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CAS Receives 2011 Royal College Accredited CPD Provider Innovation Award

The Royal College of Physicians and Surgeons of Canada (RCPSC) has announced that the Canadian Anesthesiologists' Society (CAS) received one of three 2011 Royal College Accredited CDP Provider Innovation Awards for CAS' Session Tracker. The Award was presented to CAS during the CAS Annual Meeting in Toronto in June.

In a letter to CAS from Dr Craig Campbell, RCPSC's Director, Professional Affairs, he noted "the Committee was impressed with CAS' submission and the innovative administrative tool that [CAS] has developed. The adaptation of Scholar One to improve the administrative effectiveness of the management of a complex multi-day meeting and to improve adherence to the accreditation standards of the Royal College is commendable and we are thrilled to highlight [the Society's] achievements."

CAS was also encouraged to continue its commitment to innovation and excellence in developing high-quality CME and CPD programs.

Dr Craig Campbell (right), Director, Professional Affairs for the Royal College of Physicians and Surgeons of Canada, presenting the 2011 Royal College Accredited CPD Provider Innovation Award won by the Canadian Anesthesiologists' Society and accepted on behalf of CAS by Mr Stanley Mandarich, Executive Director.

Patient Safety: What Can Be Done about It?

Dr Steven Dain, FRCPC
Chair, Standards Council of Canada Advisory Committee to ISO TC 121
Member, CAS Standards and Patient Safety Committees

Much is said and written about patient safety. In Canada, a small group of dedicated physicians, nurses and engineers participates in the Canadian Standards Association and Standards Council of Canada Advisory Committees writing basic safety and essential performance requirements for a large range of anesthesia, respiratory care and critical care equipment.

Over the past several years, in recognition of the globalization of trade and the international nature of medical device design and manufacturing, Canadian Anesthesiologists' Society members Dr Steven Dain, Dr Karen Brown, Dr Matt Kurrek, Dr Ken LeDez, and Dr Jeremy Sloan have primarily participated in Organization for International Standardization (ISO) Technical Committee 121 and the International Electrotechnical Commission (IEC) Committee 62.

This past June, Canada hosted the Annual Meeting and Plenary of ISO Technical Committee 121, anesthetic and respiratory equipment and 13 of its subcommittees and working groups in Vancouver. Over 100 delegates representing 15 countries participated in this meeting by writing standards for anesthesia workstations, supraglottic airways, homecare medical devices, non-invasive sphygmomanometers, critical care ventilators and medical gas pipelines to name but a few. We had a very successful and productive meeting, marred only by the Stanley Cup final riot, two blocks away.

The CAS members participating in the International Standards process bring their academic knowledge and clinical experience to the table, providing practical expert opinions on the use and misuse of equipment on a day-to-day basis. This bidirectional knowledge transfer process, between clinicians, medical device designers, industrial psychologists, human factors engineers and others greatly improves the quality of the work done in creating technical requirements, guidance and validation tests on how to produce a safe, efficacious and easy-to-use device. The knowledge gained by the CAS members in these meetings also enriches the knowledge of the physician committee members, information that they can then impart to their students, Residents and colleagues.

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The standards process is an all-inclusive academic exercise. The first step is to identify what the device is going to do, who is going to use it, what is their educational level and training. Are there similar devices already available? We then identify all the hazards and faults that may occur. A literature search and incident report databases search is performed to ascertain past problems and previous solutions. After all the risks are identified, means to mitigate the risks are written into the standard as requirements. As it is often impossible to mitigate all the risks, either because the solution is too costly or the solutions will lead to complexities that will introduce other risks, are the residual risks as low as reasonably practical?

Working drafts are written, as later refined to one or more Draft International Standards (DIS) and then as a Final Draft International Standard (FDIS). After each step, a vote of participating countries is taken, and comments are received and resolved and a consensus is formed. Our National Standards Committee, organized by the Canadian Standards Association, either approves the International Standard, or writes minor changes ("deviations") and recommends its adoption as a Canadian National Standard.

Many of these standards are incorporated into National Healthcare Policies by Health Canada and other countries' regulatory bodies (for example, the US FDA, Japan, Australia, New Zealand and the European Union) as a basis for licensing purposes.

As many countries around the world cannot afford the medical equipment we use, nor have reliable sources of water, medical gases and electricity, recent standards writing activities have focused on providing minimum requirements for anesthesia equipment for use in areas of minimal infrastructure.

I would particularly like to thank the Canadian Academic Anesthesiologists, who volunteer up to 20 days of their unpaid vacation time to attend meetings on a yearly basis, and often at their own expense. Thanks to the University Departments of Anesthesia that help to support some of these endeavours.

I would also like to thank the Canadian Standards Association, CADTH – The Canadian Agency for Drugs and Technologies in Health, Standards Council of Canada and the Canadian Anesthesiologists' Society for their financial support for much of the travel expenses incurred by the Committee.

Canadian physicians, biomedical engineers, respiratory therapists and industry representatives, who are well respected internationally, have participated in the writing and editing of these International Standards and other standards, transferring our knowledge and clinical experience to the medical device industry and other physicians, improving patient and healthcare provider safety in Canada and around the globe. Anyone interested in furthering patient safety through equipment standards can contact me at sdain@uwo.ca.

Symposium Now On CAS Website

During its Annual Meeting in June 2011 in Toronto, the Canadian Anesthesiologists' Society held a Patient Safety Symposium. The files can be found at: http://www.cas.ca/English/Symposium-2011

… AND THE WINNERS ARE …

In the June 2011 issue of *Anesthesia News,* 16 award winners had been recognized for their significant efforts and accomplishments. CAS is pleased to recognize additional 2011 award winners.

Emeritus Membership

To recognize retired individuals who during their long-standing practice made a significant contribution to anesthesia.

Dr John Price – Fredericton, NB

Richard Knill Research Oral Competition

In honour of Dr Richard Knill, a special session at the CAS Annual Meeting that highlights the best scientific papers

Winner:
Tina Hu – University of Toronto, Toronto, ON
β1-Antagonism *Preserved Brain Perfusion in Anemic Rats*

Residents' Oral Competition

To encourage scientific excellence in physicians training in the specialty of anesthesia in Canada

Winners: *1st place*
Dr Sinziana Avranescu – University of Toronto, Toronto, ON
Inflammation Increases the Efficacy of Anesthetics in Mouse Neurons

2nd place
Dr Antoine Halwagi – Université de Montreal, Montreal, QC
Tracheal Intubation Through the I-Gel Supraglottic Airway versus the LMA Fastrach: A Randomized Controlled Trial

3rd place
Dr Mandeep Singh – University of Toronto, Toronto, ON
Is a Higher Score on the Stop-Bang Questionnaire Associated with a Higher Incidence of Postoperative Complications?

Best Paper Awards

Ian White Patient Safety Award: $500

Dr Ludwik Fedorko – Toronto General Hospital, Toronto, ON
Avoidance of Drug Errors by Point-of-Care Barcoding

Award for Best Paper in Ambulatory Anesthesia: $500

Dr Boris Mravovic – Thomas Jefferson University, Philadelphia, PA
N20 at the End of Anesthesia Hastens Recovery without Increasing PONV

CVT Raymond Martineau Prize: $1,000

Dr Chirojit Mukherjee – Leipzig Heartcenter, Leipzig, Germany
Intraoperative Conversion to Valve in Valve Procedure during TAAVIS

Award for Best Paper in Obstetric Anesthesia: $1,000

Dr Mrinalini Balki – Mt Sinai Hospital, University of Toronto, Toronto, ON
Myometrial Contractions in Pregnant Rats with Combinations of Uterotonic Drugs

Award for Best Paper in Regional Anesthesia and Acute Pain: $500

Dr Mahesh Arora – All India Institute of Medical Sciences, New Delhi, India
To Study the Efficacy of Magnesium as an Adjuvant to Bupivacaine in Three-in-One Nerve Blocks for Arthroscopic Knee Ligament Repair

Award for Best Paper in Anesthesia Education and Simulation: $500

Dr Victor Neira – Children's Hospital of Eastern Ontario, Ottawa, ON
"*Gioset*": A Reliable and Valid Evaluating Tool to Assess Medical Core Competencies *During Crisis Simulation*

Medical Student Prize

To increase awareness among undergraduate medical students of the specialty of anesthesia and the role of anesthesiologists in healthcare

Winners: *1st place:* $1,000
Alistair Smith – University of Saskatchewan, Saskatoon, SK
Addiction in Anesthesia: Past, Present and Future Hope

2nd place: $500
Sophie Davie – University of Manitoba, Winnipeg, MB
Cerebral oximetry: opening a window to the brain and beyond

3rd place: $250
Chunzi Jenny Jin – University of Toronto, Toronto, ON
Contributions beyond the operating theatre Anesthesiology origins of intensive care

To view more pictures from the 2011 CAS Annual Meeting, please go to:
http://www.pinpointnationalphotography.com/gallery_cas.php

Passport to Quebec City Winners

At the CAS 2011 Annual Meeting, exhibitors contributed to a charitable pot, with the goal of dividing the proceeds between the Canadian Anesthesia Research Foundation (CARF) and the CAS International Education Fund (CAS IEF). Delegates were issued either a CARF or a CAS IEF passport and were required to have it validated by the exhibitors whose booths they visited.

The charity with the most completed passports won 75% of the pot and the other charity received the remaining 25%. Delegates were eligible to win prizes ranging from complimentary full meeting registration at the CAS 2012 Annual Meeting to hotel and restaurant gift certificates.

The Winners

Charitable Foundation: CAS IEF

Draw:

1st Prize: Dr Gail Hirano, Mississauga, ON
2nd Prize: Dr Kathryn Sparrow, Portugal Cove, NL
3rd Prize: Dr Achal Dhir, London, ON

Thank you for the Contributions

We are pleased to report that **$3,787** was raised for the charitable pot this year.

A special "thank you" to all the exhibitors at the CAS 2011 Annual Meeting who contributed – your support is much appreciated!

2011 Annual Meeting presentations are now at:
https://www.cas.ca/Members/2011-Presentations
Please note: These presentations are for members only.

Accreditation information can be found at:
https://www.cas.ca/Members/CAS-CPD-resources

Canadian Anesthesiologists' Society

2012 Call for Nominations

"Recognize excellence in your peers and help present these awards at the June 2012 Annual Meeting in Quebec City!"

Dr Richard Bergstrom, CAS Membership Services Committee Chair

Gold Medal Award

The Gold Medal is the highest award of the Canadian Anesthesiologists' Society. It is a personal award consisting of an inscribed gold medal given in recognition of excellence in matters related to anesthesia.

Eligibility

The medal may be awarded to any individual, ordinarily a Canadian:

- who has made a significant contribution to anesthesia in Canada through teaching, research, professional practice, or related administration and personal leadership;
- who is not a member of the current Board of Directors or its committees;
- who may be active or retired from his/her field of interest.

Nomination and Selection

- Nominations shall be made in the form of a written, confidential submission.

Research Recognition Award

The Research Recognition Award will be presented by the Canadian Anesthesiologists' Society to honour a senior investigator who has sustained major contributions in anesthesia research in Canada.

Nomination and Selection

- Nominations, in the form of three letters from sponsors, plus one copy of the current curriculum vitae of the nominee must be submitted by the deadline.

Attention:
Chair of the CAS Research Advisory Committee

Nomination and Selection information

Unless otherwise specified, the following applies to all awards.

- Nominations shall be made in the form of a written, confidential submission by two Active members (unless otherwise specified) to the Chair of the Membership Services Committee.
- Nominations shall contain extensive supporting documentation, which should include the nominee's curriculum vitae.
- Nominations shall be referred to the Membership Services Committee for consideration, with the addition of a Resident member for selection of the Clinical Teacher Award.
- Each nomination shall be held for a period of not less than **five** years and shall be reviewed annually. At the end of five years, a nomination will become inactive. Nominations may be resubmitted.
- Recommendations from the Committee shall be made to the President and presented to the Board for its approval. A two-thirds majority vote is required for approval.
- The recipient shall not be a member of the Board of the Society.
- The award need not be awarded annually.

Nominations must be received by
October 28, 2011
Canadian Anesthesiologists' Society
1 Eglinton Ave East, Suite 208
Toronto, Ontario M4P 3A1
Fax: (416) 480-0320 membership@cas.ca

Canadian Anesthesiologists' Society

2012 Call for Nominations

Emeritus Membership Award

To recognize retired individuals who during their long-standing practice made a significant contribution to anesthesia.

Eligibility

The recipient will have been an Active member of the Society in practice for 30 years or more.

Nomination and Selection

- This nomination must also be supported by the nominee's division, with letters of support submitted by the division.
- Each nomination shall be held **indefinitely.**

Clinical Practitioner Award

To recognize excellence in clinical anesthesia practice.

Eligibility

The award shall be given to a member of the CAS who has made a significant contribution to the practice of clinical anesthesia in Canada.

Clinical Teacher Award

To recognize excellence in the teaching of clinical anesthesia.

Eligibility

The award shall be made to a member of the CAS who has made a significant contribution to the teaching of anesthesia in Canada. The recipient shall not be a member of the Board of the Society.

John Bradley Young Educator Award

To recognize excellence and effectiveness in education in anesthesia.

Eligibility

The award shall be given to an Active member of the CAS within his/her first 10 years of practice who has made significant contributions to the education of students and residents in anesthesia in Canada.

Refer to **Nomination and Selection information** on previous page

Medical Student Prize

To increase awareness among undergraduate medical students of the specialty of anesthesia and the role of anesthesiologists in healthcare.

A first, second and third prize will be awarded.

Eligibility

Full-time medical students in any Canadian medical school.

Format

- Written submission: 1000 to 1500 words.
- Topics related to anesthesia preferred. Alternatives can be discussed with your local undergradute education director.
- Anesthesia undergraduate education directors at each university oversee the submission process and assist with topic selection.
- Microsoft Word is preferred, but other formats are accepted.

Selection Process

- Initial review process at each university with maximum of two essays forwarded to national review committee.

Local submission deadline:
February 17, 2012

Final decision by national review committee in April 2012.

For more information, please contact:

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Recent Amendments To CAS Bylaws

By Dr Salvatore Spadafora, FRCPC
CAS Secretary

At the June 2011 Annual Business Meeting, CAS members approved important amendments to the CAS Bylaws, which were previously approved by the CAS Board. There were a number of changes, which are highlighted below.

There was an impetus for strengthening the CAS Board governance structure and electing Directors at the CAS Annual Business Meeting to help improve accountability and to help the Divisions that find the election process challenging.

It is important to note that each Division will keep their say in who represents the Division on the CAS Board. There will be a nominating process within each Division, which can be as open as each Division wants and enables multiple candidates to run for the nomination. Divisions should note that their Board Representative does not have to be the Division President and they do not have to be elected at the same time.

Divisions will nominate representatives and provide notice to the CAS Board by February 1 each year. Currently, Divisions give notice by September 1. If a Division is unable to nominate an individual by the deadline, the CAS Board would have to wait until the following year to elect a Board representative from that Division. If an elected representative is unable to complete their term, the CAS Board will appoint a replacement.

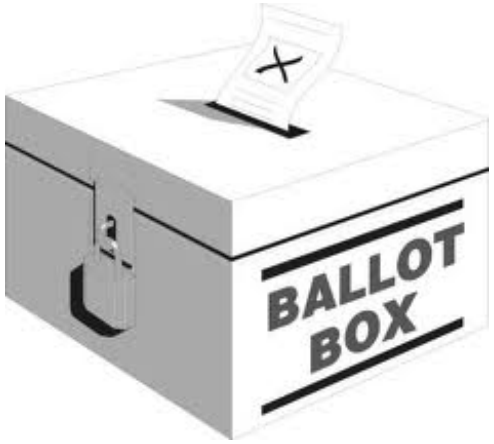
Existing directors will complete their terms. In 2011, Divisions will have at least one last opportunity to elect or re-elect a Board representative for a two-year term beginning on September 1.

The first election under the new framework will take place in 2012 to replace the current Board representatives whose terms expire on August 31, 2012. The second election will be in 2013 to replace the Board representatives whose terms expire on August 31, 2013.

Other changes to note are that the CAS President and Vice-President will serve one two-year term (in place of two one-year terms) and the ACUDA Chair is now a voting Director (previously, it was a non-voting position).

Call for Nominations: CAS Vice-President

By December 31, 2011, the Nominating Committee, chaired by Past President Dr Pierre Fiset, is required to present the Board of Directors with a nominee for a new CAS Vice-President to take office September 1, 2012. 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 contact Joy Brickell at mailto:adminservices@cas.ca

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

"Research, like cycling in Newfoundland, is an uphill challenge. That's why I give to CARF."

Dr. Susan O'Leary
Department of Anesthesia
Memorial University
of Newfoundland

Susan O'Leary

Our profession deserves a firm foundation

CARF
Canadian Anesthesia Research Foundation
www.anesthesia.org/carf

2011 Medical Student First Prize Paper

Addiction In Anesthesia: Past, Present and Future Hope

By Alistair Smith

Since its development almost 175 years ago, the field of anesthesia has evolved rapidly. The development of new techniques such as spinal and regional anesthesia has increased the efficiency of operations and decreased recovery time for patients. Similarly, the advent of new medications has resulted in increased patient safety and comfort during procedures. In spite of all of the progress that has been made regarding patient care, the issue of physician addiction in the field continues to be a major problem and appears to be as prevalent today as ever, if not more so[4,9]. Addiction in anesthesia is almost as old as the specialty itself; one of the early leaders in the development of volatile anaesthesia, Dr. Horace Wells, eventually became addicted to chloroform, battled with depression, and eventually took his own life in 1848[10]. It is both surprising and troubling that after so many years that addiction in anesthesia remains such a persistent problem. Fortunately, improving the situation is a surmountable task as awareness of the problems continues to grow and novel solutions are put forward.

The actual prevalence of addiction among anesthesia providers is difficult to ascertain[4,9]. What is known for certain is that anesthesia personnel are overrepresented in treatment and rehabilitation programs for physicians dealing with addictions[3,5,7]. Two potential conclusions could be drawn from this fact: that the prevalence of addiction among anesthetists is indeed higher than among other medical specialties, or that anesthetists are simply more likely to seek treatment for their problem. While some authors have argued the latter, many studies report that levels of addiction are indeed higher in anesthesia as compared to other specialties, and almost every study agrees that it is a major occupational hazard in the field of anesthesia[1,4,9,15]. Currently, the most common substances of abuse within anesthesiology are fentanyl, alcohol, midazolam, oral opioids, and propofol[3,6,A]. Several studies have noted that while rates of alcohol addiction between medical specialties are comparable to one another and to the level in the general public, anesthesia personnel are much more likely to become addicted to opioids than the two aforementioned groups[1,4]. Additionally, a separate study found that the anesthetists participating in the study were more likely to have tried intravenous drugs than physicians from other fields[5]. Although the risks of the commonly abused drugs are well known, a study conducted in 2000 found that anesthetists have a higher risk of death from accidental poisoning and suicide – particularly drug related suicide – when compared with a cohort of internists and with the general public[1]. While this finding further illustrates that anyone is susceptible to addiction, it raises the question of why is it so prevalent among anesthetists?

Various theories have attempted to explain the potential etiologies behind the prevalence of addiction in anesthesia. While the potentially high levels of stress in the workplace – and in anesthesia training programs – no doubt contribute to addiction for some individuals, other programs in the medical field are also potentially stressful[4,6]. Stress is therefore unlikely to be an independent cause[9]. Some authors have argued that close proximity to commonly addictive drugs, and knowledge of dosage and administration of these drugs plays a role in addiction[2,4,6,10]. Furthermore, that anesthetists commonly work alone and are able to prescribe, draw up, and administer medications may be contributing factors[2]. Another explanation is offered by a recent study which found that low doses of aerosolized narcotics and propofol could be found in areas of the operating room, particularly around the anesthetists work area as the patient exhales small amounts of the drugs – even intravenous drugs such as propofol[9]. It was proposed that this prolonged low dose exposure to opioids in the operating room could increase the risk for addiction in susceptible individuals. Other factors found to increase the risk for addiction were genetics and previous history of marijuana or tobacco use[9]. The same authors postulated that certain personality types common in anesthesia may also predispose individuals to addiction. It may be that in the addicted individual, there has been a "perfect-storm" of factors that have all contributed to the current situation.

Given the multitude of potential contributing factors for addiction it is not surprising that many different options have been discussed as possible solutions. Close regulation of narcotic usage, "for cause" testing, and education programs have been implemented at various sites in Canada and the United States in an attempt to decrease addiction in anesthesia[4,11]. Unfortunately, the determined addict will often find a way to feed their addiction regardless of deterrents. With increased monitoring of narcotic usage there have been reports of some physicians drawing up an amount of narcotic and administering less than the full dose to the patient, keeping the remainder for personal use[6]. They may use volatile anesthetic to keep the patient asleep and substitute non-controlled IV agents in place of narcotics[6]. This type of behaviour obviously in-

A While propofol still makes up a relatively small percentage of common substances of abuse, it is worth noting that its popularity has increased dramatically over the last decade[14].

creases the possibility of adverse patient outcomes, and there have been reports of intra-operative patient morbidity related to anesthetist impairment[7]. At this time, it appears as though the best available option to help addicted physicians is early identification and early registration in a physician rehabilitation or physician health/wellness program[4,6].

Identification of physician addiction can be challenging. One study reported that anesthetists are less likely than other medical specialists to seek help for alcohol addiction, but more likely to seek help for opiate addiction[11]. That being said, for those who do not voluntarily seek help, they often become adept at hiding indications of their condition and therefore signs can be subtle[4,5]. Vigilance is required on the part of the physician's colleagues to notice the subtle signs of addiction. In a recent article on the topic, the author mentions that the addicted physician may demonstrate mood swings; withdrawal from friends, family, and leisure activities; spending extra at the hospital often while not on duty; refusing lunch or coffee breaks; and weight loss and pale skin among other signs[4]. There is a scarcity of Canadian literature on this topic and therefore it is difficult to discuss the specific details regarding reporting and rehabilitation protocols for addicted physicians. Every province in Canada has some form of Physician Rehabilitation Program designed to help physicians who are dealing with stress or illness in their lives, including addiction; however, the efficacy of similar programs in other centers remains controversial[3,4]. Studies have reported highly variable relapse rates among anesthetists enrolled in these programs, with several factors such as the presence of a comorbid personality disorder or family history of addiction altering an individual's risk for relapse[3,4,5,6,11,14]. Similarly, there remains debate as to whether previously addicted anesthetists and residents are able to safely return to work in the field of anesthesia without relapse. Currently, it appears that the most cases should be assessed on an individual basis[4]. Studies have shown that the highest risk for addiction in anesthesia is in the 5 years after graduation from medical school; in Canada, this would be during the residency period[1,6]. This means programs to increase awareness, educate and promote wellness among physicians and residents in anesthesia, and also amongst medical students could provide some very positive results.

While physician, resident and student wellness programs are still in their early stages, they have been established in a few centers already and are likely to continue to develop in more centers across the country. Although these programs are relatively new, they may have great potential. Addiction may not be the most upbeat topic, but the reality is that is has affected many anesthesia departments and residency programs across the country. While not an issue isolated to anesthetists – though it may be more prevalent in anesthesia compared to other specialties – there has been a continued awareness of the issue in the field of anesthesia for quite some time[3]. This sustained awareness, combined with the desire to improve the situation and ideas such as the developing wellness programs, will hopefully allow addiction to be less of a burden on the specialty and more of an opportunity to improve and be leaders in healthcare and wellness.

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*** The author would also like to thank Ms. Susan Baer and the staff at Regina General Hospital Library for their assistance in research for this essay.*

CAS Responds To Letter From BCAS

June 21, 2011

Dear Dr. Chisholm,

I would like to bring to the attention of the CAS Board my serious concerns about recent events in British Columbia, and the threat they are posing for our specialty throughout Canada.

As you know, we have been experiencing very significant and worsening recruitment problems throughout BC; not just in the more rural sites, but in Metro Vancouver and other urban areas. For the last few years, recruitment of "new" anesthesiologists to BC has consisted almost entirely of retired or retiring anesthesiologists from other provinces, as well as a general decline in the qualifications sought throughout our province.

Urban referral and tertiary hospitals which have traditionally been staffed by Canadian certified (FRCPC) anesthesiologists are now relying on foreign-certified specialists and GPAs; situations which raise concerns about scope of practice and the limits of effective "supervision".

Our shortage of qualified staff is so acute that some foreign-certified IMGs are attracting multiple competing job offers in BC, and it is not uncommon for them to continue practising in BC without Royal College certification, essentially on a permanent basis.

Despite having the lowest anesthesiologist remuneration in Canada, coupled with the highest cost of living, both the BC government and our provincial medical organization (BCMA) have staunchly denied the existence of a problem, while simultaneously declaring additional BC communities as "under-serviced areas of need".

Meanwhile, in attempts to meet the needs of our patients, BC anesthesiologists have worked progressively longer hours, have cancelled holidays, and face unsustainable call schedules.

Rather than work with us to create an environment conducive to recruitment and quality patient care, there are now credible threats arising from government circles that they will sacrifice patient safety by imposing non-physician anesthesia providers.

We are deeply concerned for patient safety and what this means for the future of the profession beyond BC.

We appreciate the support of the CAS in responding to these threats to our patients and to our specialty.

Sincerely,

Dr James A Helliwell, FRCPC
President, BCAS

July 22, 2011

Dear BCAS Member,

The Canadian Anesthesiologists' Society is aware of the evolving situation with regard to Anesthesia human resources in British Columbia. At the recent June CAS meeting in Toronto I heard from representatives of the British Columbia Anesthesiologists' Society (BCAS) as well as your Board representative. The Physician Resource and Economics Committees as well the Divisional Forum received a report on the situation in British Columbia. I think I can say the majority of the rest of the country is aware of your rather unique situation and is concerned.

Recently the CAS collaborated with Dr Dale Engen from Queens University on a survey of human resources in Anesthesia in Canada. BC is one of only 3 provinces that did not have some degree of decrease in their provincial vacancy rate from 2002 to 2010. In regards to income, BC has a much lower proportion of their departments earning more than $400,000/year compared to the rest of Western Canada. Departments earning less than $400,000/ year were more likely to report vacancy rates.

The CAS Economics Committee has reported BC to be in the lower range of income whether it be dollars per hour or net yearly income.

The independent practice of Anesthesiology is a specialized field of medicine. As such, it should be practised by physicians with appropriate training in anesthesia. The only route to specialist recognition in anesthesia in Canada is through the certification process of the Royal College of Physicians and Surgeons of Canada. The Canadian Anesthesiologists' Society acknowledges the fact that remote communities often lack the population base to support a specialist anesthetic practice. In these communities, appropriately trained family physicians who have undertaken accredited training in PGY 3 Enhanced Skills programs under the auspices of the College of Family Practice of Canada (or equivalent training) may be required to provide anesthesia services.

Departments should be staffed appropriately, bearing in mind the scope and nature of the services provided, and should strive to ensure that these services are available as required by the patients, community and health care facility. Physicians should not be expected to practice beyond their scope of practice and we as practicing Anesthesiologists must endeavour to promote this in the spirit of patient safety and in the name of improving the health and outcomes of the populations we serve.

The CAS understands the severity of the health human resources issues but most importantly the need to maintain quality and patient safety despite heavy recruitment challenges.

Sincerely,

Dr Rick Chisholm, FRCPC
President
Canadian Anesthesiologists' Society

Board Update

Membership Services

The Board approved minor revisions to guidelines for honour awards. Among the changes, in future nominations will be sent to the Membership Services Committee Chair and held for a period of not less than five years (nominations for Emeritus Membership will continue to be held indefinitely).

The Membership Services Committee considered the membership criteria for physicians practising in the subspecialty in pain medicine. No changes were recommended to the CAS membership criteria. Anesthesiologists practising in pain medicine would continue to be covered by the Active Membership category, and other medical practitioners in pain medicine would be covered by the Associate Membership category. The Committee considered creating a semi-retired or part-time membership category, with lower membership fees similar to other provincial bodies. The Committee concluded it is very difficult to manage such a membership and no changes were recommended to the CAS membership categories or fee structure.

Research Advisory

The Board approved minor revisions to the terms of reference for the Research Advisory Committee. The Board also established a new Grant Standing Subcommittee to recommend to the Board the recipient of each award, fellowship and grant offered by the Society for research. The Committee is continuing to streamline guidelines to eliminate duplication and provide clear instructions for research applications. Among the changes, all applicants are required to submit a CIHR-validated Common CV; in 2012, there will be expanded instructions for first-time users.

Standards

The Airway Interest Group, an informal group consisting of a number of CAS members, has proposed developing guidelines for airway management. The Board accepted the following recommendations from the Standards Committee to apply whenever the Society's "endorsement" of standards is to be considered: (a) such standards should be coordinated by the Standards Committee; (b) a member of the Committee should be a member of the working group of the Guidelines Committee; and (c) the guidelines should be developed with the principle "Collaboration, Simplicity, Transparency".

Dr Richard Merchant, CAS Standards Chair, was invited to establish guidelines for pacemakers with the Canadian Cardiovascular Society (CCS). The Board accepted in principle the CCS/CAS position statement on the Perioperative Management of Patients with Pacemakers, Implantable Defibrillators and Neurostimulating Devices. The Standards Committee considered a request from the Chief Coroner of Ontario to develop guidelines for the use of an Airway Exchange Catheter (AEC) and an Endotracheal Ventilation Catheter (ETVC). A safety alert had been posted to the CAS website, as reported in the November/December 2010 issue of *Anesthesia News*, and a review article, *Supplementing oxygen through an airway exchange catheter: efficacy, complications and recommendations* by L.V. Duggan, J.A. Law and M.F. Murphy was published in the June 2011 issue of *CJA*. The Committee did not feel there was sufficient need for developing further guidelines for the use of these devices.

The Board approved various updates to the Guidelines to the Practice of Anesthesia, to be published in the January 2012 issue of *CJA*. The approved changes included modifications to Appendix 5, "Position Statement on Anesthesia Assistants", through recommendations developed by the Allied Health Committee.

Patient Safety

With its commitment to improving patient safety and quality of care, CAS is supporting the collaborative efforts of the Institute for Safe Medication Practices Canada (ISMPC), the Canadian Patient Safety Institute (CPSI) and its partners in establishing a voluntary national standard for automated identification and data capture of pharmaceuticals in Canada.

This initiative – known as the Canadian Pharmaceutical Bar Coding Project – is an important development in patient safety. These ongoing efforts to increase awareness of the automated identification of medications, and develop a Canadian strategy for the safe adoption and administration of hospital and community medication systems will reduce preventable medications errors. Patients will benefit from point-of-care applications that use automated identification technologies and improved management and tracking of pharmaceuticals throughout the supply chain.

The Board agreed that CAS will offer support to the initiative in the following ways:

- Advocate for implementation of automated identification of pharmaceuticals throughout the healthcare system as an important advance in patient safety.
- Endorse the intent of the Joint Technical Statement on Pharmaceutical Automated Identification and Product Database Requirement.

The Patient Safety Committee will continue to monitor the progress of the Canadian Pharmaceutical Bar Coding Project.

Ethics

The Ethics Committee has prepared a revision to the research ethics guidelines to assist investigators involved in anesthesia research with human subjects. The Board endorsed the Guidelines on the Ethics of Clinical Research in Anesthesia (http://www.cas.ca/English/Guidelines).

HHR Survey

The results of Dr Dale Engen's study, "Canadian Anesthesia Workforce Assessment 2010" were submitted as an abstract to the 2011 CAS Annual Meeting. Dr Drew McLaren presented the findings to the Physician Resources Committee as well as during the Resident Competition. Click here to view the abstract: http://www.cas.ca/English/Page/Files/464_1067905.pdf

WFSA

Dr Tony Boulton's term on the WFSA Executive Committee will conclude in 2012. The Society will nominate Dr Pierre Fiset to replace Dr Boulton at the next WFSA general assembly in Buenos Aires.

Royal College Launches Revitalized MOC Program

As part of an ongoing commitment to high-quality health care provided by competent physicians, the Royal College of Physicians and Surgeons of Canada recently launched a redesigned MAINPORT web application to complement its revised Maintenance of Certification (MOC) Program that came into effect in January 2011.

"We developed the new systems after an extensive period of analysis," said Dr Craig Campbell, director of the Royal College's Office of Professional Affairs. "The revisions are informed by two streams of evidence: a comprehensive study with 3,000 Royal College Fellows and a thorough review of the continuing professional development research literature."

First launched in 2001, the MOC Program is an evidence-informed educational initiative designed to support, enhance and promote the continuing professional development (CPD) activities of specialist physicians in Canada and to support the lifelong learning goals of its membership.

The new MOC Program is streamlined and more flexible than its predecessor. For example, it is now organized under three learning sections (instead of six) and incorporates a wider range of learning activities, offering MOC Program participants greater opportunities to earn credit.

To complement the MOC Program improvements, MAINPORT — the web application system where CPD activities are documented — has also been redesigned. In the new MAINPORT, MOC Program participants can now set practice goals, including plans and dates for completing them, and link their learning activities to one or more Roles within the *CanMEDS Physician Competency Framework*.

The Royal College has also built MAINPORT Mobile, an app that enables users to enter CPD activities from their iPhone, iPad, Android or BlackBerry.

To ease the transition from the former system, the Royal College is providing MOC Program participants with several training opportunities. These include a MAINPORT flash tutorial, one-on-one sessions with a Membership Services Centre, and help from 12 regional PCD educators recruited from across the country. More information on the MOC Program and MAINPORT is available on the Royal College's website: http://rcpsc.medical.org/opa/moc-program/index.php.

The Royal College encourages MOC Program participants to try out the new MAINPORT before January 31, 2012, the deadline to submit 2011 MOC activities.

2011 Wait Time Alliance Report Card: Time Out!

The Wait Time Alliance (WTA) recently released its June 2011 "Time Out" Report Card. While there is some "good news" in that some progress has been made in improving Canadians' access to timely care in the original five priority areas, the "bad news" for anesthesiology is that no provinces are reporting on wait times for the use of anesthesiology to treat chronic pain.

As shown in the extract below (Table 3 from page 6 of the report), the most striking finding continues to be the lack of provincial reporting on wait times outside the original five priority areas (cancer, cardiac care, diagnostic imaging, joint replacement and sight restoration).

Table 3. Provincial wait times compared to select WTA benchmarks

Treatment/service/procedure	WTA Benchmark	NL	PE	NS	NB	QC	ON	MB	SK	AB	BC
Anesthesiology (chronic pain)											
Acute neuropathic pain	30 days	?	?	?	?	?	?	?	?	?	?
Acute lumbar disc protusion	3 months	?	?	?	?	?	?	?	?	?	?
Cancer pain	2 weeks	?	?	?	?	?	?	?	?	?	?
Subacute chronic pain working age	3 months	?	?	?	?	?	?	?	?	?	?

CAS is concerned that there is no reporting for wait times for chronic pain provided by anesthesiologists. In terms of the public's healthcare, these services provide a significant contribution to the overall health system in Canada.

To access the full report, go the Wait Time Alliance website: www.waittimealliance.ca and click on the top icon under "What's New" (WTA Report Card 2011: Time out).

Global Oximetry Project Strives To Meet Its Goal

The June 2011 issue of *Anesthesia News* highlighted the LifeBox global oximetry educational project now underway in Rwanda and, in particular, the immediate need for donations to enable the purchase of much-needed oximeters.

Help a Colleague Save Lives

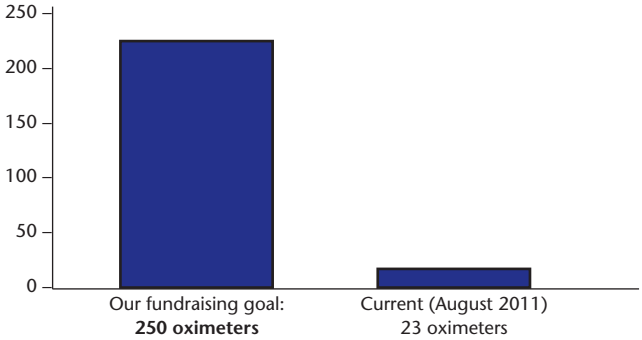
The oximetry project relies extensively on financial donations. Can we count on you?

Please consider making a donation to this important educational initiative, as we are well short of our target at this time.

A $250 donation to the Global Oximetry Project will put this essential safety device into the hands of colleagues who need it most. Each kit comes with training materials and a WHO Surgical Safety Checklist. It has already been shown to significantly reduce operating room complications and mortality rates.

Your Generosity is Greatly Appreciated

To make your donation, please go to http://www.cas.ca/English/Oximetry-Project. A Canadian charitable tax receipt will be issued.



The Self Assessment Program from the *Canadian Journal of Anesthesia* — CPD Online

NEW CPD MODULE: Anesthetic management of patients with an anterior mediastinal mass (**SEPTEMBER 2011)**

ALSO AVAILABLE

- Assessment and treatment of preoperative anemia (**June 2011)**
- Perioperative glucose control: living in uncertain times (**March 2011)**
- Locating the epidural space in obstetric patients: ultrasound a useful tool (**December 2010)**
- Management of sleep apnea in adults - functional algorithms for the perioperative period (**September 2010)**
- Anesthetic management for pediatric strabismus surgery (**June 2010)**
- Ultrasound guidance for internal jugular vein cannulation (**May 2010)**
- Perioperative pain management in the patient treated with opioids (**December 2009)**

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 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.

Publication of this Continuing Professional Development Program is made possible through unrestricted educational grants from the following industry partners:

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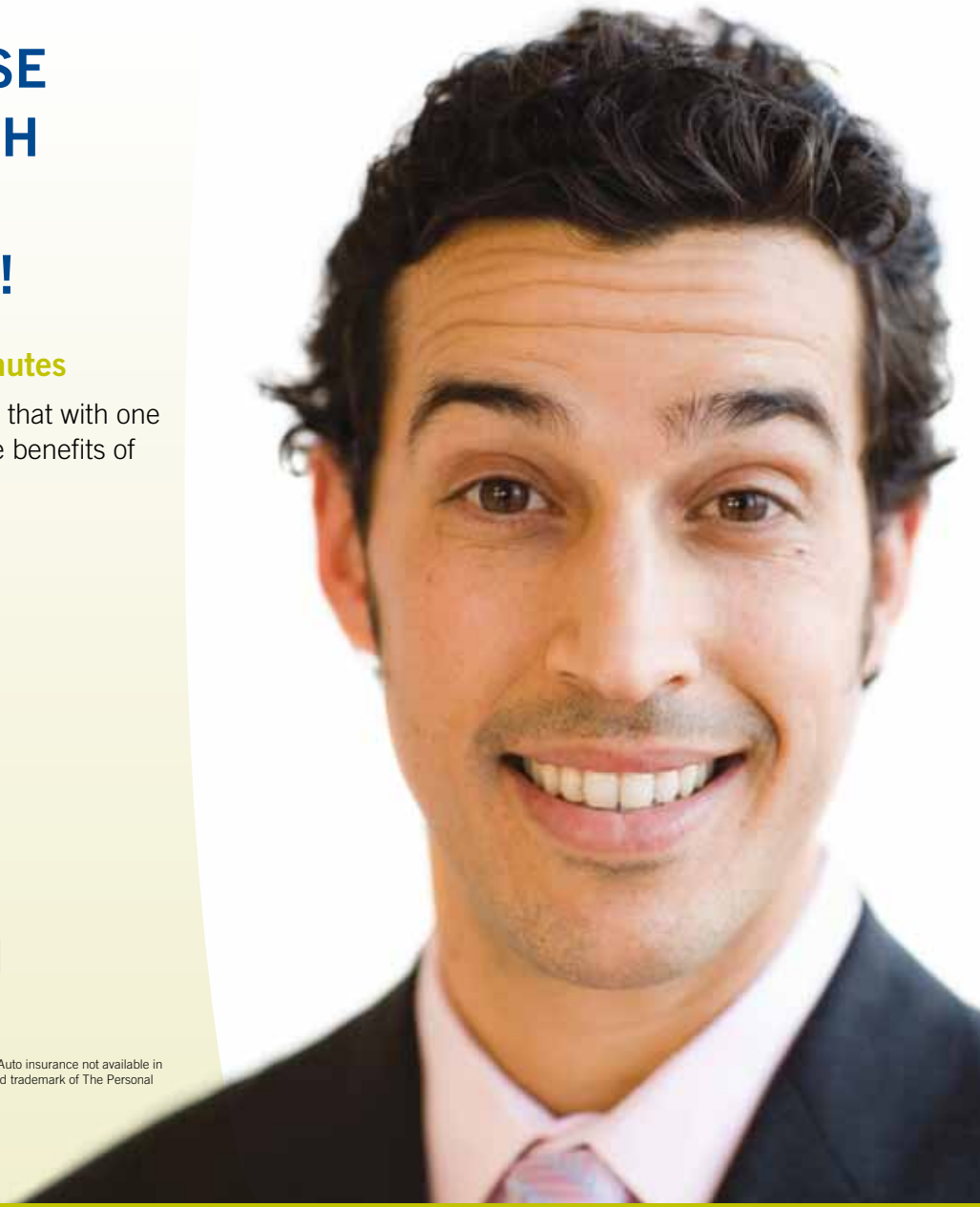

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Canadian Anesthesiologists' Society 2010 Research Award

Dr Kong Eric You-Ten
Mount Sinai Hospital
Toronto, ON

The Impact of Simulation on the Performance of Cricothyrotomy on a Hybrid Porcine Larynx-High Fidelity Patient Simulator

Background

A "Cannot Intubate – Cannot Ventilate" (CICV) event is one of the most feared airway crises that can rapidly lead to significant patient morbidity and mortality. Traditionally, cricothyrotomy is taught using various models including human cadavers, mannequins and animal larynxes. However, these models are "static" in that they cannot replicate the psychological and time stresses associated with a clinical CICV crisis. We have developed a unique hybrid porcine larynx-high fidelity patient simulator model that simulated a CICV crisis, with the added realism of a replicated human larynx. Currently, little is known on the impact of simulation on the performance of cricothyrotomy.

Objective

In the proposed study, our model was used to determine the impact of a simulated airway crisis, when compared to a non-simulated scenario, on the performance of cricothyrotomy.

Results

The study is now completed; however, we continue to analyze the videos of the recorded sessions for global rating performance. The data that has been completed included the insertion time of the breathing tube, severity of injury and failure rate. Sixty-five participants completed the study, where 32 participants performed cricothyrotomy using the uncuffed Melker 3.5 mm and 33 participants used the cuffed Melker 5.0 mm cricothyrotomy kits. Insertion times, injury severity (three-point scale) and failure rate (defined as insertion time > 5 mins or more than two insertion attempts) were compared between simulation and non-simulation.

As shown in the figures below, our results demonstrated that simulation, when compared to non-simulation, had no significant difference (NS: non-significant) in insertion time (Fig. 1), injury severity (Fig. 2) and failure rate (Fig. 3).

Figure 1: Insertion Time

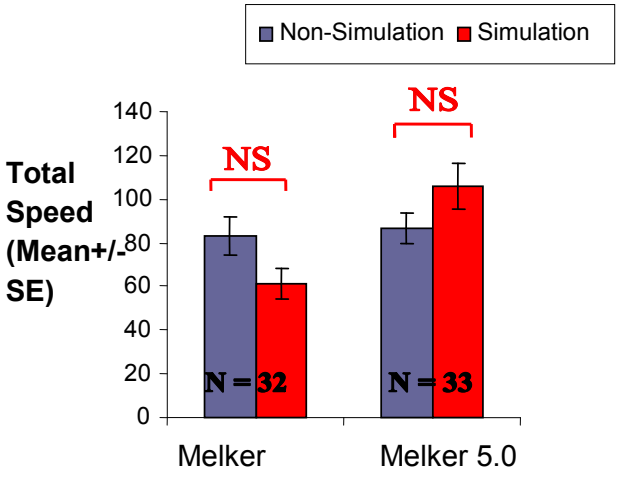


Figure 2: Severity of Injury

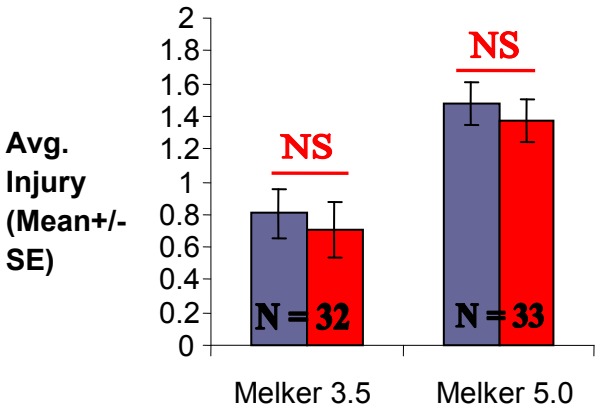
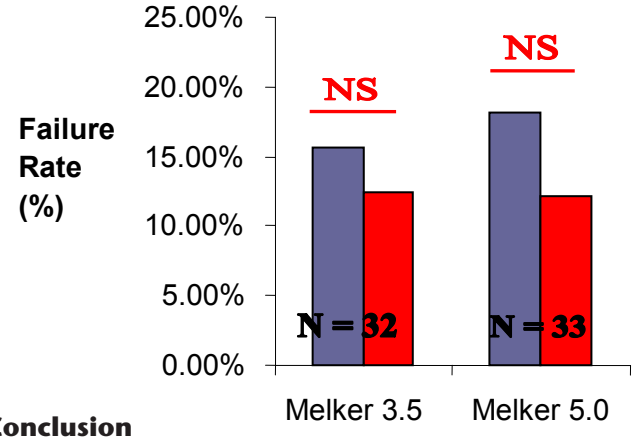


Figure 3: Failure Rate



Conclusion

Our results showed that simulation does not affect the insertion time, severity of injury and failure rate of performing cricothyrotomy on our hybrid model. These data suggest that that stressors associated with a simulated crisis had no impact on the performance of cricothyrotomy. However, the global rating scale performance will be completed to complete the data analysis.

continued on page 18

2010 Baxter Corporation Canadian Research Award In Anesthesia

Dr Gillian Lauder
British Columbia Children's Hospital (BCCH)
Vancouver, BC

Naloxone for the Treatment of Opioid-induced Pruritus in Children: A Double-blind, Prospective, Randomized, Controlled Study

Progress to Date

Initial REB approval was received on May 3, 2010. Phase 1 of the study, the stability and compatibility testing of morphine with naloxone, has been completed. Results have been analyzed, written up and submitted for publication.

We began recruiting participants to Phase 2 of the study, the clinical evaluation of naloxone in patient-controlled analgesia (PCA), on February 21, 2011. To date, 20 patients have consented to participate: data collection has been completed for 12 of these; l is awaiting surgery; 7 were excluded preoperatively according to study protocol exclusion criteria (recent opioid consumption, requiring ICU post-surgery, decision to administer epidural or continuous morphine infusion rather than PCA for postoperative pain management).

The BCCH pharmacy, anesthesiologists, nursing staff and research team are fully engaged with the study and data collection stage is proceeding smoothly. We are now in a position to increase our recruitment rate and anticipate that we will be able to complete this stage by June 2012. There have been no problems or concerns, so far, at any time from recruitment to completion for any individual patient recruited to the study.

We are currently planning a parallel study on the use of naloxone in patients receiving continuous morphine infusions.

We are also conducting a study on the use of naloxone in patients receiving epidural pain management (Naloxone Infusion for the Prevention of Neuraxial Opioid-induced Pruritus: A Double-blind, Prospective, Randomized, Controlled Study in Children).

2010 DR R A Gordon Patient Safety Research Award

Dr Gregory Bryson, FRCPC
The Ottawa Hospital
Ottawa, ON

Functional Recovery and Caregiver Burden Following Surgery in the Elderly

Summary of Progress to Date

Our project entitled "Functional Recovery and Caregiver Burden Following Surgery in the Elderly" began recruiting in the week of July 19, 2010. Slow recruitment in the first three months prompted several amendments to the protocol to increase eligible patients and facilitate data collection. These changes have markedly improved our recruitment and retention and as of May 31, 2011 we had recruited 74 of a planned 100 patient:caregiver dyad participants. With a conservative estimate of ten patient: caregiver dyads recruited per month, we anticipate completing the trial by summer's end and moving to data cleaning/analysis in the fall of 2011. To date, we have also collected functional outcome data on six additional patients who live alone and have no defined caregiver.

As mentioned in our interim report, our study was submitted for an internal, peer-reviewed competition for departmental funding. We are pleased to report that we were successful in securing an additional $20,000 of departmental funds to support recruitment on all three sites of The Ottawa Hospital.

Thanks to the support of the Canadian Anesthesiologists' Society, we anticipate sharing our findings regarding the impact of ambulatory surgery on both patients and their families at the 2012 Canadian Anesthesiologists' Society Meeting.