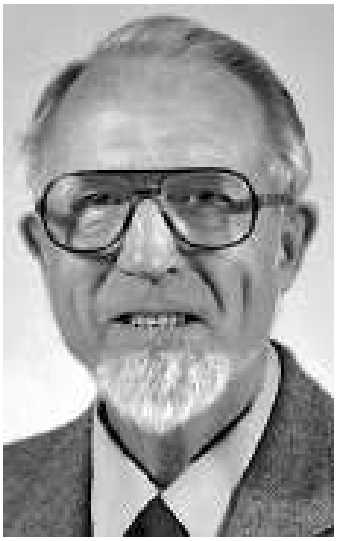
ASA would like to express its condolences to those affected by flooding in Alberta, Canada, which prompted a state of emergency in Calgary and surrounding areas in mid-June.

While, we realize that severe weather necessitated the cancellation of the CAS 2013 Annual Meeting, we wanted you to know that ASA will continue to honor your intentions to attend.

ASA will extend a special discount to all CAS Active members who registered to attend the 2013 CAS Annual Meeting.

Watch for your exclusive promo code via email from CAS.
Visit www.anesthesiology2013.org to register.

REMEMBERING DR PHILIP BROMAGE



A great pioneer of epidural analgesia, Philip Bromage, died in Vermont on June 7, 2013.

Born in England in 1920, he graduated in medicine in 1943 and then served in the Navy. After the war, he pursued a career in anesthesiology. Mentored by J Alfred Lee, he became interested in epidural anesthesia and in 1956 published *Spinal Epidural Analgesia*.

Philip emigrated to Canada and worked in the McGill Department of Anesthesia from 1956 to 1977, becoming Chairman in 1970. While at McGill, his reputation in teaching and research attracted students from all over the world. His wide-ranging research included work on regional anesthesia and pain mechanisms and today he is most remembered for the Bromage Score. His lectures were a model of clarity and he possessed a masterful command of the English language, truly enjoying a verbal academic argument. Already a renowned ambassador for epidural analgesia in obstetrics, in 1978 he published his outstanding single-authored textbook *Epidural Analgesia*. For this and other work he received the highest honours of our profession including the Gold Medal of the Canadian Anesthesiologists' Society.

After leaving McGill in 1977 and before retiring to Vermont, Philip worked at Duke University, the University of Colorado, King Khaled University in Saudi Arabia and Thomas Jefferson University.

Always elegant and charming and with impeccable manners, Philip was a generous host. While Chairman at McGill, he often entertained members of the Department at his farm in Vermont. These were happy times and allowed Philip to indulge his taste for the outdoor life.

Philip's first marriage to Brenda Fernyhough ended in divorce and he then married Meg Parkinson. Philip was predeceased by Brenda and Meg and by his daughter Jenny, and is survived by his children, Richard and Susan.

Dr Sally Weeks
McGill University
Department of Anesthesia

Dr Franco Carli, FRCPC
McGill University
Department of Anesthesia

HONOURING DECEASED MEMBERS

To appropriately recognize the passing of a CAS member in a future newsletter, CAS appreciates hearing about it. Please provide an obituary (a link is acceptable) or any pertinent details about the individual, including the names of colleagues who may wish to write a remembrance. Forward to: membership@cas.ca

UPDATE ON OXIMETERS IN NEPAL

By: Dr Angela Enright, FRCPC

Through the generosity of CAS members, 100 pulse oximetry kits from Lifebox have been delivered to the Society of Anesthesiologists of Nepal (SAN). Dr Angela Enright participated in their annual meeting in April, speaking about the Lifebox project and its work throughout the world. The SAN was pleased to be able to work with the Nepal Department of Health to facilitate the duty-free import of the oximeters.

Currently, we are working on the distribution of the oximeters. Hospitals in Katmandhu are reasonably well equipped with oximeters, at least in the Operating Rooms. They need them in their Recovery Rooms. However the situation is very different outside the Katmandhu Valley. We are now working to ensure that oximeters, and the education to go with them, reach those in need in the rural areas.

This was the 25th Anniversary of the SAN and so it was a very special meeting. Many references were made to the help received from the CAS over the years without which anesthesia in Nepal would not be where it is today. It was wonderful to see some of the first Nepal anesthesia graduates taking over leadership positions and now training their own Residents. These young leaders and their trainees took a very active part in the scientific program, which was excellent. Academic anesthesia in Nepal has come of age.

Dr Enright presents an oximeter to the outgoing President of SAN, Dr N Marhatta (right) and the incoming President, Dr BB Singh (left).

RWANDA RESIDENTS PRESENT AT BETHUNE ROUND TABLE

While spending four months training in Halifax this past spring, two Residents in Anesthesiology from Rwanda had the opportunity to present at the Bethune Round Table Conference. This international meeting of surgeons and anesthesiologists interested in overseas work was hosted in May in Vancouver by the University of British Columbia Branch for International Surgery.

Dr Isaac Nshimyumuremyi (below) spoke about the SAFE (Safer Anesthesia from Education) Obstetric Anesthesia Course held in Rwanda in January.

Dr Gaston Nyirigira (right top) gave a poster presentation on the Lifebox Project in Rwanda. Both were very well received. One of the guest speakers at the meeting was Dr Vincent Rusanganwa from the Ministry of Health in Rwanda. I am sure he was very proud of his two young countrymen.

Dr Faye Evans of Boston Children's Hospital, a CAS member and Rwanda volunteer, assisted Gaston and Isaac with the preparation of their presentations. Dr Patty Livingston and the Department of Anesthesia at Dalhousie provided encouragement, advice and support. Dr Tony Boulton, Vancouver, donated their hotel accommodation and Dr Angela Enright, Victoria, their air travel. The Branch for International Surgery waived their registration fee and provided gala dinner tickets for them.

Well done, Gaston and Isaac.

EXPANDING OPPORTUNITIES FOR ANESTHESIOLOGISTS AND THE SURGICAL COMMUNITY TO ENGAGE IN GLOBAL SURGERY

Anesthesiologists such as Dr Angela Enright and Dr Kelly McQueen are all too familiar with the challenges of providing safe anesthesia, as well as the demands of reducing surgically treatable and preventable diseases in low-resource settings. While many in the anesthesia and surgical community are interested in tackling these surgical care challenges, there is a dearth of practical, innovative training that specifically focuses on surgical care issues.

The University of British Columbia's Branch for International Surgery launched its e-global surgery courses to provide cutting-edge access to global surgery learning. Three graduate-level courses are now offered:

- Surgical Care in International Health
- Global Disability: a Surgical Care Mandate
- Surgical Care in Humanitarian Disasters

Next year, the Branch will offer a fourth course, Planning and Evaluation Literacy, as well as a Certificate and Master's program. The flexibility of the online format has created a truly global classroom where learners from across North America and abroad share knowledge and their own experiences. While learners' experiences vary considerably, the motivations don't — to acquire and enhance their knowledge in global surgery.

As a 4th year anesthesiology Resident says, "In taking this course (SURG 510), my goal is to have a more robust background in the theory and practicalities of being "a global health practitioner'. I hope to translate this knowledge to my future practice in both Canada and abroad."

Find out more about the global surgery program: http://www.internationalsurgery.ubc.ca/ Follow us on Facebook: https://www.facebook.com/UBCBIS?ref=hl

For more information, email: surgery.international@ubc.ca

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