Anesthesia News
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Canadian Elected President of World Federation

Dr Angela Enright from Victoria BC was elected President of the World Federation of Societies of Anaesthesiologists in March of 2008. She is only the second Canadian to achieve this honour. The first was the WFSA's founding President, Dr. Harold Griffith, from McGill in 1955. Please join the CAS in congratulating Dr. Enright!

HALIFAX: History, Hospitality and Culture Abound

Preparations are well underway for the 2008 Annual Meeting, and the Local Arrangements Subcommittee is working hard to showcase Halifax and Nova Scotia to the rest of the country.

Get your orientation to the city by attending the Welcome Reception on the Friday evening at the World Trade and Convention Centre, in downtown Halifax. Join us at Pier 21, Canada's national immigration museum on Saturday evening for the culmination of an "Amazing Race" through Halifax as teams compete for the Golden Glottis Cup! No doubt your provincial representatives will be asking for volunteers; this is your opportunity to compete in a version of the famous TV series. The CARF Fun Run on Sunday will take place on our traditional route in Point Pleasant Park. Come see the park as it starts to regenerate from the devastation of Hurricane Juan. You will be amazed at the new vistas opened up by that storm.

The wine and food pairing event was such a hit last year that we have decided to expand it. This year, by request, we will also offer a beer and food pairing. Both will be held on Sunday night in the Halifax Citadel National Historic Site; the wine event in the North Magazine and the beer event in the Soldiers Library. We will showcase Nova Scotia wines and beers along with sensational food. Tickets for this event are limited, so be sure to sign up early.

This year the President's Dinner will be a traditional lobster party and seafood extravaganza held on the Monday night. Don't worry if you are not a pescivore — there are excellent non-seafood alternatives. The venue will be in the Cunard Centre, Halifax's home based cruise lines embarkation centre situated directly on Halifax Harbour. We have kept the entertainment to a minimum to allow delegates to chat with old friends and meet new acquaintances. Last time the CAS was in Halifax we held two lobster dinners and both sold out well in advance of the meeting so please book early as you won't want to miss it!

Delegates will receive a list of tour companies at registration, providing information on some short fun tours such as the world famous Halifax Harbour Hopper, an amphibious tour of the city and harbour! We will also be supplying a list of restaurants, and their best dishes, recommended by our Halifax colleagues.

Finally, we strongly recommend that delegates book their hotel rooms early, and are anxious to welcome you to Halifax in June.

John G Muir MB ChB, FRCPC
Chair, Local Arrangements Sub-committee

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You may contact members, representatives, and invited delegates of the Board of Directors through the CAS central office.

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President's Message

Sedation: Everyone Wants To Do It

Sedation of patients occurs throughout the country by a variety of caregivers besides anesthesiologists. Historically, we have been the providers when the procedures occurred in the operating room but had little role in the rest of the hospital. That may drastically change. Forces outside our specialty demand that the CAS re-evaluate our role in provision of sedation and supervision of sedation for a variety of patients in Canada. Should we be involved in sedation for endoscopy or topical cataracts? What about the ER, outpatients or private clinics?

The Canadian Association of Gastroenterologists has asked for our opinion on the safety of gastroenterologists delivering propofol to assist with endoscopy. Clearly they see this as an improvement in efficiency and patient satisfaction. Current practice in Canada for endoscopy sedation varies widely. The CAS needs to formulate a position on sedation and the supervision of sedation by others.

The Canadian Ophthalmological Society is drafting a position statement, "Evidence-based Clinical Practice Guidelines for Cataract Surgery in the Adult Eye". There is a section on involvement of anesthesiology based on patient selection and the use of a screening questionnaire. They reference our "well documented manpower shortage" and propose that our input is only required in about 4% of cases. The trend in Canada is to use anesthesia extenders to assess and monitor these routine cases.

Other patients receive deep sedation outside the OR for a variety of diagnostic and therapeutic procedures. Training levels vary widely and monitoring is inconsistent.

The matching of anesthesiologist supply and demand in Canada has been an elusive target. The impact of our involvement in these areas of sedation is far larger than the looming effects of demographics. We know from experience in the USA and Australia that sedation accounts for up to 25% of all anesthesia billings. Defining our role in that market will have a massive effect on demand for our services.

Forces outside our specialty demand that the CAS re-evaluate our role in provision of sedation and supervision of sedation for a variety of patients in Canada.

Tell us what you think! Talk to your provincial representatives or email Executive members. Your CAS Board will continue to represent the wishes of all members as we forge ahead in the midst of constant change.

Shane Sheppard, MD FRCPC
President

News from the Board

Highlights from January 19-20, 2008 Meeting in Toronto

Strategic Planning Task Force

This Task Force has been established chaired by Dr Pierre Fiset, CAS Vice-President. The Task Force will classify the action steps as high, medium and low priority, and will make recommendations to the Board, based on appropriate input, such as from Committees. The five or six top priorities will be budgeted and presented to the Board in June.

CAS to remain part of CAGA

The CAS, the College of Family Physicians of Canada and the Society of Rural Physicians of Canada jointly sponsor the Collaborative Advisory Group for General and Family Practice Anesthesia (CAGA). Each year CAS is asked to fund one third of the costs of CAGA. Dr Robert Seal represents CAS in CAGA and has done so since it was initiated. Dr Seal provided a report recommending that family doctors are better equipped than nurses to administer anesthesia. CAGA is scheduled to meet in Halifax during the CAS annual meeting. There was support for CAS to remain part of CAGA as it provides an opportunity to keep involved with issues that are relevant to our specialty.

2008 Annual Meeting, Halifax

Scientific and social programs are near completion. A CAS IEF Global Outreach Course will run from Friday, June 13 through Sunday June 15.. The local arrangements committee is busy making final arrangements for the Welcome reception, Golden Glottis Cup Challenge, CARF Fun Run, Food and Wine Pairing, Beer and Food Tasting and the President's dinner.

2011 Annual Meeting in Toronto

The 2011 CAS Annual Meeting was originally scheduled to be in Ottawa, but the Ottawa Convention Centre is being rebuilt and may not be completed on time. As a result, we will hold the 2011 meeting in Toronto.

Anesthesia Assistants

The core members of the Allied Health Committee reviewed the curricula from the four institutions (Michener Institute and Fanshawe College in Ontario, Thompson Rivers University in British Columbia, and the University of Manitoba) that are currently offering an Anesthesia Assistant (AA) program. The committee will work with the Canadian Society of Respiratory Therapists (CSRT) to standardize training across Canada. The Board has asked the Standards Committee to develop a position on how to supervise AAs attending a sedated patient.

Continuing Education

The Continuing Education and Professional Development Committee (CEPD,) with advice from the Ethics Committee, updated the CAS Industry Guidelines and Disclosure forms and presented them to the Board for review. CAS meets the requirements of the Royal College of Physicians and Surgeons of Canada to maintain status as an accreditor. The CEPD Needs Assessment information collected by Dr François Donati and the CJA will be used to help guide both the content of the annual meeting and the CME articles developed by the CJA. An ongoing process for regular needs assessments of the membership will be developed to help guide CEPD activities in the future. This will be a joint effort with ACUDA. CAS has hired a medical education consultant to support the annual meeting and CEPD committee.

Common Issues Group

Dr Shane Sheppard and Mr Stan Mandarich travelled to Sydney, Australia to participate in the Common Issues Group meeting with representatives from the American Society of Anesthesiologists (ASA), the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the Australian Society of Anaesthetists Ltd. The focus of the meeting was on health human resources and scope of practice issues. Canada will host the next Common Issues Group Meeting in Vancouver, June 2009.

CAS Office Update

A Communications Manager will be added to CAS staff. Ms Anne Aleixo, formerly Membership Coordinator, is now Events Coordinator with responsibilities for speaker communications, awards, abstracts, and various other duties involving the annual meeting. Ms Pamela Santa Ana, Administrative Assistant, has assumed responsibility for the membership database, including renewals and new member applications. Both of them, as well as Ms Yolanda Vitale, Journal Coordinator (responsible for the subscription database) report to Ms Susan Witts, Manager of Finance and Administration.

CAS IEF

The Board is pleased to announce that the name change request for CAS IEF has been approved. CAS IEF now stands for International Education *Foundation* (rather than Fund).

In Memoriam:

Ian William Craig White (1950-2008)

On March 13, 2008 Dr. Ian White died in Brampton, Ontario following a year long illness. A graduate of St. Thomas' Hospital in London, Ian accepted a staff position at St. Boniface Hospital, Winnipeg, in 1982. Whilst he excelled in the various modalities of anesthesia, Ian's first love was neuroanesthesia and it was in this area he very clearly demonstrated his expertise. He was Section Head of Neuroanesthesia at St. Boniface for many years. In all areas of anesthesia, Ian enjoyed the challenge of adopting new techniques of delivering patient care. In 2004 Ian moved to Brampton where he accepted the position as Corporate Chief of Anesthesia at William Osler Health Centre.

Known as "Big White" to family and friends, Ian's contributions to Manitoba and Canada were associated with ground breaking work in a number of areas. His early interest in anesthesia physician resource issues involved him both provincially and nationally. At the CAS level he served as Chair of the Physician Resource Committee for a number of years. During this time he sounded the alarm, through presentations and publications, of the impending shortage of anesthesiologists. Ian was also instrumental in developing the Manitoba Medical Association long term clinical service fund which recognized the contributions of long term practice in Manitoba.

During and following his tenure as President of the CAS (1996–97), Ian presided over the strategic planning sessions for the organization. This resulted in significant changes to both the structure and direction of the CAS. Ian White's third major contribution to Canadian Anesthesia was his early recognition of the need to formalise the structure and organization of Patient Safety. He worked tirelessly as Chair of this CAS Committee to promote these goals.

To those of us who knew Ian, it was always a joy to see the pride and pleasure on his face when talking about Erica and his three children. He encouraged his children to explore the world and supported them in all their endeavours. Holidays with his family were particularly special to Ian. To Erica, Philippa, Catherine and Ziggy we extend our sincere condolences. It is indeed a fitting memory to Ian that a large number of people attended a celebration of his life held in Winnipeg and in Brampton later in March.

Diane Biehl and Neil Donen

Research Awards

RA Gordon Patient Safety Award

Pamela Angle
University of Toronto, Toronto ON
Randomized Controlled Trial Examining the Effect of Small versus Large Tuohy-type Epidural Needles on the Incidence and Severity of Postdural Puncture Headache

Dr Angle is an obstetric anesthesiologist/health research methodologist at Women's College Hospital/Sunnybrook Health Sciences Center at the University of Toronto. This international randomized clinical trial will examine the impact of using small gauge (19Ga) vs traditional large gauge epidural needles on the incidence of postdural puncture headache. Over 3000 labouring parturients will be recruited in eight centres in Canada, the USA and Israel.

In addition to examining the impact of epidural needle gauge on postdural puncture headache (PDPH) development within the first 14 days after epidural placement (primary outcome), this study will also examine additional important secondary outcomes:

- Quality of life in women with PDPH
- Development of chronic headache in women with and without PDPH as part of a longitudinal followup
- Effectiveness of epidural blood patching
- Feasibility of using smaller epidural catheters for patient controlled epidural labor analgesia

This work follows early pilot studies by the authors which examined patient controlled epidural analgesia pump performance with 23Ga epidural catheters and labor analgesia in a small group of women receiving the 19Ga epidural needle and catheter.

This study pushes the "technologic envelope". Its overall goal is to reduce the morbidity associated with PDPH as well as to improve our understanding of its impact upon women.

Baxter Corporation Canadian Research Award in Anesthesia

Richard Brull
Toronto Western Hospital, Toronto ON
Can ultrasound-detected intraneural injection predict nerve injury?

Dr Richard Brull completed his Anesthesia residency training at the University of Toronto in 2004 and undertook subspecialty fellowship training in regional anesthesia at the Hospital for Special Surgery of Cornell University in 2005. Dr Brull is currently a staff anesthesiologist at the Toronto Western Hospital and the Director of the Regional Anesthesia Fellowship training program at the University Health Network. He is an Assistant Professor of Anesthesia at the University of Toronto. Dr Brull's academic interests lie in ultrasound guidance for regional anesthesia and neurological complications of regional anesthesia.

Under the mentorship of Dr Vincent Chan, the Regional Anesthesia Research Program at the Toronto Western Hospital recently demonstrated that ultrasound can be a reliable method to detect intraneural injection during peripheral nerve blockade. As such, ultrasound may be a useful aid to improve the safety of regional anesthesia by avoiding nerve injury. The goal of the present study is to evaluate in a pig model the association between ultrasound-detected intraneural injection and neurological deficit. Specifically, the correlation between the degree and pattern of nerve expansion visualized on ultrasound during intraneural injection of different volumes of local anesthetic and consequent clinical and histological nerve injury will be examined to determine if there exists a characteristic sonographic image of intraneural injection that can predict nerve injury. If ultrasound-detected intraneural injection translates into clinical neurological deficit, then ultrasound may be a useful modality to decrease the risk of nerve injury related to intraneural injection during peripheral nerve blockade.

Abbott Laboratories Ltd/CAS Fellowship in Anesthesia

Meredith Ford
University of Toronto, Toronto ON
Association of beta-blocker half-life with clinical outcomes and heart rates after non-cardiac surgery

Dr Ford is an anesthesia fellow at the University Health Network.

The focus of Dr Ford's research is to determine:

1) If long-acting beta-blockers are associated with reduced MI and/or death as compared to short-acting beta-blockers
2) If heart rate control is associated with improved perioperative outcomes

In the future, the outcome of this project may help guide design and interpretation of clinical trials of perioperative beta-blockade.

Bristol-Myers Squibb Canada-CAS Research Grant in Neuroanesthesia

W. Alan C. Mutch
University of Manitoba, Winnipeg MB
A Comparison of the EEGo and BIS Monitors to Assess Emergence from Neuroanesthesia

Dr Mutch is a staff anesthesiologist at the Health Sciences Centre and Professor and Vice Chairman, Research and Academic Affairs in the Department of Anesthesiology at the University of Manitoba.

He has a number of areas of active research with an over-arching interest in nonlinear dynamics as applied to medicine:

1. ß-testing of the EEGo monitor developed by Walling and Hicks of Baylor University. This monitor uses phase delay plots to enable the EEG trace to have readily recognizable 3-dimensional plots that correlate to depth of anesthesia. Use of this monitor will be assessed in the clinical environment.
2. Development of nonlinear life support devices that use computer-controllers to add physiological variability to drive life support devices – including mechanical ventilators and perfusion pumps.
3. Mathematical modeling to account for the advantages seen with nonlinear life support devices.

Attempting to improve life support devices to optimize patient management in the acute care environment is the overall goal of the laboratory.

CARF CORNER

Canadian Anesthesia Research Foundation

FOCUS ON DR STEPHAN SCHWARZ, UNIVERSITY OF BRITISH COLUMBIA, VANCOUVER BC

2006 RECIPIENT OF THE CAS/ABBOTT LABORATORIES LTD CAREER SCIENTIST AWARD IN ANESTHESIA

In our continued efforts to educate and inform readers of anesthesia research and its relevance to everyday practice, I recently interviewed Dr Schwarz about his important work: Lidocaine Effects on Signalling and Calcium Conductances in Thalamocortical Neurons.

Describe briefly the research project you are working on now.

The overall aim of these studies is to identify the mechanisms by which systemic lidocaine produces its various therapeutic and toxic effects in the brain. While we all are aware of the CNS toxicity associated with high systemic local anesthetic concentrations, a renewed interest in the analgesic properties of intravenous lidocaine has recently emerged, both in acute postoperative and chronic neuropathic pain. Since the start of this project, as often happens in research, some observations with the quaternary lidocaine derivative, QX-314, have led us to "go off on a tangent"; hence, in addition to the work on lidocaine, we have been pursuing investigations into this compound's properties.

QX-314 has traditionally been considered to be devoid of clinically useful local anesthetic activity due to its permanent positive charge. However, we found in animal models that QX-314, administered peripherally, concentration-dependently and reversibly produces long-lasting local anesthesia with a slow onset. This raises the possibility that quaternary ammonium compounds may be clinically useful as long-acting agents in humans. Short of catheter-based techniques, we really have no drug currently available that produces long-lasting sensory and nociceptive blockade after a single-shot application. We published these results in Anesthesiology in August 2007, and with great excitement we subsequently learned that the article was chosen as one of their top twelve papers of the year! The CAS research awards really have been instrumental in being able to do this work. At present, we are working on manuscripts with results from the ongoing lidocaine project and also more follow-up work with QX-314.

Lidocaine is a long established and commonly used drug in medical and anesthetic practice. What sparked your interest in this "old drug"?

Well, I would argue that lidocaine, synthesized in 1943, is one of the "younger" drugs that we use… If we think about it, for example with regard to the volatiles, records indicate that diethyl ether was first discovered as early as 1275 by Raymundus Lullus; Paracelsus described its analgesic properties around 1540. Opioids have been used at least since approximately 800 BC. The therapeutic properties of willow bark (i.e., NSAIDs) have been known for centuries. It is true, however, that local anesthesia per se also has been around for a while – the surgeons of the Incas chewed Coca leaves and spat into the wounds of their patients.

I have long been fascinated with the idea of "teaching an old dog new tricks," and, in trying to understand the fundamental mechanisms of drugs that we thought we knew so well, learning exciting new things about them. Look at aspirin as an example of an "old drug" – since its introduction in 1899, it was used for almost three quarters of a century before some of its mechanisms were discovered, and only recently the 1990s' "COX-1/2 story" became somewhat more complex by

the discovery of COX-3 and COX-2b. My interest in lidocaine from this sort of perspective has initially been sparked and tremendously supported by my research mentors at UBC, Ernie Puil and Bernard MacLeod.

How do you see the ultimate results of this work being applied to the clinical practice of anesthesia? Is this relevant to someone like me who takes care of patients in the OR everyday?

Well, first of all, don't forget that I am a practising anesthesiologist myself, and my motivation for anesthesia research is fueled by looking after patients. In the short term, particularly given the current decrease in the use of thoracic epidurals for abdominal procedures due to the progress in minimally invasive surgery, I think we will learn more about the specific indications, benefits, and risks associated with perioperative lidocaine infusions as an analgesic modality and component of balanced anesthesia. Second, we hope that this work will lead to a better understanding of the cellular and molecular mechanisms of local anesthetic CNS toxicity and ultimately pave the way for the development of specific treatments. Third, another large clinical area is of course chronic pain, and we hope that our results will expand our knowledge about the supraspinal mechanisms of effective therapeutic approaches on the one hand and prevention of pain chronification on the other hand.

How does this improve anesthetic patient care?

As touched upon, recent randomized clinical trials indicate that perioperative lidocaine infusions can reduce post-operative pain and analgesic consumption. You may argue that these are surrogate outcomes, but there also is evidence that postoperative recovery is improved, as indicated, for example, by a faster return of bowel function. There is a potential to reduce opioid analgesia-induced adverse events, which are well known to delay recovery. Our studies aim to elucidate the fundamental mechanisms that underlie these observed lidocaine effects.

Can this knowledge be extended to other areas of patient care (i.e. non-anesthetic)?

Absolutely! Work in the last decades has vastly enhanced our knowledge of how the brain generates consciousness. The thalamus – the principal supraspinal somatosensory and nociceptive relay station and focus of some of our experiments with lidocaine, plays a critical role as part of the brain's "pacemaker" in the generation of the cerebral oscillations that correlate with the various conscious states, and also some forms of epilepsy. IV lidocaine produces characteristic changes in these oscillations in virtually all mammals studied. Incidentally, and somewhat ironically, a whole textbook on lidocaine's anticonvulsive properties was published in 1965. So, to answer your question, we believe that this knowledge will be relevant for quite a variety of clinical conditions associated with thalamocortical "dysrhythmia," including seizure disorders. In 1959, Huneke and Kern published on procaine as a rejuvenating agent, but I unfortunately cannot tell you based on our studies whether or not lidocaine has such effects.

Doreen Yee, MD FRCPC MBA
(Clinical anesthesiologist)
Chair, Canadian Anesthesia Research Foundation
www.anesthesia.org/carf

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CASIEF Update

Our January volunteer in Rwanda, Dr Julie Williams from IWK in Halifax, with the Head of Anesthesia for the National University of Rwanda, Dr Jeanne Uwambazimana.

Dr Julie Williams from IWK in Halifax just completed her month in Kigali. Dr Joel Parlow from Queen's University has just arrived. He is accompanied by a senior resident, Dr Kara Gibson. On the day of their arrival, there was a significant earthquake along the rift valley. Fortunately they just felt a few tremors in Kigali.

The programme in Rwanda has made much progress but continues to present many challenges. The biggest challenge at the moment is a move of the operating rooms at CHUK to temporary quarters to allow for a major renovation. This is definitely needed but it certainly is disruptive. However both staff and volunteers are very resilient and cope magnificently with all the challenges.

Good news concerns the addition of several Rwandan anesthesiologists to the staff at both sites, Kigali and Butare. Some of these have trained abroad and returned to take their final exams in Rwanda. Others have done some training overseas and had their last year or two in the programme in Rwanda. From one Rwandan anesthesiologist (Dr Jeanne) when we began, there are now 3 additional in Kigali and 2 additional in Butare. This has made a tremendous difference. Another piece of good news is that we are now including the King Faisal Hospital, Kigali, in the training programme and the volunteers will go there every week to teach. It has the best facilities and does more complex surgery.

A big thank you goes to all the departments of anesthesia, provincial divisions and groups of anesthesiologists who contributed to our request to send young anesthesiologists from the developing world (especially Rwanda) to the World Congress in Cape Town. Canada supported fourteen Fellows, by far the largest group. I will report separately on the congress and our Fellows in the next issue of the Newsletter.

Finally I want to draw your attention to a wonderful new enterprise in which the CASIEF is partnering with the Department of Anesthesia at Dalhousie. This project is led by Dr Tom Coonan. As a satellite meeting of the CAS, we will have a Global Outreach programme. There are speakers coming from all over the world who have tremendous experience in working in challenging conditions. There will be hands-on sessions so you can learn how to use draw-over anesthesia, familiarize yourself with strange equipment and learn how to safely function in a challenging environment.

Watch for details of this workshop, the CASIEF panel and the CASIEF dinner in your meeting registration package. Numbers of registrants for the workshop will be limited due to the hands on nature of the course. Also the workshop will start on the Friday morning so you will need to arrive in Halifax a day earlier than usual. If you want to work overseas, this is the workshop for you.

Dr Angela Enright DCH, DAB, FFARCS, FRCPC

Dr Angela Enright surrounded by Fellows sponsored by the CAS to attend the WFSA meeting in Cape Town.

Front row: Christine and Dr Panjat (both Rwanda)

Middle row: Dr Ruslan (Moldova: sponsored by Baxter), Dr Bona (Rwanda), Dr Babu (Nepal), Dr Shyam (Nepal), Dr Daniel (Mexico), Dr Theo (Rwanda), Dr Damascene (Rwanda: sponsored by USA)

Back row: Dr Hugh Devitt (CAS), Dr Jeanne (Rwanda), Dr Willi (Rwanda), Dr Enright (CAS), Dr Sheppard (CAS), Dr Carli (CAS), Mr Mandarich (CAS)

Anesthesia News

Please send contributions to:
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Anesthesia News serves to inform CAS members about current CAS activities and topics of general interest to Canadian anesthesiologists.

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Serving or Self-Serving?

I need your help. As Chair of the Membership Services Committee, I want to do a good job, refine my role, and serve the membership. How can I make a difference for you? What do you want the CAS to do for you? How can we do a better job?

This is not about "pie in the sky". This is about the existence and focus of the CAS as it speaks for and works for Canadian Anesthesiologists. The CAS needs to be seen as a powerful voice. I know that I am grateful to have a national body that allows for a unified voice. I also am thankful for the time and effort put in by so many of the other committee chairs as I see them volunteering for sometimes thankless work.

Yet, there are many voices "out there." When I walk around the annual meeting, I often hear negative comments (we as physicians are trained to seek "what can be made better"). I would encourage people to send your comments to the CAS, although, I would ask you to be "business focused" on your response. I would ask you to let me know:

1) Does the problem you see have a "national focus" or is it regional? The CAS will be much more engaged with a national issue.
2) Do you have a solution acceptable to anesthesiologists nationally? I, as Membership Chair, must serve the needs of the membership across the nation.
3) Are there significant costs involved? The CAS runs on volunteerism. The budget is real, as real as the problems you see; they need to mesh for the solutions to be enacted.

I want the CAS to be seen as a serving organization, not self-serving. The CAS must serve the membership and its members. Take a moment, think about what we can do better, and "drop me a line". How can I do my job better? Where do you want the CAS to go? I do not think we need "clout", rather, I would see us as a "valued resource with significant leverage in the medical community and with the provincial and national governments".

Richard Bergstrom, MD FRCPC
Chair, Membership Services Committee

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Resident's Report

Resident Report on ASA 2007 Annual Meeting in San Francisco

Anesthesia is at a crossroads. A short supply of anesthesiologists, an aging population, and patients with increasingly complicated medical problems requiring a higher level of care are providing many challenges for future consultant anesthesiologists. Employing alternative anesthesia providers such as nurse practitioners and anesthesia assistants may be a way in which the shortage of qualified, skilled anesthesiologists will be addressed in some Canadian cities.

> I was very curious to hear what residents in the US training system had to say about working alongside alternative anesthesia providers during their training.

This past fall I was fortunate enough to represent the CAS as a resident member at the ASA 2007 Annual Meeting in San Francisco. Many American residents work with alternative anesthesia providers during their training. I was very curious to hear what residents in the US training system had to say about working alongside them.

I spoke to three different residents (two female and one male) from three different programs (New York, Washington, Texas) at length regarding their experiences. All unanimously felt that CRNAs had a great job description. At each institution CRNAs function independently, are excused from call duties, have regular predictable hours, and have readily available backup. The majority of cases done by CRNAs are ASA class I and II patients.

Anesthetic cases with educational benefits and increased complexity are often reserved for residents. However, all reported to have been in a situation where educational opportunities had been taken from them so that a CRNA could practice or advance their skills. One resident stated that at her home program, staff are financially motivated to preferentially work with CRNAs rather than residents. When supervising residents, staff cannot bill for two rooms simultaneously — when supervising CRNAs, they can. This was very concerning to the resident as she believes that some of her department's better educators and mentors are sacrificing teaching for fiscal reasons.

The residents I spoke with all felt that their ability to obtain employment was not threatened by CRNAs, but they did report that CRNAs were very well organized and have Political Action Committees at both the state and federal levels of government to lobby for their interests. All stated that the majority of CRNAs they had worked with were reasonable and knowledgeable, but, given a choice, they would prefer to train and work in institutions without CRNAs.

The implementation of alternative providers is a very controversial and sensitive issue among many Canadian anesthesiologists. Some argue that we are undermining our specialty and that we may one day find ourselves in the same situation as some of our neighbours across the border where alternative providers have more clout than physicians in providing anesthetic care. Others argue that this is the only way we will be able to solve the current shortage of anesthetic providers and that as long as physicians set the guidelines regarding training and supervision of alternative providers we have nothing to worry about.

As a resident, my primary concern is that I would not want to see my education or that of my future colleagues to be sacrificed in any way. This issue will continue to be debated, but ultimately, regardless of what happens, the safety of our patients should continue be our primary goal.

By Dr Mark Knezevich,
PGY 4 Anesthesia,
University of Alberta