CAS Newsletter

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Editor: Dr. D.W. Fear / Volume 6, Number 3 / Fall 1990

The Best is Yet to Come

Dear Colleagues,

The holiday season is almost upon us, and we will soon look back, perhaps with some nostalgia, at the year 1990 and at the time which passed so quickly.

The Canadian Anaesthetists' Society is enjoying a period of relative stability and is working at the forefront of those issues which concern our specialty. As a united body, the Executive Committee is grappling with environmental issues. As a concerned member pointed out at the Annual General Meeting in June, the Society must examine the adverse environmental impact(s) of the practice of anaesthesia, with reference to anaesthetic products, their packaging and waste materials. This important issue will be confronted head-on in 1991.

Another issue which will be subject to scrutiny is the maintenance of professional competence. We have realized that where the practice of our specialty is concerned, nothing is unchanging. We recognize and accept that competence is not a *fait accompli,* and the Society, via the Committee on Continuing Education, has taken a leadership role in the development of criteria for the maintenance of competence. The next step is implementation. Accordingly, in collaboration with the Royal College, the Society will participate in a maintenance of competence pilot project which will ensure our continued input in this important area.

As our primary concern is the provision of high quality patient care, the adherence to high standards of practice is essential. Nevertheless, there is an economic side which comes into play. In economic terms, the situation seems dire across the board. Canadian anaesthetists, dedicated to caring for patients in hospitals across the country, must protect and defend the quality of anaesthetics administered in the face of widespread budget-cutting policies at all levels.

The revised Guidelines to the Practice of Anaesthesia, published recently in the Members' Guide, serve as a reference to defend and promote the quality of anaesthetic practice; we must use this document to our fullest advantage.

In closing, I wish you all a very happy holiday season and New Year. I sincerely hope the holidays are a time of peace and happiness, a time to think ahead to the upcoming year and to be confident that the best is yet to come!

Sincerely,

Jacques Samson, President

CMPA Fees for Anaesthetists Decrease

The Council of the Canadian Medical Protective Association met in October 1990 and reviewed the classification system and fee structure for 1991.

- Anaesthetists move from Class 5A to Class 5, and their membership fees will be $8,000.
- General Practitioners who give anaesthetics remain in Class 4A, and their membership fees will be $2,500.

When the CMPA introduced differential membership fees related to risk in 1984, anaesthetists were placed in the highest risk group (Class 6) along with cardiovascular surgeons, neurosurgeons, obstetricians and orthopedic surgeons. They stayed in that class until 1988 — by which time their membership fees had risen to $8,250. In that year, they were moved to a new and lower risk group (Class 5A), and remained there with unchanged membership fees, until now. By contrast, Class 6 membership fees have risen annually, and are now $13,000. These changes in Class and membership fees for anaesthetists reflect their ongoing favourable claims experience in the latter part of the 1980s. They are the only group of high-risk physicians who have not had significant fee increases during this time.

While it is not possible to identify specific reasons for the experience of anaesthetists, credit must be given to the different groups who worked to improve standards of care in the past decade. Better training, ongoing education, higher equipment standards and better monitoring have all played a part. Pulse oximeters and capnometers/capnographs have been given considerable credit by some, but it should be remembered that these monitors have only very recently become "standards of care," and their impact on anaesthetic safety will only be fully appreciated in the coming years.

We end on a cautious note by quoting the recently published Pritchard Report on Liability and Compensation in Health Care: " . . . That in the absence of policy intervention there will be inexorable growth over time in the number of claims made against health care providers . . . " Anaesthetists are forewarned that they can expect CMPA membership fees to rise in the future unless anaesthetic safety continues to improve. To do so will require considerable and ongoing efforts by all anaesthetists in Canada.

David W. Fear
Ruaraidh McIntyre
CMPA Council

Joint Meeting with Australians Approaches

Enclosed is information on the joint meeting of the Australian Society of Anaesthetists and the Canadian Anaesthetists' Society. The meeting will be held October 12–16, 1991 in Brisbane, Australia. We will keep you informed when anything further is known.

The deadline for the submission of abstracts is May 31, 1991.

We hope to receive a small supply of abstract forms; however, in the meantime, please request them from:

Conference Secretariat
Dr. J.P. Bradley, Conference Chairman
Combined Scientific Meeting of the Australian Society of Anaesthetists and the Canadian Anaesthetists' Society
P.O. Box 1280
Milton, Queensland
Australia 4064

RCPS Specialty Committee Voices Concerns

I have been asked to review some of the issues currently before the Royal College Specialty Committee for Anaesthesia. Most people are aware of "what" this committee decides. I will also try to communicate some of the "why" behind these decisions.

The most recent revision of Residency training requirements went into effect in 1988. In essence, the revisions established a five-year program for all trainees, consisting of a rotating internship plus four further years. The option of double-counting a straight internship in internal medicine for both the internship and the internal medicine requirements disappeared. This change was the product of extensive discussion and reflects the desire of the Committee to maximize the value of the internal medicine experience to the trainee by having it done at an R-II or R-III level rather than as an intern. In addition, very clear guidelines were established as to what constitutes acceptable medical rotations, to counter the problem of anaesthesia trainees being used to cover "scut rotations" in some programs. This particular move has increased the ability of our anaesthesia Program Directors to have a substantial "say" in the deployment of anaesthesia trainees in accordance with the primary educational objectives of our specialty, not someone else's. These changes reflect the Committee's conviction that the internal medicine component is fundamental to sound anaesthesia practice.

At the same time, the required minimum time on anaesthesia rotations was increased from 24 to 30 months, with clear specifications as to minimum periods in a number of subspecialty areas such as paediatrics and obstetrics, plus the management of chronic pain. Such a move does not imply that the Specialty Committee thinks a one-month pain rotation makes anyone expert in the field any more than three months of paediatric anaesthesia makes someone an expert in that field. It does, however, reflect the philosophy that all graduates of our anaesthesia training programs should have some expertise in the basic diagnostic and therapeutic blocks plus a grasp of what the experts can offer should further referral be indicated. The Committee's philosophy is that there are certain types of expertise that are clearly identified with our specialty, and may not be available through any other specialist, particularly in a smaller hospital. Our graduates must have basic competence in these areas.

"books are not an adequate substitute for hands-on experience."

These trends are occurring at the same time that a number of factors such as contractual limitations of resident working hours are shrinking the available pool of resident clinical contact hours. This issue is of major concern to the Specialty Committee, particularly since the examination boards have stated repeatedly over the past few years that candidates seem long on theory and short on actual experience. In essence, we now have more to teach and fewer hours in which to do it. The only answer short of increasing the total duration of residency is to maximize the time available. Libraries are essential, and residents must cull the background knowledge they need out of texts and journals, but books are not an adequate substitute for hands-on experience. Books can meet the cognitive needs, but the actual laboratory for developing both technical skills and — more importantly — good judgment while under fire, is the operating room or critical care unit.

I mentioned earlier that we now have more to teach than ever before. Perhaps this trend is most obvious in the emergence of areas of emphasis that have been around for a long time as an assumed part of the environment, but which are now being singled out for special attention. Two current examples are quality assurance and biomedical ethics. These areas are now and always have been fundamental to sound professional practice. The difference now is that we are all being asked to systematize our approach to these matters to ensure that all residents grasp these issues before exiting our programs. The old apprenticeship pattern of postgraduate education works well in many spheres but is vulnerable to gaps: areas the trainee simply did not happen to encounter, that were not specifically evaluated, and that therefore were never spotted within his/her training milieu. Such random systems are no longer adequate in the face of the increasing complexity of professional practice, hence the increased emphasis on structured objectives, regular evaluation and specified minimum requirements.

One urgent need in this changing environment is faculty development. We are now being asked to address issues in areas in which most of us in senior positions never received formal training. Biomedical ethics is one excellent example. Although one may have practised anaesthesia with high ethical standards for years, that does not automatically mean that one knows how to crystallize one's thinking on the matter nor to communicate it to residents. Ethics has a language of its own. It goes far beyond the basics of consent forms. Undoubtedly, faculty development and the wise use of available institutional resources will be needed for us to respond to this particular challenge constructively. The recent presentation by Dr. McKnight at the June ACUDA Education Committee was our first attempt to start this process of faculty development at the level of the Program Directors.

Evaluation:

Another responsibility of the Specialty Committee is that of resident and program evaluation. This remains an area of tension in all our departments. Understandably, it is not pleasant either to give or receive a "bad" evaluation. However, as discussions about maintenance of competence grow year by year, it is clear that the best gift we could give our trainees would be to have them leave our programs comfortable with the need for, and benefits of, regular evaluation, for they are going to face evaluations of one kind or another for the remainder of their careers.

In this context we must realize that negative reactions to evaluation are exacerbated by having them done poorly. A poor evaluation is one that is performed subjectively, without reference to known criteria, and so late that there is no time for remedial action. Such evaluations quickly become both punitive and restrictive. If evaluations are done in a timely fashion, there is a built-in opportunity to rectify the problems identified. As such a program functions over time, it begins

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to show the benefits of providing validation of sound practice rather than just "dropping the axe" on the outliers! We need to build an environment in which we, as professionals, can evaluate each other, identify a problem, identify what can be done to fix it and then move forward together. Over the past five years, significant progress has been made in many of our training programs in the area of resident evaluation, but little has been made in the area of faculty evaluation. This remains an area in which we need to develop new approaches that, again, are objective, fair and timely.

"Yet another area of traditional anaesthesia expertise becomes a separate, defined training area."

Other Concerns:

The Specialty Committee also participated in the multi-party discussion of general practitioners and anaesthesia held in 1988. Our Committee strongly supported the recommendation that all anaesthesia training should be under the direction of a Royal College-accredited training program. First of all, the Committee approved the guidelines for a five-year combined training program in anaesthesia and family medicine devised at Queen's University. This program meets all the requirements of both the RCPS and the CFP and has the potential to produce a broadly trained physician with competence in both family medicine and anaesthesia, who would be ideally suited to meet the needs of our country's smaller communities. Secondly, the Committee has requested that all training centres evaluate their current programs for providing anaesthesia training for general practitioners and it recommends a maximum value for the amount of credit that could be considered for that training, should the candidate return at some future date to seek full RCPS training in anaesthesia. It is hoped that this will increase the motivation to move family practice anaesthesia training programs into organizational relationships where there is clear direction by RCPS Program Directors.

The Specialty Committee has also been working hard to represent anaesthesia's interests as new subspecialty areas proliferate in closely related fields such as critical care and clinical pharmacology. It is essential that we **all** make opportunities to be represented at discussions on these matters at both local and national levels. Anaesthesia's greatest tactical weakness is our relative immobility during the prime committee hours of the rest of the hospital community. We must make sure we are represented. One good example is that of the development of programs of accreditation without certification in critical care. Currently, each accredited centre for critical care training makes its own **local** decisions as to which rotations will be viewed as creditable for the one cross-over year (i.e. the year which can be credited towards training in both critical care *and* the base specialty). Not all of these committees share our perceptions of which anaesthesia rotations should be creditable. We must be represented well, recognizing that this can only be done at the local level where the front-line decisions are being made.

In the area of clinical pharmacology, Dr. Rick Hall has been providing the liaison between our Specialty Committee and that for clinical pharmacology, in order to represent our interests as yet another area of traditional anaesthesia expertise becomes a separate, defined training area whose initial design excluded our trainees from the possibility of participation. Rick's efforts on our behalf have been very valuable and are starting to bear some fruit.

These latter developments raise substantial philosophical questions about the long-term impact of increased fragmentation and diversity. In practical terms, no one will be able to maintain competence in all areas related to anaesthesia over the long haul. Such developments raise valid fears and insecurities in many quarters. The problems will be soluble, however, if we transform our tensions into the motivation to devise flexible retraining/upgrading modules to enable us to maintain the necessary processes of continuing education throughout our careers. Such developments will need the creative input and support of all members of our specialty.

Alison B. Froese
Queen's University
Kingston, Ontario

CAS Plays Host to the World

As many members know, the Canadian Anaesthetists' Society will play host to the world in the year 2000 when the 12th World Congress of Anaesthesiologists convenes in Montreal.

The dates for the 12th World Congress are June 13–23, 2000.

The 10th World Congress will be held in The Hague, The Netherlands, June 12–19, 1992. This follows the Canadian Anaesthetists' Society's 49th Annual Meeting in Toronto, June 5–9, 1992. It is planned that the Society will be present in The Hague both to promote Canada as a travel destination and to promote itself as a future host Society.

Please plan to attend the 10th World Congress and visit the Canadian booth, where you will be given a token to proudly wear to indicate that your country will be a future host of this prestigious event.

For information on the 10th World Congress, please contact:

Secretariat
10th World Congress of
Anaesthesiologists
% Holland Organizing Committee
16 Lange Voorhout
2514 EE The Hague
The Netherlands

CAS Goes to Vegas

For the second consecutive year, the Canadian Anaesthetists' Society attended the American Society of Anesthesiologists annual meeting, held this year in Las Vegas. Delegates from around the world visited the booth and made many positive comments about the excellent quality of the Canadian Journal of Anaesthesia and the CAS Annual Meeting. It was especially gratifying to meet the many CAS members and other Canadians who dropped by to "fly the flag." The Society will be present at next year's ASA meeting, which will be held October 26–30, 1991 in San Francisco. Next summer, we will inform you of our booth number and invite you to visit us there.

Ann Andrews, Executive Director, at the CAS booth in Las Vegas.

About Anaesthesia

INFORMATION FOR PATIENTS

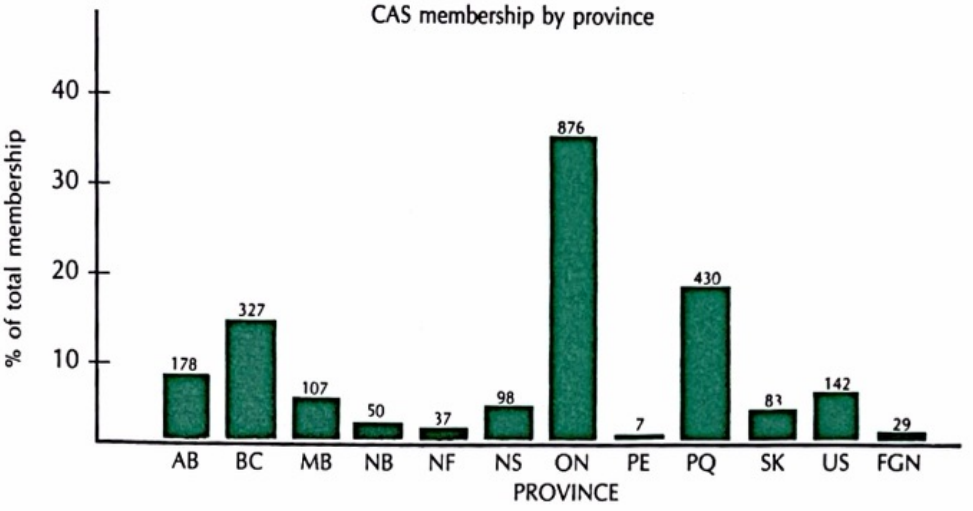
"ABOUT ANAESTHESIA"

— Pricing update —

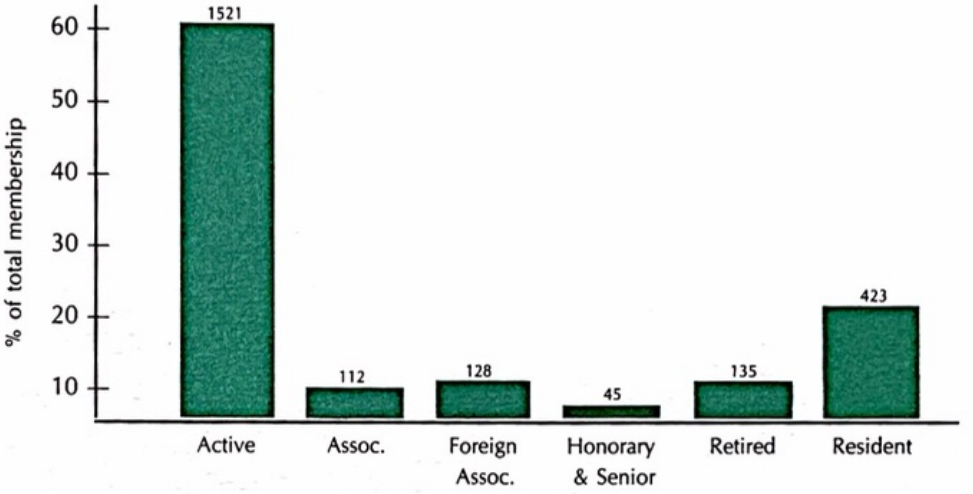
There has been much interest in the recently published patient information brochure, "About Anaesthesia." However, some members have expressed the concern that a 50 cent per copy price is prohibitively high. In response to these concerns, the Society will subsidize the printing costs and will thereby offer members and hospitals substantial bulk-order discounts. If you or your department are interested in ordering "About Anaesthesia," please contact the central office of the Society for a quote.

MEMBERSHIP ANALYSIS
(Total membership: 2,364 as at November 1, 1990)

CAS membership by province



CAS Membership by membership class



North American Malignant Hyperthermia Registry

This Registry is a non-profit, privately supported foundation dedicated to serving MH-susceptible patients throughout Canada and the United States through the provision of patient-specific information to their anaesthetists. It maintains a central database of MH-susceptible patients in Canada and the US.

The Registry also sponsors epidemiologic research which includes examination of high risk identifiers of MH susceptibility, ways to reduce anaesthetic risk for MH-susceptible patients, and evaluation of invasive and non-invasive diagnostic techniques. The Registry Board requires ongoing funding in order to defray some of the costs associated with the provision of clinical services to Canadian anaesthetists and their MH-susceptible patients.

For further information, please contact:

Marilyn Larach, MD
Director
The North American Malignant Hyperthermia Registry
Department of Anesthesia
College of Medicine
Pennsylvania State University
P.O. Box 850
Hershey, PA
17033-0850

QUEBEC '91 UPDATE

The first registration mailing, which includes hotel reservation cards, airline and car rental information, updates on the scientific and social programmes, plus an information piece on Quebec City, will be mailed in December. Below is a list of the proposed social activities and tours, together with an update regarding scientific activities.

PROPOSED SOCIAL ACTIVITIES/TOURS

Friday, June 21

Welcome Reception

Saturday, June 22

Guided Tour of Charlevoix
Fashion Show and Lunch at Manoir St. Castin
City Tour, open to all, followed by reception hosted by BOC Healthcare

Sunday, June 23

Typical Quebec Breakfast and Walking Tour
Sainte-Anne-de-Beaupré Tour and Lunch
Fun Night: Dinner/Cruise on the St. Lawrence River aboard the *Louis Jolliet*

Monday, June 24

Tour of L'Île d'Orléans
Tour of Quebec's fortifications and Castle and Lunch
President's Reception/Dinner

Tuesday, June 25

Whale Observation in Charlevoix

SCIENTIFIC ACTIVITIES

Refresher Courses

Dr. Claude Trepanier will speak on "Infection and anaesthesia," replacing Dr. Jean-François Hardy.

Workshop

Subject: Advanced Trauma Life Support
Location: Laval University (transportation provided)

Breakfast Seminars

I Quality Assurance
II Medico-Legal Problems

Great Gift Ideas for CAS Members

The Canadian Anaesthetists' Society offers the following items for sale to members.

Prices include shipping and handling. All orders must be pre-paid and sent with a cheque (payable to the Canadian Anaesthetists' Society) to 187 Gerrard Street East, Toronto, Ontario, M5A 2E5. Allow 4–6 weeks for delivery. Do not send cash!!!

Canadian Anaesthetists' Society Man's Silk Tie

100% silk tie bearing the shield of your Society. Available in navy or burgundy with or without matching silk pocket handkerchief.

Cost: $20.00/tie $5.00/pocket handkerchief
(free gift box available on request)

Canadian Anaesthetists' Society Mug

Made of durable white ironstone with the CAS shield in blue. Holds 12 ounces of your favourite beverage.

Cost: $10.00/mug

Canadian Anaesthetists' Society Pen

Large, sturdy "roller-ball" pen with the CAS logo "wrapped" on the pen lid. Blue ink.

Cost: $3.00/pen

Upcoming Meetings

New York State Society of Anesthesiologists
44th Postgraduate Assembly in Anesthesiology
New York, New York
December 8–12, 1990

For information:
Mr. Kurt G. Becker
Executive Director
NYSSA
41 East 42nd Street, Suite 1605
New York, NY 10017
Telephone: (212) 867-7140

Clinical Update in Anesthesiology
9th Annual Symposium
Hilton International, Barbados
January 12–19, 1991

For information:
Ms. Helen Phillips
Department of Anesthesiology
Mount Sinai Medical Center, Box 1010
1 Gustave L. Levy Place
New York, NY 10029
Telephone: (212) 241-7630

International Anesthesia Research Society
65th Congress
San Antonio, Texas
March 8–12, 1991

For information:
International Anesthesia Research Society
2 Summit Park Drive, Suite 140
Cleveland, OH 44131-2553
Telephone: (216) 642-1124

International Association for the Study of Pain
2nd International Symposium on Pediatric Pain
Montreal, PQ
April 24–27, 1991

For information:
Pain Secretariat, Conference Office
McGill University
3450 University Street
Montreal, PQ H3A 2A7
Telephone: (514) 398-3770

Anaesthesia in Community Hospitals
Toronto, Ontario
May 4, 1991

For information:
Continuing Education, Faculty of Medicine
Medical Sciences Building
University of Toronto
Toronto, ON M5S 1A8
Telephone: (416) 598-7445

1st Asian-Oceanic Symposium on Regional Anaesthesia in Taiwan
Taipei, Taiwan
May 18–19, 1991

For information:
Prof. J.H. Lee
P.O. Box 26–473
Taipei, Taiwan
10713

Canadian Anaesthetists' Society
48th Annual Meeting
Quebec City, Quebec
June 21–25, 1991

For information:
Canadian Anaesthetists' Society
187 Gerrard Street East
Toronto, ON M5A 2E5
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Australian Society of Anaesthetists/
Canadian Anaesthetists' Society
Combined Scientific Meeting
Brisbane, Australia
October 12–16, 1991

For information:
Dr. J.P. Bradley, Conference Chairman
P.O. Box 1280
Milton, Queensland
Australia 4064
Telephone: (7) 369-0477