Anesthesia News
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First Anesthesiologist Elected and Inducted into the Fellowship of the Canadian Academy of Health Sciences

Davy C H Cheng, MD MSc FRCPC FCAHS

Dr Davy Cheng (Professor and Chair/Chief, Department of Anesthesia and Perioperative Medicine, London Health Sciences Centre and St Joseph's Health Care London, and the University of Western Ontario) is the first anesthesiologist elected and inducted into the Fellowship of the Canadian Academy of Health Sciences (FCAHS), in September 2007. The mission of the Academy is to provide advice on key issues relevant to the health of Canadians (www.cahs-acss.ca). The CAHS works in partnership with the Royal Society of Canada and the Canadian Academy of Engineering to form the three Members Academies of the Council of Canadian Academies. Fellows elected to the Academy are recognized by their peers nationally and internationally for their contribution to the promotion of health sciences. And they will have demonstrated leadership, creativity, distinctive competencies and commitment to advance academic health sciences.

Dr Davy Cheng was also elected as the Canadian Member on the Board of Trustees of the International Anesthesia Research Society (IARS) at the Annual Meeting in March 2007. IARS is the oldest anesthesia society, founded in 1925. His influence at both the front-lines and the policymaker's table, have been acknowledged through national and international awards of recognition.

Start Your Preparations for the 2008 CAS Annual Meeting

June 13 to 17

The Annual Meeting Committee is looking forward to an informative, challenging, and stimulating scientific meeting. The theme of the 2008 meeting is **The Role of Anesthesiologists in Future Anesthesia Care Delivery**.

Delegates will be offered refresher course lectures, seminars, symposia, workshops, case discussions, problem-based learning discussions (PBLDs), and satellite symposia, as well as social activities that will reflect the history of Halifax and the hospitality of the Maritimes.

The meeting will be held at the World Trade and Convention Centre, the Delta Halifax and the Delta Barrington in the heart of downtown Halifax, within walking distance to gardens, historic sites and the harbour.

Blocks of hotel rooms have been reserved on your behalf at three hotels chosen for their comfort and convenience, and we have negotiated excellent rates. **We strongly encourage you to book your hotel reservations as early as possible.**

If you are considering submitting an abstract, please note that the **abstract submission deadline is 23:00 EST, Friday February 1, 2008**. Details on awards and competitions for abstracts and instructions for online submission are posted on the CAS website.

I look forward to seeing you in Halifax!

Hugh Devitt, MD MSc FRCPC
Chair, Annual Meeting Committee

Last of its kind!!

This is the last edition of the newsletter to be printed on paper. Future editions will be published in electronic format only. If you do not currently receive the e-newsletter and would like to, please send your name and e-mail address to membership@cas.ca.

In This Issue

Editor-in-Chief
Dr David McKnight

Managing Editor, Design and Production
Ms Ruthe Swern

Contributors
Dr Michael Bautista, Dr Davy Cheng, Dr Hugh Devitt, Dr Bryan J Houde, Dr Brian Knight, Dr Colin McCartney, Dr Jennifer Szerb, Dr Homer Yang, Dr Doreen Yee

President's Message

Following our recent Strategic Review, you can expect some improvements at the CAS. Our online member survey provided the starting point to redraft our Mission Statement and set new goals and priorities. With the guidance of Leader Quest, the Board evaluated the results and set 5 priority areas. They are advocacy, research, education, standards and membership services. Goals were set for each of these priorities. Some of the goals are easily achievable with current resources, others will take years, and new investment, to realize.

There are financial implications to many of the action items discussed. I maintain that volunteer membership organizations must provide value equal to or greater than the cost of membership. The CAS provides many services with direct financial benefit such as reduced rates at the Annual Meeting. Other activities such as standards and advocacy have indirect benefit and are much harder to put a value on. Academic missions including research and CME have tremendous benefit for all clinicians in excess of their costs.

Upgrading our website is essential to many of the priority items discussed. Information will be available more quickly and in more detail. Web based CME is a key priority for members and will be enhanced. We plan to expand the public access areas as well to include more educational material and possibly a new FAQ section.

In order to keep better informed of members' needs, the CAS will poll the society from time to time to realign our activities with the wishes of the membership. Data can also be gathered on HHR and economic issues to aid the CAS in lobbying federal and provincial policy makers on your behalf.

Change is inevitable. Our new Mission Statement will be:

The Canadian Anesthesiologists' Society enables anesthesiologists to excel in patient care through research, education and advocacy.

Shane Sheppard, MD FRCPC
President

News from the Board
October 27 and 28, 2007

Several new Members have joined the CAS Board in 2007: Dr Susan O'Leary, Treasurer; Dr Annabelle Mang, Saskatchewan Representative; Dr Jean-Yves Dubois, Prince Edward Island Representative; Dr Michael Bautista, Newfoundland and Labrador Representative; Dr Richard Chisholm, New Brunswick Representative; Dr Stephen Kowalski, Manitoba Representative; and Dr Homer Yang, ACUDA President.

The Board met in Toronto for an abbreviated meeting, primarily to approve the 2008 operating budget, followed by a strategic planning session.

Annual Meeting Update

We received 405 completed evaluation forms (approximately 44%) from the Calgary meeting. The majority of session evaluations were in the good to very good range. Speakers will receive their evaluations by the end of November. Congress Canada, who were retained early this year to manage the Calgary meeting, will again assist with organizing the 2008 Halifax meeting. A new abstract review program will go live in mid-December. Dr William Splinter, Scientific Affairs Chair, is in the process of selecting reviewers.

Anesthesia Assistants

CAS has collected information about the Anesthesia Assistants programs around the country. CAS will move forward, in collaboration with the Canadian Society of Respiratory Therapists, with defining training requirements for respiratory therapists to work intraoperatively as Anesthesia Assistants.

Nominations Committee

A Call for Nominations for the next Vice-President was published in the last edition of the newsletter. The Nominations Committee has been formed. Dr Daniel Lazaric, of Nova Scotia, will be the Board member of the committee.

Journal Effectiveness Study

The Board reviewed a study by a publishing expert, Mr Glenn Tinley, who concluded that while the scientific quality of the *CJA* remains high, there are opportunities to improve online capabilities and streamline workflow. New initiatives are planned in the coming months to implement these recommendations.

Update from the Royal College: Enhancements to MAINPORT

Several enhancements have been made to MAINPORT. It has a new look with added features such as MY HOLDING AREA where Fellows can record their thoughts and questions for future reference. WEB RESOURCES provides links to useful websites. (A tutorial is also available offering step-by-step assistance). The new format has been designed to support Fellows in recording their learning as it happens and to enhance their learning and practice benefits.

Once a Fellow has entered the new MAINPORT home page (www.mainport.org), there are two entry points from which to choose:

- REPORT CPD ACTIVITIES — the basic option for recording key aspects of your learning, with some opportunities for reflecting on how it will be useful; or
- PRO-FILE (formerly WEBDIARY) — a more elaborate option, with many opportunities for reflecting on key learning and how the learning will be useful.

Visit the MAINPORT website today and let the Royal College know what you think. Send your comments to: opinions@rcpsc.edu.


Dr Colin McCartney


Dr Jennifer Szerb

Regional Anesthesia and Acute Pain Section News

I have recently started a term as Section Chair of the Regional Anesthesia and Acute Pain Section of the Canadian Anesthesiologists' Society. Given the excellent job performed by recent section chairs Ban Tsui and Scott Lang this will be a difficult role to fill.

However, I am looking forward to serving you as section chair over the next three years and seeing many of you at our Annual Meeting. My first action as Section Chair was to institute a new position of Section Vice-Chair that is now been ably filled by Dr Jennifer Szerb from Halifax. Jennifer is a talented regional anesthesiologist and teacher and I look forward to working with her over the next few years to improve the strong foundations of the regional anesthesia and acute pain section.

Recent surveys of the CAS membership indicate that regional anesthesia and acute pain topics remain very important in the overall Annual Meeting program with ultrasound-guided techniques being the leader in the field with respect to most popular suggestion. Other popular topic meeting topic suggestions include "best-recent papers" and regional anesthesia for the anticoagulated patient.

My first role working with Jennifer will be to plan the best program possible for you in Halifax next year with the aim of maintaining and improving the quality of regional anesthesia and acute pain education throughout the meeting. The usual format will be maintained with a repeat of the popular cadaver workshops from last year. In addition several ultrasound workshops will be available both for residents and staff. We will aim to improve overall quality by reducing the ratio of delegates to faculty in the workshops to make them truly "hands-on."

We would greatly welcome any suggestions for improvements to the section that you feel would benefit regional anesthesia and acute pain education for Canadian anesthesiologists.

Although we appreciate the benefits that regional anesthesia and good pain management have for our patients we also understand that performing regional anesthesia in some of our institutions has many challenges that go beyond simply learning where to put the needle.

To those of you that perform regional anesthesia on a regular basis: keep up the great work. To those of you that meet many challenges in this regard: Let us know how we can help you.

We look forward to seeing you in Halifax.

Colin McCartney, MBChB
Chair, Regional and Acute Pain Section
Jennifer Szerb, MD
Vice-Chair, Regional and Acute Pain Section

ACUDA News

As the new President of the Association of Canadian University Departments of Anesthesia (ACUDA), I shall endeavour to keep everyone informed regarding the activities of ACUDA. Under the current rapidly changing environment, the only "constant" is "change." That certainly applies to academic anesthesia.

There has been a long tradition of collaboration between the CAS and ACUDA in advancing Canadian anesthesia. It is in this spirit that I attended the CAS Strategic retreat on the weekend of October 27 to 28. There were excellent discussions and the strategic directions derived from the retreat will place Canadian anesthesia in good stead. The collaboration between the CAS and ACUDA will continue to play a significant role in advancing Canadian anesthesia.

The issue of Anesthesia Care Team and training of its members is moving forward rapidly nation-wide. By virtue of the teaching functions of the academic centers, many of them are already involved in the curriculum setting and actual training of Anesthesia Assistants. The CAS is moving forward and will set the standard for the curriculum in intraoperative anesthesia assistance.

Continued on page 5.

Interview with Dr Colin McCartney

CARF
Canadian Anesthesia Research Foundation

2006 Organon Canada Ltd Canadian Research Award in Anesthesia

A Randomized Controlled Study Comparing Dual Endpoint Nerve Stimulation with Ultrasound Guided Infraclavicular Block for Hand Surgery

An interview with Dr Colin McCartney, Sunnybrook Holland Orthopedic and Arthritic Centre University of Toronto.

This is the second interview of a series that I have conducted with previous CARF award winners to help us clinicians understand what our award winning anesthesia researchers are doing and why they think their project is relevant.

1. Describe your current research project. Why did you choose this specific block to compare these two techniques of nerve localization?

Infraclavicular block is one of the most effective methods of anesthetizing the brachial plexus. But the best technique currently used to localize the plexus, using peripheral nerve stimulation, still results in a 20% incidence of block failure and can be difficult to learn. I wanted to examine a newer technique of performing this block using ultrasound, and placing local anesthetic around the infraclavicular axillary artery and directly compare this with the best existing technique to see if efficacy and performance time can be improved.

2. I understand that the infraclavicular and supraclavicular approaches are two of the more "efficient" ways of anesthetizing the brachial plexus, but not being a regional person, I have always been concerned that I could give the patient a pneumothorax! Do you think ultrasound guided technique would lessen that chance?

Ultrasound has the potential to reduce many complications associated with peripheral nerve block techniques including intravascular injection, nerve injury and pneumothorax.

It is very important, however, that the practitioner is able to visualize the needle tip during insertion and injection, and, as in any technique, has adequate experience prior to independent practice.

3. What endpoints are you measuring in the study when comparing these two localization techniques?

The primary endpoint is the degree of motor and sensory block in the median, ulnar, radial and musculocutaneous nerves 20 minutes after block completion. Secondary endpoints include time to perform the block, pain during the block procedure and requirement for rescue block for surgery. The assessment time at 20 minutes is quite soon after block completion, however, I wanted to closely examine how these techniques compare under the most stringent criteria.

4. Do you think ultrasound guided imaging makes regional anesthesia safer? Do you think blind techniques for invasive procedures will become obsolete in the 21st century?

I learned to perform peripheral nerve block techniques using paresthesia and nerve stimulation, and successfully performed many of those techniques until 2003, when I started using ultrasound. However, having now performed an equivalent number of ultrasound guided blocks, I have no doubt that visualizing the anatomy and needle during block insertion, and watching local anesthetic spread has made my practice safer. However, imaging techniques are only the latest step forward in technology to assist performance of invasive procedures. We still need to use all our previously learned lessons to maintain quality and safety of our practice now and in the future.

Doreen Yee MD FRCPC MBA
Chair, CARF

ACUDA News Continued from page 4.

The current phase is focused on the collection and collation of the various existing curricula.

Research activities in Canadian Anesthesia continue to be an important ingredient for us to advance as a specialty and as a profession. The CAS, CARF, and ACUDA are aligned in recognizing this importance. The creation of a body of new knowledge, and its subsequent transfer to the anesthesia community, will be instrumental in maintaining Canadian anesthesia as a leader in anesthesia and perioperative care. It is anticipated that all three organizations will be initiating discussions and strategic plans to further advance on this front.

Canadian anesthesia certainly is on the brink of significant changes and it is evermore important that the anesthesia community work together in advancing the cause of the specialty. It is with great excitement that one sees there is an alignment of common purpose and strategic directions between the CAS and ACUDA. After all, the relationship between academic anesthesia and the anesthesia community at large is a symbiotic one. There are great expectations for Canadian anesthesia in the next few years.

Homer Yang
President, ACUDA

CAS/Vitaid-LMA Residents' Research Grant Competition

Bryan J Houde

Université de Montréal, Montréal, Québec

Orotracheal intubation with Trachlight® and flexible fibre optic bronchoscope; comparison of cervical spine motion using cinefluoroscopy

Dr Houde is completing the third year of his residency in the Department of Anesthesia at the Université de Montréal. He is doing research at the Centre hospitalier de l'Université de Montréal under the supervision of Dr Stephan Williams, staff anesthesiologist.

Research project

Tracheal intubation of patients with unstable cervical spines (C-spines) is a challenge for the anesthesiologist. The patient should be intubated in such a way that the risk of further deterioration of their already critical situation is mimimised. Some anesthesiologists will consider a technique using a fibre-optic bronchscope (FOB) in the awake patient as a standard of care. However, in many situations, awake FOB intubation may be difficult, impossible or simply not be the best option. In some cases, general anesthesia remains necessary before tracheal intubation can be accomplished. The question of which intubation technique minimises motion of the C-spine in anesthetised patients remains open.

We therefore reviewed the literature on spine motion during intubation. Two methods were retained for comparision: the Trachlight® (TL) intubation wand, and the FOB. Both methods are recognised as producing minimal C-spine motion during intubation. However to date no experiment has compared the C-spine movement produced by the TL to that caused by the FOB in the anesthetised patient. We designed a randomized cross-over study using cinefluoroscopy to compare C-spine motion generated by each of the two intubation methods in 20 patients. Secondary end-points included the success rate and the time required to intubate with each technique. We hope the results of this study will help anesthesiologists in their selection of a method to secure the airway in patients with unstable C-spines.

Report from the Newfoundland Labrador Division

Dr Shane Sheppard, Dr Steve Crummey, Dr Renwick Mann and Dr Todd Cheddore.

The major project of the Newfoundland Labrador Division was the Atlantic Regional Meeting held in St John's, September 21 to 23, 2007. The program centred on two areas — the use of ultrasound technology in anaesthesia and chronic pain management. The former included morning didactic sessions as well as hands-on workshops with live models. The latter was geared to specialists and family doctors. The chronic pain session was a unique educational experience that was endorsed by the provincial college of physicians and surgeons as an important educational event for all physicians involved in the management of chronic pain.

In typical Newfoundland fashion, the meeting began with a Screech-In for our "come-from-aways", including our national President Dr Shane Sheppard. The highlight of the meeting was a wine-tasting held at our new provincial art gallery "The Rooms", which is known for one of the most spectacular views of the city. Dr Paul Gardiner, one of our local thoracic surgeons and a qualified sommelier, gave a highly entertaining and informative accounting of the six wines tasted. It was certainly a great warm-up to the banquet and the hospitality that followed. Following dinner, Fredricton physiatrist Dr Colleen O'Connor spoke on "Team Canada Helping Hands" a volunteer group that helps with rehabilitation medicine in Haiti.

The Division is setting up a new website, casnl.org, as a means of communication for CAS members in a province with significant geographical challenges. The Division also represents the interests of all anaesthesiologists to the Newfoundland Labrador Medical Association, and is presently surveying the province's anesthesiologists concerning our next funding microallocation. This process includes the consideration of a few new items such as a morbid obesity code.

Michael Bautista, MD FRCPC
President
Newfoundland Labrador Division

CAS Membeship Survey

Earlier this year the CAS undertook a new strategic planning initiative. Leader Quest, an outside consulting firm, was engaged to work with the CAS. This summer, Leader Quest conducted telephone interviews with a random sample of CAS members. The results of those interviews were used to develop a questionnaire that was made available to all members this Fall. The following results represent the first data collected in four years on CAS member satisfaction.

Overall Member Satisfaction

6-	7.4%	**Highly Satisfied** 5 or 6
5-	40.1%	
4-	34.4%	**Satisfied** 3 or 4
3-	9.1%	
2-	4.2%	**Dissatified** 1 or 2
1-	9.0%	

What is Important?

Highest rated activities by importance are publications and education:

- *Guidelines to the Practice of Anesthesia*
- *Canadian Journal of Anesthesia*
- Continuing Medical Education
- National advocacy
- Annual Meeting

Future Role – Prioritized

- Standards are the primary future goal for the CAS.
- Education is the second most important for members.
- Advocacy is among the top three priorities.

Anesthesia News

Please send contributions to:
Anesthesia News
Canadian Anesthesiologists' Society
1 Eglinton Avenue East, Suite 208
Toronto, Ontario M4P 3A1

Or email:
production@cas.ca

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

Wait Time Benchmarks for Patients with Chronic Pain: Position of the Canadian Anesthesiologists' Society

1.Many patients with chronic pain can be treated effectively by their family doctors using treatments that include medications available in the community. Unfortunately, many family doctors are reluctant to prescribe the medications with proven efficacy in alleviating chronic pain (eg, they may be concerned about the risk of addiction associated with the use of opioids). If family doctors were provided with proper training in the treatment of chronic pain and if they were adequately remunerated for the extra time that is often required to care for patients with chronic pain, the burden on pain clinics would be reduced and many patients would have a better quality of life.

2. The Canadian Pain Society reviewed the evidence concerning acceptable wait times for the treatment of chronic pain at multidisciplinary pain centers.[1] The Canadian Anesthesiologists' Society examined their findings and held informal consultations with anesthesiologists who are directors of pain clinics. It is apparent that there may be a marked decline in function in patients who suffer chronic pain for more than six months. The Society recommends that patients wait no longer than six months from the time of referral by their primary physician to their first assessment by a subspecialist in chronic pain management, with the proviso that shorter wait times should be targeted for certain conditions for which early intervention may be particularly beneficial (see Table). Because of lack of resources, many chronic pain subspecialists currently have long wait lists and may not be able to provide services within the recommended time intervals.

Dr Brian Knight, MD FRCPC

Recommended Benchmarks

Condition	Wait time for first assessment by pain subspecialist after referral by primary physician[a]
Acute neuropathic pain of less than 6 months' duration	30 days
Acute lumbar disc protrusion	3 months
Cancer pain[b]	14 days
Subacute chronic pain in an adult of working age where intervention may improve function	3 months
Other types of chronic pain	6 months

a These wait times do not include subsequent waits for rehabilitation programs, psychology-based programs, or interventional procedures that may be deemed appropriate after the initial consultation with a pain subspecialist.

b Service within 14 days is recommended for patients who do not have access to a palliative service or in cases in which a palliative care team has asked for a specific procedure.

Reference

1.Lynch ME, Campbell F, Clark AJ, Goldstein D, Dunbar M, Peng P, et al; a Canadian Pain Society Task Force. *Toward establishing evidence based benchmarks for acceptable waiting times for treatment of pain*. Whitby (ON): Canadian Pain Society; 2006. Available: www.canadianpainsociety.ca/WaitTimes_ForPainTreatment.pdf (accessed 2007 Sept 19).