Anesthesia News

Wait Time Alliance – Chronic Pain Management

The Wait Time Alliance (WTA) annual report card now includes data from anesthesiologists treating patients with chronic pain - 106 days is the median wait time experienced by patients with chronic pain from GP/family physician referral to treatment, procedure or diagnostics.

For this year's report card, the WTA wished to report on total wait times for an expanded list of specialty interventions. As a result, the WTA commissioned Ipsos-Reid to conduct a quantitative study of wait times for access to physician specialists within each of the WTA specialties partaking in the study.

The goal was to gather patient data via physicians that would provide a snapshot of the total amount of time Canadians are waiting to see specialist physicians and then for treatment, procedures or diagnostics. These data were also to serve as a baseline for potential subsequent assessments.

For chronic pain, the consultation with the specialist physician is also the date of the decision to treat and the first date of treatment. The research objectives for anesthesiologists treating patients with chronic pain included:

(i) Collecting data on the time that elapsed between the referral to the specialist and the date of the first consultation with the specialist;
(ii) Collecting information on the outcome of the consultation.

Among the possible outcomes from the referral by the family physician, the study found median wait times of:

- 85 days where the specialist decides to treat the patient;
- 201 days where the patient is referred back to the family physician;
- 224 days where the patient is referred to another specialist;
- 329 days where further investigation is ordered; and
- 268 days for all other outcomes.

44% of patients with chronic pain wait longer than 18 weeks, the maximum allowable target time set by England's National Health Service for referral by family doctor to the day of treatment.

The Physician Diary Study is the first study of its kind in Canada to survey 11 national specialty societies (NSS), including members of the Canadian Anesthesiologists' Society, concerning their actual charted wait times as well as expectations for the future.

Overall in a survey field window of three weeks in February of 2009:

- 1,189 specialist physicians were surveyed on their views of wait times in Canada – response rate of 14.6%;
- Of the 255 anesthesiologists who completed the survey, 41 (16%) said that they practice chronic pain management and 214 (84%) said they do not.
- Those who said they practiced chronic pain management were asked to answer another series of questions and then were asked to enter patient wait times.
    - In the last five years, 54% think that wait times for chronic pain have increased, 10% think that wait times decreased and 37% think that wait times stayed the same.
    - In the next five years, 66% think that wait times in their health region will increase, 5% think that wait times in their health region will decrease and 20% think that wait times in their health region will stay the same.
    - 25% say they refuse to accept referrals to manage their wait list either often or very often.

In This Issue

Call for Nominations: CAS Vice-President

By December 31, 2009, the Nominating Committee, chaired by Past President Dr Shane Sheppard, is required to present the Board with a nominee for a new CAS Vice-President to take office September 1, 2010. In normal circumstances, the Vice-President will move to become President after two years.

Under the CAS bylaw, the nominee must have been a member of the CAS Board or a committee Chair within the past three years. A list of eligible members is available on request; please contact Joy Brickell at adminservices@cas.ca.

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

Deadline: October 31, 2009

2009/2010 Board of Directors

Editor-in-Chief
Dr Patricia Houston

Design and Production
Ms Josée Ouellet

Contributors
Dr Franco Carli; Dr Angela Enright

Call for Honour Awards Nominations

Nominations must be received by October 31, 2009* These awards will be presented at the 2010 Annual Meeting in Montreal.

Please visit http://www.cas.ca/research/research_award/ for more on nomination/selection as well as nomination instructions.

Gold Medal

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.

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.

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. 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. The recipient shall not be a member of the Board of the Society.

Emeritus Membership

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.

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.

The award will consist of a framed certificate and will be presented at the Annual Meeting of the Canadian Anesthesiologists' Society.

Other award: Medical Student Prize

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

Eligibility

Full-time medical students in any Canadian medical school.

*Note: Deadline for the Medical Student Prize is February 2010

2009 - Winners
Research Grants, Career Scientist and Residents' Award

Canadian Anesthesiologists' Society Research Award
$30,000
Dr Donald Griesdale
Vancouver General Hospital, Vancouver, BC
Randomized Controlled Trial to Evaluate the Efficacy of Video Laryngoscopy vs. Direct Laryngoscopy for Endotracheal Intubation in Critically Ill Patients

Baxter Corporation Canadian Research Award in Anesthesia
$20,000
Dr Simon Whyte
British Columbia Children's Hospital, Vancouver, BC
Evaluation of the Intubating Laryngeal Airway in Children

David S Sheridan Canadian Research Award
$10,000
Dr Ronit Lavi
London Health Sciences Centre, London, ON
Sevoflurance Sedation During Primary Percutaneous Coronary Intervention – A Randomized Pilot Trial

Dr R A Gordon Patient Safety Research Award
$40,000
Dr Davinia Withington
Montreal Children's Hospital, Montreal, QC
An International Randomized Controlled Trial Comparing Neurodevelopmental Outcome and Apnea after Regional Compared to General Anesthesia in Infants

Dr Earl Wynands Research Award in Cardiovascular Anesthesia
$30,000
Dr André Denault
Montreal Heart Institute, Montreal, QC
Inhaled Milrinone in Cardiac Surgery

CAS/GE Healthcare Canada Research Award in Perioperative Imaging
$30,000
Dr Dolores McKeen
IWK Health Centre, Halifax, NS
Maximizing Cesarean Postoperative Analgesia
Ultrasound guided 0.25% ropivacaine transversus abdominis plane block in addition to intrathecal morphine and multimodal analgesia for the management of postoperative pain among women undergoing cesarean delivery

Canadian Anesthesiologists' Society Research Grant in Neuroanesthesia
$10,000
Dr Gilles Plourde
Montreal Neuro Hospital, Montreal, QC
Electrophysiological Study of the Mechanisms of Action of General Anesthetic Drugs

Smiths Medical Canada Ltd Canadian Research Award in Pain Research and/or Regional Anesthesia
$10,000
Dr Peter Choi
University of British Columbia, Vancouver, BC
The PeriOperative Epidural Trial (POET) II

CAS/Vitaid Residents' Research Grant Competition
$5,000
Dr Ferrante Gragasin
University of Alberta, Edmonton, AB
The Effects of Propofol on Resistance Arteries in an Aging Animal Model

Invitation to Submit 2010 Research Grant Applications

Career Scientist Award

- CAS/Abbott Laboratories Ltd Career Scientist Award in Anesthesia

New Investigator Awards

- Canadian Anesthesiologists' Society Research Award

Baxter Corporation Canadian Research Award in Anesthesia
David S Sheridan Canadian Research Award

Subspecialty Awards

- NEW NAME! Dr Earl Wynands/Fresenius Kabi Research Award
- Dr R A Gordon Patient Safety Research Award
- CAS/GE Healthcare Canada Research Award in Perioperative Imaging
- CAS Research Award in Neuroanesthesia *in memory of Adrienne Cheng*
- NEW NAME! Canadian Research Award in Pain Research and/or Regional Anesthesia

Residents' Award

- CAS/Vitaid Residents' Research Grant Competition

For more information, please contact:
Research Grants, Career Scientist and Residents' Awards Program
Canadian Anesthesiologists' Society
1 Eglinton Avenue East, Suite 208
Toronto, Ontario M4P 3A1
Phone: 416-480-0602, ext 11
Fax: 416-480-0320
Email: meetings@cas.ca
Online: www.cas.ca/research/grants_awards

Application Deadline
January 8, 2010

Call for Abstracts

June 25 to 29, 2010

You are invited to submit your Abstract and/or Case Reports/Series to the Canadian Anesthesiologists' Society's 2010 Annual Meeting.

Deadline for submissions:
Friday, January 15, 2010
16:00 ET.

Submission forms and requirements, as well as details about competitions and awards, are now available on the CAS web site (http://www.cas.ca/annual_meeting/abstracts/).

Online submission will once again be available.

Board Update

New on the Board
Dr Mark James (Saskatchewan) was welcomed to his first Board meeting.

Anesthesia Assistants
The CAS Task Force on Anesthesia Assistants is working on a document that defines the core competencies that has been endorsed in principle by the National Alliance of Respiratory Therapy Regulatory Bodies (NARTRB).

Other organizations: the Canadian Nurses Association (CNA), Association of Canadian University Departments of Anesthesia (ACUDA), National Association of PeriAnesthesia Nurses of Canada (NAPANc), Canadian Society of Respiratory Therapists (CSRT), National Alliance of Respiratory Bodies (NARTRB), Canadian Anesthesia Advisory Association of Canada (CAAAC) are reviewing the document with the expectation that all organizations participating on the Task Force, including CAS, will endorse it this Fall.

Annual Meeting
The 2010 CAS Annual Meeting will be organized in cooperation with the French Society of Anesthesia and Intensive Care (SFAR). There will be a Francophone Day on Sunday, with educational tracks in French.

Common Issues Group
The leaders of the American, Australian, British/Irish and Canadian societies of anesthesiologists met in Vancouver. One outcome (to be confirmed) will be mutual discounts on annual meeting registration fees charged to members of each society.

Wait Times Survey
The June newsletter reported on results of the Ipsos Reid survey of HHR issues affecting Canadian anesthesiologists. Two provinces, Quebec and British Columbia, felt they did not have adequate numbers of anesthesiologists. The survey also collected data on anesthesiologists treating patients with chronic pain to be reported (further information on this may be found later in the newsletter.).

Sedation by non-anesthesiologists
The Physician Resources, Standards and Patient Safety Committee Chairs were asked to come forward with a proposal on recommendations for sedation by non-anesthesiologists.

Royal College Reaccredidation
CAS has been reaccredited as a CPD provider by the Royal College for the next five years. There are a few areas where we need to make changes to adhere to the standards. This work will be done by the CEPD Committee and the Education Advisor over the next year.

CPD Modules
With the transition of the online CJA from HighWire Press to SpringerLink, the University of Montreal has developed a user authentication tool to permit members to access the CPD Online modules.

Young Investigators Forum
CAS sponsored Dr Kong (Eric) You-Ten to attend the 2009 Young Investigators Forum.

Guidelines to the Practice of Anesthesia
The Board approved the 2009 updates to the Guidelines to the Practice of Anesthesia, to be published in the January 2010 issue of CJA. Arrangements will be made to provide members with a cover-bound reprint.

Staffing Update
Ms Josée Ouellet, interim Communications Officer, is replacing Ms Temi Adewumi while she is on maternity leave. Ms Pamela Santa Ana is scheduled to return from maternity leave in the summer.

2009 Medical Student Prize Winner

A Brief Overview of Awareness During General Anesthesia

Austin Lamb
(University of Saskatchewan College of Medicine, Class of 2010)

Abstract:
Awareness during general anesthesia is a very common concern among patients undergoing a surgical procedure, and its existence is as old as the specialty of anesthesia itself. While the occurrence of awareness with recall with general anesthesia is rare at least from a statistical standpoint, it can be a frightening experience that may result in both negative psychological sequelae for the patient and medicolegal implications for the anesthetist. There are, however, certain patient and anesthetic factors which should be considered to help identify at-risk patients. Additionally, both clinical signs and depth of anesthesia monitors can be employed to monitor for potential patient awareness and help prevent its occurrence.

Full article

Awareness during anesthesia is nothing new. In the 1840s, with the arrival of the first anesthetic agents such as etherand nitrous oxide, physicians and patients were so happy that surgery could be provided without pain that it was of little significance that the patient would be aware during the procedure. When neuromuscular blocking agents first started coming into use in the 1940s, however, there simultaneously emerged the potential risk of having patients being aware during their surgeries without the knowledge of the anesthetist, who would be lacking the most common clinical sign of an overly light anesthetic and potential patient awareness – movement. For a patient, awareness during anesthesia ranks only second behind death as the most feared complication of a general anesthetic, and the risk of adverse psychological consequences resulting from it should make its possibility very important to the anesthetist. In North America, over 40 million patients receive general anesthetics annually, and with the awareness incidence being approximately 1 or 2 in every 1000 patients, between 40,000 and 80,000 patients will be affected each year. As a result, countless studies have been conducted in an effort to learn more about the various sequelae associated with awareness during anesthesia, the causes and risk factors contributing to it, and lastly, the ways to detect and prevent it.

Awareness during anesthesia can manifest itself postoperatively as either explicit memory with recall or implicit memory without recall. Unless otherwise stated, however, awareness under general anesthesia will be used with reference to unintended intraoperative awareness with postoperative recall. The typical symptoms reported by patients with awareness are vague auditory perceptions, a sensation of paralysis, anxiety or panic, and a sense of helplessness. The other most common symptom is pain, which can be severe and has been reported at incidences of up to or near 40%. Unfortunately, as many as 48.9% to 70% of patients with awareness suffer unpleasant consequences including sleep disturbances, nightmares and dreams, and flashbacks and anxiety during the day. Some of these patients go on to develop post-traumatic stress disorder (PTSD), with one study citing the incidence of such being 14.3%. Awareness can also result in medicolegal implications, with approximately 2% of claims against anesthetists being attributed to cases of awareness.

There are a variety of contributing factors that can lead to a state of awareness during anesthesia. Firstly, certain procedures such as cesarean section (0.4% incidence), heart surgery (1.5% incidence), and trauma cases (11-43% incidence) have an increased risk. These instances, however, are often the result of intentionally light anesthesia owing to patient factors such as limited cardiac reserve, hypotension or hypovolemia, and in the case of cesarean section and obstetrical procedures, the fear of decreasing uterine tone and increasing blood loss. In other instances, patient dose requirements can be unexpectedly higher due to the altered expression or function of target receptors. A patient's chronic use of certain substances such as benzodiazepines, monoamine oxidase inhibitors, amphetamines, cocaine, alcohol, and opiates also appear to increase the anesthetic requirements and the incidence of awareness. Further patient related factors include a higher ASA status, a past history of awareness, and patient age.

With regards to specific anesthetic techniques, nitrous and opiate anesthesia alone can be insufficient to prevent awareness and must be supplemented with other inhalational or intravenous agents. Opiates may reduce awareness, but they have no effect on learning and memory, and nitrous is not as effective as other inhalational agents in preventing awareness. As alluded to previously, whether or not a neuromuscular block is used also has an impact on the incidence of aware-

ness. In an often cited Swedish study, the incidence of awareness was 0.10% in patients who did not receive a neuromuscular block and 0.18% in patients who had. Because higher concentrations of anesthetic agents are needed to produce akinesia than amnesia, a non-paralyzed patient receiving inadequate anesthesia will likely move before forming a memory that can be recalled postoperatively. Thus, muscle relaxants should only be use if absolutely necessary. Other very important factors which can result in an overly light anesthetic and precipitate awareness are a difficult intubation, the premature discontinuation of anesthesia, and equipment malfunction or misuse (including syringe swaps). In a patient at high risk for awareness, one can consider the administration of an amnestic medication preoperatively or when the anesthetic is presumed to be too light intraoperatively.

Over the years, there have been numerous attempts to determine the adequate depth of anesthesia to prevent awareness. Traditionally, anesthetic depth is assessed by using end tidal volatile gas concentration and indirect clinical signs of autonomic responsiveness such as tachycardia, increased blood pressure, pupillary dilation, lacrimation, and diaphoresis. While these parameters can be useful, they can also result in a patient receiving more anesthetic than is necessary, and many studies have disputed their reliability. Opioids and anticholinergics can attenuate or eliminate autonomic responses, and the hemodynamic measurements in particular can be affected by a wide range of factors including ß-blockers, calcium channel blockers, volume status, and preoperative ventricular function. The reliability of end tidal MAC values has also been questioned. Hypotension, bronchodilators, and emphysema can all cause end tidal concentrations to be misrepresentative of the actual partial pressure of volatile agents in the brain. Nevertheless, literature suggests administering 0.8-1.0 MAC if using volatile agents alone, and to supplement nitrous and opioid anesthesia with at least ≥ 0.6 MAC.

Because there are many reports of patient awareness when there have been adequate end tidal MAC levels and no changes in autonomic indicators, a variety of monitors have been developed in an attempt to better gauge whether or not a patient will have awareness. These monitors do not measure learning and the possibility for later recall, but consciousness. Most of these monitors utilize a processed EEG reading in some capacity (e.g. Bispectral Index, Patient State Index, Narcotrend Index, Entropy, and Auditory Evoked Potentials). While these monitors have some proponents, none of them have proven effective enough to become universally adopted. With respect to Bispectral Index (BIS) (Aspect Medical Systems, Norwood, MA), the most extensively studied depth of anesthesia monitor and the only one to be approved for such use by the FDA, the evidence thus far is conflicting. Some studies support its use, while there is other research which indicates that awareness incidences are not statistically different when BIS is employed. In addition, research indicates that the consciousness threshold values of the various depth of anesthesia monitors may not only be dependent on the various anesthetic combinations used, but also on different types of patients. Given that there is no single formula of anesthesia that can be used on every patient, this presents an obstacle to their use. Whether or not these monitors are cost effective is also questioned. These monitors do appear to decrease the amount of anesthetic used, however, and recovery times appear to be quicker. Interestingly, while the claim that these monitors may result in overly light anesthetics and actually increase the incidence awareness seems at least plausible, there is evidence which refutes this notion. At present, it is recommended by the ASA that brain function monitors are only to be used on a case to case basis and that they are not routinely indicated.

Another method, the Isolated Forearm Technique, uses movement in response to commands in paralyzed patients to assess the depth of anesthesia, employing the theory that if movement can not be elicited in an isolated non-paralyzed arm, then the patient is sufficiently anesthetized to prevent awareness. While this technique has been regarded by some as the most reliable tool to detect intraoperative amnestic wakefulness, it is cumbersome and can only be used for very short time periods. Nevertheless, it remains a useful technique when judging the efficacy of other methods.

While there have been many advancements in anesthesia over the years, the issue of unintended intraoperative patient awareness with recall still exists and is likely to be around for some time. While the occurrence of awareness is rare statistically speaking, patient volume and the potential for adverse psychological consequences to the patient necessitates that anesthetists are vigilant in identifying patients at risk. Unfortunately, there is currently nothing that can prevent awareness, as both clinical signs and depth of anesthesia monitors rely on parameters which correlate only indirectly with potential patient awareness. Therefore, the only reliable indicator of awareness is the patient's own experience and subsequent testimonial of it. As such, despite the multiple preventative measures that can and should be taken, awareness can happen even under the care of the most well-trained and experienced anesthetist.

References available on request.

CASIEF Update

Dr Franco Carli, MD FRCPC
CASIEF Chair

It is a pleasure to report our numerous activities during the first six months of 2009:

The Canadian course on Anesthesia for Challenging Environments organized by the Dalhousie University Department of Anesthesia and the CASIEF was held for the second time in Halifax, in May 23-26 2009. This course, limited to 25-30 people only, is mainly targeted to those individuals who wish to undertake medical missions. The majority of the participants were anesthesiologists from Canada with some from the USA. Dr Michael Dobson from Oxford, England was again in town to share his vast knowledge with the participants. As the feedback from those who attended the course was again very positive, it was decided to repeat it next year. The 2010 course is scheduled to be held in May again in Halifax, and we take the opportunity to invite all those who are actively involved in humanitarian medical missions. Please contact Dr Tom Coonan if you wish to enrol in the 2010 course. Places are limited. Also see the CASIEF website for announcement.

This year our guest speaker at the CASIEF dinner in Vancouver was Dr Tarek Razek, Chairman of the Canadian Network for International Surgery (CNIS) and Director of Trauma at the McGill University Health Centre. Dr Razek and his CNIS colleagues have been working on many missions in various parts of Africa. . In his lecture entitled “Our ongoing global responsibility for safer surgery” he spoke about the urgent need to develop safety measures to minimize perioperative mortality and morbidity in the low income countries. He also reiterated the need for more cooperation between groups involved in perioperative care. As there are many groups working in various humanitarian missions, CASIEF could explore more collaboration with other leading surgical and nursing groups aiming at sustainable education initiatives and capacity building.

Our mission in Rwanda is going from strength to strength. All months of 2009 are covered with volunteers, and by December 2009 a total of 26 staff anesthesiologists and 12 residents, 1 recovery and 2 pain nurses and one biomedical technician would have participated in the Rwanda mission since January 2006. We are also pleased that the recruitment for 2010 is going very well, in fact there are still a few months available (May, July and August 2010).

Anyone interested to go to Rwanda in 2010 and 2111, please contact me directly (franco.carli@mcgill.ca). Also for more information on the Rwanda program please look at the website at: www.cas.ca/casief

Thanks to the generosity of our donors we have been able to bring the Rwandan Anesthesia Program Director, Dr Theogene Twarimugabe, to Canada for three months during which he has had the opportunity to assist various educational activities, and come into contact with many anesthesia program directors, teachers and residents. Hopefully, this experience will help Dr Theo to coordinate the didactic work of our volunteers and enhance the teaching activities. We were very pleased to have Dr Theo addressing the Residents at the CAS meeting in Vancouver, presenting the Canada-Rwanda anesthesia partnership at the International Global Health workshop in Montreal, and participating at the Halifax course on Anesthesia for Challenging Environments.

I am also pleased to announce that the Anesthesia International Health office at Dalhousie, under the leadership of the Chairman Professor Mike Murphy and Dr Patricia Livingston, is working closely with CASIEF to bring two fourth-year Rwandan residents, Drs Paulin and Bona, to Halifax where they will be spending six months of their residency program. This initiative will provide the Rwandan resident exposure to a greater variety of anesthesia and surgical practice.

It is almost 35 years that CASIEF was founded with the mission to provide anesthesia education to those countries in need. Many Canadian anesthesiologists have volunteered their time and traveled to various locations of the world to teach safe anesthesia. Many anesthesiologists have donated generously to CASIEF and such generosity allows us to help the volunteers with some of their travel expenses. With this in mind, the CASIEF Board at their annual meeting in Vancouver proposed to organize a CASIEF Reunion in 2010 in Montreal where the next CAS meeting is going to be held. This will be the

occasion to celebrate CASIEF achievements throughout the years and say thank you to all those who have been generous. We hope to have many friends and colleagues attending this event and the symposium. More details will be available in the next newsletter and on the website.

I want take the opportunity to thank our donors for their support. Please continue to be generous and donate to CASIEF. This is the only source of funding which allows us to help our volunteers with their travel expenses. We are very please to inform you that donations to CASIEF have steadily gone up over the last five years and for this we are indeed very grateful.

CASIEF and ASA OTP are grateful to all our volunteers who from January 2006 till December 2009 would have spent time in Rwanda with our teaching mission. Some of them have been more than once. Needless to say they have been able to spend some time far from home thanks to the support of their families and their colleagues at work.

CASIEF:

Fiona Turpe, Franco Carli, Catherine Paquet (Resident), Angela Enright, Brendan Finucane, Judy Nevett (Recovery Nurse), Henri Wiebe, David Archer, Desiree Teoh (Resident), John Cockburn, Krista Brecht (Pain Nurse), Ann Moore, Masaru Yukava (Resident), Julie Williams, Joel Parlow, Kara Gibson (Resident), Sue Ferreira, Annik Otis (Pain Nurse), Doug Maguire, Tim Dickson (Resident), Avinash Sinha, Janius Tsang (Resident), Patricia Livingston, Genevieve McKinnon (Resident), Tom Coonan, Dale Morrison (Respiratory Technician), Sam Oakinbolue, Gordon Wood, Jennifer Szerb, Kwesi Kwofie (Resident), Peter Slinger, (Residents), Jan Francisco Asenjo, Eding Mvilongo (Resident), Janice Chisholm, Anita Cave (Resident)

ASAOTP:

Arthur Ackerman, Shigemasa Ikeda, Hafez Sami, John Stanec, Janey McGee (Resident), Mounir Hanna, Terry Loughnan

Course Announcement

Third Annual CASIEF/Dalhousie Global Outreach Course
May 29-June 1, 2010

Faculty: Haydn Perndt (Hobart), Adeyemi Olufolabi (Durham NC); Holly Muir (Durham NC); Peter Daley (Lahore); Robert Neighbor (Gloucester); Richard Tully (Gloucester); Brendon Finucane (Edmonton); Doug Maguire (Winnipeg); Alison Froese (Kingston Ontario); Krista Brecht (Montreal); Franco Carli (Montreal); Julie Williams, Ron George, Adam Law, Patty Livingstone, Shawna O'Hearne, Lynette Reid, Dale Morrison. Dan Cashen, Steve Williams, Tom Coonan (Halifax)

The course will assist volunteers in preparing for work in conditions that they are unlikely to have encountered in either their training, or their normal practice, and to prepare intellectually, technically, psychologically, ethically and attitudinally for what awaits them in the many areas of the globe for whom health and medical care is a great challenge.

WFSA - One Year On

It is just over one year since the last world congress in Cape Town and time to review what has been achieved in that time.

Communication:

A major effort has been undertaken to improve communication with member societies. We have a new and much better web site (www.anaesthesiologists.org), thanks to Dr Peter Kempthorne of New Zealand, our webmaster. With help from colleagues throughout the world, most items are translated into French, Spanish and Chinese. Reports and items of interest are updated frequently. Important links to other groups are maintained. In particular, it is very easy to access our educational publications. If you have ideas and suggestions for the website, please let us know.

Instead of producing our own newsletter, the WFSA now sends out regular updates like this one, for publication in society newsletters throughout the world. This has proved to be very effective. Translation, where necessary, is done by local society members. Some societies place the bulletin on their website.

We have also improved communication within the Executive committee with regular minutes from the management group and an internal newsletter called Exco News and Views.

Education:

Dr Jannicke Mellin-Olsen of Norway, Chair of the Education Committee, will be writing a newsletter article in the coming months to bring everyone up to date on committee activities. She has continued the work with training centres and two more should open later this year. The second International School for Instructors in Anesthesiology (ISIA) will begin in October. The 'spin-off' from the first school has been fantastic with each set of graduates developing courses and workshops in their own countries.

Publications:

Dr Iain Wilson Chair of Publications will also write a Newsletter update later this year. The activity of this committee continues to grow and Update in Anaesthesia goes from strength to strength. The weekly, peer-reviewed, Tutorial of the Week, is very popular and easily accessed through our website. Plans are in hand to produce a textbook of anesthesia suitable for use in less-well resourced environments.

Safety and Quality:

The last newsletter described the activities of this committee led by Prof. Alan Merry. The focus on providing pulse oximeters, wherever anesthesia is given, continues. Together with our partners in the World Health Organization, we will be commencing pilot projects in October.

Scientific Committee:

Professor Philippe Scherpereel has been busy getting this committee started. His first project was to mentor a group in St Petersburg, Russia, to develop their own malignant hyperthermia laboratory. He has also begun a programme of WFSA Symposia at major regional congresses.

Professional Wellbeing:

Dr Gastao Duval Neto of Brazil is leading a working group looking at issues related to Professional Wellbeing. These are assuming even greater importance than before due to the stressful environments in which we work. This group will be bringing forth suggestions as their work progresses.

Other:

Under this heading we can mention a whole variety of activities.

A survey was completed of all those who presented at the World Congress in Cape Town. This is the first time that contributors have been asked for their opinions. As a result we will be implementing some changes at the next world congress in Buenos Aires in 2012.

With financial assistance from Baxter, we have organized a scholarship programme for young African anesthesia providers to attend the 4th All Africa Anesthesia Congress in Nairobi, Kenya.

WFSA and the European Society of Anesthesiology (ESA) hold regular meetings at the ESA Congress. Cooperation and coordination continue to grow in all of our activities. We now have many common projects.

We have made contact with many other world organizations, such as our sister world society in obstetrics and gynecology, FIGO, with the object of

finding out what we can do to work together to improve maternal health. The Chair of our obstetric committee, Dr Paul Howell, will be presenting at their world congress later this year so we hope this will lead to major cooperation between the two societies.

We continue to work with WHO on a variety of issues as well as pulse oximetry, including essential care at the district hospital, requirements for a department of anesthesia and publications.

WFSA has presented a report on its activities at the Working Group on the Global Burden of Surgical Disease where it was well received. We have embarked on several cooperative activities with this group which also includes WHO representatives, surgeons and public health experts.

So overall it has been a busy and productive year. As always we are grateful to Mrs Ruth Hooper in our London office who keeps everything running smoothly. We love to hear from our members so please feel free to contact any of the officers or Mrs Hooper with suggestions, comments or new ideas.

Angela Enright,
President, WFSA

Institute of Circulatory and Respiratory Health (ICRH) Event: 2009 Young Investigators Forum

The CAS co-sponsored the attendance of Dr Kong (Eric) You-Ten at the Institute of Circulatory and Respiratory Health (ICRH) Young Investigator meeting in Ottawa in May of this year with a Travel Award.

Dr You-Ten is in the Department of Anaesthesia, University of Toronto.

For more information on the event, please view the CIHR newsletter at: http://www.cihr-irsc.gc.ca/e/39961.html#5

The **Self-Assessment Program**
from the *Canadian Journal of Anesthesia*

CPD online

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2. Select the module, log-in and complete the Self-Assessment Program.
3. Obtain section 3 Maintenance of Certification credits.

Successful completion of the self-assessment program will entitle readers to claim 10 hours of continuing professional development (CPD) under section 3 of CPD options, for a total of 20 maintenance of certification credits. Section 3 hours are not limited to a maximum number of credits per five-year period.

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