Don’t miss CSF in Halifax!

Please don’t miss this year’s CSF in Halifax. The meeting this year is truly a great mix of sessions with appeal across the surgical subspecialty spectrum. There are a large number of internationally renowned Visiting Professors. This meeting will take place in beautiful Halifax, NS and will feature an exciting list of local attractions, and a President’s Dinner that will highlight Nova Scotia culture! Don’t miss this opportunity to take part in all the CME opportunities at the meeting, to reacquaint yourself with old friends, and to make new ones! See you in Halifax!

Elijah Dixon MD BSc MSc(Epi) FRCSC FACS

Win BIG at the CAGS AGM
By attending the CAGS AGM on Saturday, September 13th at this year’s CSF, you’ll be eligible for a chance to win a gift certificate for 2 nights stay at the beautiful Fairmont Empress Hotel! The Empress will be hosting the 2009 CSF in Victoria, British Columbia next year. See you at 4:30pm in Room 200D, level 2 of the World Trade Convention Centre.

Calling all Residents at the CSF?
All Residents attending the CSF are invited to attend the Residents’ Lunch on September 12th at 12:00 noon. There will be a full lunch served and the presentation of the Covidien Excellence in Teaching Awards and the CAGS Stevens Norvell Awards. If you are a Resident and would like to attend, please RSVP at CAGS@rcpsc.edu or call the CAGS line at 613-730-6280.

First year FREE
If you are a General Surgery Resident planning on going into your first year of professional practice in 2008 - 2009, please come to the CAGS booth to identify yourself and we’ll give you your first year as a Full CAGS Member for FREE.

Resident Harbour Cruise
Join us for a cruise on the “Halgonian III” — a great way to start your evening out in Halifax and mingle with residents attending CAGS. The boat will be leaving at 7:30 pm on Friday, September 12th, from the dock at 1751 Lower Water St - look for instructions and a map at the CAGS conference site. All residents are invited on this hour and a half cruise. Please RSVP by e-mailing Dr. Yarrow McConnell at ymcconne@dal.ca
President’s Message

How I am spending my summer!

I am writing this message as the July long weekend is upon us. I just finished seeing the last of 65 patients for this week, of which 10 were new breast cancer patients. Over the past 10 years, my practice has gradually shifted to breast diseases and breast cancer. I have always had a strong interest in breast diseases and breast cancer. About 10 years ago, I made a conscious decision to only provide care to breast patients, at least for my so-called elective practice. I follow all of the breast cancer cases that I have ever operated on and also follow those patients at high risk of developing cancers either because of family history or because they are genetic carriers for genes that are known to cause breast and other cancers. Referrals are made from family practitioners or directly from patients themselves who may know some of my former patients or have heard of me through nurses or others. I try to see them all in the clinic usually within one week of the first call for referral. Each comes with their own expectations, their fears and concerns and despite my best reassurances, when they present with cancer, they of course want their surgery done yesterday.

So I book them for surgery, I need radiology for needle localization, even if I could do ultrasound examination, which I will soon be doing, many still need mammogram localization.

Continued on page 3
they need sentinel node biopsies which requires an injection by nuclear medicine (blue dye is not used much around these parts), they require an assessment from the pre-admission clinic in order to come in the day of surgery. My secretary is feverishly trying to organize all of these requests, no wonder she is retiring. 10 years with me is enough. Other surgeons maybe are far less demanding than I, or is it the patient population? It does not matter. I now need to replace her.

By Friday, I have 10 patients waiting for breast cancer surgery. That is for this week. Last week was the same. Oh and did I mention the week before that with 11 new cases of breast cancer. I am given 3 days per month to operate. On a good day, I can do 5 cases and it all depends on how good the resident is. If I am lucky, he or she is a senior person and he or she understands the disease and the anatomy and we do 5 cases that week. The Health Region’s computer does not care that I work in a University Hospital and that teaching takes place in the clinic and the operating room. Teaching also takes place with nurses and anesthetists and many more so that we really cannot do as many cases as we would like to do to satisfy the demand. Many of the cases are left for the next week.

Sometimes there is extra operating room time available and I use it but it takes me away from other duties and responsibilities. The University does not understand that patients come first. The Health Region does not understand anymore than anyone else. I soldier on. I should say no to new referrals, that is really what I should do so that no one waits for longer than they should. Of course it does not work that way, some surgeons have left for the summer, others are already all booked and worse, patients keep coming and the operating room resources are cut by a large percentage this summer as with all summers. Try explaining that to someone with cancer.

Anyway, we beg, borrow and steal operating room time from others to get them done, we beg with radiology and pre-admission to get them seen. Nuclear medicine is working as fast as they can (did I mention, they go away on vacation too?). I guess radical node dissections were simpler for the system. Get them done and let someone else (the patient) worry about the consequences. I also spend a significant portion of my life dealing with administration, and trying to convince them that I need more time in the operating room than someone else. In fairness, they have been very good to me. Perhaps they know the angst felt by breast cancer patients, perhaps they know that I also know the system having led and spoken on behalf of a large department of surgery for the greater part of 13 years. In any case, we manage to do most of the patients within 3 weeks of the paperwork going in. I suppose that’s not too bad.
President’s Message cont’d

Continued from page 3

Unfortunately or fortunately, I also follow all of my patients for life, I see the lymphedemas created by my surgery or made worse by radiation, I see the breast pain made worse by radiation, I can see the anxiety in their eyes when I spend too much time examining a portion of their breast or axilla, and I know that when they call me after seeing their medical oncologist, it is because they want my so called ‘impartial evaluation’ of the situation.

At the end of the day, I am extremely grateful that I truly have the best job in the world. Yes, I am a surgical oncologist; yes, I am a “breast specialist”, but I am first a general surgeon who looks after people. I observe, listen and communicate, treat and refer to the appropriate resources. I comfort them, I am there for them for life or until such time as I retire and there is no way, that I would give this up for anything or anyone.

I work with, within or outside the system to get the job done. That is my role behind the scene. I am proud of my heritage and my training, and I want to tell the world, that truly there is no better life than helping people through surgery because as a general surgeon, I not only do surgery but I perform medicine the way it was always meant to be; with care and compassion.

Dr. Rene Lafreniere
President
Canadian Association of General Surgeons

2008 Stevens Norvell Award

CAGS recognizes the following residents for their achievement on the CAGS Examination. Year 1 awards go to Anton Cherney from Queen’s University - $500.00 and William Leeper from the University of Western Ontario - $300.00, Year 2 awards go to Akram Aljahdali from the University of Alberta - $500.00 and Kris Croome from the University of Western Ontario - $300.00, Year 3 awards go to Luc Dubois from the University of Western Ontario - $500.00 and Rene Boisvert from Dalhousie University - $300.00, Year 4 awards go to Salman Alsaba from McGill University - $500.00, and Hassan Bukhari from the University of Manitoba - $300.00, and Years 5 awards go to Lawrence Gillman from the University of Manitoba - $500.00, and Eric Tardif from the University of Montreal - $300.00.

CONGRATULATIONS to the 2008 Stevens Norvell Award Winners

Notice of Annual Meeting of Members
(For CAGS members only)

Pursuant to Articles XII of the CAGS Bylaws, notice is hereby given that the Annual Meeting of Members of CAGS will be held in Halifax, Nova Scotia on Saturday, September 13th, 2008 from 4:30 to 5:30 p.m. at Room 200D on the 2nd Level of the World Trade and Convention Centre. Please try to attend this important meeting – your presence is valued and appreciated.

The Agenda and other materials will be available at the meeting.
Generic guide to the acquisition of new surgical skills outside a residency or fellowship program: a position paper

Innovation, research and technological advances add to and modify surgical techniques. To provide accepted standards of care, practising surgeons will have to upgrade their skills from time to time and may be expected to acquire some completely new skills over the course of their career.

The safe acquisition of new skills is an emerging challenge in continuing professional development. This guide aims to help individuals and institutions functioning in an environment of evolving surgical procedures by outlining a reasonable framework for the acquisition of new skills. Four conditions will usually need to be met when a new surgical skill is applied to patient care.

First, surgeons must be or become knowledgeable about the condition for which the skill is to be applied. They should know appropriate indications and potential complications and have technical and safety knowledge pertaining to any specialized equipment required for the procedure. This may be acquired by taking accredited courses or through self-directed study, ideally documented in the Royal College Maintenance of Certification Program.3

Second, surgeons should initially become familiar with technology and technique by observing experienced operators. This experience can be obtained through accredited courses with “live surgery” or video link-up. It may also be obtained by formally assisting experienced colleagues or mentors as they perform the procedure.

Third, surgeons should initially perform the procedure in a proctored environment. The proctor may be an experienced local colleague or an outside expert. This person will help guide the surgeon through the procedure and will also be available if questions or difficulties arise. The number of procedures carried out in a proctored setting will vary with the procedure and experience of the surgeon. The medical literature offers suggested numbers of performed procedures required to competently exercise such new skills as sentinel node biopsies and advanced laparoscopic surgery.

Fourth, once a surgeon begins to independently practise a new procedure, an outcome assessment should be undertaken to ensure that its quality is in line with accepted practice. Ideally, this might be done within, or just after, a year’s experience or after a predefined number of completed procedures. This assessment could be documented in the Royal College Maintenance of Certification Program as Category 5 credits (practice review and appraisal).

Dr. Ralph George Chair, CAGS CPD Committee

Competing interests: None declared.

References

The safe acquisition of new skills is an emerging challenge in continuing professional development...

New CAGS Website Launch — August 29th!

The new CAGS website will launch August 29th! The site will be a fresh new look, to allow for easier navigation of existing web pages, and also feature new and exciting tools and programs for CAGS Members. Some new components to the site include: Second Opinion - a new on-line chat room for Members to discuss difficult cases; Home of the Office of International Surgery Website; ASAP – an on-line accredited self assessment program; Home of the new Residents in General Surgery website; and much, much more! Visit us at: www.cags-acccg.ca
Laparoscopy and Endoscopy Committee

The CAGS Laparoscopy and Endoscopy committee is pleased to announce Dr Thomas Read and Dr Dimitrius Litwin as Keynote speakers at this year’s MIS Post Grad Course. The course will feature several presentations by each of these well known experts in Minimally Invasive Surgery as well as presentations on laparoscopic colorectal surgery, upper GI surgery and abdominal wall hernia repair. The theme of this year’s course is “Tips, Tricks and Complications in Minimally Invasive Surgery” and includes panel discussions and a presentation over lunch. Thursday September 11, 0800-1600hrs.

Along this same theme, Dr Allan Okrainec has organized the CAGS Video session this year, focusing on key aspects of laparoscopic surgery. National experts will share “pitfalls and pearls” in this popular session.

Saturday September 13, 0700-0750.

The CAGS Laparoscopy and Endoscopy committee is also pleased to announce the second Allied Health Care Symposium chaired by Dr Jaap Bonjer. The symposium has been expanded to a full day course entitled “Advanced MIS Nursing: Embrace the Challenge”. This session is offered to all allied health care professions with a focus on operative nurses and will feature presentations by MIS Surgeons and Nurses. The role of the MIS operative nurse will be discussed and emphasis will be placed on the development of the MIS Surgical Team. An afternoon hands-on session at the Skills Centre in Halifax will provide appropriate training to prepare the nurse for Advanced MIS. All surgeons with a clinical practice that emphasizes advanced MIS are encouraged to sponsor one or more members of their nursing team to attend this important educational event. Saturday September 13, 0700-1600hrs.

The Canadian Association of Bariatric Physicians and Surgeons (CABPS) will host its third annual Symposium at the Canadian Surgery Forum hosted by CABPS President Dr Nic Christou and Vice President Dr Arya Sharma. A series of guest speakers will discuss the health benefits of Bariatric Surgery including mortality reduction and cost implications. National strategies for increasing awareness and resources for obesity management will be presented. Friday September 12, 1430-1550.

Dr. Daniel W Birch MSc MD
FRCS FACS
Associate Professor
Dept of Surgery
University of Alberta
Director CAMIS
www.capitalhealth.ca/CAMIS

Covidien Resident Awards for Teaching Excellence

CAGS is happy to congratulate the following winners of the Covidien Resident Awards for Teaching Excellence:

Andre Hodder - Memorial University; Wendy Willmore – Memorial University; Pascal Lamarre – McGill University; Salman Al-Sabah – McGill University; Anna Bendzsk – University of Toronto; Jonathan Cardella – University of Toronto; Paul Karanicolas – University of Western Ontario; Savraj Brar – University of Calgary; Chris Murphy – Dalhousie University; Pascal Rheume – Laval University; Tim Jackson – University of McMaster; Sammad Malik – University of Saskatchewan; André Begin – Sherbrooke University; Geneviève Boulais – Sherbrooke University; Andrea Gutauskas – University of Ottawa; Sharadh Sampath – University of British Columbia; Adrienne Melck – University of British Columbia; David Robertson – Queens’ University; Damian Paton-Gay – University of Alberta; Hassan Bukhari – University of Manitoba.
Evidence Based Reviews in Surgery

Evidence Based Reviews in Surgery (EBRS) is now into its 8th year — four years of them under the auspices of the Canadian Association of General Surgeons as well as the American College of Surgeons. Some of the highlights of the past year:

- EBRS has now published 37 articles in the Canadian Journal of Surgery and the Journal of the American College of Surgeons; our first article in the Diseases of the Colon and Rectum will be published in the next few months.

- In April 2008, our group had a lunch time symposium at the Association of Program Directors in Surgery meeting (US equivalent of the Canadian Program Directors in General Surgery) in Toronto and discussed the use of EBRS to teach critical appraisal skills to residents. There was standing room only and lots of enthusiasm for EBRS.

- EBRS launched a colorectal surgery module this year which is endorsed by both the CSCRS and ASCRS.

- Our group completed a randomized controlled trial to determine whether an internet based journal club is as effective as a standard journal club format in teaching critical appraisal skills. Stay tuned for the results!

EBRS will continue to offer 8 packages per year, which starts in October and continues until May of the following year. The topics for 2008-2009 will be as follows:

- Demand vs. relaparotomy for severe peritonitis
- CT angiography for diagnosis of blunt cervical vascular injury
- Prophylactic antibiotics for mesh inguinal hernioplasty
- Non-surgical treatment of appendiceal abscess or phlegmon
- Use of colonic stents in emergent malignant left colonic obstruction
- Student quality of life declines during 3rd year clerkship
- Laparoscopic surgery associated with lower incidence of VTE vs. open surgery
- Insulin therapy and pentaspan use in severe sepsis
- Mortality rates in patient with and without colectomy for ulcerative colitis and Crohn’s disease
- Non-surgical treatment of appendiceal abscess or phlegmon
- Use of colonic stents in emergent malignant left colonic obstruction
- Symptomatic uncomplicated diverticular disease
- Lymph node examination rates and survival after resection for colon cancer

Look for the following changes (improvements) in 2008-2009:

- New website with easier accessibility of old and current packages
- Links to other sites for information on Evidence Based Medicine
- US and Canadian listservs will be combined so surgeons will be able to share their views across the border. As well, there will be more participation by clinical experts.

EBRS continues to be funded by Ethicon and Ethicon Endo-Surgery Canada and Ethicon Inc. and Ethicon Endo-Surgery Inc. in the USA and we are grateful for their ongoing support.

EBRS is gaining in popularity and we hope that you will participate. If you wish to be a part of either listserv discussion and receive Maintenance of Certification credits for completion of the monthly packages, please register for either module by contacting Marg McKenzie at mmckenzie@mtsini.on.ca.

If you want more information on EBRS, we will be presenting a lunch symposium at the Canadian Surgery Forum on Saturday September 13, 2008 from 12:15 – 1:30pm. Residents and members are invited to attend to learn more about EBRS.
We now find ourselves beginning the fourth year of a four year contract and still not realizing any financial increase to our fees...

The section of general surgery of BC has just completed its part in a very arduous series of arbitration disputes. In 2005 the BCMA agreed with government on a financial contract regarding fee increases running from 2005 thru 2009.

The process in BC is that this increase is then divided into segments (macro allocation) one going to General Practice (SGP) the second to be re-divided by the Specialist Council (SSPS). This division of funds took place in spring of 2007 and was appealed by the SSPS. This appeal was overturned and the original award granted to general practice. Microallocation then began in Nov. 2007 and failed to reach an agreement. For microallocation to be successful there can be no dissenter. In this case, and for the first time in its history, the Section of Anesthesia dissented forcing another arbitration process. The arbitrator’s award has just been delivered and is not substantially different from the agreement struck in November 2007 by the other 31 specialist sections. During the arbitration hearings general surgery argued that the surcharges for out of hours work should be doubled. We were only partially successful, obtaining an extra 3 million to the already extra 3 million for a total of six million to be divided by all physicians doing out of hours work.

We now find ourselves beginning the fourth year of a four year contract and still not realizing any financial increase to our fees. Retro active payments are expected by December 2008.

Anesthesia had argued that it wanted to correct inter provincial disparity and in fact equity with Alberta. A major problem with any inter-provincial fee schedule comparison lies in the differences in the preambles. There appears to be a shortage of anesthetists in British Columbia, whether it is real or perceived is irrelevant since it will affect our ability to access the operating room.

Dr. Raymond Dykstra

What’s new in Clinical Audit?

Dr. Chris deGara, Chair of the CAGS Clinical Practice Committee, says audit is a component of revalidation and individuals will and should be able to elect to undertake their own clinical audit. The Clinical Practice Committee’s intention is to make CAGS Members aware of the key concepts of practice audit, and to provide some tools with which to familiarize themselves. It is predicted that clinical audits of some kind will be required for all clinical practice in the future. Accordingly, CAGS wishes to demonstrate to the membership how audit can be done reasonably easily and effectively. Dr. deGara feels that it is best and most appropriate to “start small” when initiating the use of an audit tool, and that beginning with a modest number of clinical indicators that general surgeons can usefully track is an optimal start. The CAESaR audit tool is available for download from the homepage of the CAGS website at www.cags-accg.ca, along with other audit tools including NICE, the Otago Audit System and the audit tool used by the Royal Australasian College of Surgeons. You can find these tools by clicking on “Links” and then “Clinical Resource Links” from the CAGS homepage. Soon to appear on the CAGS website will be the Statement on Clinical Audit, by the Clinical Practice Committee.
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A HEARTFELT THANK YOU!!
To the CAGS President, Dr. René Lafrenière, the CAGS Executive, the CAGS Board Members, and all Standing Committee Members for their exceptionally hard work over the 2007-2008 year!

This year has seen many changes and new initiatives, sprung from the commitment and will of all CAGS Members to move CAGS forward and be the voice of the Specialty of General Surgery in Canada. The Association has made great strides this year, by first identifying new vision and mission statements and then by consolidating four key organizational objectives at the February mid-term meeting: Residents & Education, Continuing Professional Development, Political & Public Advocacy, and Research. The momentum will continue in September, when the CAGS Board will carry on their work to further develop the strategic plan while following through on their mandate of how to best represent the continuously-evolving needs of the General Surgeons of Canada.

**Vision**
The Canadian Association of General Surgeons is the voice of the specialty of General Surgery in Canada.

**Mission**
The Canadian Association of General Surgeons promotes the training, education, continuing professional development, thoughtful practice and research essential to the provision of the exemplary surgical care Canadians expect and deserve.

**4 Organizational Objectives**

1) **Residents & Education**
CAGS contributes to the content and processes of all general surgery training & education programs to enhance students & residents’ career development.

2) **CPD**
To promote best practices and provide the facility for every CAGS member to fully meet their personal practice-based CPD and recertification needs.

3) **Political Advocacy**
CAGS will effectively advocate all issues relating to the specialty of general surgery across Canada.

4) **Research**
CAGS contributes to the health of Canadians through the promotion of general surgery research.

For regular updates and a complete view of the CAGS Progress Report, please visit www.cags-accg.ca.

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