Watching Closely Those Who Sleep

A HISTORY OF THE CANADIAN ANAESTHETISTS' SOCIETY 1943-1993

DAVID A.E. SHEPHARD

The Seal of the Canadian Anaesthetists' Society. The emblem is symbolic of anaesthesia, with the God Hypnos in the Cave of Sleep. The poppies (lower right) produce sleep; the thistle (representative of the Scottish connection with anaesthesia) causes arousal. The Society's motto, *katheudontos parateroumen*, means "we watch closely those who sleep."

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With a Chapter on the
Canadian Anaesthetists' Society Journal and
the *Canadian Journal of Anaesthesia*
by R.A. Gordon, D.B. Craig and D.R. Bevan

To those anaesthetists whose concern for the best of care for their patients
steadily enhanced the standard of anaesthesia in Canada,
and to those countless patients over whom anaesthetists watched.

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To Dr. R.A. Gordon a special word of thanks is due for courteously sharing with me some of his unparalleled knowledge of the Society. I am also indebted to him for permitting me to consult the material from his own manuscript concerning the Society. It is my hope that he will find the present book an acceptable and accurate record of all the many years in which he has been associated with the Society – and to whom the Society also owes so much.

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Preface

THE invitation to write a history of the Canadian Anaesthetists' Society brought with it the privilege of examining the Society's archives, but also the opportunity to consider the value of a knowledge of history for anaesthetists. To have been able to examine not the only the Society's Minutes but also its voluminous files and correspondence, enough to eavesdrop on thoughts and dialogues of the past, was in itself instructive and a rare privilege. This I acknowledge here. In studying the Society's archives, I have been able to see a "re-run" of some of the highlights of the evolution of Canadian anaesthesia.

This book is an attempt to edit this re-run and to do so with several objects in mind: to distil from a large volume of source material a coherent history of the Society that would include the principal events in its evolution over a span of 50 years; to provide a history that would satisfy the need for a "factual" account as a source of reference for future use; to write an account that would be of interest to all members of the Society – those who, for want of a better word, are anglophones and, though I write in English, those who are francophones; and to do all of this in a fashion that would suit the occasion of the Society's 50th anniversary in 1993.

This endeavour originated as part of the larger project of celebrating this anniversary, and the results of this task appear elsewhere in this book. Here I consider the value of what lies between the lines of this book: the value that "history" has for physicians in general and for anaesthetists and for the Canadian Anaesthetists' Society in particular. In essence, I wish to answer the question, Why bother about history?

It is entirely possible to practise medicine without having a knowledge of, or an interest in, the history of medicine. Henry Ford is reported to have said that "history is bunk," but that remark reflects a point of view for which few people have sympathy. In fact, every physician and every anaesthetist accepts the value of a knowledge of history, for the case history is a fundamental source of information on which we base the approach to each patient and the management of each case. This is as true in anaesthesia as it is in any other branch of medicine. The anaesthetist who ignores a patient's history does so at his peril –

and, too often, that of the patient.

But, it may be argued, this has nothing to do with the history of an organization such as the Canadian Anaesthetists' Society, and certainly one can be a member of the Society without being aware of, or having an interest in, its past. Yet to do so is to ignore the heritage of Canadian anaesthesia and the work of those anaesthetists of former years who laid the stones that have made our path today a much smoother one than theirs. Many of our predecessors, both those before and after the Society was formed, were, by any standards, remarkable individuals in whom few of us could fail to take an interest. I think particularly of Edward Dagge Worthington, Horace Nelson and William Marsden, who lived long before the Society was ever founded; of William Webster, Samuel Johnston and Wesley Bourne, who, with a few other anaesthetists in the 1920s, were members of the Canadian Society of Anaesthetists, the forerunner of the present Society; and of Harold Griffith, Georges Cousineau, Digby Leigh and Roméo Rochette, who, with Bourne, founded the Society. All were *interesting* individuals who practised anaesthesia, just as we do, but who also had to face challenges far more daunting than any we face today.

Essentially, the Canadian Anaesthetists' Society may be regarded as a collection of individuals, from the founders onwards, who put their stamp on it, and whose ideas and actions created the matrix on which the Society developed. Thus to the interest that members, as individuals, have generated is added the interest that the Society, as an institution, has generated. The history of the Society, therefore, has created a twofold interest. There is, first, the inherent interest in what our predecessors thought and did and in how they behaved and acted. Like us, each of them practised anaesthesia; and so, to paraphrase R.G. Collingwood, one can state that the value of knowing this aspect of the Society's history lies in learning what they did as anaesthetists and, in short, what it is like to be an anaesthetist.[1] Second, there is the less identifiable interest in what the Society itself has achieved and how it has evolved. This is not unimportant, for, to quote John Tosh, "history is collective memory, the storehouse of experience through which people develop a sense of their identity."[2] Collective memory is a powerful cohesive force in society; as Tosh added, "one of the strongest bonds uniting a large social group is its members' awareness of a common history."[3] At times the past may seem unreal and remote, and yet the past is not just the dead past that happened only to others; it is that part of the continuum of time that is, in truth, part of the present. It has moulded us. When Dr. Harold Griffith, the Society's founding President, said in 1946 that "anaesthesiology is still in its infancy, and I have no doubt that great progress will be made in Canada during the immediate future,"[4] that future was for him the future, but for us it became the present and even, as progress continues to be made, part of the past for us, just as this present will become the past for those who follow us. The historical perspective enables us to see our predecessors and ourselves on the same moving belt that is Time.

The history of the Society, then, provides access to a collective memory of what has been achieved by Canadian anaesthetists, and this is present in us even though it is also of the past. But a history of the Society does more than let us recall, or have recalled for us,

Signatures of attendees, Annual Meeting, 1951.

what others did before us. The evolution of the Society is part of the larger evolution of Canadian society over the past 50 years. And since, in a broader sense, history also preserves our cultural heritage, a knowledge of that heritage makes us more acutely aware and empathetic of our predecessors and of their achievements, as seen in the context of their time yet in ours as well. Thus history, in enlarging our understanding of the role they played – in anaesthesia, in Canadian society and even in anaesthesia and society in other countries – enriches our present experience.

For Canadian anaesthetists a knowledge of the history of the specialty in Canada is doubly enriching, for physicians from two principal linguistic groups contributed to this history. The Canadian Anaesthetists' Society originated in the intellectual and professional cooperation among three anglophones and two francophones who joined together in forming a national organization that would represent all anaesthetists across Canada. They did so with a common cause in mind, and they were able to do so readily and harmoniously not only because they were each prominent anaesthetists but also because they knew and respected each other and, indeed, each other's cultural heritage. Two of them, an anglophone and a francophone, were in due course elected to the Society's presidency, and since then it has been the contributions of anglophones and francophones alike, both separately and together, that have complemented each other in giving anaesthesia in Canada its individual identity.

In this respect the historical perspective is of the profoundest importance. It is this, and only this, that enables us to look back on what Canadian anaesthetists have achieved, and to appreciate not only their technical achievements but also the manner in which they contributed to the professionalization of Canadian anaesthesia in, moreover, the context of biculturalism. Canadian anaesthesia is the richer in this respect (and in many others) because of the professional approach to anaesthesia that was taken in the early days by such outstanding physicians as Georges Cousineau, Fernando Hudon, André Jacques and Léon Longtin (to name the most prominent of the early francophone members of the Society) and, in concert, by their anglophone contemporaries – Wesley Bourne, Harold Griffith, Digby Leigh, Harry Shields, Bev Leech and Ken Heard, for example. The twin paths that these two groups built were extended later by other francophones and anglophones whose names will become familiar in the pages of this book. With the expansion of the Society, both numerically and geographically, beyond the *nidus* of Montréal in 1943 the ties between the two cultural groups became less close; yet it is of the greatest importance that each cultural group recognize and understand the contributions that each other has made, for it is these that together have been worked into the matrix of Canadian anaesthesia, and of the Society, for it is this matrix that has given anaesthesia in Canada its identity. The historical perspective is what has enabled me, as an anglophone, to value the dimension that Georges Cousineau and Fernando Hudon, for example, added to anaesthesia in Canada, and I hope that this book will enable my anglophone colleagues to take a similar perspective. The same is true, of course, for my francophone colleagues; and it is in the hope that the essence of this Preface will be clearly understood by them that I accepted the generous offer of Dr. J.P. Tétrault to translate just the Preface of this book.

In a striking image, the great John Snow envisioned the thread of life spinning continuously.[5] The great value of a knowledge of history lies in enabling us to appreciate how this thread links us to the past and to those who paved the path that we now tread. The Canadian Anaesthetists' Society is only a microcosm and small indeed in comparison with the larger worlds of medicine and of society in Canada from 1943 to 1993, and infinitesimally small in comparison with the still larger worlds of medicine and society of

earlier times. By learning how the Society came to be founded and how it developed, we can not only appreciate the achievements of the past of this Society but also value our links to other anaesthetists and other physicians, elsewhere and in former times, for, ultimately, we are all members of one larger society.

David A.E. Shephard
Regina, November 1992

Préface

L'INVITATION à écrire une histoire de la Société canadienne des anesthésistes donne le privilège d'examiner les archives de la Société, et aussi l'occasion de saisir l'importance de connaître de l'histoire pour les anesthésistes. J'ai pu examiner non seulement les procès-verbaux de la Société mais aussi ses volumineux dossiers et sa correspondance, suffisamment pour être attentif aux pensées et dialogues de nos prédécesseurs; ceci demeure font instructif et constitue un privilège rare. Je le reconnais ici. En étudiant les archives de la Société, j'ai pu voir en « reprise » certains des moments les plus importants de l'évolution de l'anesthésie canadienne. Ce livre est une tentative de reproduire cette « reprise » en conservant plusieurs objectifs en tête: extraire à partir d'une documentation abondante une histoire cohérente de la société qui incluerait les principaux moments de son évolution dans les cinquante dernières années; produire un document qui pourra satisfaire le besoin d'un compte-rendu « factuel » utile comme source de référence pour usage futur; écrire un ouvrage intéressant pour tous les membres de la Société – autant anglophones que francophones, même si j'écris cet ouvrage en anglais; et enfin faire tout ceci pour être à la hauteur de l'événement que constitue le cinquantenaire de la Société.

La célébration de cet anniversaire est à l'origine de cette entreprise, et le résultat apparait plus loin dans ce livre. Dans cette préface, je considère la valeur sous-jacente que peut avoir « l'histoire » pour les médecins en général, pour les anesthésistes, et en particulier, pour les membres de la Société canadienne des anesthésistes. Au fond, j'aimerais répondre la question: « A quoi bon se préoccuper de l'histoire? »

Il est tout à fait possible de pratiquer la médecine sans connaissance ou intérêt pour l'histoire de la médecine. Henry Ford aurait dit que « l'Histoire est futile »; cette remarque reflète l'étroitesse de son esprit et met l'emphase sur un point de vue extrémiste peu populaire. En fait, chaque médecin et chaque anesthésiste accepte la valeur de la connaissance de l'histoire, puisque l'histoire de cas est une source fondamentale d'information à partir de laquelle nous établissons l'approche de chaque patient et la conduite à tenir dans chaque situation. Ceci est aussi vrai en anesthésie que dans les autres secteurs de la

médecine. L'anesthésiste qui ignore l'histoire clinique d'un patient le fait à ses risques et périls, – et aussi à ceux de son patient.

Cependant, l'on pourrait dire aussi que cela n'a pas de rapport avec l'histoire d'une organisation telle que la Société canadienne des anesthésistes, et on peut être membre de la Société sans connaître ou ou s'intéresser à son passé. Ceci nous laisse dans l'ignorance de l'héritage de l'anesthésie canadienne et du travail de ces anesthésistes des temps passés qui ont pavé le chemin et rendu notre démarche plus facile que la leur. Plusieurs de nos prédécesseurs, avant ou après l'établissement de la Société, furent des individus remarquables dont la carrière laissera peu d'entre nous indifférents. Je pense particulièrement à Edward Dagge Worthington, Horace Nelson et William Marsden, qui ont vécu bien avant la fondation de la Société; à William Webster, Samuel Johnston et Wesley Bourne, qui, avec quelques autres anesthésistes, ont été membres de la Société des anesthésistes canadiens, organisme précurseur de la Société actuelle; et à Harold Griffith, Georges Cousineau, Digby Leigh et Roméo Rochette qui ont fondé la Société avec Wesley Bourne. Tous furent des personnages *intéressants*, praticiens de l'anesthésie comme nous, qui ont aussi eu à affronter des défis beaucoup plus ardus que ceux que nous avons aujourd'hui.

Dans son essence, la Société canadienne des anesthésistes peut être considérée comme un ensemble d'individus, depuis ses fondateurs, qui y ont laissé leur empreinte, et dont les idées et actions ont créé la matrice à partir de laquelle la société s'est développée. Dès lors, s'ajoute à l'intérêt créé par les membres comme individus celui généré par la Société comme institution. L'histoire de la Société a donc créé un double intérêt. Il y a d'abord celui propre à la pensée, aux gestes et au comportement de nos prédécesseurs. Comme nous, chacun de ceux-ci était un praticien de l'anesthésie; ainsi, pour paraphraser R.G. Collingwood, l'on peut établir que la valeur de cette facette de l'histoire de la Société provient de ce que l'on peut apprendre de leur vie d'anesthésistes et en bref, ce que cela représente d'en être un[1]. Ensuite, il y a l'intérêt, moins facile à définir, propre aux accomplissements de la Société et à son évolution. Ceci n'est pas sans importance, puisque, pour citer John Tosh, « l'histoire est une mémoire collective, le grenier de l'expérience à travers lequel les personnes développent un sens de leur identité[2]. » La mémoire collective est une force cohésive puissante dans la société; Tosh ajoute « un des liens les plus forts qui unisse un groupe social important se trouve dans la connaissance collective d'une histoire commune[3]. » Il y a des moments où le passé semble irréel et lointain, et pourtant il n'est pas fait de moments qui n'ont appartenu qu'à d'autres; il fait partie du continuum où se retrouve le présent. Le Dr Harold Griffith disait en 1946 que « l'anesthésiologie est encore dans son enfance, et il n'y a aucun doute dans mon esprit que de grands progrès se produiront au Canada dans l'avenir immédiat[4] »; ce lendemain était pour lui au futur, mais pour nous il est devenu le passé et même, puisque le progrès continue, il est aussi le présent, prédestiné lui aussi à devenir le passé pour nos successeurs. Dès lors, la perspective historique nous permet de voir nos prédécesseurs et nous-mêmes dans le même continuum.

L'histoire de la Société nous donne donc « accès à la mémoire collective de la contribution d'anesthésistes canadiens; pour nous elle fait partie du présent même si elle

Signatures des délégués du congrès
annuel de 1951

relate le passé. De plus, une histoire de la Société fait plus que simplement nous rappeler ce que d'autres ont fait avant nous. L'évolution de la Société fait partie de l'évolution plus vaste de la société canadienne dans les 50 dernières années. Comme l'histoire, dans une perspective plus large, préserve notre patrimoine culturel, une connaissance de celui-ci nous rend plus attentifs et emphatiques à la contribution de nos prédécesseurs, lorsque vu dans le contexte de leur époque et de la nôtre. Ainsi, l'histoire, en amplifiant notre connaissance

du rôle qu'ils ont joué – en anesthésie, dans la société canadienne et même dans d'autres sociétés – enrichit notre expérience actuelle.

Pour les anesthésistes canadiens, la connaissance de l'histoire de la spécialité au Canada est doublement enrichissante, puisque des médecins des deux principaux groupes linguistiques ont contribué à cette histoire. La Société canadienne des anesthésistes trouve ses origines dans la coopération intellectuelle et professionnelle entre trois anglophones et deux francophones qui ont uni leurs efforts pour créer une organisation nationale qui représenterait tous les anesthésistes du Canada. Ils avaient un objectif commun et ils ont pu le réaliser harmonieusement qu'ils et efficacement non seulement parce qu'ils étaient des anesthésistes en vue mais aussi parce qu'ils se connaissaient qu'ils et respectaient mutuellement la patrimoine culturel de chacun. Deux d'entre eux, un anglophone et un francophone, accédèrent à la présidence de la Société; depuis lors, les contributions respectives de chaque groupe, ensemble ou séparément, ont donné à l'anesthésie canadienne son identité propre.

A cet égard, la perspective historique est de la plus grande importance. C'est elle seule qui nous permet de jeter un regard sur les accomplissements des anesthésistes canadiens, et d'apprécier non seulement leurs réussites techniques mais aussi l'habileté avec laquelle ils ont contribué au statut professionnel de l'anesthésie canadienne dans un contexte biculturel. L'anesthésie canadienne s'enrichit à cet égard (et à plusieurs autres) à cause du professionalisme adopté à l'époque par des médecins remarquables comme Georges Cousineau, Fernando Hudon, André Jacques, Léon Longtin et Eugène Allard (pour citer les membres francophones les plus éminents de la Société à ses débuts) et, du côte de leurs pairs anglophones, Harold Griffith, Harry Shields, Bev Leech et (Ken Heard), pour en citer quelques-uns. Le défrichage accompli par ces deux groupes s'est poursuivi par d'autres anglophones et francophones dont les noms deviendront familiers dans les pages de ce livre. Avec l'expansion de la Société, autant géographique que numérique, et au delà du noyau de Montréal de 1943, les liens entre les deux groupes culturels sont devenus moins serrés; pourtant, il est de la plus grande importance que chaque groupe reconnaisse et comprenne sa contribution propre, puisqu'elle donne son identité particulière à la Société et à l'anesthésie canadienne. Cette perspective historique m'a permis comme anglophone d'apprécier la dimension de la contribution que Fernando Hudon et Georges Cousineau, par exemple, ont apporté à l'anesthésie au Canada, et j'espère que ce livre permettra à mes collègues anglophones d'adopter une perspective similaire. Ceci est aussi vrai pour mes collègues francophones; et c'est dans l'espoir qu'ils comprendront l'essence de cette préface que j'ai accepté l'offre généreuse du Dr J-P Tétrault de la traduire.

John Snow se représentait la vie comme un écheveau qui se déroule sans fin[5]. L'histoire nous permet de reconnaître le lien qui nous unit au passé et à ceux qui nous ont pavé le chemin du présent. En apprenant comment la Société a été fondée et s'est développée, nous pouvons non seulement apprécier ses réalisations mais aussi les liens qui nous unissent aux autres anesthésistes et médecins, ailleurs, dans le passé et le présent.

David A.E. Shephard – Regina, novembre 1992

Watching Closely Those Who Sleep

CHAPTER ONE

The First Century of Anaesthesia in Canada 1847–1942

THE Canadian Anaesthetists' Society was founded in 1943. For a century before that, however, Canadian physicians had been practising anaesthesia. From 1847, when Dr. George Van Buskirk and Dr. Samuel Adams first gave ether in Saint John, New Brunswick,[1] to 1942, when Harold Griffith and Enid Johnson introduced curare into anaesthetic practice in Montréal,[2] a host of physicians laid the foundation stones of Canadian anaesthesia. Many obstacles had to be overcome, some professional and some economic, as a few Canadian anaesthetists endeavoured to establish the basis for an independent specialty. But finally, after World War I, the time seemed ripe for the formation of a professional organization, and the Canadian Society of Anaesthetists was founded in 1920.

This Society was the first formal association of specialists in Canada.[3] However, it survived only eight years. In 1928 the Society was absorbed into the Canadian Medical Association (CMA) as the Section of Anaesthesia. It would be another 15 years before a second, but lasting, organization took its place.

Nevertheless, from 1844 to 1942 much was done to lay the basis of the specialty of anaesthesia in Canada. First, it was necessary to sow the seeds of the art and science of anaesthesia, which was the work of the first 50 years. Then the roots of professionalism had to take hold, which took another 15. Finally, the plant of Canadian anaesthesia had to become strong enough to survive the stranglehold of the weeds of the Depression and salaried employment. By 1943 viability seemed assured, and a second professional society – the present Canadian Anaesthetists' Society – was founded.

1844 to 1905 The Seed is Sown: The Origins of Canadian Anaesthesia

Exactly who gave the first anaesthetic in Canada, and when, remains in doubt. According to A. McAvenney, a Saint John dentist writing in 1905, Dr. William Bayard administered ether in 1844 in the dental office of the Van Buskirk brothers in Saint John.[4] There is,

however, no documentary evidence to support his claim.[5]

Much sounder is a claim by Dr. J.A. MacDougall, a Saint John anaesthetist, that the first anaesthetic was given on 18 January 1847.[6] A contemporary newspaper (*The Weekly Chronicle*, Saint John) reported on 22 January 1847 that a Mr. Beatteay "was rendered entirely insensible to pain by the inhalation of the vapor of a compound of which aether appears to form the chief ingredient," so that a tumour could be removed from his arm. The anaesthetist was Dr. Samuel Adams, a "visiting consultant" from Boston; the surgeon was Dr. Martin Hunter Peters of Carleton, New Brunswick.

In terms of medical reports, the first Canadian anaesthetist seems to have been the maverick Dr. Edward Dagge Worthington of Sherbrooke, Québec. In a report dated 20 March 1847,[7] he described a below-knee amputation that was performed under ether on 11 March 1847. The patient was a 30-year-old man who was "quite willing, indeed anxious, upon a fair representation of facts, to try any means that promised to lessen the dreadful pain of an operation." This was only five months after W.T.G. Morton had demonstrated the use of ether in Boston on 16 October 1846. Anaesthetic apparatus was then far from standardized, and Dr. Worthington was evidently imaginatively inventive as well as acutely understanding of the requirements of anaesthesia and its associated physiological basis. This is his description of the anaesthetic:

> A large ox-bladder, with a stop-cock attached, a mouth-piece, made of thick leather, covered with black silk and well padded around the edges, with a connecting long brass tube that had done service as an umbrella handle in many a shower, formed an apparatus that, though rude looking, and bearing marks of having been got up in haste, presented withal a very business-like, and, for the country, tolerably professional appearance. A couple of ounces of ether were poured into the bladder, which was then filled with air from a bellows. Not having time or ingenuity sufficient to construct a double valve, the objection to inhaling carbonic acid gas again into the lungs was done away with, by simply allowing the patient after a full inspiration from the bag, to expire through the nose, for three or four times, when the nostrils were kept closed, and the breathing confined to the bladder. From this time about six full inspirations sufficed to produce a complete effect ...

For a rural practitioner, and so early in anaesthesia, this was high art.

If Dr. Worthington had mastered the art of anaesthesia, a contemporary of his in Montréal mastered the science at much the same time: Dr. Horace Nelson, Lecturer on Anatomy and Physiology in the School of Medicine and Surgery. Dr. Nelson's report was published on 14 May 1847,[8] but it is quite likely that he began his work on ether as early as January 1847. Thus he wrote that "in the month of January, a 'chevalier d'industrie' visited Montréal, to speculate on the sale of his secret (of ether) and apparatus ... and it was determined, that in the presence of some friends, and of Jones, the vender, I should try the efficacy of the ether in a series of experiments." Dr. Nelson first carried out the experiments on dogs.

"Fully convinced of the deadening properties of ether," he experimented on himself, inhaling ether "over 100 times" before using it on a patient; he even had one of his own teeth extracted while under the influence of ether. "Some weeks" before the date of his report, his dentist colleague, a Mr. Webster, also administered ether while Dr. Nelson assisted his father, Dr. Wolfred Nelson (known in Canadian history as a patriot in the 1837 war) excise a tumour from a patient's thigh.

The date of this operation is not given. The only clue is the statement that it was performed "some weeks since" the date of the report, 14 May 1847. Dr. Nelson's report illustrates the earliest anaesthesia research in Canada.

Chloroform was also given soon after its introduction into surgical practice. Sir James Young Simpson, in Edinburgh, used the new anaesthetic for the first time on 4 November 1847; it was first used in Canada on 24 January 1848, again by the remarkable Dr. Worthington.[9] He reported its use on a 70-year-old woman for reduction of a fractured hip. He also used it to anaesthetize a child with a tumour of the hand on the following day, and then to alleviate the labour pains of a woman who gave birth to a stillborn infant. Dr. Worthington used "about a drachm" (approximately 4 ml) of chloroform on a folded handkerchief in his first case but preferred "a piece of sponge an inch square" for his other cases, finding that the sponge provided a greater surface for the evaporation of the chloroform and made for less wastage.

Like the great English anaesthetist John Snow, Worthington preferred chloroform to ether. He wrote of its "being cheaper and more easy in its applications; to the physician more agreeable, certain in its effect, less exciting, and followed by less unpleasantness to the patient."

Dr. Worthington's report is dated 10 February 1848, and follows a report on 25 January 1848 by Dr. A.F. Holmes, Professor of the Theory and Practice of Medicine, McGill College.[10] Dr. Holmes had rushed into print, writing the report almost immediately after giving chloroform early on the morning of 25 January to a woman in labour. Chronologically, however, he used chloroform just a few hours after Dr. Worthington.

Just as ether had been used by several people for the first time early in 1847, so chloroform was used by several physicians within a short interval. Reports from Québec included those by William Marsden, of an anaesthetic on 4 February 1848,[11] James Johnston, of chloroform prior to 15 February 1848,[12] and J. Martin, of chloroform on 3 February 1848.[13] Dr. W.J. Almon of Halifax (later, Senator Almon), also used chloroform as early as 5 February 1848.[14] So the value of anaesthesia was rapidly established in Canada soon after the introduction of ether in Boston and of chloroform in Edinburgh.

The clinical practice of anaesthesia, therefore, became part of Canadian medicine from 1847 onwards. The first reported death from anaesthesia occurred on 1 February 1858.[15] Experience in Canada was no different from experience elsewhere, for chloroform, despite its popularity, did seem to be associated with death more often than ether. In an address to the CMA on 6 August 1873, Dr. William Hingston, a prominent Montréal surgeon, cited statistics to show that one death occurred in 23,204 ether anaesthetics, while one occurred

in only 2,873 chloroform anaesthetics.[16] Thus, said Dr. Hingston, "we are using the most hazardous of all the anaesthetics."

Anaesthesia in those days was a hit-or-miss affair, and mortality associated with it was feared, but accepted. The cause of sudden death under chloroform anaesthesia was not understood until A.G. Levy demonstrated the occurrence of ventricular fibrillation associated with *light* chloroform anaesthesia in 1911.[17]

Desperate events called for desperate remedies. A catalogue of "anaesthetic requirements" listed in 1901 by Dr. Charles O'Reilly of the Toronto General Hospital[18] included restoratives such as spirits of ammonia and brandy and whiskey, as well as oxygen and digitalis and nitroglycerin; but the catalogue also included a stimulant in the form of "Ice, for rectum." A half-century after the introduction of anaesthesia, the practice was still far from scientific; even the introduction of the sphygmomanometer into operating-room practice by Harvey Cushing was still two years away.[19]

Even so, a new page in an early chapter in the history of Canadian anaesthesia was being turned at the beginning of the 20th century. As in Great Britain and the United States,[20] professionalism was beginning to rationalize the practice of anaesthesia and to mark the origins of anaesthesia as a specialty.

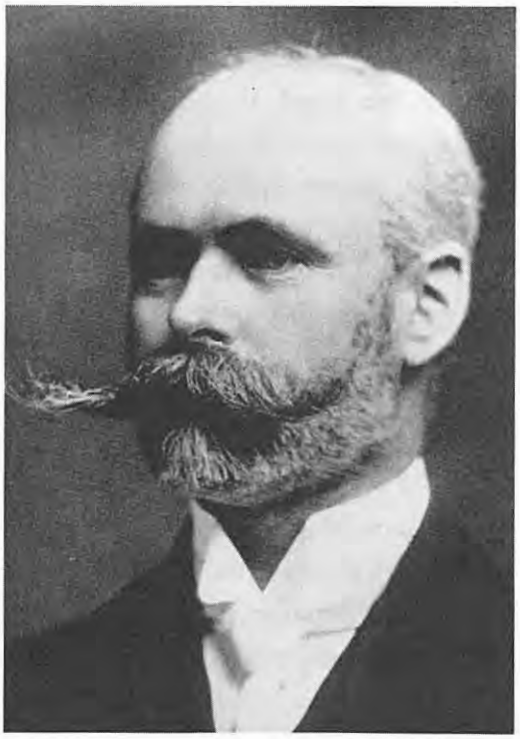
1899 to 1920: The Roots of Professionalism Established

An event in 1899 may be taken as the beginning of the specialty of anaesthesia in Canada. In that year a Dr. Hutton was appointed honorary anaesthetist to the Winnipeg General Hospital. He was followed in 1901 by a Dr. Chestnut and then, in 1902, by Dr. William Webster.[21] It was with Dr. Webster's appointment that the professionalization of Canadian anaesthesia began.

If Drs. Van Buskirk, Worthington, Nelson, Holmes and Marsden are examples of the first generation of pioneers of Canadian anaesthesia, Dr. Webster (1865–1934) and Dr. Samuel Johnston (1869–1947), of Toronto, are examples of the second generation. In their careers lie the origins of academic anaesthesia in Canada.

Dr. Webster took the need for education seriously.[22] As a medical student he received only one lecture on anaesthesia, by the professor of materia medica. Soon interested in the subject, he determined to learn more. During a visit to England in 1897 he met and observed the work of prominent English anaesthetists, particularly Sir Frederick Hewitt and Dr. Dudley Buxton. Webster also noted that "a goodly number" of medical schools taught anaesthesia to medical students and that the London Society of Anaesthetists, the first professional organization of anaesthetists, had been formed in 1893.

Impressed by the advanced state of the specialty in England, Webster returned to Winnipeg determined to advance anaesthesia in his part of the world through teaching. In 1904 he gave a course of four lectures to students, and in 1905 he was appointed Lecturer on Anaesthesia in the Faculty of Medicine at Manitoba Medical College. This appointment was the first academic appointment in anaesthesia in Canada. In 1919 the Manitoba Medical



Dr. William Webster.

Dr. Samuel Johnston.

College merged with the University of Manitoba, and Dr. Webster was appointed Associate, Clinical Surgery (Anaesthesia) at the University.

His academic interest became further evident in 1924 when his book, *The Science and Art of Anaesthesia,* was published.[23] This book remains the only comprehensive textbook on anaesthesia ever written by a Canadian anaesthetist.

Although Dr. Webster was the first to bring academic interest to bear on Canadian anaesthesia, he played another important role in Canadian anaesthesia. In 1921 he became the second president of the Canadian Society of Anaesthetists, which was the forerunner of the Canadian Anaesthetists' Society.

Dr. Johnston also was an academically oriented anaesthetist who contributed to the professionalization of Canadian anaesthesia in the first quarter of the 20th century. He established a department of anaesthesia in 1905 at the Toronto General Hospital, and gained insight into the practice of teaching anaesthesia by visiting leading anaesthetists in other countries. He visited New York and Chicago after giving up general practice in 1907, and then England in 1908 and 1909.

Dr. Johnston's commitment to anaesthesia was recognized by his appointment as Lecturer in the Faculty of Medicine at the University of Toronto in 1907. He had a broader vision than Dr. Webster, building up departmental staff who would carry forward the tradition of teaching through the next generation of anaesthetists. This generation included William Easson Brown, Charles H. Robson, Ralph Hargrave, Tom Hanley, Ken Heard and Harry Shields.

In Montréal the specialty of anaesthesia took longer to gain autonomy principally because, as in Winnipeg, anaesthetists were salaried hospital employees, even into the 1950s. William Nagle (1880–1918), chief of anaesthesia at the Royal Victoria Hospital, is remembered for his early advocacy of endotracheal administration of ether, 300 cases of which he reported in 1913.[24] On Nagle's death, Wesley Bourne (1886–1965), who had graduated from McGill in 1911, was asked to take over the department, on salary. However, Bourne preferred the independence of private practice and the opportunity to conduct research, so took up practice in Montréal at the Western Hospital, Maternity Hospital and St. Mary's Hospital. In contrast William B. Howell (1873–1947) and Charles C. Stewart (1887–1958) were content to work as salaried employees at the Royal Victoria Hospital and the Montréal General Hospital, respectively.

Among French-speaking anaesthetists in Montréal of that era, Charles LaRocque (1891–1932) was preeminent. Well known by American anaesthesiologists as a member of the International Anesthesia Research Society (IARS), LaRocque did much to make Canadian anaesthesia known outside Canada. Within the country, he emphasized the importance of friendly cooperation between anglophone and francophone anaesthetists.

1920 to 1942: The Budding of Canadian Anaesthesia

Harold Griffith has said "it is fortunate ... that we had Wesley Bourne and his three colleagues Johnston, Webster and LaRocque, and other enthusiastic pioneers" in Canada at the end of the first World War.[25] Inspired by the American, Francis H. McMechan of Cincinnati, they did much to found the Canadian Society of Anaesthetists in 1920. A great deal of clinical expertise and experience had developed by then, partly as a result of World War I, and a cadre of Canadian anaesthetists who had demonstrated talent and enthusiasm for teaching (Webster, Johnston) and research (Bourne, then Brown). If the establishment of the first academic posts in anaesthesia in Winnipeg and Toronto marked the birth of the *specialty* of anaesthesia in Canada, the founding of the Canadian Society of Anaesthetists marked its coming of age.

The founding of this Society provided an organizational base and a forum for its members. Although the Society was short-lived, it brought Canadian anaesthetists together and gave them a sense of identity.

Canadian anaesthetists were particularly close to their American colleagues in the 1920s, partly through the friendship extended by McMechan, and the Society welcomed American anesthesiologists to Canadian meetings. The first annual meeting of the Society, held at The Clifton Hotel, Niagara Falls, Ontario, on 1–3 June 1921, emphasized this relationship, for it was held jointly with the Interstate Association of Anesthetists and the New York Society of Anesthetists, as well as the Ontario Medical Association.

The scientific program for this historic meeting (Table 1.1) illustrates the topics of interest from this era. Evidently, problems for anaesthetists have not changed over the years.

The scientific program also illustrates the calibre of anaesthetists who attended; some

TABLE 1.1
The Canadian Society of Anaesthetists Scientific Program
First Annual Meeting, 1921

Wednesday, 1 June

Morning	Afternoon
Anesthesia – Its Place in the Practice of Medicine (President's Address, New York Anesthetists) J.J. Buettner MD, Syracuse, New York	Symposium of Anaesthesia and the Circulatory System
Charting the Signs and Symptoms of Anesthesia for Teaching A.E. Peebles DDS	Clinical Observations on the Effects of Operations and Anesthesia in [sic] Blood Pressure C.J. Weils MD, Syracuse, New York
Lessons from Anesthetic Accidents and Near Fatalities R.M. Waters MD, Sioux City, Iowa	Clinical Studies in Circulatory Depression from Anaesthesia Records E.I. McKesson MD, Toledo, Ohio
A Consideration of Ethyl Chloride Anaesthesia W. Webster MD, Winnipeg	Circulatory and Other Reflexes Under Various Ether Tensions E.A. Tyler MD, Philadelphia, Pennsylvania
A Classification of Anesthetic Signs and Cardiovascular Effects of Ethyl Chloride in Dosage in Man A.E. Guedel MD, Minneapolis, Minnesota	Blood Pressure Reactions Under Ether-Oil Colonic Anaesthesia G.M. Geldert MD, Ottawa
The Effects of General Anaesthesia on the Liver C.A. LaRocque MD, Montréal	Clinical Studies on the Effects of Various Nitrous Oxid-Oxygen Administration on Blood Pressure and Some Considerations of Rebreathing in Prolonged Anesthesia G.W. Tong MD, Brooklyn, New York
	The Cardiac Reserve in Fibroid Operations T.D. Buchanan MD, New York, New York

Thursday, 2 June

Morning	Afternoon
Symposium on O_2-need and Acidosis in Relation to Anaesthesia and Operation	The Value of Expert Anaesthesia to All Concerned (President's Address, Canadian and Interstate Anesthetists) S. Johnston MD, Toronto
Oxygen in Relation to Anoxaemia and Anaesthesia R.D. Rudolph MD, T.R. Hanley MD, Toronto	The Pathology and Treatment of Chronic Brain Injuries with a View to Determining the Safest Operative Period W. Sharp MD, New York, New York
A Preliminary Report on Experimental Work in Oxygen Tension During Anesthesia Mary Botsford MD, San Francisco, California	Anaesthesia for Brain Tumor Operations C.T.W. Hirsch MD, London, England
Further Studies in Oxygen Need During Anesthesia W.J. Jones DDS, Columbus, Ohio	Synergistic Anesthesia and Analgesia with Nitrous Oxid-Oxygen and Magnesium Sulphate J.T. Gwathmey MD, New York, New York
The Acidosis Condition W.H. Porter MD, New York, New York	Postoperative Complications of Respiratory Tract H.R. Decker MD, Pittsburg, Pennsylvania
Tissue Acidosis in Blood Acidosis W.H. Mercur MD, Pittsburg, Pennsylvania	Morbidity and Mortality in Obstetrics as Influenced by Anaesthesia W. Bourne MD, J.W. Duncan MD, Montréal
Acidosis in Relation to Operation and Anaesthesia Edith M. Ross MD, Winnipeg	Rebreathing and Etherization J.R. McCurdy MD, Pittsburg, Pennsylvania

Friday, 3 June

Morning	Afternoon
Anaesthesia for Nose, Throat and Abdominal Surgery by the Nitrous Oxid-Oxygen C.E. Combination H.E.G. Boyle MRCS, London, England (Honorary Chairman's Address – Official Representative of the Anaesthesia Section, Royal Society of Medicine)	The Medical Profession and the Nurse Anaesthetist W.B. Howell MD, Montréal
Case Reports Nitrous Oxid-Oxygen Anesthesia for Tonsil Operations J.H. Evans MD, Buffalo, New York	An Unusual Case of Obstructed Respiration Isabella C. Herb MD, Chicago, Illinois
Experimental and Clinical Observation on Cotton Process Ether P. Cassidy DDS, Cincinnati, Ohio	Syphilis and Anesthesia F.H. McMechan MD, Avon Lake, Ohio
Pressure in Relation to More Efficient Ether Anesthesia Bea Morgan MD, Chicago, Illinois	Prolonged Nitrous Oxid-Oxygen Minimal Ether Anesthesia for Neurological Surgery O.H. Warner MD, Washington, DC
Handling the Toxic Thyroid Under Ether-Oil Colonic Anesthesia G.K. Dickinson MD, Jersey City, New Jersey	
Intratracheal Anaesthesia W.G. Hepburn MD	

were leaders of the profession from England as well as the United States and Canada. Exchange of ideas must have been as stimulating informally as formally. As well, the program urged members of the Canadian, Interstate and New York societies to "bring in all the new members" they could, for the three organizations' secretary-treasurers (Wesley Bourne, Frank McMechan and Phillip Brundage) wanted "all of those of the allied professions vitally interested in anaesthesia, on their rosters." The three organizations must have worked hard to fashion a successful social program, as suggested by the following excerpt from the program:

> On Wednesday evening, June 1, a popular dinner will be served in one of the banquet rooms of The Clifton. This will be a delightful though informal affair, and Canadian, Interstate and New York Anesthetists are urged to attend and bring their Ladies to lend grace and charm to the occasion. The dinner will be enlivened with music and clever speakers.
>
> On Thursday evening, June 2, a dinner will be served for the members of all the Associations in Joint Meeting. This dinner will be followed by a Smoker and Vaudeville. On the same evening there will be a separate entertainment for the Ladies in the Ballroom.

The program of this first Annual Meeting is notable for one other item: what amounts to an epilogue published on the final page. The first and last sentences are still inspiring: "In our modern enthusiasm for organization, we are in danger of forgetting that system and survey and encyclopedic knowledge can never support real thinking ... Genius is found in men, not in organizations."

Despite such a brilliant inaugural meeting, the Society did not survive. Why remains unclear. Dr. R.A. Gordon reported that one of his "elders" once told him that it was because the Society elected a secretary who did not write letters.[26] Be that as it may, the Society did not survive beyond 1928, when it surrendered its federal charter to become absorbed by the CMA. At least three other reasons may explain the Society's demise.

First, the CMA established a section of anaesthesia in 1927. To some Canadian anaesthetists, a larger organization might have offered administrative and other advantages. Meetings would be easier to arrange, as would association with other physicians. British and American anaesthetists, after all, had formed anaesthesia sections within their national medical associations.

Second, very few physicians were practising anaesthesia in Canada in the 1920s. Although many members of the Society were remarkable individuals (e.g., the Presidents [Table 1.2]), the number of full-time anaesthetists must have been extremely small because only 38 individuals attended the inaugural meeting of the CMA Section on 15 June 1927.[27]

A third reason may be the most valid. In the 1920s the anaesthetists' lot, like the policeman's, was not a happy one. The attitude of the medical profession (and, no doubt of surgeons in particular) was that anaesthesia was a rather boring technical procedure that

TABLE 1.2

The Canadian Society of Anaesthetists: Presidents, 1921–1928*

1921	Samuel Johnston, Toronto
1922	William Webster, Winnipeg
1923	David Arnott, London
1924	Walter Muir, Halifax
1925	John Buettner, Syracuse, New York
1926	Charles LaRocque, Montréal
1927	David Freeze, Vancouver
1928	William Howell, Montréal

* *Wesley Bourne was never President of this Society nor of the Canadian Anaesthetists' Society. He was clearly held in high esteem by his colleagues of the 1920s, for in 1930 the Canadian Society of Anaesthetists presented him with the President's Gavel in recognition of his services to anaesthesia.*

could be carried out by students, interns or doctors who had failed at the "important" aspects of the practice of medicine. To a number of Canadian anaesthetists, particularly salaried employees, affiliation with the CMA may well have seemed an attractive and protective option. Dr. Johnston, secure in a university post, regarded the CMA's initiative, as announced by the President, prominent Toronto surgeon Dr. F.N.G. Starr, as "an honour ... coming as it does, from one who occupies such an eminent position in surgery."[28] The CMA, however, with a mandate for all physicians, served no particular specialty.

Even though the Society failed to survive, its members remained active in the CMA Section of Anaesthesia, and so provided continuity in organized Canadian anaesthesia. The Section held annual meetings from 1927 until 1955, and many of the members of the old Society took part in these meetings. So too did younger anaesthetists who in due course joined the successor to the Canadian Society of Anaesthetists, the Canadian Anaesthetists' Society.

The more independent of Canadian anaesthetists, with ideas of what anaesthetists required for the development of the specialty, found the CMA Section of Anaesthesia a less than ideal forum. Consequently, some started looking for a new organization that might serve their needs.

The Montréal Society of Anaesthetists was founded in 1930 as a small organization that could serve the specific needs of anaesthetists more effectively than the CMA Section of Anaesthesia. At about the same time it was suggested that the defunct national organization be revived, but response was half-hearted.[29] Montréal remained the centre of organized anaesthesia in Canada and formed the *nidus* of ideas that led eventually to the formation of a new society of anaesthetists in 1943.

CHAPTER TWO

The Canadian Anaesthetists' Society: The Founder, the Founding and the Foundations

WHY was the Canadian Anaesthetists' Society founded? Who were the founders? What was their vision? What kind of foundation did they lay for the Society? This chapter answers these questions.

Events and Ideas Underlying the Founding of the Society

The years following the disbanding of the Canadian Society of Anaesthetists in 1928 were extraordinarily difficult in Canada, as in all western countries. The first year was marked by the Depression, and doctors, like everyone else, were at times hard put to make ends meet. Physicians, and particularly recent graduates, who wished to work as anaesthetists found that it was not easy to find work in hospitals. Administrators, feeling the financial pinch, "froze" new staff positions. Fewer men and women, therefore, took up the practice of anaesthesia in the 1930s.

At the same time physicians practising a specialty wished to become recognized as specialists.[1] The Royal College of Physicians and Surgeons of Canada served primarily the needs of university consultants, and its emphasis on excellence in general medicine and general surgery meant that a specialist had to become a Fellow in either the Divisions of Medicine or Surgery before being recognized by the Royal College as a specialist.[2]

Most anaesthetists, like most radiologists and pathologists, wanted a form of recognition that was midway between an MD degree and the Royal College's Fellowship. Other options seemed attractive – to form independent specialty colleges or join American specialty associations. Even when the Royal College approved a Fellowship examination modified for several specialties in 1937 (dermatology, ophthalmology, otolaryngology, paediatrics, radiology and urology), anaesthesia remained unrecognized. Anaesthesia was not granted such recognition until 1942, and then only with Certification rather than Fellowship. In a sense, this made matters worse, for it reinforced the view of some physicians, particularly surgeons, that anaesthetists were second-class medical citizens.

Coincidental with the negative effects of the Depression and the failure of anaesthetists to gain specialist recognition was the increasing likelihood of some form of health care insurance plan for Canada. This did not necessarily instill fear into the hearts of physicians – indeed, in 1935 the Canadian Medical Association (CMA) declared itself in favour of national health care insurance[3] – but it did encourage the more enlightened among Canadian anaesthetists to organize themselves on a national basis if they wished to preserve what little autonomy they had.

Concurrently, the leaders of Canadian anaesthesia in the 1930s and early 1940s realized that no one was speaking for anaesthetists as a group, either in Montréal or across the country. The Montréal Society of Anaesthetists served as a focus for anaesthetists in and around Montréal, but neither the CMA Section of Anaesthesia nor the Royal College could speak for all Canadian anaesthetists. As Dr. Harold Griffith himself recalled years later, "it seemed increasingly clear to some of us that we were lost in the anonymity of the larger Association (CMA), and that the special interests could be looked after better in an organization of our own."[4]

Thus five members of the Montréal Society of Anaesthetists concluded early in 1943 that it was again time to form a national organization of anaesthetists. Supported by some of the more senior Toronto anaesthetists, including Drs. Ken Heard and Harry Shields, the Montréal society transformed itself legally into a new national organization: the Canadian Anaesthetists' Society. Of the five founding members, three were anglophones: Wesley Bourne, Harold Griffith and Digby Leigh. The two francophones were Drs. Roméo Rochette and Georges Cousineau. They were colleagues of Dr. Charles LaRocque, who had done much to promote friendship between English- and French-speaking anaesthetists in Montréal, and who had been president of the Canadian Society of Anaesthetists in 1926.

The Founders of the Society

WESLEY BOURNE (1886–1965)

Wesley Bourne[5] was the oldest and, in terms of organized anaesthesia, the most senior of the five members of the Montréal Society who decided to form a new national organization. Encouraged by Dr. Samuel Johnston and Dr. Frank McMechan, the American organizational genius, Bourne had been one of the moving spirits behind the founding of the original Society in 1920 and its first Secretary-Treasurer. In 1942 he became President of the American Society of Anesthesiologists. The other four Montréal anaesthetists who were thinking about a new Canadian society naturally turned to Bourne, then 57 years old, for advice.

In the history of Canadian anaesthesia Wesley Bourne occupies a special place. For Harold Griffith, he was "the great Canadian pioneer of modern anaesthesiology."[6] An adept and skilled anaesthetist, he was an inspiring teacher and active researcher. His research, particularly on the pharmacological aspects of volatile anaesthetic agents, led him to emphasize the importance of the basic sciences as the foundation of sound clinical anaes-

Dr. Wesley Bourne (1886–1965).

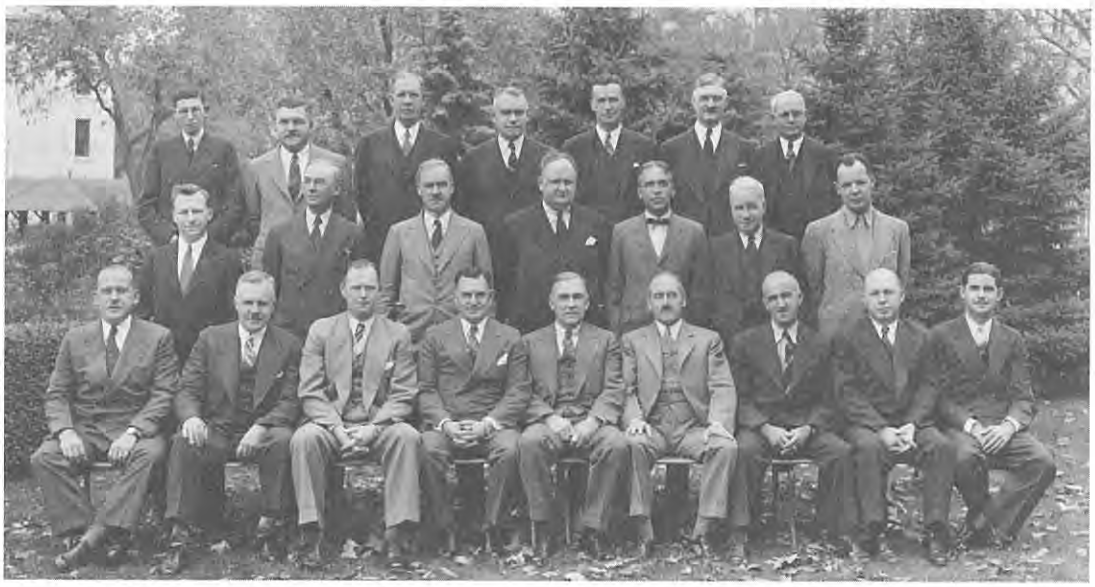
Dr. Harold Griffith (1894–1985).

thesia. The only anaesthetist who had a Fellowship in Medicine of the Royal College, Bourne was perhaps the most erudite and literate of anaesthetists anywhere. In England, he had been awarded the first Henry Hill Hickman Medal by the Royal Society of Medicine in 1935, and in the United States he was the only Canadian ever to become President of the American Society of Anesthesiologists. He sat tall in the saddle of Canadian anaesthesia and was the leader of anaesthesia in Montréal. Two years later, in 1945, he became the inaugural professor and chairman of the new Department of Anaesthesia at McGill University, the first such department in Canada.

HAROLD GRIFFITH (1894–1985)

Harold Griffith[7-8] was a leader of the younger generation of anaesthetists in Montréal who had graduated after World War I. Having served in the Canadian Army during the war, where as a corporal one of his duties had been to "pour ether," Griffith was a mature man when he returned from France and completed his medical training in 1922. As an intern he learned more about anaesthesia, seizing an opportunity to make a few dollars by skipping classes to give ether and chloroform. He learned anaesthesia the hard way, for conditions were indeed crude, as he recalled in 1967:

> The equipment available was primitive indeed. We had no gas machine, no oxygen, no airways, no suction – only bottles of chloroform and ether, some ether and chloride for rapid induction, and gauze-covered wire masks. For tonsillectomies we vaporized the ether with a hand-operated Junker bottle attached to a mouth hook.[9]



The Anesthetists' Travel Club, Rochester, Minnesota, October 12–13, 1938. Enhancing the development of academic anaesthesia in Canada in the 1930s and 1940s was the membership of a number of Canadian anaesthetists in the Anesthetists' Travel Club. This was founded in 1929 by John Lundy, who was himself honoured by the Society in 1968 with a Gold Medal. The members of the Club at this meeting were the following (from left to right and from rear to front, with names of Canadians in bold face): G. Kaye (Australia), **Beverley Leech** (Regina), T.J. Collier, **David Aikenhead** (Winnipeg), S.C. Wiggins, R.T. Knight, W.W. Hutchinson, R.M. Tovell, A.M. Caine, **Harry Shields** (Toronto), P.M. Wood, P.D. Woodbridge, T.D. Buchanan, J.G. Dunlop, H.S. Ruth, **William Easson Brown** (Toronto), **Jack Blezard** (Edmonton), C.F. McCuskey, R.C. Adams.

But his experiences induced him to pursue anaesthesia as a career, and he spent a year in Philadelphia doing postgraduate work in anaesthesia as the equivalent of a resident in the days before residency programs had been introduced. Then he returned to Montréal to join the staff of The Homeopathic (later, the Queen Elizabeth) Hospital, where he remained for the rest of his career.

From his base in Montréal, Griffith in due course became a figure of international renown. His first international success came from a paper he read at a 1928 meeting in Boston. His topic was "Intratracheal Ethylene-Oxygen Anaesthesia," which he thought would interest few of his audience because "of the hundred or more anaesthetists who were in the audience probably not more than ten had ever passed an endotracheal tube."[10] But among the listeners was the great Ralph Waters of Madison. His interest in Griffith, who was still a young man, was a high point in the Canadian's career.

When they met again at a 1929 meeting in Montréal, Waters visited Griffith at work in The Homeopathic and witnessed his skills as an anaesthetist. Waters then invited Griffith to join the elite and influential Anesthetists' Travel Club. This organization, the brain-child of John Lundy, of the Mayo Clinic, comprised the leaders of American anaesthesiology and

a number of leading Canadian anaesthetists.[11] For these Canadian anaesthetists, membership in the Travel Club was a stimulating experience that provided them with ideas that they brought back to their own academic environments.

Another American anesthesiologist who befriended and influenced Griffith was Dr. Francis McMechan, who had struggled to have anaesthesia accepted as a respected medical specialty. He was the founder of the National Anaesthesia Research Society (NARS, later the International Anesthesia Research Society [IARS]) in 1916 and of numerous other anaesthesia organizations. He also had been the catalyst in the formation of the short-lived Canadian Society of Anaesthetists in 1920.

Griffith, who became the new Society's founding President, was a sociable and congenial companion, liked by everyone who met him. He was a natural raconteur and added stories to his technical accounts of anaesthesia. One such story concerned endotracheal intubation, which too few anaesthetists were using in the 1920s and 1930s:

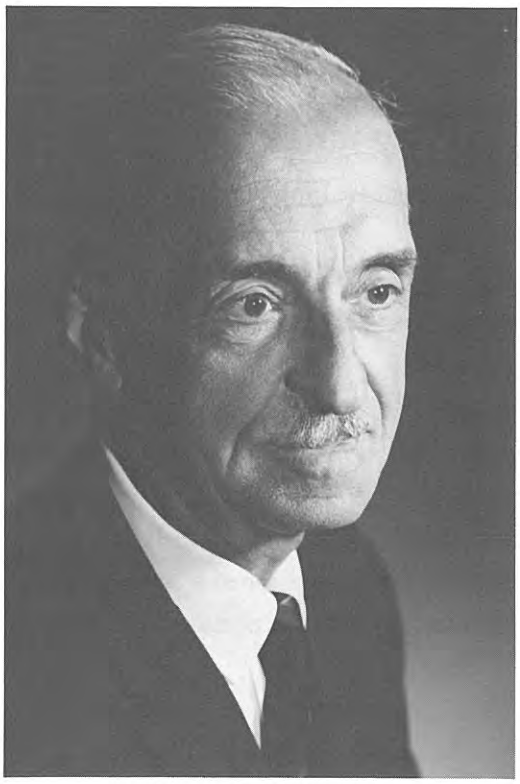
> Very few anaesthetists of the 1920s were even attempting the endotracheal technique. Ivan Magill in London had just started to preach its advantages, and Charles Stewart in Montréal and Ralph Hargrave in Toronto were early enthusiasts. The tubes we used and the methods of administration were changing frequently, and dexterity at intubation was perhaps more important than now, since this was long before the advent of muscle relaxants. Gradually many of us abandoned ether insufflation for a semi-closed inhalation technique with more oxygen and nitrous oxide or ethylene, and this called for larger endotracheal tubes. I found some French silk-woven urethral catheters which seemed to be ideally flexible without kinking them and we ordered them directly from the manufacturer in increasingly larger sizes, which they eventually made for us in size F36. We were amused one day when the manufacturer's representative from France came to the hospital and told us that the girls in his factory had asked him to have a look at those Canadians who needed a size 36 catheter.[12]

Griffith went from strength to strength, and his advocacy of ethylene, then cyclopropane, and finally curare gave him the reputation of an innovative and up-to-date anaesthetist. He was rightly regarded as one of the leaders of clinical anaesthesia in Canada, and his courageous decision to use curare in 1942, together with Dr. Enid Johnson,[13] set the seal on his career. This revolutionary advance came just before he and his Montréal colleagues were seriously considering the need for a new organization of Canadian anaesthetists. Griffith, like Bourne, was a Montréal anaesthetist who had become famous and was well qualified to become a leader of organized anaesthesia. Canadian anaesthetists were indeed fortunate to be led by two men of such high calibre.

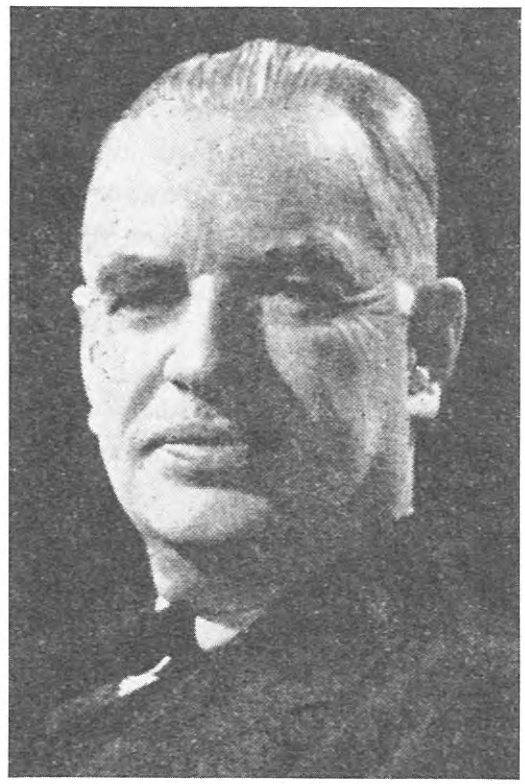
M. DIGBY LEIGH (1904–1975)

Digby Leigh[14] was the third of the Montréal anglophones who founded the Canadian Anaesthetists' Society. A native of Jersey, one of the Channel Islands between England and France, Leigh was an outgoing and often outspoken man best known as a paediatric anaes-

Dr. Digby Leigh (1904–1975).



Dr. Georges Cousineau (1906–1987).



Dr. Roméo Rochette (1895–1958).

thetist. His base in Montréal was the Montréal Children's Hospital. He joined Bourne and Griffith early in World War II in setting up a teaching program for physicians required to work as anaesthetists in the Canadian armed forces. This highly successful program, which provided short courses of basic anaesthesia instruction, and which would lay the basis for the successful McGill residency program after the war, brought Leigh close to Bourne and Griffith in their discussions about the new Canadian organization of anaesthetists.

ROMÉO ROCHETTE (1895–1958)

Dr. Roméo Rochette,[15] a graduate of Laval University, became chief of anaesthesia at the Hôtel-Dieu in 1934. As Griffith said, his reputation was based on "friendliness, dependability, integrity, humility and good humour."[16] Distinguished personally and professionally, he tended to remain in the background. He was greatly admired in Montréal for his insistence on professional respect for anaesthetists and on satisfactory economic conditions in anaesthesia. His contribution to the work of the founding five was reliable counsel.

DR. GEORGES COUSINEAU (1906–1987)

Georges Cousineau[17] was a pioneer of anaesthesia for thoracic and orthopaedic surgery. Working at Montréal's Hôpital du Sacré-Coeur, he was influenced by Normal Bethune, who suggested that Cousineau use endotracheal tubes, and by Harold Griffith, who showed him how to use them. Cousineau became well known in the United States and England as well as in Canada. He was an active member of the IARS, and in 1953, under Dr. Eugene Allard of Québec City, organized one of the few meetings of the IARS to be held outside the United States. Cousineau was elected Honorary FFARCS in 1951, while representing the Canadian Anaesthetists' Society of which he became President in 1952. He also helped set up a residency program in the University of Montréal, and the recognition of anaesthesia as a specialty by the Québec College of Physicians and Surgeons in 1950 was largely due to his efforts and those of Dr. León Longtin.

The Vision of the Founders

On 27 May 1943, the five founders of the Society – Drs. Griffith, Rochette, Leigh, Bourne and Cousineau – met to draw up an official document that would formalize their vision of a new national organization. On that day they drafted a Memorandum of Agreement whereby they did "severally covenant and agree each with the other to become incorporated ... under the name of *The Canadian Anaesthetists' Society*." They envisioned a Society guided by certain Objects that would join anaesthetists across Canada in a common association. These objects were:

> To advance the art and science of Anaesthesia and to promote its interests in relation to Medicine with particular reference to the clinical, educational, ethical and economic aspects thereof, to associate together in one corporate body members in good standing of the Medical Profession who have specialized in this particular science, to promote the interests of its members, to maintain a Society Library and Bureau of

> Information, to edit and publish a journal of Anaesthesia, to acquire and own such property and real estate as may become necessary to effectively carry out the purposes of the Society, and to do all such lawful acts and things as may be incidental or conducive to the attainment of the above Objects.[18]

That statement describes the goal of the founders, and has remained the goal of the Society ever since.

The Memorandum of Agreement also identified Dr. Griffith and his four associates as the first members of the Society and, for the time being, its directors.

In the Memorandum the five anaesthetists set out the Society's original Bylaws (Appendix 2). These Bylaws served to keep the Objects as the Society's lodestar and as reminders of the founders' vision. Since no records of the original Society are extant, it is impossible to determine whether the Bylaws of the two societies are similar.

The only factor common to the two organizations, other than membership of the more senior anaesthetists, is the seal. It comprises an illustration of the Greek god Hypnos pouring poppy juice from his horn, and a motto featuring the Greek words *katheudontas parateroumen* ("We watch closely those who sleep"). The seal was designed by Wesley Bourne in 1920, in consultation with Dean Moyse, Professor of Classics at McGill University. Both illustration and motto were entirely in keeping with the vision of the founders of the new Society and so were transcribed into the Bylaws of the new Society in 1943. The seal appears on the front cover of every issue of the Society's Journal.

The document drawn up on 27 May 1943 was simply an initial memorandum of agreement, and had no legal force. It was therefore necessary to obtain Letters Patent (Appendix 2). The Letters Patent legitimized the Canadian Anaesthetists' Society as a "Body Corporate and Politic without share capital, for the purposes of carrying on in more than one province of Canada, without pecuniary gain to its members ..." The Letters Patent were signed on 21 June 1943 by E.H. Coleman, Under Secretary of State, and recorded on 24 June 1943 by W.P.J. O'Meara, Acting Deputy Registrar General of Canada.

Once again Canadian anaesthetists had a national and autonomous organization to represent them.

The Foundation Examined

In drawing up the Bylaws, the five founders provided an organizational structure for the Society. To what extent did this structure reflect the wisdom of the founders, and how successful was their blueprint for a new society? These questions may be answered by examining the Society at any given moment in its history, but the Society's survival, growth and achievements indicate the wisdom and success of its founders. The Constitution and Bylaws are discussed in Chapter 3, and other aspects of the Society are examined in detail elsewhere, but it is instructive here to look at some of the Society's original organizational structure and the foundations laid by Dr. Griffith and his colleagues. Several elements are worthy of commentary.

1 *The Objects*

It would be difficult to better the statement of the founders today. This mission statement provides a ready means for evaluating the Society's performance over the years. The statement of Objects comprises seven separate clauses:

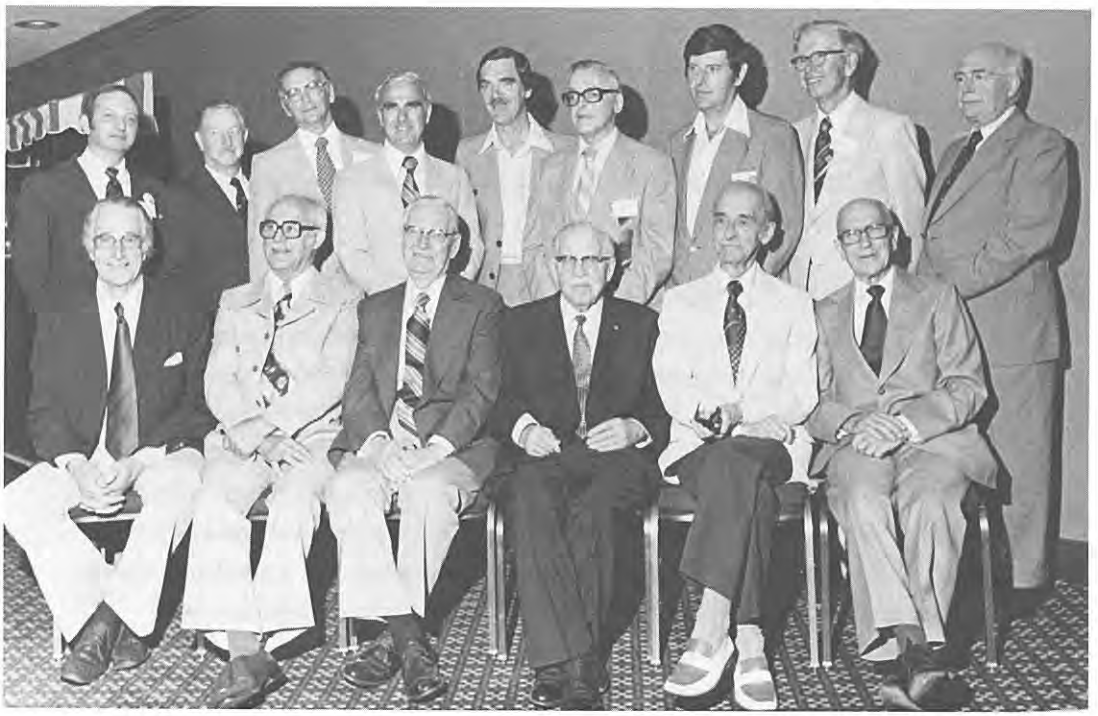
- *"To advance the art and science of anaesthesia ..."*
  Both aspects have been regularly and successfully advanced by the annual meeting (Chapter 9), through application of the Society's Guidelines to the Practice of Anaesthesia (Chapter 5), and through the Society's involvement in developing standards for anaesthetic equipment (Chapter 6). The science of anaesthesia has also been advanced by the Society's commitment to research, even though this was somewhat tardy and less than wholehearted at the beginning (Chapter 7).

- *"To promote its interest in relation to medicine with particular reference to the clinical, educational, ethical and economic aspects ..."*
  The four principal sections of this book analyze the manner in which the Society has promoted its principal interests. The Society has successfully promoted the clinical and educational aspects of anaesthetic practice in Canada at its annual meeting (Chapter 9) and through its Journal (Chapter 10). The ethical aspects have been promoted not only by emphasizing ideal standards of practice but also by establishing and maintaining relationships with other medical organizations and the pharmaceutical industry (Chapter 12). Only with respect to the economic aspects of anaesthesia in Canada has the Society been less than wholly effective in promoting interests of anaesthetists (Chapter 13). The original tariff of fees was applicable across Canada, but the provincial structure of Canada, with regional differences in many aspects of life, including cost of practice and living, made it impractical to apply a single, national tariff.

- *"To associate together in one corporate body members in good standing of the Medical Profession who have specialized in this particular science ..."*
  The continued growth of the Society is an index of the validity of this object. The Society's annual meeting and regional meetings as well as the Society's Journal and newsletter have all worked together in this regard. However, the fact that not all specialist anaesthetists in Canada are members of the Society means that this Object has not been completely achieved.

- *"To maintain a Society Library and Bureau of Information ..."*
  The Society's central office frequently answers questions from members and others, and in this sense the Society maintains a bureau of information through the Society's files, including the Archives. A formal Library, however, has never been formed.

- *"To edit and publish a Journal of Anaesthesia ..."*
  Beginning in 1954, the Journal has gone from strength to strength (Chapter 10). The change of name in 1987 from *Canadian Anaesthetists' Society Journal* to *Canadian Journal of Anaesthesia* represents an evolution from primarily a society journal to a scientific journal of anaesthesia of interest to authors and readers



La crème de la crème ... The Past Presidents, 1976. From left to right are, standing: Stuart Vandewater, Iain MacKay, John Lawrence, John Feindel, Ian Purkis, Jean-Paul Dechêne, Earl Wynands, Norman McMillen and Rod Gordon; and sitting: Dick Gilbert, Léon Longtin, Rice Meredith, Harold Griffith, Georges Cousineau and Eugène Allard.

around the world. The Journal began as a quarterly publication in 1954 and increased in stature and frequency to become a monthly publication in 1993. This is the only means whereby the Society frequently and regularly serves *all* its members.

– "*To do all such other lawful acts and things as may be incidental or conducive to the attainment of the above objects.*"
This all-inclusive Object provides flexibility for the development of miscellaneous activities. Examples include publication of a newsletter (Chapter 4), regional meetings (Chapter 9), and revision of the Constitution and Bylaws in 1968–1971, which led to the granting of Supplementary Letters Patent (Chapter 3). However, the Society's capability of, and commitment to, bilingualism has not reached the standard attained, for example, by the CMA or The Royal College of Physicians and Surgeons of Canada.

2 *Officers*

Originally the Society's Officers were the President, two Vice-Presidents and a Secretary-Treasurer. Over the years the composition was modified on several occasions. While at any one time there have always been one President and two Vice-Presidents, the number of Past Presidents has varied from one to three, and in 1969 the position of Secretary-Treasurer was divided into Honorary Secretary and Honorary

Treasurer. (The Society's Officers over the years are listed in Appendix 5.) The Bylaws state (Section 9) that "the President shall not hold office for more than three consecutive years," but only the first president, Dr. Harold Griffith, served for as long as three years. The question has been raised as to whether one year is long enough to satisfactorily and effectively complete the presidency. There are advantages and disadvantages to a shorter or longer term.

The manner whereby the Officers have been "elected" has been questioned from time to time. On the Society's founding, the Officers were the five founding members because they were the only members at that time. However, they laid down that "the officers shall be nominated by the Council, the nominations to be specified in the notice of the Annual General Meeting ..." It was also stipulated that "nominations may also be made by any two Active members prior to the date of notice calling the Meeting." This has not prevented members from suggesting that the procedure is not democratic. While this view is understandable, the procedure has been almost wholly successful, and a mechanism does exist whereby an alternate to nominations by Council may be effected by members who are not on Council. Also, the route to Council from the divisions is open to any member who is interested, and Council comprises individuals who have been elected from the provincial divisions.

When the founders drew up the Bylaws, it seemed that the four Officers originally identified were sufficient. In due course it became evident that the duties of the Secretary and Treasurer were too extensive and time-consuming to be performed actively by full-time practising anaesthetists. Therefore, in 1983 it was decided to appoint a lay executive director. Since then the number of office staff has increased. The Society's administration is now conducted by a full-time office staff (Chapter 4).

3 *Council and Executive*

It was originally intended that "the Council shall have general management, supervision and direction of the affairs of the Society ... (and that) they shall adopt at all times the best possible measures for the advancement of the Society's interests, and shall be entrusted with the maintenance and care of the property of the Society" (Section 11). Initially, Council comprised the Officers and 10 other active members "to be selected annually by the Active Members of the Society." It was also required that "at least two members of the Council shall reside in and represent each of the four divisions of the Society (Maritime Provinces, Québec, Ontario, Western Provinces)." With time it became necessary to change the size and composition of Council and, in particular, the representation of individual provinces, as opposed to the original four divisions (Chapter 3). As a result, each province is represented by one or more delegates, the number of delegates being proportional to provincial representation among Society members.

Council 1976. Sitting (left to right) are: Drs. D.W. Aitken (Honorary Treasurer), R.A. Gordon (Editor), S.L. Vandewater (Honorary Secretary), G. Houle (Chairman), J.H. Feindel (President), F.G. Brindle (ACUDA), J.H.A. Lawrence (Past-President), and A.J. Dunn (Assistant Honorary Secretary). For a complete list of Council members, see Appendix 6.

Executive Committee, October 1989. From left to right: Ann Andrews (Executive Director), Dr. David Fear (Honorary Secretary), Dr. Richard Baxter, Dr. Crawford Walker, Dr. Jacques Samson, Dr. Peter Duncan, Dr. Lewis Hersey (Honorary Treasurer), Dr. John Cowan, Dr. Andrew Davies, and Miss Cynthia Lank.

A great trio: Drs. Wesley Bourne (left), John Gillies of Edinburgh, and Harold Griffith. Each was honoured by the Society's Gold Medal: Dr. Bourne and Dr. Griffith in 1962 and Dr. Gillies in 1969.

Originally, it was stated that Council "shall be the Executive and Administrative body of the Society ..." Initially the terms *Executive* and *Council* were used interchangeably in the Minutes, but the term Council was used exclusively in the 1950s and 1960s. In 1971, however, under the revised Constitution and Bylaws (Chapter 3), a formal Executive Committee looked more closely at "the general management, supervision and direction of the affairs of the Society." Then Council could do its business adequately by meeting twice yearly, in the winter and summer. The Executive Committee comprised the President, First Vice-President, Second Vice-President, the Immediate Past President, the Honorary Secretary, the Honorary Treasurer and two members elected from Council. According to the new Constitution and Bylaws, the terms of reference of the Executive Committee are: "The day-to-day affairs of the Society shall be managed by the Executive Committee of the Council hereafter referred to as the Executive Committee."

❦

"Dr. Harold" was president of the Canadian Anaesthetists' Society from 1943 to 1946. On his retirement from the presidency there was a "changing of the guard." None of the original Officers remained, though Dr. Griffith remained on Council, as did Dr. Cousineau, who went

on to become president in 1952. Concluding this brief evaluation of the work of the founders it is appropriate to quote some of Dr. Griffith's own words in 1946.

During his President's report at the 1946 Annual Meeting in Banff, Dr. Griffith pointed out that "the membership and influence of the Canadian Anaesthetists's Society (had) developed in a highly satisfactory manner" and that "the Society (was) now recognized as representative of the great majority of Canadian anaesthetists ..." From 1943 to 1946 the Society's membership had grown from 5 to 369.

Some of Dr. Griffith's observations concerned developments in the immediate postwar period, including demobilization of anaesthetists in the armed forces and veterans affairs, but also indicated the Society's concern with economic matters and the possibility of exploitation of anaesthetists in hospitals, training and certification of anaesthetists, and the growth of the provincial divisions. All this was indicative of the role of the new society that he and his four Montréal colleagues had founded three years earlier, and gave him encouragement for the future. So he ended his address on an optimistic note, in words that are still relevant today:

> Anaesthesiology as a specialty is still in its infancy, and I have no doubt that great progress will be made in Canada during the immediate future. We have our worries as to the changes in organization and economic status which may come to the medical profession. I honestly believe, however, that there will be satisfactory work and adequate reward for young men (and, he could have added, young women) who wish to become properly qualified and to devote their professional lives to the practice of anaesthesiology. Let us face the future with confidence and enthusiasm.

CHAPTER THREE

Council, the Constitution and Bylaws, and Forces of Change

> The Council shall have general management, supervision and direction of the affairs of the Society. They shall adopt at all times the best possible measures for the advancement of the Society's interests, and shall be entrusted with the maintenance and care of the property of the Society. They shall be the Executive and Administrative body of the Society and shall have charge of all arrangements for the Annual Meetings of the Society.
>
> *Canadian Anaesthetists' Society Bylaws, Ottawa, June 21, 1943*

THE Council is a central component of the structure of the Canadian Anaesthetists' Society, and virtually all of the Society's affairs and interests have been the subject of Council deliberations. The Minutes of fifty years of Council meetings therefore provide an *entrée* to the history and nature of the Society.

Many of these affairs and interests are discussed elsewhere in this book. This chapter concerns Council discussions that led to amendments to the original Constitution and Bylaws, which define and limit the Society's activities.

Studying these amendments is one way to understand how the Society as "a Body Corporate and Politic" changed over the years. Many may seem dry and unexciting, yet some were the outcome of discussions that were often anything but unexciting. This is particularly true of some Council meetings from 1968 to 1971, which led to a revision of the Constitution and Bylaws. The Minutes of those meetings convey a sense of drama: the forthright opinions of councillors, the cut and thrust of debate heated by controversy. Council will be seen as a group of individuals ready to debate issues as well as an association of concerned anaesthetists who accepted the need for change within the Society, while at the same time adhering to the Objects laid down in 1943.

Most amendments have been minor and as acceptably pedantic as might be expected, but those of 1971 were radical enough to require thorough revision of the Constitution and Bylaws, and the issuance of Supplementary Letters Patent. Since the move that led to this major revision was initiated in 1968, and since the changes were in place by 1972, this

account of Council and the Constitution and Bylaws is separated into three periods: 1943 to 1967, 1968 to 1972, and 1973 to 1992.

1943–1967: Amendments in the Early Years

Article 16 set out three requirements for approval of amendments: (1) the Secretary-Treasurer had to be informed of an intention to introduce an amendment in writing; furthermore, the document had to be signed by two active members; (2) an amendment had to be approved by a majority of at least two-thirds of the votes cast at an annual general meeting (or of votes in a mail ballot); and (3) an amendment took effect only after it had been approved by the Secretary of State. This Article itself was revised in 1971.

The first amendments to the original Constitution and Bylaws were introduced on 7 December 1944, following recognition of the need to base divisions of the Society on Canada's nine provinces of Canada, rather than the original four regional divisions. Dr. Harry Shields of Toronto and Dr. Digby Leigh of Montréal moved that "each division should elect a local secretary-treasurer to collect the fees for each division, these fees to be forwarded to the 'Canadian Anaesthetists' Society' at Montréal." The motion was carried.

For several years a popular meeting place for early members of Council was the Café au Lutin qui bouffe. The principal attraction was a pig that enjoyed the admiring attention of dinner guests. Whether pork was part of the menu is not known ... The group shown here includes, from the milk-bottle anticlockwise: Drs. Wesley Bourne (Montréal), Stanley Campbell (Toronto), Jack Blezard (Edmonton), Harry Shields (Toronto), Harold Griffith (Montréal), Rod Gordon (Toronto), Ralph Hargrave (Toronto), Carl Stoddard (Halifax) and Kenneth M. Heard (Toronto).

Immediately afterwards, Drs. Ken Heard of Toronto and Wesley Bourne of Montréal proposed that Articles 13 and 11 be amended. The amendment to Article 13 emphasized that membership comprised members in each of the nine provinces. The amendment to Article 11 introduced two changes: first, that the number of councillors, additional to the four officers, be increased from 10 to 14; and, second, that "the Council must include at least one representative member from each Division." From then on, provincial representation on Council has been a fundamental aspect of the Society's organization.

The amendments to Articles 13 and 11 were approved by the membership at the annual meeting on 13 June 1945. Approval by the Secretary of State was announced at the Council Meeting of 3 March 1946.

At this meeting it was agreed that annual dues must be increased. These were originally $5.00,[1] the same as an anaesthetist's fee for a "minor" operation. The Executive now decided that dues for Active Members should be set at $10.00, the same as the fee for the first hour of a "major" operation, and that dues for Associate Members be $5.00. This, however, required an amendment to Article 3, Section (c) of the Bylaws: "associate members pay the same due as active members." The amendment met with some opposition at the annual meeting on 12 June 1946: it passed with 151 votes in favour and 40 against.

How councillors were elected was questioned from time to time. This was not spelled out in either the original Article 11 or the amendment of 7 December 1944, which stated that the councillors, in addition to the Officers, were to be "selected" annually by the active members of the Society and that Council must include at least one representative member from each provincial division.

At its meeting on 13 June 1946, Council agreed that this was a provincial responsibility, and that councillors should be nominated and elected by the provincial divisions. A further amendment to this effect was approved by the membership on 25 June 1947. It directed that "members of Council representing each provincial Division shall be elected annually by mailed ballot by the members of that Division." Provision was also made to send an alternate to Council if the elected councillor was unable to attend.

Another amendment, to Article 13 (b), was allied to the previous amendment. Approved at the 1947 Annual General Meeting, it stated that each division was to elect a Secretary-Treasurer who had to "perform for that division such duties as are detailed to the Secretary-Treasurer of the Society." However, the Secretary of State did not accept the wording of this last amendment, and a minor revision was deemed necessary before it could be accepted.[2]

How the Society's Officers were elected also has been questioned. The original Article 9 was ambiguous. It stated that Officers "shall be elected at Annual General Meetings by a plurality of those voting," but also that "voting shall be by mail," the ballots to be sent out to Active Members one month before the annual meeting. The Secretary was directed to clarify this and submit an amendment for approval. The amendment, approved by Council on 9 October 1946 and by the membership at the annual meeting on 25 June 1947, read as follows:

> The officers shall be nominated by Council, the nominations to be specified in the notice of the Annual General Meeting. Nominations may also be made in writing by any two Active Members prior to the date of Notice calling the Annual General Meeting. Officers shall be elected by ballot, by plurality vote. Voting shall be by mail. Ballots will be sent to Active Members in good standing one clear month prior to the notified date of the Annual Meeting, and shall be returned to the Secretary-Treasurer of the Society at least two clear weeks prior to the notified date of such Annual General Meeting.

By the summer of 1947 there had been amendments to Articles 3(c), 9, 11 and 13(b). On 14 March 1948 Council authorized the printing of the Constitution and Bylaws, and their distribution to the membership in a booklet that included the Society's original schedule of fees.

The next amendment reflected the growth of Canada. At a meeting on 6 March 1949, Council unanimously approved the motion of Drs. Russell J. Fraser of Hamilton and Rice Meredith of Toronto "That if and when Newfoundland is taken into Confederation ... an amendment be made to the Constitution to include Newfoundland in the Canadian Anaesthetists' Society." This motion was approved by the membership on 16 June 1949. An amendment was duly entered into Article 13 in recognition of the creation of the tenth provincial division of the Canadian Anaesthetists' Society. This justified a further revision of the Constitution and Bylaws booklet, which for the first time was printed in both French and English.

The number of representatives that each province could have on Council was never clearly stated in the early years; the amendment to Article 11 of 15 October 1946, for example, had simply allowed the chair of each provincial division and "such number of other Active Members as shall from time to time be determined by the Active Members of the Society in the Annual General Meeting." The first mention of numerical representation occurred during the Council meeting of 9 March 1947, when "the present basis of representation on Council was calculated to be one member per twenty-six plus Active Members." Drs. Harold Griffith of Montréal and H.B. MacEwen of Vancouver moved "That for the next year, Ontario have four Members on Council, Québec three, and the other provinces one each." This proportional representation amendment was approved by the members on 26 June 1951.

The original Constitution and Bylaws referred to the possibility of a Society Journal, which was eventually inaugurated in 1954 (see Chapter 10), but made no reference to other types of publication, such as an article for the lay press. Dr. Harry Slater, a well-known paediatric anaesthetist of Montréal and then Toronto, was concerned about preparing an article for a magazine, and asked Dr. R.A. Gordon, the Secretary Treasurer, of Toronto, for a statement of policy. A motion presented by Drs. Alan B. Noble of Montréal and Carl C. Stoddard of Halifax during the winter meeting of Council in 1953 led to the formulation of a policy and an amendment to Article 15 by the addition of Paragraph (c): "Any article or paper prepared by a member of the Society or with his assistance for publication in the lay

press shall be submitted in full and complete form to the Public Relations Committee of the Society for approval before publication." This was approved by the membership on 2 June 1953.

Most of the early amendments related in some way to Society membership. On 6 March 1955 Council reviewed the growth in membership (Appendix 7), and especially the possibility of increasing it. At that time the membership had climbed slowly but gradually from 5 on 24 June 1943 to 593 in 1955. Behind the discussion during the midwinter Council meeting of 1955 lay the question of whether potential members must, like full members, be members of the Canadian Medical Association or an equivalent, such as L'Association des Médecins de la Langue Française de l'Amérique du Nord, or of a local or provincial medical society approved by the Council (Article 3). Originally there were four classes of members:

a) *Active*. Physicians who have spent the majority of their time in the practice or study of anaesthesia for not less than three years. (The only class with voting privileges.)

b) *Members-Elect*. Graduate physicians training in anaesthesia, with a limit of three years. (In 1959 the limit was extended to four years; in 1966 this class was restricted to physicians taking their training in Canada.)

c) *Associate*. "... surgeons, physicians, dentists or other scientists who have rendered special service to, or have shown special interest in anaesthesia and allied subjects and who have been invited by Council to apply for such membership."

d) *Honorary*. "... such distinguished persons who have rendered services to Anaesthesia as the Society may desire to recognize."

These membership classes, designed by the founders of the Society, reflected the needs of the day; in 1943 there was no thought of a class of membership that might accommodate, for example, those anaesthetists who were senior enough to have been members of the previous Canadian Society of Anaesthetists. Their continued involvement in the Society was to be encouraged, and further amendments in 1956 and 1957 created two new classes of membership.

Life Membership was suggested by Dr. Gordon during the Council meeting of 18 June 1956. This class would be granted "in recognition of distinguished service to the Specialty of Anaesthesia and to the Canadian Anaesthetists' Society." Nomination by Council or provincial division was a requisite; the perquisites were all the privileges of full membership together with the waiving of annual dues. Immediately this had been approved at the annual meeting on 20 June 1956, Council nominated the first of a distinguished list of Life Members: Dr. R.J. Fraser. He was followed by others who had given a lifetime of service to Canadian anaesthesia.

The second new class was Retired Membership. The three requirements were a) retirement from practice, b) age of 65 years or more, and c) either membership in the Society since 1945, for those applying before 31 December 1964; or a minimum of 20 years' membership, for those applying subsequently. Retired members would not be required to pay dues, but could not vote.

Subsequently these two classes of membership, with some modifications, were merged into one. In the 1968 edition of the Constitution and Bylaws, Retired Membership was expanded to include retirement "because of a crippling physical disability." In the 1971 edition, Retired Membership was replaced by Senior Membership.

Over the years the status of Senior Membership has been enhanced, for Life Membership, like Retired Membership, was omitted during the extensive revision of the Constitution and Bylaws in 1971. Further changes to these two classes of Senior and Retired Membership occurred in the 1970s and 1980s (see page 45).

In these early years the definition of Active Membership remained unchanged. In 1959, however, a request for recognition of general practitioner anaesthetists led indirectly to changes in this category. Discussion on general practitioner anaesthetists was intense. During the annual meeting of 5 May 1959, Dr. Gordon Wyant of Saskatoon suggested that some recognition be given to general practitioners who had some training in anaesthesia. As Dr. J.R. Loudon pointed out, general practitioner anaesthetists constituted a considerable proportion of the membership, and he proposed a resolution that their "problem of recognition" be investigated. However, Dr. J.B. Fulton noted that the question of recognizing non-specialists in a specialist society had been raised in other specialist societies and "voted down." That was the nub of the matter: was the Canadian Anaesthetists' Society to be primarily, if not wholly, a society in which Active Members were specialists, or was membership to be more open? Not surprisingly the matter was directed to a committee for study.

This committee was chaired by Dr. David Power of Montréal. He reported to Council in February 1960. Most of the committee concluded that membership in the Society would be the best form of recognition for non-specialist anaesthetists. Dr. Power suggested that the Society might best advance "the art and science of anaesthesia in its clinical and educational aspects" by arranging formal training for those general practitioners who practised in communities that could not support a specialist anaesthetist. (For a further discussion on anaesthesia in general practice, see Chapter 8.)

Two factors had to be considered. One concerned criteria for the duration of training and examinations. This was subordinate to the second factor: setting up different or special standards for those who had not taken a full program of training in anaesthesia would be contrary to an important resolution that had been approved by the membership at the annual meeting on 5 May 1959. This resolution stated "THAT the Canadian Anaesthetists' Society approves the recommendations contained in Dr. Botterell's (Royal College) report (on a single examination standard) and will *in every way* cooperate with the College to establish a single standard of competence in the Specialty of Anaesthesia" (italics added).

Therefore, Dr. Power recommended to both Council and the Annual General Meeting later in 1960 that no change be made to the Constitution and Bylaws "to include any further recognition of Non-Specialist Anaesthetists than has already been made."

This was a key decision: it established that the Canadian Anaesthetists' Society would primarily be a society of specialist anaesthetists. The Constitution and Bylaws were then amended to state the requirements for active membership in unequivocal terms, which have remained in force to this day. The essence of this amendment is as follows:

> Active Members: – These shall be medical practitioners who are accredited specialists in Anaesthesia. They shall be entitled to attend, take part in and vote at all meetings of the Society, shall be eligible for membership on Council and entitled to propose or second candidates for admission to the Society.
>
> Before a medical practitioner may be elected an Active Member of the Society, the Council must approve of his or her training and experience.

The next amendments affected the sections concerning Council (Article 11) and the divisions (Article 13). Amended Article 11 permitted a division to send an alternate member to a Council meeting if the elected member could not attend. Amended Article 13 required that each division be presided over by a Divisional Chairman elected by that division's active members.

By 1961 the number of amendments to the Constitution and Bylaws warranted further reprinting of the booklet. However, amendments continued to flow forth. In the next seven years these concerned: the extension of the Past President's term on Council from one year to three (Article 11)[3]; the inclusion on Council, as a permanent member, of the Editor of the Society's Journal (Article 11)[4]; and the creation of a Foreign Associate Membership ("physicians holding a qualification as a specialist in anaesthesia which is satisfactory to the Council and who are resident outside of Canada," Article 3).[5] Three other amendments of note were the following: an amendment to Article 3(b) to the effect that "no member may remain a Member Elect who is not in training"[6]; an allied amendment restricting membership-elect to physicians training in Canada[7] and an amendment that "a crippling physical disability" forcing retirement would be considered in the granting of retired membership.[8]

By 1966 there had been so many amendments that Drs. Wyant and Gordon proposed that the pertinent rules and regulations be collated and added to the next version of the Constitution and Bylaws booklet. Drs. A. Stuart Wenning and Ian E. Purkis, both of Halifax, preferred the well-tried solution of a committee.[9] There was evidently some delay in the appointment of this committee, for one year later Drs. Wyant and T. Stentaford, of Newfoundland, reiterated the proposal that a committee draw up the Rules and Regulations pertaining to the Constitution and Bylaws.[10] This time a committee was struck, with Dr. James H.S. Mahood of Kingston appointed Chairman.

Dr. Mahood presented a report four months later.[11] He proposed, and Dr. Stuart L.

Vandewater, also of Kingston, seconded, a motion that the Constitution and Bylaws booklet be reprinted to include amendments since 1961, plus a section under "Regulations" giving information about resolutions passed by Council since 1950. The revised version was published in 1968. But at this time larger ideas were being mooted, and it was these ideas rather than yet more amendments that would clarify the Society's "laws," eventually enabling Council to conduct Society affairs more effectively, and permitting the Society to develop further.

1968–1971: The Era of Change and a New Constitution and Bylaws

> ... we have taken a long first stride towards the goal of updating our corporate structure, but much needs to be done. Patience, understanding, free and steady communication, and a deep sense of commitment will be needed until our ultimate aims are achieved.[12]

A pervading desire for change characterized the second half of the 1960s. Professional organizations were not immune, and the acceptance of the need for change was even a requirement of continued growth, if not survival. In Canada, for example, The Royal College of Physicians and Surgeons of Canada debated and completely redefined its criteria for Fellowship.[13] Profound changes were also wrought in the Canadian Anaesthetists' Society. These changes were engineered in the Society's governing body and affected the essence of the Society as a professional organization: its Constitution and Bylaws.

The era of change covered the years from 1968 to 1972. In this brief period much thought was given to the purpose and role of the Society, to its organizational structure, and therefore to the Constitution and Bylaws, because for changes to occur this fundamental document had to be thoroughly revised. Changes were introduced, though not in the form in which Dr. Wyant, their principal author, had envisioned. The initial proposal was subjected, in Council, to a protracted period of discussion, dialectic and debate. The changes were modified as a result of cut and thrust on each of the two sides of radicalism and conservatism. Out of this debate emerged a blueprint for a rejuvenated and more efficient professional Society.

In developing a new Constitution and Bylaws, Council proved itself capable of entertaining new ideas and of discussing them in a democratic spirit and with maturity and dignity. It forged a new tool in the heat of debate and then tempered it in the cooling waters of reflection and compromise. At no other time in the Society's history was Council so intensely concerned with a single issue. The story of the reorganization of the structure of the Society and of the revision of the Constitution and Bylaws therefore merits telling in detail. It is in part a story of a handful of practising anaesthetists, each with a strong personality and firm views, and all of whom brought drama to the normally sedate stage of the Society's Council.

The story begins with the Council meeting of 29 June 1967. The seed of a fruitful idea was planted, almost casually, at the end of the meeting. Dr. Wyant stated that "the Council

The Incoming President, Dr. Jean-Paul Dechêne, with Dr. Gordon Wyant (President, 1971–72), Halifax 1972.

should realize that the Canadian Anaesthetists' Society has grown, that time and money must be spent if it is to be run as a large society should be run." He asked that this issue be placed on the agenda for the next meeting.

In introducing new ideas, Dr. Wyant played the role of protagonist. Professor of Anaesthesia at the University of Saskatchewan, he was a well-organized and experienced anaesthetist known for his interest in research and his understanding of, and contributions to, the intricacies of standardization of equipment. His ideas, if different, were sound, well thought out and clearly presented.

Sympathetic to these ideas, was another thoughtful, organized and essentially meticulous man: the Society's incoming President, Dr. Vandewater, Professor at Queen's University. One of the Society's philosophers, Dr. Vandewater relished Dr. Wyant's ideological challenge and, in preparing himself for the next Council meeting, gave the matter much thought. Profoundly interested in Canadian anaesthesia, at the midwinter Council Meeting of 1968 he asked two important questions: (1) What is the future of the Society? and (2) What is the Society's pertinent policy?

Dr. Wyant said it was obvious that the affairs of the Society were becoming more complex. An organizational chart showing the lines of responsibility within the Society indicated that he had done his homework. As a reward, he was promptly appointed a one-man committee to help develop the future policies of the Society. He then drafted a brief for Council to consider.

On 16 May 1968, he invited Council's comments and, with Dr. Purkis, moved that a

committee report on the executive reorganization of the Society and rewrite the Constitution along the lines of his recommendations. Once again he found himself chairman of a new committee. Dr. Wyant made recommendations that would, to quote Dr. Vandewater, "lead to major revisions in our Society, to promote growth, development and strength as we enter our second quarter century."[14]

The members of Dr. Wyant's committee were as follows: Drs. Reynald Déry and André Jacques, both of Québec; Dr. Mahood; Dr. Frederick L. Parney of Calgary; and Dr. Purkis. Dr. Richard (Dick) G.B. Gilbert of Montréal, Dr. Gordon and Dr. H.B. Graves of Vancouver, served as consultants. With their assistance, Dr. Wyant drafted his concept of a new organizational structure.

The principal elements of the Wyant plan were the following:

1 Two governing bodies, named the Lower House and the Upper House. The Lower House would resemble Council except that it would meet only once a year, during the Annual Meeting, and that its meeting would be open to the members at large. The Upper House would be the equivalent of the present Executive Committee; meeting four times yearly, it would transact the current business of the Society throughout the year.

2 In due course, abolition of the Annual General Meeting. This might be considered a logical next step in the reorganization, since the Lower House would be open to the membership at large.

3 Representatives in the Upper House drawn from five regions, as opposed to the provinces, of Canada.

4 Increased responsibility for the two Vice-Presidents. In overseeing the work of several major committees and in taking part in the business of the Lower House and the Upper House, they would be better prepared to become effective Presidents.

5 A somewhat complex hierarchy of committees.

Dr. Wyant presented his brief to Council during the midwinter meeting of 1969, when Dr. Max Minuck of Winnipeg was President. The Minutes state that "discussion was prolonged and certain recommendations were controversial." Council asked for changes and referred the brief back to the committee and the divisions for comment.

Dr. Wyant had hoped for greater support and, later in the meeting, perhaps needled by some councillors who opposed his ideas, he submitted his resignation from the chair of the committee, "for personal reasons." Drs. Vandewater and Gordon moved that his resignation be accepted, though with regret. A colleague from southern Saskatchewan, however, did not; he held that the reasons for the resignation were inadequate.

This colleague was Dr. Douglas F. McAlpine of Regina. Capable of prickliness, this

Two Presidents of the 1960s: Dr. Douglas McAlpine (President 1965–66) (left) and Dr. H.B. ("Horky") Graves (President, 1962–63).

Scottish expatriate from Glasgow was, more than once, Dr. Wyant's nemesis. If "the Honorable Member for northern Saskatchewan" was the protagonist in this drama, "the Honorable Member for southern Saskatchewan" was the antagonist. Not that the two were always engaged in combat. Indeed, at one point in this debate Dr. McAlpine congratulated Dr. Wyant on his presentation, and on another the two combined in proposing a motion. It is just that each of the two men, having strong personalities and equally strong principles, were always ready to cross swords when their principles seemed to be threatened.

Dr. McAlpine believed that, should the Wyant plan be accepted, the integrity of provincial representation on Council would be lost. As Dr. Vandewater concluded later, "the serious issue is that of provincial representation."[15] This is what Dr. McAlpine, often to the vexation of Dr. Wyant, as well as many of their fellow councillors, fought to preserve.

The two councillors from Saskatchewan – each of whom was at one point a President of the Society, such was their calibre – differed in two other respects. Dr. Wyant had proposed a new schema; Dr. McAlpine wished not so much to see a new organization as a revised one, as long as provincial representation on Council was preserved. Dr. McAlpine asked whether so "massive" a reorganization was really necessary; Dr. Wyant replied that one good reason was the long period separating Council meetings, when only routine business was done. Dr. Purkis agreed with Dr. McAlpine, and emphasized that "the thought of re-organization grew from Council meetings ... (and) that some provincial divisions felt

they did not have adequate representation." This latter view was supported later by Dr. Graves, who had observed "some dissatisfaction across the country."[16] If regions were to predominate over provinces, the influence and the representation of the average member on Council would be diluted. In other respects, however, Dr. Wyant's plan was largely acceptable.

In view of what happened next, two motions assumed more than average interest. One was proposed by Dr. McAlpine, seconded by Dr. Wyant and passed by Council:

> THAT this body approve in principle the re-organization of the Canadian Anaesthetists' Society with a view to improving the efficiency of the conduct of the affairs of the Society, provided that there is no reduction in the functions and authority of this Council.

The other was a motion proposed by Dr. McAlpine and seconded by Dr. P. McGarry of Winnipeg as an amendment to a preceding motion:

> THAT there only be one Executive and that this Executive be the President's Executive, which shall consist of the President himself, the two Vice-Presidents, the Secretary-Treasurer, and one Representative at Large, elected by the Council from amongst their own number for a period of one year. This Executive may meet at the discretion of the President on occasions other than the meetings of Council.

In his presidential report to Council at its midwinter meeting in 1969, Dr. Minuck referred to the Wyant Committee's deliberations and said that the Minutes of the Committee's Meeting of 25–26 November 1968 were "understandably incomplete." He did so to draw attention to the inability of Minutes to "reflect the depth and the breadth of the discussions" and to "adequately portray the keen interest by all who attended this meeting." And at the Council meeting of 14 June 1969 it was precisely the incompleteness of the Minutes of the Council's midwinter meeting that offended Dr. McAlpine. So he put forward the following motion:

> Whereas it is mandatory that the Minutes of any Meeting must present an accurate record of the business of the Meeting and, Whereas, these two motions ... were duly proposed, seconded and passed by the Meeting and, Whereas, these two motions were directly responsible for the whole matter being referred back to the Committee on Re-organization, Be it resolved that they be added to the Minutes of the last Meeting of the Council of the Canadian Anaesthetists' Society, which took place in Toronto on 28 February to 2 March 1969.

Dr. McAlpine won his point, for the Minutes were amended as he wished. But Dr. Wyant had won points too, for Dr. Minuck suggested that "with the submission of Dr. Wyant's report on Re-organization we have taken a long first stride towards the goal of updating our corporate structure ..." Much credit is due to Dr. Wyant, not only for

conceiving a plan for re-organization that served as the basis for a revision (if not a re-organization) but also for the statesman-like manner in which he accepted the need for modifications to his plan. Although provincial representation on Council and the Annual General Meeting were retained, his concept of an Executive Committee was accepted; so, thereby, was his concept of "a mechanism by which the affairs of the Society on a decision-making basis may be transacted on a more continuous basis than has been possible hitherto."[17] Dr. Wyant had served as a catalyst for change.

❦

At the midwinter Council meeting in 1969, Dr. Minuck also said that "much needs to be done ... until our ultimate aims are achieved," and much of the next two years were taken up by staging the second act in the drama. It was now necessary to revise the Constitution and Bylaws in accordance with the achievements of the first act. This was the work of the Committee on the Constitution and Bylaws.

Dr. Mahood had been Chairman, but in 1969 he was elected Secretary-Treasurer of the Society and resigned as chair. The obvious choice for his successor was Dr. Vandewater. His meticulous and thorough nature suited him well to this arduous and detailed task.

Having participated in the dissection of the Wyant proposals, Dr. Vandewater knew what he faced. Now the protagonist, he knew that Dr. McAlpine, still the antagonist, would continue to press for a constitution that preserved the integrity of provincial representation on Council. But Dr. Vandewater was equal to the challenge; as President in 1967 and 1968, he had been instrumental, with Dr. Wyant, in initiating the move to reorganization.

Over the years, Council had focused on the economic elements of Society business at the expense of other aims,[18] and so Dr. Vandewater was anxious to redress the balance in revising the Constitution and Bylaws. By February 1970 he had prepared a draft of proposed changes for Council's consideration.

The discussion and amendments to Dr. Vandewater's proposals for the revision of the Constitution and Bylaws took up much of Council's time in 1970 and 1971. It was heavy going, but Dr. McAlpine's objections were now little more than attempted delaying actions. His principal objection was that the presentation of draft proposals for a revised Constitution and Bylaws as a Notice of Motion at the Annual General Meeting of 24 June 1970 (for final approval by the membership at the 1971 annual meeting) would leave insufficient time for "proper consideration" by Council.

In a sense, by this time the two men had resorted to the rhetoric of frustration. During the Council meeting of 20 June 1970, for example, Dr. McAlpine asked for a decision "once and for all" if there was to be divisional representation on Council from each province; Dr. Vandewater was constrained to emphasize that Council should state "here and now" if it wished to have the Constitution revised or to leave it as presently worded. At all events, Council adhered to the plan to present the draft proposals to the 1970 Annual General Meeting as a Notice of Motion.

The Annual General Meeting on 25 June 1970 gave the antagonist one more oppor-

Dr. Stuart Vandewater (President, 1967–68) (left) with Dr. Ernest Michel (President, 1982–83).

tunity to face his protagonist, and this time before the membership. The following question-and-answer scenario provides an example of Dr. McAlpine's tenacity and Dr. Vandewater's patient responses.

Questions by Dr. McAlpine	*Answers by Dr. Vandewater*
1 Did the members of Council have the opportunity to study and if necessary amend this new Constitution which is now being presented as a Notice of Motion, and will be circulated to all C.A.S. members?	1 Yes. The members of Council did have an opportunity for study.
2 Is the new Constitution a carefully considered document which could and should be approved as it now stands, OR, is it just a proposal for discussion?	2 It was approved by Council on 20th June 1970 that the draft would be circulated to all members for their approval.
3 Many people are convinced that a National Society with Provincial Divisions cannot function effectively or perhaps even survive, unless it has Provincial representation on the effective decision-making body – which is our Council under the present Constitution. Does the new Constitution provide for the continuation of such representation on the effective decision-making body?	3 Divisional representation could not be discussed until members have had an opportunity to read the circularized draft.

4 If a new Constitution is approved at the Annual General Meeting in Québec in 1971, will that be the last Annual General Meeting which the ordinary member of the C.A.S. can attend and have both a voice and a vote?

4 There must be an Annual General Meeting by law. All members will have an opportunity to attend.

The drama was now approaching its final act. At the Council meeting of 25 June 1970, agreement, with honour, was finally reached. The following motion of Drs. Iain M. MacKay of Toronto and Donald W. Aitken of Peterborough was, perhaps to everyone's surprise, carried unanimously:

> THAT the proposed constitution distributed to members at the Annual Meeting of the Canadian Anaesthetists' Society held on 24 June 1970 be sent to all active members of the C.A.S. before 1 September 1970, and that this document be accompanied by –
>
> 1) A letter of explanation and recommended revisions signed by all members of the committee on Constitution and Bylaws of the Canadian Anaesthetists's Society.
>
> 2) A letter signed by Dr. Douglas McAlpine on the controversial items contained in the said document.
>
> 3) A letter signed by the President of the C.A.S. requesting the full attention of all members of the Society, and soliciting opinions of the said members.
>
> 4) A copy of the present Constitution and Bylaws of the Canadian Anaesthetists' Society.

Acknowledging that his points had been made and recognized, Dr. McAlpine graciously thanked the meeting for its "assistance."

Even then, however, the drama had still not been played out. As late as April 1971, when the first of the new series of Executive Committee meetings was held, it was observed that "it was apparent that the submissions were not yet ready for presentation to the meeting of Council in June and subsequently to the Annual General Meeting of the Society." (Dr. McAlpine would have been forgiven for feeling smug satisfaction at learning this.) Dr. Vandewater enlarged on this:

> The present problem is a lack of direction and explicit terms of reference to this Committee ... the deliberations of the Committee have aroused some contentious issues and ... it is obvious that further alterations must be made. The serious issue is that of provincial representation ... the Committee would recommend reversion back to the system of Provincial representation now in effect. The tiers of Government will be as they exist ... with the powers of the Executive Committee explicitly delineated.

Dr. Vandewater sustained his endeavour and presented the final draft of the amendments to Council on 26 June 1971. He was satisfied, for he could now say that the draft was "the accumulation of three years' work in an attempt to present an amended constitution to assist and guide the Society for the future." The final draft had been prepared in French and English, though a few editorial changes and deletions were required to satisfy the requirements of the Ministry of Consumer and Corporate Affairs. Dr. Vandewater then moved, with Dr. Wyant, that, as required by law, these changes be approved. After Council had approved this motion, the same two proposed the important motion that Supplementary Letters Patent be applied for in order to change the Society's name to the bilingual form and to revise the Objects of the Society. They were now as follows:

1 The Society shall promote the medical and related arts and sciences of Anaesthesia and maintain the honour and the interests of the medical profession.
2 The Society shall aid the furtherance of measures designed to improve the delivery of health care to the people of Canada through promotion of research, education and practice of anaesthesia, and medical services in general, however rendered.
3 The Society may publish periodic journals or publications as may be authorized from time to time and which promote the objects of the Society.
4 The Society shall assist in the promotion of measures designed to improve the standards of hospital and related anaesthetic services.
5 The Society shall promote the interests of the members of the Society and act on their behalf where appropriate, in the promotion thereof.
6 The Society shall form a liaison and affiliate with The Canadian Medical Association.
7 The Society shall grant sums of money out of funds of the Society for the furtherance of these objects.
8 The Society shall do other lawful things as are incidental or conducive to the attainment of the above objects.

Even at this point, some members of Council raised objections. Dr. John H.A. Lawrence of Calgary and Saint John objected that notice of revisions had not been sent to the divisions. Drs. McAlpine and MacKay suggested that the final revisions be delayed until the annual meeting of 1972, to allow time for members of Council having objections to submit these to the Constitution committee so that the committee could submit a final report to the midwinter Council Meeting in 1972.

Dr. Vandewater was convinced that any objections could be cleared up quickly. Dr. Wyant suggested that the Constitution Committee might meet with Drs. Lawrence and McAlpine in order to reach final agreement, and the suggestion of Drs. McAlpine and MacKay became redundant. This informal committee meeting took place on 29 June 1971, when Drs. Graves, Jacques, Lawrence, McAlpine, Vandewater and Wyant hammered out an agreement that satisfied everyone. Council then approved the final amendments to the Constitution and Bylaws and agreed that the entire set of amendments could be recommended to the membership for their approval at the Annual General Meeting on 30 June 1971.

Upon approval by the membership, a new Constitution and Bylaws became part of the Society's records. It was appropriate that on this occasion Council passed a motion proposed by Dr. Gordon and seconded by Dr. Aitken thanking the Constitution and Bylaws Committee "for their tremendous amount of work over the last four years, and finally bringing this matter to final conclusion and approval." Let the committee, then, have the last words:

> The final draft of the proposed Constitution allows the Society to carry on essentially in its present manner but will provide greater flexibility and change both in the government, aims and committee structure ...
>
> ... these proposals will allow the Society to grow, have greater influence on the practice of Anaesthesia in this country, have sufficient flexibility in its By-laws to change without seeking the costly and time consuming permission of government authorities, and finally will improve the method of self-government.[19]

It was with great satisfaction, and no doubt with great relief, that the Committee heard shortly afterwards that the new amendments to the Constitution were officially approved. The new Constitution took effect on 12 October 1971.

All that remained now was to draft the Rules and Regulations that would serve as a reference manual for the day-to-day execution of the business of the Council, its Executive Committee and the other committees. At the Council meeting of 17 June 1972, Dr. Wyant observed that the new Constitution and Bylaws now permitted the Society to conduct its affairs more efficiently, with a much greater involvement by many, than in the past." He predicted that "specific" Rules and Regulations would be required within the coming year. Therefore, the formulation of such Rules and Regulations was a priority for Council in 1972 and 1973.

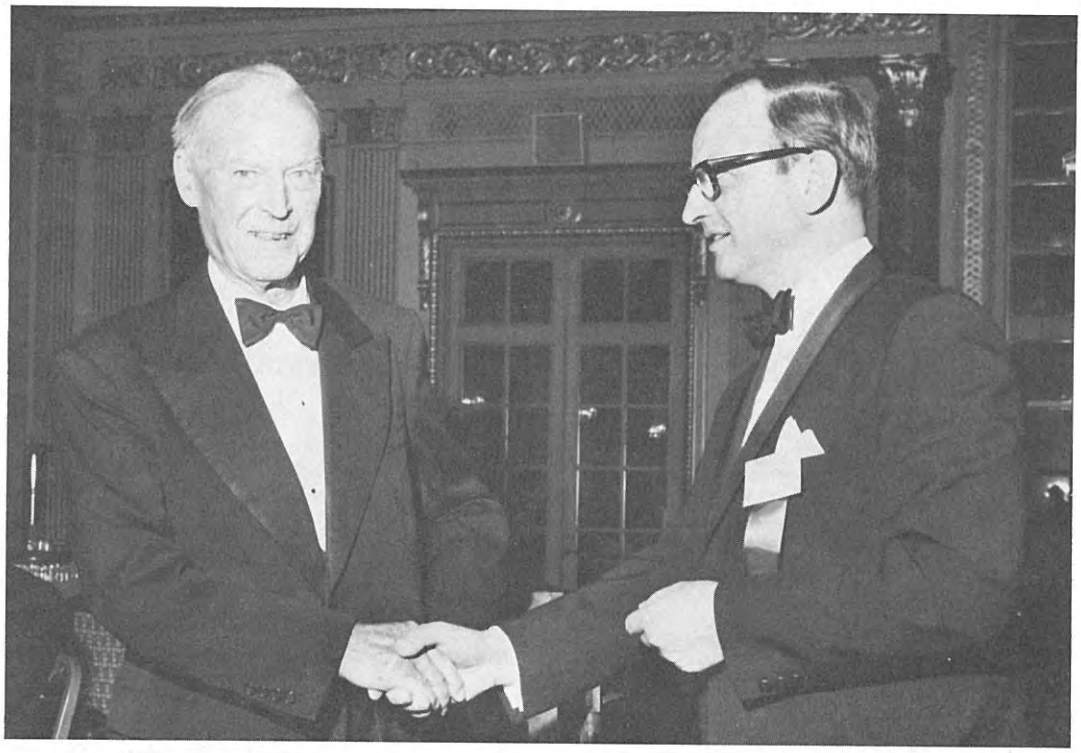
A need for Rules and Regulations had always been recognized, and Article 23 of the original Constitution and Bylaws gave an indication of their role:

> The Council may from time to time make such rules and regulations, not in any way inconsistent with (the) Bylaws, for the internal management of the Society as the Council may deem advisable.

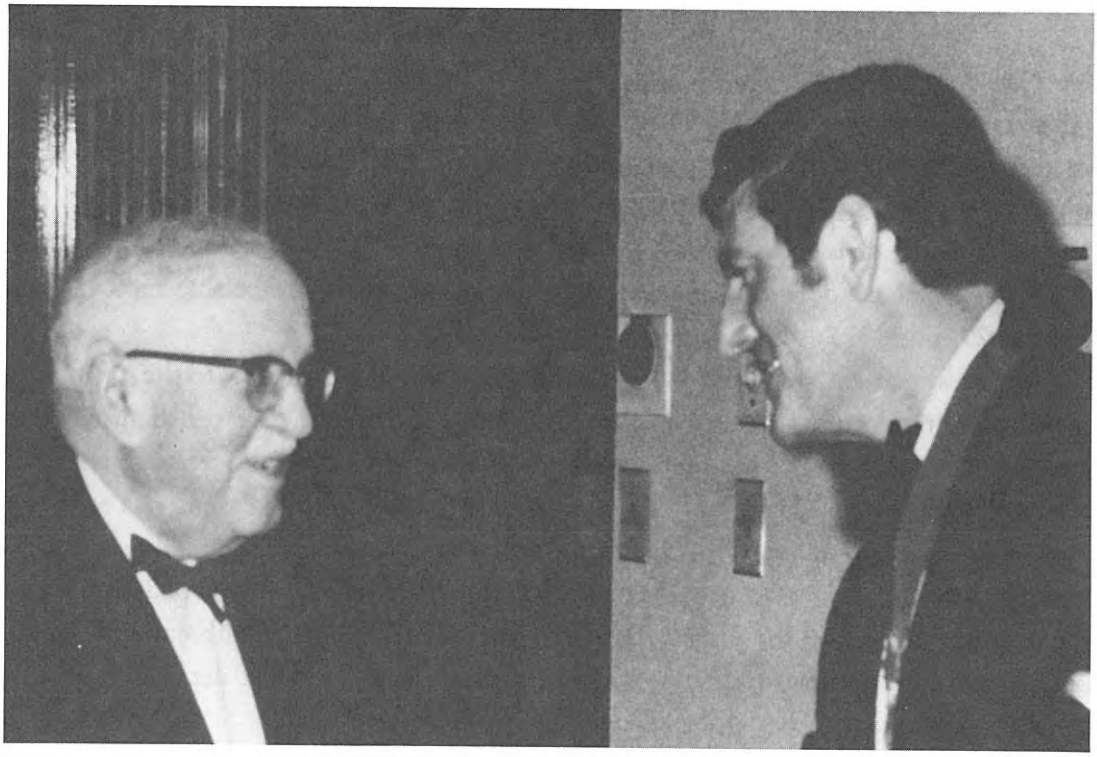
When the Society was small, with few individuals concerned with running the Society – indeed, for many years it was Dr. Gordon and Miss Edna ("Happy") Campbell who did this – the absence of specific guidelines did not present difficulty. As the Society's affairs became more complex, and particularly as the Constitution and Bylaws required revision, the need for detailed rules and regulations became evident.

The Rules and Regulations were developed in two parts: Part I (or Section A) and Part II (or Section B). Although they were drafted, discussed and finally approved as separate documents the two parts were eventually published together, as a single document.

Part I was drafted by the Committee on the Constitution and Bylaws, then chaired by



A memorable occasion was the recognition by Dr. Stuart Vandewater (President, 1967–68) during the Society's meeting in Ottawa in 1968 of the contributions to the Society of Dr. Harry Shields (President, 1947–48).



A generation apart but sharing membership in – and presidency of – the Society: Dr. Harold Griffith (President, 1943–46) with Dr. Earl Wynands (President, 1974–75), St. John's Newfoundland, 1974.

Two presidents of the 1970s: Dr. John Lawrence being installed as President by the immediate Past President, Dr. Earl Wynands, Kingston, June 1975.

Dr. André Jacques, Gold Medallist 1982, receiving the award from the President, Dr. Jean Claude Pouliot, in Québec City.

Dr. Constantine T. Ethans of Winnipeg. Based on a collection of decisions on matters of policy made by Council over a number of years, its purpose was to facilitate the execution of many of the Society's central activities: membership; divisions; Council; Executive; committees; Officers; meetings; fees and expenses. It also stated the principle that representation of divisional delegates to Council or on Council was to be one councillor per 100 active members (or part thereof) in a particular division. The membership approved Part I at the 27 June 1973 Annual General Meeting.

Meanwhile the Committee on Organizational Affairs (the successor to the Committee on the Constitution and Bylaws) had drafted Part II. Chaired in this period first by Dr. Lawrence and later by Dr. J.F. McConnell, the committee clarified the terms of reference for committees. After Council's approval late in 1973, the draft of Part II was sent as a Notice of Motion for approval by the membership at the next annual general meeting.

Thus came to an end a critical period in the Society's history. This period encouraged a new way of looking at the Society and its role in anaesthesia and health care in Canada. The revision of the Constitution and Bylaws and the formulation of detailed Rules and Regulations stimulated the Society to develop further.

Also needed, however, was a vision for the Society's role in the future. This required that all members of the Society, and especially of Council, do what Dr. Vandewater urged a little later: "take steps to broaden our horizons and our understanding to promote the

continuance of a national organization that truly represents and recognizes the linguistic, cultural and professional qualities of francophone and anglophone anaesthetists."[20] Such a vision had informed the actions of the francophone and anglophone founders of the Society in 1943; 30 years later it was still a desirable goal. Two decades later the goal still lies in the future.

1973–1992: Recent Changes

With the new Constitution and Bylaws and Rules and Regulations in place, and with an active Committee on Organizational Affairs specifically intended to continually review the Bylaws and the Rules and Regulations, further amendments were introduced in more orderly fashion. None introduced in the next 20 years was of the magnitude of the amendments from 1968 to 1973, but some are worth noting. So, too, are some changes of policy affecting Council.

MEMBERSHIP CATEGORIES

At the Executive Committee meeting of 11 May 1974 it was suggested that the purpose of Senior Membership was not well stated in the new Constitution: to recognize retired members who had made a distinctive contribution to anaesthesia. It was an honour. This was not generally understood, for some members wrote simply asking to become Senior Members. It was therefore agreed that Senior Membership be defined more clearly and that the possibility of reinstituting a category of Retired Membership be considered.

The Committee on Organizational Affairs, chaired now by Dr. G. Fred Brindle, then of Sherbrooke, favoured the additional category of Retired Membership; Senior Membership would remain as described in the Constitution. Retired Membership would encourage retired members (active and associate) to continue participating in the affairs of the Society, though neither holding office nor having voting privileges, but at a reduced rate of 50% of the dues paid by Active Members. This was duly approved at the Annual General Meeting on 25 June 1975.

As time passed, however, the dues for Active Members rose, and by 1984 the dues for Retired Members approached $100.00. Dr. John Price of Fredericton, then President, suggested that the issue be re-examined. The proposed solution was to make the fee simply a "reduced" one, without stating a particular sum. This amendment was approved at the Annual General Meeting on 11 June 1985.

Another amendment related to physicians who were resident in Canada and whose qualifications gave them "specialist status" in anaesthesia in the jurisdiction where such qualifications were obtained and acceptable to the Council and Society. The Annual General Meeting on 26 June 1984 approved a membership category for physicians with "equivalent qualifications" to those of The Royal College of Physicians and Surgeons of Canada and the Professional Corporation of Physicians and Surgeons of Québec, so that these physicians were thus able to become Active Members of the Society.

Dr. Andrew Davies, President, 1992–93.

EXPANDING THE MEMBERSHIP OF COUNCIL

The revised Constitution of 1971 permitted two categories of observer representation in addition to those delegates from provincial divisions. One comprised student (i.e., resident) representatives. None, however, had attended Council meetings until 22 June 1975, when Dr. Andrew O. Davies, a third-year resident from Queen's, was invited to inaugurate this new tradition.

Dr. Davies found that as a resident-in-training he did not have the same commitment to the Society as a practising anaesthetist would, for his concern was directed more towards training and obtaining certification. However, residents might be able to contribute to committee work on education and the scientific program. It was therefore decided to explore ways of formalizing student memberships on Council. This done, the practice proved useful to residents, who learned about the Society in a way that they would not otherwise have done, and Council, which learned from the resident observers' comments. It was, for example, appropriate for residents to be known as "residents" rather than as "students," as Drs. H. Clifford Yanover and James Dunsmuir pointed out after attending the 1989 midwinter Council meeting.[21] Evidently Dr. Davies benefitted from this first contact with the Society, for he retained an interest in organizational aspects of the Society and became President of the Society in 1992.

The second potential category of observer representation permitted attendance at Council meetings by a delegate from the Association of Canadian University Departments of Anaesthesia (ACUDA). The practice was not taken up until the midwinter Council meeting of 1985. It proved mutually satisfying. For ACUDA, ties with the Society were strengthened and it could influence the Society, through Council, on current concepts and

practices in education and research in anaesthesia. For the Society, this gave Council a new link in the broadening network of Canadian anaesthesia. (See Appendix 8.)

Another issue of representation at Council meetings was opening meetings to members at large. In Dr. Wyant's proposals for reorganization of the Society, he had provided for attendance of members at large at Council meetings, but this was never introduced because his plan for an Upper House and a Lower House was never fully accepted.

At the Executive Committee Meeting of 3 November 1984, Dr. Germain Houle of Montréal pointed out that attendance by members at open Council meetings might be advantageous to them; the American Society of Anesthesiologists, for example, permitted this. Dr. Lewis Hersey of London, and Chairman of Council, was asked to consider this matter.

Dr. Hersey thought the Society should indeed encourage attendance by members at large. A comment was therefore included with the notice of the next annual meeting inviting members to attend. Although the practice was never established, it may become reality as the Society grows.

OTHER AMENDMENTS

Two amendments approved at the Annual General Meeting of 1986 are of interest. One permitted greater continuity of the services of the Chairman of Council. Until then, the Council representatives to the Executive Committee and the Chairman of Council could be re-elected for a total term not exceeding two consecutive years. The amendment allowed the Chairman of Council to be re-elected annually for a total term not exceeding three consecutive years.

The second amendment expanded the duties and powers of Council. Reproduction of the amended Chapter 8, Section 8.5.1 provides a fitting conclusion to this discussion on Council and the Constitution and Bylaws of the Canadian Anaesthetists' Society:

> 8.5.1. The Council shall act for the Society in all matters not otherwise reserved, and more specifically, shall as far as possible, deal with and dispose of all matters relating to:
>
> a) written and verbal reports of the Executive Committee;
> b) the reports of the Statutory Committees (see Chapter 4);
> c) any matters relating to the general health and welfare of the public, the speciality of Anaesthesia and the Society;
> d) the Nomination of the Officers of the Society, the election of the Chairman of Council, and representatives to the Executive Committee;
> e) the proposal of By-laws not contrary to this By-law, subject to the provision of Section 16 below (on Amendments);
> f) such matters as the Chairman of Council shall, from time to time, determine.

CHAPTER FOUR

Creating a Data Base: The Society's Committees

> The major aim of the Society as stated in our Constitution is to advance the art and science of Anaesthesia by promoting the clinical, educational, ethical and economic aspects of the Specialty. This is a major undertaking and Council has come to depend to an increasing extent on our numerous Standing and Special Committees ... The major function of these Committees is to collect information, to make this available periodically in the form of a report, and to arrange for the provision of specific information on request. When action is required, these Committees may be authorized to act on behalf of the Society, but their primary function is to summarize the situation and to present appropriate recommendations to Council. These recommendations will then be discussed and approved, modified or rejected as Council sees fit.
>
> *Dr. D.F. McAlpine, Council, 26–27 February 1966*

ALTHOUGH Council is the Society's principal decision-making and policy-forming body, the committees provide Council with information that enables it to discharge its responsibilities. A description of the evolution and role of the Society's committees complements that of Council and its role. This chapter completes a review of the development of the Canadian Anaesthetists' Society's more important organizational elements.

From 1943 to 1992 Council established many committees whose titles indicate the range of the Society's interests and activities (Tables 4.1 to 4.5 and 4.7). However, listing the committees provides only a chronological record, and it is more useful historiographically to review just a few. Additional information summarizing the terms of reference of the more important committees as of 1992 is provided in Appendix 4.

Committees of the 1940s

Harold Griffith's presidential address at the 1946 annual meeting reminded members that it was the first full year of peace, and Canadian anaesthetists could now join other

Canadians in looking ahead, no longer restrained by wartime uncertainty and anxiety. With experienced, military anaesthetists returning to civilian life, one of the Society's chief tasks was to develop anaesthesia as a specialty in Canada. Much of the ground work in these postwar years was accomplished by the earliest of the Society's committees.

The second half of the 1940s was a formative period, and the titles of the committees reflect the Society's basic concerns: clinical practice (Committee on Anaesthetic Services, 1946, Committee on Standardization of Anaesthetic Gas Machines, 1948); research (Committee on Research 1947); and education (Committee on Postgraduate Education 1947).

COMMITTEE ON ANAESTHETIC SERVICES

Council first had to learn more of the conditions under which anaesthesia was being practised. Many physicians who had practised anaesthesia in the armed forces had returned to Canada, and Council had two goals: seeking possible openings for trained anaesthetists, and elucidating the economic conditions of practice, "with particular reference to determine economic abuses."[1] This need was not unique to Canada, for Dr. Griffith had corresponded with his friend Ralph Waters in Madison, Wisconsin, then President of the American Society of Anesthesiologists, concerning the possibility of a joint American–Canadian survey. Since the American society wished to wait until it had appointed a full-time executive secretary, Council decided to proceed on its own.[2]

The plan was to send a questionnaire to all Society members, asking for information about anaesthesia service in "organized" hospitals. This was the mandate of the first committee in the Society's history, the Committee on Anaesthesia Services, chaired by Dr. William Cody of Hamilton.[3] Although it was noted on 13 June 1946 that "this committee had not functioned" (Dr. Cody had been ill), Council agreed that the plan for a survey should be studied. However, by 15 October no action had been reported, and Council directed the Society's Secretary, Dr. R.A. Gordon of Toronto, to obtain the desired information by writing to each provincial secretary.

The formation of this committee is of historical significance even though no survey ever seems to have been carried out. First, Council emphasized the link between conditions of practice and economic conditions, a link that continued to be a concern as numerous other committees on economics, manpower and health care insurance were established.

Second, although the committee itself appears not to have survived, the Society's concern with anaesthetic services in Canada did. A second Committee on Anaesthetic Services was struck in 1965,[4] and another – the Manpower Committee – was appointed in 1984.[5] Dr. H.B. Graves prepared a report on the subject in 1960,[6] which was complemented by *Anaesthesia Services in Canadian Hospitals*, a report based on a survey of Canadian Hospitals for the year 1970.[7]

Third, the perceived need to work through the provincial divisions illustrates what is often evident in the Society's 50-year history: though primarily thought of as a national organization, it has been built equally of its provincial divisions.

TABLE 4.1
Committees of the 1940s

Committee	Year of Formation	Comments
Executive	1943	Although the term "Executive" was used from the very first days of the Society (see, for example, the minutes of 1943–46 and 1956–57, and the annual meeting programme from 1950 onwards), the term designating an identifiable committee was not used formally until 1971, following the introduction of the revised Constitution and Bylaws.
Survey	1946	A forerunner of the Anaesthesia Services Committee (1965) and the Manpower Committee (1984).
Research	1947	An antecedent of the Research Fund Committee (1978).
Postgraduate Education*	1947	Later, the Committee on Education (1963, 1968) and the Committee on Continuing Education (1985).
(Royal College Specialty)	1947	(Relating to Certification Examination).
Gas Machine Inspection	1948	An antecedent of numerous Committees on Standardization of Equipment.
Economics	1949	

*A continuing committee, its members were nominated by the Society.

COMMITTEE ON RESEARCH

A meeting of Council on 13 June 1946 brought up another issue that, though short-lived at the time, has been of recurring importance: research. Dr. Harold Griffith proposed and Dr. Ernie H. Watts of Edmonton seconded a motion that the Secretary ask the National Research Council (NRC) to consider appointing a research subcommittee on anaesthesia. At the next Council meeting, held at the Sheraton Hotel in Boston – where the New England Society of Anesthesiologists was sponsoring a commemoration of Morton's demonstration of the use of ether a century earlier – Dr. Beverley C. Leech of Regina submitted a proposal for the formal establishment of an anaesthetic research committee within the Society. Although the Society still had not heard from the NRC, the NRC did seem to be the appropriate body to consider such a proposal. Action was therefore deferred until Council's next meeting, on 9 March 1947.

Dr. Beverley C. Leech, President, 1948–49.

Council then met at Dr. Griffith's hospital, The Homeopathic, in Montréal. Correspondence from the NRC was read, as was reiterative correspondence from Dr. Leech, who favoured direct involvement by the Society. Dr. Leech, though one of the two Vice-Presidents, was not present at that meeting, for in those days travel from Regina to Montréal would have meant taking several days off work. However, he was later pleased to learn that Council approved a motion of Drs. Wesley Bourne of Montréal and Harry J. Shields of Toronto that a Committee on Clinical Research in Anaesthesia be formed. Dr. Leech was appointed Chairman, Dr. F. Hudon of Québec and Dr. Gordon, the members.

Like the survey committee, the research committee remained dormant. Dr. Leech, perhaps because he practised in the distant city of Regina and perhaps because of forthcoming presidential duties, asked at the next Council meeting (26 June 1946) that he be relieved of his duties as committee chair. Council granted his request, and Dr. Digby Leigh of Montréal was appointed to succeed him. Still the committee remained inactive, and no more was heard of research until 1960. A generous offer by British Oxygen Company (Canada) Limited then enabled the Society to consider establishing a prize for the best original work in anaesthesia.[8]

In a small way this stimulated the Society's interest in research. Even so, it was much later that the Society demonstrated a greater interest in research. On 18 June 1978, the creation of a Canadian Anaesthetists' Society Foundation for Research was mooted in Council by the Finance Committee. This move eventually bore fruit in 1985 with the establishment of the Canadian Anaesthetists' Society Research Award. (See also Chapter 7.)

COMMITTEE ON POSTGRADUATE EDUCATION

Certification in anaesthesia was approved by The Royal College of Physicians and Surgeons

of Canada in 1942, although the first certification examination did not take place until the fall of 1946. Of the 14 candidates, only 9 passed.[9] Some lacked formal training, which led to concerns about training facilities in Canadian hospitals. Certainly, as Sclater Lewis pointed out, "the discussion on imperfections in the training plan centred about the question of hospital approval.[10]

The poor examination results concerned Council, in view of the emphasis the Society had placed on education in its Letters Patent. On 26 June 1947 it struck a committee to consider the problem. The committee's purpose was twofold: to deal with standards of postgraduate training, and to prepare a list of hospitals approved for training leading to the certification examination. Dr. Hudon was appointed chairman, Drs. Leigh and A.C. Rumball (of Regina) were appointed members, and Dr. Gordon, the secretary.

This committee was relatively quiescent. A letter from Dr. Hudon was read to Council on 14 March 1948, though it was "left over for further consideration" by the committee. Consideration was evidently drawn out, for at Council a year later it was suggested that the committee's report "be left for one year in order to obtain further information."

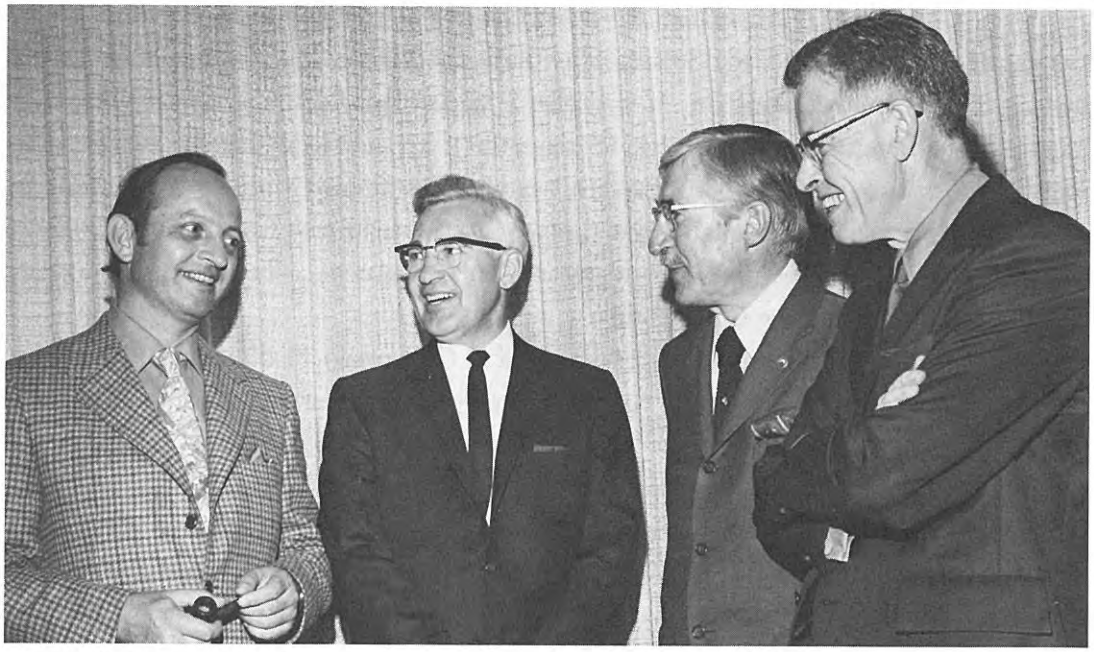
This information must have been elusive, for the next mention of "available information on residencies in approved training hospitals" did not occur until 25 February 1951. Then, on a motion by Drs. Alan Noble and Georges Cousineau, both of Montréal, Council agreed to put a Notice of Motion regarding a further committee before the next annual general meeting. At the same time, Council decided to send a letter and questionnaire regarding information on anaesthetic training to the superintendents of hospitals approved by the Royal College for training. After that, no more was heard of the committee.

In 1957, an apparent successor, the Special Committee on Examination Requirements, was struck.[11] Chaired by Dr. Edward A. Gain of Edmonton, this latter committee included some distinguished anaesthetists: Dr. Stanley M. Campbell of Toronto, and Drs. Cousineau and Graves. Its report to Council on 1 March 1958 recommended changes in the training and examination requirements for the Fellowship and Certification qualifications. These changes were consonant with changes proposed by The Royal College of Physicians and Surgeons of Canada in the Royal College's Botterell Report of 27 June 1958, and contributed to deliberations that eventually led to a single standard for training and examination by the Royal College.[12]

A new Education Committee was formed in 1963 as a result of a recommendation made by the Heads of University Departments of Anaesthesia.[13] This appeared to be no more viable, and by 1966 its future seemed uncertain. There was dark talk of criticism from "other members" of the Society,[14] and another committee was appointed in 1968,[15] principally to define the terms of reference for a rejuvenated committee.

Even this did not prove wholly effective, for in 1971 it was said that the Society was failing to meet its objectives in relation to education.[16] Thereafter, the Committee on Education never looked back. No longer would it be said that education was "an area which has been somewhat overlooked and neglected."[17]

In 1985, a change in emphasis led Council to rename it the Committee on Continuing Education.



Four Past Presidents share a moment during the Annual Meeting in Winnipeg, June 1970. From left to right: Dr. Stuart L. Vandewater (1967–68), Dr. Ted Gain (1959–60), Dr. André Jacques (1969–70) and Dr. Horky Graves (1962–63).

Dr. Rod Gordon receiving the Gold Medal in 1969 from President Max Minuck. Dr. Stanley Campbell (President, 1950–51), a Gold Medallist in 1968, looks on.

COMMITTEES ON STANDARDIZATION OF EQUIPMENT

The latter 1940s witnessed the Society's first expression of basic concerns about clinical practice, research and education. It was also a period in which the Society began to emphasize the importance of standards for anaesthetic apparatus, an activity of which the Society can be proud. Interest in this area has been maintained with distinction on the international as well as national scene throughout the following five decades. Initially, however, this interest was fuelled at a distance in committees, subcommittees, working groups and task forces. (See Chapter 6.)

Standards for equipment were first discussed in Council on 14 March 1948. Professor J.K.W. Ferguson of the University of Toronto's Department of Pharmacology drew Council's attention to the concern of dentists about the need to periodically inspect anaesthetic gas machines. He suggested that a committee under the NRC might consider the problem.

Council approved the appointment of two representatives to an NRC committee "to investigate the desirability and possibility of periodic inspections by the manufacturers of anaesthetic gas machines." Although this committee was intended to be under the NRC, at Council's next meeting (24 June 1948), Dr. Griffith and Dr. Russell J. Fraser of Hamilton moved that a committee be formed "to cooperate with other interested bodies." The chairman, Dr. W. Easson Brown of Toronto, and of ethylene and cyclopropane fame, was empowered to select another committee member that would act with him to ensure periodic inspection and repair of anaesthetic machines.

On 6 March 1949 this committee's area of interest was referred to as standardization of anaesthetic gas machines; Dr. Brown was evidently thinking of the regular servicing of anaesthetic machines. Although his committee did not issue a further report, interest in standardization was kept alive for many years by Dr. Gordon, the Society's Secretary-Treasurer. It was Dr. Gordon's tenacity in the 1950s and early 1960s, as an official representative of the Canadian Anaesthetists' Society on the Canadian Government Specifications Board and the Canadian Standards Association, that enabled the Society to contribute to, and be kept informed of, developments on standardization of anaesthetic equipment.

Committees of the 1950s

If the 1940s was a formative period in the Society's history, the 1950s was a period in which concerns for the future well-being of the Society's members were considered. Four committees and one subcommittee shared a concern with fiscal matters: the Committee on Economics (1949), the Subcommittee on the National Fee Schedule (1956), the Committee on Finance (1957), and a committee on a pension fund (1956), which later became the Board of Directors of the Canadian Anaesthetists' Mutual Accumulating Fund.

The importance of communication was increasingly recognized in this period, and three other committees with a concern for the written word were established: a committee overseeing publication of the *Newsletter* (1950), another for publication of the Journal (1954), and a third, the Committee on Public Relations (1953).

TABLE 4.2
Committees of the 1950s

Committee	Year of Formation	Comments
Labelling of Ampuls	1950	Those to be sterilized before use
Newsletter	1950	Developed the first generation of newsletters
Public Relations	1953	See also 1966
Program	1953	First mention of such a committee; not formalized until 1967
Retired Membership Fee	1954	
Editorial Board, CASJ	1954	
Additional Divisional Fee	1955	
Pension Fund	1956	Led to formation of CAMAF
State Medical Schemes	1956	Known by other names in succeeding years
Life Membership	1956	Work done by the "Executive"
National Fee Schedule	1956	A one-man Commission
Retired Membership	1957	Work done by the "Executive"
World Congress Subcommittee	1957	For planning of 1960 World Congress in Toronto
Finance	1957	
Examination Requirements	1958	Name of the Special Committee on Examination Requirements of The Royal College of Physicians and Surgeons of Canada
Judicial	1958	
Honorarium for Assistant Secretary	1959	
General Practitioner Anaesthetists	1959	

The 1950s was also a period in which the integrity of the practice of anaesthesia – indeed, of medicine – seemed threatened, as the advent of government-controlled health insurance became increasingly evident. As a result, the Committee on State Medical Schemes was struck (1956).

COMMITTEE ON ECONOMICS

In Dr. Leech's presidential report during the Annual General Meeting on 16 June 1949, he made three points. First, "the economic problems of Anaesthesia have always been the concern of the Society"; second, "the entry (into health care insurance) of certain provincial

governments (Saskatchewan and British Columbia) has brought new problems"; and third, "in all these situations the Canadian Anaesthetists' Society has been prepared to collect and forward relevant information, to deal directly with the Canadian Medical Association or through it with Government agencies, and to provide advice and all possible assistance when requested." Council recognized the validity of these points and, at an earlier meeting, had set up a Committee on Economics "to obtain the information from each province on tariff and economic questions."[18]

Dr. Leech also noted that "one of the early efforts of Council ... was the setting up of a minimum schedule of fees for anaesthesia ... (which was) adopted as the basis for ... schedules of fees in most of the provinces." Although a subcommittee on a national fee schedule was formed in 1956,[19] a national fee schedule never proved feasible because of the provinces' jurisdiction in matters of health and a range in the cost of living among various provinces and cities. President H.J. Shields had pointed out in 1948 that, "as economic conditions vary from province to province it seems logical for each division to modify the CAS tariff to meet their own particular needs."[20]

The role of the Society as a national organization became that of a facilitator of discussions on fees in the provinces. (See also Chapter 13.) Provincial governments became the paymasters in health care early in the Society's history, and the Society came to serve as a clearing house where economic data could be pooled and shared by the provincial delegates to Council and then used by the delegates in negotiations with their own government agencies. This has been the main function of the Committee on Economics, which has provided a particularly good example of data-gathering.

As government health care insurance planning intensified and the responsibility for payment of physicians' services became more clearly that of the provincial governments, the role of the committee changed. It is now the Committee on Medical Economics.

COMMITTEE ON FINANCE

Remarkably, a decade and a half passed before Council struck a Finance Committee. In the 1950s the Society was still small: in June 1957 there were only 767 members (Appendix 7), the annual budget did not exceed $10,000,[21] and the Society's business affairs were managed by Dr. Gordon with the able assistance of Edna ("Happy") Campbell, the Assistant Secretary, and L. Lees, a typist.

The financial statement for the year ending 31 December 1956, though, showed that the Society's financial position was precarious. The balance of $305.62 was $608.55 less than at the beginning of the year.[22] This disturbed the members at the Annual General Meeting on 25 June 1957, held at the Bessborough Hotel in Saskatoon. Dr. Gordon M. Wyant, himself of Saskatoon, minced no words in decrying the bare financial cupboard. The financial situation was "completely inadequate"; the Society was "bankrupt" at each year's end; and it had not faced up to the need for "adequate clerical help."

Raising dues was an obvious step, and the meeting approved an increase to $30.00 for certificated members, and $20.00 for others. This was but a stopgap measure. Dr. Gordon

pointed out that the Society's budget did not allow for spending on special projects such as reprinting the Constitution and Bylaws, and on the public relations pamphlet, or preliminary financing for the World Congress to be held in Toronto in 1960. He agreed that proper secretarial assistance and office equipment were badly needed. Nor was it acceptable to rely on the philanthropy and dedication of the Assistant Secretary and her assistant, to say nothing of Dr. Gordon's long hours of devotion to the Society.

At the Council meeting that followed the annual meeting, Dr. Gordon requested consideration of a Finance Committee. Its purpose would be "to have the duty of preparing the budget of the Society for the coming year."[23] A Finance Committee was then appointed.

Dr. Gordon welcomed the assistance of the Finance Committee, for it removed him from "the embarrassing position of conducting the business affairs of the Society on an *ad hoc* Budget, which has always been suspect by some Divisions."[24] The Finance Committee, chaired at first by Dr. Foster Smith of Toronto, worked hard to strengthen the Society's financial position, and by the end of 1958 increased the balance to $2,606.69.[25] After that, the importance of a standing committee on finance was regularly demonstrated.

The Finance Committee continued to play a central role in the internal affairs of the Society, and it was gracious of Dr. Wyant, during the mid-winter Council Meeting of 1971, to congratulate the Society's office on the current positive financial balance.

COMMITTEE ON A PENSION FUND FOR ANAESTHETISTS

In Dr. Gordon's report to Council on 4 March 1956, he spoke perceptively of the importance of anaesthetists making preparations for their income after retirement. "It is evident," he said, "that it is probably more important in the Specialty of Anaesthesia than in most other branches of medicine that provision must be made for a retirement income after the termination of hospital appointments." Dr. Gordon also decried the "discrimination in the Income Tax Act which imposes handicaps not experienced by employed persons," and stated that he had been "exploring" possible ways of overcoming these handicaps. He told Council that he had "a suggested plan."

This plan originated from an approach made by William M. Mercer, Ltd., a pension management company, to Dr. Gordon as Secretary of the Society.[26] Council appointed an *ad hoc* committee "to study this question further." Although it was not permissible for the Society to create a pension fund for its members, a mutual accumulating fund was legally acceptable.

On 3 March 1957 Dr. Gordon introduced Mr. Fraser Sweatman, of Fry and Company, to Council in order to discuss a proposal for a mutual investment fund tailored to the needs of the Society. Council agreed that members should be informed of the plan, including the nature of any contribution commitments, and the members were duly notified.

Interest proved high. By 24 June 1957, Dr. Gordon reported to Council that some 200 returns had already been received, representing an original investment fund of approximately $70,000. He asked Council to decide whether this fund should in fact be sponsored by the Society. Council decided in favour and recommended to the Annual General Meeting that

a Fund be incorporated. Thus was established a Fund that, as reported in 1991, "had a record of excellent and stable performance despite four financial recessions."[27]

As of November 1991 the Canadian Anaesthetists' Mutual Accumulating Fund Limited held more than $57,000,000 in assets for 2,450 shareholders.[28] A tall oak had grown from a very little acorn!

COMMITTEE ON A NEWSLETTER

Communication between Council (and the office) of the Society and the membership before 1950 was effected by the presence of provincial delegates to Council and by the annual meeting. This did not adversely affect communication in times when the membership was small (by 27 June 1950 there were only 327 paid-up members),[29] but as the Society grew, another communication vehicle became necessary. Council struck a committee on 26 June 1950 to oversee publication of a quarterly newsletter. Publication began in October 1950 with Volume 1, No. 1, the first generation of the *CAS Newsletter*.

The complaint familiar to newsletter editors was soon heard: a lack of news from the membership. Nevertheless, optimism prevailed and readership was extended to hospitals and medical schools. Publication continued successfully, and with the appearance of Volume 3 in May 1953, the *CAS Newsletter* had a named editor, Dr. Harry Robinson of Toronto.

By this time, Dr. Gordon had initiated publication of a new venture, the Society's proceedings. First published in 1952, the *Proceedings* comprised papers presented at that year's annual meeting. Two separate publications seemed unnecessary, and on 2 March 1954 Council decided that out of the two a new publication would emerge: "a Journal, the name to be designated later, to be published four times a year." Thus started a second generation of newsletters, the first, Volume 1 and No. 1, appeared in July 1954 as part of a brand new publication, the *Canadian Anaesthetists' Society Journal*. Other generations of newsletters would be born, each taking on a new form, and becoming more sophisticated with the years.

THE EDITORIAL BOARD OF THE CANADIAN ANAESTHETISTS' SOCIETY JOURNAL

Equally successful as a committee has been the editorial board of the Society's Journal. The board was set up by Council in March 1954 to assist the versatile Secretary, Dr. Gordon, who was appointed Editor at the same time. The members of the Editorial Board were a small but select group: Dr. Noble, Dr. Louis Lamoureux of Québec, and Dr. Edward A. Gain of Edmonton.

The Editorial Board agreed to the name, *Canadian Anaesthetists' Society Journal*, and to a quarterly publication schedule. The new venture immediately proved successful and Dr. Gordon assured Council on 4 March 1956 that "it is the finest publication presently issued in the field of Anaesthesia."

The early success of the Journal must be attributed chiefly to Dr. Gordon's remarkable efforts, but the Editorial Board assisted in "the procurement of an adequate number of papers of high calibre," while Miss Campbell contributed "her extra work, much of which (was)

The Honorary Secretary, Dr. David Fear, in conversation with Miss Cynthia Lank, October 1989. Dr. Fear served as Honorary Secretary (and Editor of the *CAS Newsletter*) from 1989 to the present. Miss Lank was responsible for Journal production from 1989 to 1991.

done at night and on her nominally free weekends," for which she received an honorarium of $50.00 per month.

With publication of the Journal in July 1954, the *Proceedings* was no longer needed. The efforts of the Editorial Board under Dr. Gordon bore fruit, and the Journal evolved into a scientific publication that has achieved ever higher standards. In this regard, Dr. Gordon's successors (Dr. Douglas Craig, Winnipeg, and Dr. David Bevan, Montréal and Vancouver) also deserve credit. Another tall oak had grown from a very small acorn. (See Chapter 10.)

PUBLIC RELATIONS COMMITTEE

Inevitably the Society became involved in preparing the written word for the public as well as the profession, and early in 1953 Dr. Harry Slater, a well known paediatric anaesthetist of Montréal and later Toronto, wrote to Dr. Gordon asking if Council had a policy on the preparation of material on anaesthesia for lay publications.[30] As Council had not, a Public Relations Committee was struck.

President Cousineau asked his Montréal colleague, Dr. Griffith, to chair the committee, and he invited Dr. Noble and Dr. Eugene Allard, of Québec, to serve on it. The committee's role changed a great deal over the years, at times emphasizing the Society's relationship with the public, and at times concerning itself with the relationship between the Society and its members.

An example of the Committee's concern with the lay public's knowledge of anaesthesia is a pamphlet developed for patients. Dr. Noble showed a draft to Council on 3 March 1957. With minor changes, authorization was given to print in both French (40,000 copies) and English (100,000 copies). Entitled *Your Anaesthetic*, the pamphlet was provided "for the infor-

Dr. Eugene Allard, President, 1958–59.

mation of the Patient"; the purpose, "to help the patients and their relatives understand more fully how modern anaesthesia services are provided in Canada."

After producing the pamphlet, the Public Relations Committee appears to have become inactive, for on 6 June 1966 Council approved a motion of Drs. G. Wyant and Ian E. Purkis, of Halifax, that a Public Relations Committee be appointed. The issue that led to this decision was the question of sessions at the annual meeting being open to the press. The need to answer this question moved the Committee onto a different tack – the Society's relationship with the press, particularly at the annual meeting.

At the next Council meeting, 25–26 February 1967, the *ad hoc* committee's recommendations were presented by the Chairman, Dr. Norman E. Foster of Calgary. Essentially, the press should be invited to attend the scientific sessions (accepted) and the Annual General Meeting (declined); Council should appoint a member of the Society to take charge of press releases at each Annual Meeting (accepted); and a Public Relations Committee should become a Standing Committee (also accepted).

Dr. Dechêne was appointed chairman of the new committee. A year later, terms of reference for the committee were approved by Council, and the committee directed its activities "towards improving the relationship and standing of specialist anaesthetists with a) the general public (and) b) other members of the Medical Profession ... and increasing interest and improvement in the specialty of Anaesthesia."[31]

These terms of reference were expanded in 1972[32] under the chairmanship of Dr. Purkis, who sought an enlarged role for the committee and brought a different perspective to the attention of Council. Concerns of the committee included acupuncture and cardiopulmonary resuscitation, and the definition of anaesthesia and the anaesthetist (Appendix 9). A primary concern of the committee was communication and problems arising

from a lack of communication, not only with the public but between the Society and the membership.

In a report submitted to the Executive Committee and Council in June 1974, the Public Relations Committee made the startling statement that "the most critical problem facing the C.A.S. as a National Society is the threat to its continued existence."[33] While there was little agreement in the Society with this opinion, the reasons given – a perception that members were drawn more to their provincial divisions than to the central body[34] – forced the Executive Committee and Council to think more closely about communication. The Executive Committee held that "communication with the public at large is largely in the hands of the individual anaesthetists," which echoed the committee's statement that "the best public relations is still the pre-operative visit by the anaesthetist to the patient." However, the Executive did admit to an "obvious lack of effective communication with the membership."[35]

This interchange between the committee and the Executive and Council had a long-term impact. One result was a decision to initiate student (i.e., resident) representation on Council; the other, the inauguration of a new version of the CAS *Newsletter*. These changes, introduced in June 1975,[36] improved communication between Council and the membership.

In 1990, a later version of the committee improved communication with the public by revising and re-issuing *Your Anaesthetic* as *About Anaesthesia*. The committee expanded its interest with a brochure for high school students (*Resuscitation Anaesthesia*), and another for physicians and medical students considering a career in anaesthesia (*The Specialty of Anaesthesia*). A film (*Modern Anaesthesia*), produced by Drs. H. Drolet and M. Boisvert of the Québec Division, was approved for distribution to service groups and the general public.

COMMITTEE ON STATE MEDICAL SCHEMES

At a Council meeting on 4 March 1956, the Secretary-Treasurer expressed concern about the inevitability of a national health insurance plan. "The certain advent of Health Insurance in some form on a National Scale," Dr. Gordon said, "makes it imperative that we should give immediate attention to an analysis of the economic situation of anaesthesia in relation to the rest of the profession and the economy as a whole, and that we should mend our fences in organizational matters." Thus began committee interest in "state medicine," and the establishment of a formal Committee on State Medical Schemes.

The activities of this committee are of interest for several reasons. First, they illustrate the role of the Society's committees in collecting information from the provincial divisions. The operation of the Committee on State Medical Schemes depended on information provided by provincial members. The committee had to take account of the fact that responsibility for administering health care rests with the provinces. It was noted that "this limits to some extent the activities of a national committee on the subject ... (though the committee members) feel it should be their duty to act as a central information service to the provincial divisions."[37] In its early stages, when chaired by Dr. Vivyan Morton of Regina, the committee collected much useful information on national health insurance schemes in

different countries, and collated it in a bibliography that was circulated to the membership.

Second, the committee's activities illustrate the importance of grass-roots involvement in medical-political matters. Since responsibility for administrating health care lies with the provinces, negotiations on fee schedules are conducted on a provincial rather than national level. In such negotiations, it is important that anaesthetists make their presence felt; otherwise the particular concerns of the specialty are obscured or overridden by the weight of representations from other specialties. For this reason, Council passed a motion on 20 June 1956 directing the Secretary to write to the provincial medical associations requesting representation of anaesthetists in any negotiations concerning the development of state medical schemes, a practice that has been followed many times since.

Third, the activities show that it has been difficult, if not impossible, for a medical society to stop the progress of government-administered health insurance. The question is, then, What can be done?

On one hand, one can take an activist line; "opting out," as in Ontario, or even strike action, as occurred in Saskatchewan in 1962. On the other hand, one can simply object. As was remarked in 1961, "our reaction is limited to complaint."[38] Neither of these courses of action seems to have been productive, and a middle, more realistic, way had to be taken.

Therein lies the fourth point: the committee's activities mirror the growth of the Society in response to political events. The Society began at the same time as health care insurance in Canada, the former in 1943, the latter with the election of the CCF (New Democratic Party) in Saskatchewan a year later.

Even before the Society was founded, the introduction of "state" health care insurance seemed likely; indeed, it was one of the reasons that led the Founders to form the Society. For many years it was hoped that a national health insurance plan would not be introduced. Most physicians cherished the old order, and viewed with dismay the appearance of "the dead hand of the bureaucrat and an increase in overheads and a decrease in efficiency."[39] Many physicians felt that only high morale stood between "a future of freedom and professional dignity and honour, and a future of administrative dictation and frustration with the resulting deterioration in the standards and ideals"[40] to which they had devoted themselves. For many years, long after a government-control plan had been introduced in Saskatchewan in 1962 and then in other provinces, the Society line was to oppose "any element of compulsion,"[41] the essential point that engendered the opposition of most physicians to a national health care insurance plan.

As time passed it became evident to many people that, as Dr. Douglas F. McAlpine of Regina put it in 1965, "within the foreseeable future Federal and/or Provincial Governments (would) be forced to provide and/or subsidize a universally available medical care plan on a voluntary or compulsory basis."[42] Interference with, or attempts to control, the practice of medicine might well seem inevitable, but this did not mean that one could not do more than complain. So the middle way became the long way that continues to the present: for each provincial division to negotiate, year by year, fee schedules that seem equitable. (See also Chapter 13.)

As government-administered health care insurance came into effect, the concerns and name of the committee changed. These changes reflect the evolution of the Society's concerns within the general framework of Medicare, which was finally introduced on 1 July 1968. In 1956, it was the Committee on State Medical Schemes; in 1958, the Committee to Study the Implications on the Practice of Anaesthesia of Government Sponsored Plans;[43] in 1961, the Committee on Health Plans.[44]

Finally, as fee-schedule negotiations shaped the middle way, the Committee on Health Plans amalgamated in 1965 with the Committee on Economics.[45] From 1969 onwards, references to the former committee's concerns with health care insurance became fewer, and the new committee concerned itself wholly with information on fee schedules for Council and the divisions.

Committees of the 1960s

Unlike the previous two decades, the 1960s was a time of change, of excitement, of freedom. It was the decade of Expo '67, when Canada hosted the world. At home a growing affluence permitted the opening of new medical schools and hospitals.

Several committees established in the 1960s reflect, in different ways, the characteristics of this decade. Two committees are discussed here: one concerned with anaesthesia in Canada, another with anaesthesia overseas.

The Survey Committee on Anaesthesia in Canada (1965), at times referred to as the Manpower Committee, was a product of the growth of this period, as well as concerns regarding the need for anaesthetists in Canada. Conversely, another committee formed at the same time illustrates the Society's concern with developments that were not, strictly speaking, part of its mandate: anaesthesia training in third-world countries.

Several other committees also characterized the more expansive outlook of the Society in the 1960s, and contributed to the development of the Society. These are considered elsewhere: committees concerned with the Canadian Anaesthetists' Society prize (1960) and the Society's Gold Medal (1962) (Appendix 10); the Committee on Inhalational Therapists (Respiratory Technologists) (1961), which advanced the development of respiratory technology in Canada (Chapter 11); committees responsible for reorganization of the Constitution and Bylaws (1968–71) (Chapter 3); the committee that modernized the scientific program of the annual meeting (1967) (Chapter 9); and the committee set up to clarify the nature of the Society's relationship with industry (1959) (Chapter 12).

SURVEY COMMITTEE ON ANAESTHESIA IN CANADA

At the end of a series of reports from divisional representatives to Council at its mid-winter meeting in 1965, Dr. Gordon asked if it would be possible to keep the Society office informed about specialists in anaesthesia. Dr. Graves, whose interest in anaesthesia manpower led him to survey residency positions throughout the 1960s (Chapter 14), suggested that a committee be established to study future needs for specialists in Canada.

TABLE 4.3
Committees of the 1960s

Committee	Year of Formation	Comments
Recruitment of Anaesthetists	1960	
British Oxygen Company (Canada) Ltd. Prize	1960	The forerunner of the committee that administered the CAS Prize. The grant funds also made possible the establishment of the CAS Gold Medal
On Inhalation Therapists	1961	
CAS Gold Medal	1962	
Brief to Hall Commission	1962	
Education	1963	
Nominating	1964	
OR Infection	1964	
Foreign Membership	1965	
Anaesthesia Services	1965	Compare Survey Committee of 1947 and Manpower Committee of 1967 and 1984
Health Plans and Economics	1965	Amalgamation of Economics and Health Plans Committees
Anaesthetic Explosions	1965	
Drug Identification	1965	
Foundation, for WFSA Training	1965	
CAS Anaesthesia Training and Relief Fund	1966	
Review of Constitution and Bylaws	1966	
Public Relations	1966	
Income Tax	1966	
Subcommittee on CAS Prize	1966	
Public Relations	1967	
Terms of Reference for Education Committee	1967	
CAS Prize	1967	
Annual Program	1967	Now formalized
Manpower	1967	Renamed from Survey Committee
Centennial Medal	1968	
CAS Medal 1968	1968	
Reorganization of CAS	1968	
Associate Membership	1968	
Subcommittee, National Fee Schedule	1968	See also 1956
Revision of Constitution and Bylaws	1968	
Annual Meeting Social Program	1969	
Name of Inhalation Therapy Committee	1969	
Professional Standards and Causes of Morbidity and Mortality	1969	
Relationship to Industry	1969	

He proposed, and Dr. McAlpine seconded, that this committee study and analyze anaesthesia services in Canada, and project the needs of and provision for competent anaesthesia in various parts of the country.

Dr. Graves was appointed chairman, and Dr. A. Stuart Wenning of Halifax and Dr. Max Minuck of Winnipeg were nominated as members. The Society's study of anaesthesia manpower continued, on and off, throughout the next three decades. (See also Chapter 14.)

Dr. Graves' committee set a high standard for organization and accomplishments. Its reports were comprehensive and detailed, yet concise and cogent. Over the next three years it collected a great deal of information, producing statistics and drawing conclusions for Council's consideration.

In a report dated 21 February 1966,[46] Dr. Graves identified certain areas urgently requiring certified specialists, including Halifax, Saint John, Winnipeg, Regina, Saskatoon, Edmonton and Calgary. In a final report, presented to Council two years later,[47] Dr. Graves concluded that for the five-year period starting 1 April 1968 an extra 328 trained anaesthetists would be required in Canada. He admitted that this was not an entirely realistic appraisal because vacancies for trained anaesthetists did not exist in areas where there was "Family Practitioner controlled anaesthesia." The committee further suggested that 1200 cases yearly would be a reasonable work-load for a practising anaesthetist.

Dr. Graves' report illustrates some of the problems associated with the present conduct of anaesthesia practice, and especially problems contributing to delay and loss of anaesthetists' working time. His solution included more efficient administrative practices in the operating room, employment of paramedical personnel and "re-education of the surgeon."

The Survey Committee also addressed standards of training. Although the committee was disbanded at the midwinter Council meeting of 1969 and its terms of reference absorbed by the Education Committee, the Society maintained an interest in manpower issues. This is evident from the formation of a Working Party as part of the Federal Government's Requirements Committee in 1975, and, finally, of the formation of a Standing Manpower Committee in 1984.[48] The Survey Committee of 1965 created an admirable model, and the contributions of these two committees to research into manpower were considerable (see Chapter 14).

THE CANADIAN ANAESTHETISTS' SOCIETY ANAESTHESIA TRAINING AND RELIEF FUND

The third World Congress of Anaesthesiologists was held in September 1964 in Sao Paulo, Brazil, where the World Federation of Societies of Anaesthesiologists (WFSA) considered how to support the training of anaesthetists in underdeveloped countries.[49] From these deliberations emerged the WFSA Assembly's approval of the establishment of a Foundation to finance regional anaesthesia training centres on a continental basis. Those concerned with this project, particularly Dr. Gordon, hoped that anaesthesia societies and individual anaesthetists in developed countries would do what they could "to assist in making modern anaesthesia available to the millions of people in the underdeveloped regions who ... lack anaesthesia services."[50]

This desire to assist colleagues in less fortunate parts of the world struck a chord in Council at the midwinter meeting of January 1965. Council agreed in principle with the establishment of a foundation and sought to determine how such a foundation could be set up in Canada so that contributions would be tax-deductible.

At the next Council meeting Dr. Gordon was given authority to set up a foundation and arrange for the appointment of trustees by mail ballot to Council.[51] Efforts appeared to be proceeding favourably until the midwinter meeting of 1966. Dr. Gordon informed Council that, although the first regional training centre had been established at Caracas, Venezuela,[52] he was disturbed by two developments. Indeed, he informed WFSA that he felt bound to disassociate himself from its policies.

The first point of dissension was that just one of the three university departments of anaesthesia in West Africa had been invited to become the recognized training centre for the continent. According to Dr. Gordon, this "would tend to downgrade and destroy the usefulness of the other two departments, the future of which (was) essential for the training of medical students and practising physicians in the Specialty of Anaesthesia." Second, WFSA had invited African governments to nominate candidates for training in the Venezuelan centre, not in Africa. This raised Dr. Gordon's dander, for "a policy," he said, "could not be better designed to detract from the status of the Departments of Anaesthesia ... in Accra, Ibadan and Lagos; and besides, as a matter of simple economics, this would ... be a most expensive way to train African anaesthetists."

Council approved his motion, seconded by Dr. S.M. Campbell, that a foundation be set up in Canada. To be known as the Canadian Anaesthetists' Society Anaesthesia Training and Relief Fund, it would provide an appropriate Canadian contribution and be administered by a committee of trustees responsible to Council. Dr. Gordon was appointed chairman, a post he held until 1987.

In concept, the Fund provided a useful service. As Dr. Gordon pointed out, it would become the official instrument of the Society through which Canadian anaesthetists might contribute financially to education in anaesthesia in the international sphere and thus play a Canadian role in promoting safe anaesthesia throughout the world.[53] Society members supported the Fund, and within a year the generosity of 133 contributors brought the Fund's balance to $2,718.00.

Although an auspicious beginning, at the end of August 1991 the balance amounted to only $12,016.00,[54] an indication, perhaps, of the low profile of, and general interest in, the Fund.

The Fund's objectives are laudable: first, to support, in appropriate ways, anaesthesia training in Canada for physicians from countries in Africa, Asia and South America; second, to support the teaching efforts of Canadian specialists in these regions; and third, to enhance the training of physicians in these regions with Canadian educational material. The Fund has helped realize these objectives in a host of different countries, from Venezuela to Nepal, and continues to support a variety of educational projects.

Committees of the 1970s

The liberating momentum of the 1960s continued into the 1970s. By 1970 the Society turned to aspects of its own affairs and interests and began to examine forces and factors that would become significant throughout the 1970s and 1980s. The introduction in 1972 of a single certifying examination for specialists by The Royal College of Physicians and Surgeons of Canada freed anaesthetists, and other specialists, from the dual standard that had been so divisive in earlier years,[55] and enhanced the status of anaesthetists, particularly in the eyes of their surgical colleagues. Within the Society several committees of the 1970s reflected this newfound status.

The Committee on Standards of Practice and Accreditation (1971) was perhaps the most important, for out of its work emerged one of the Society's most productive projects ever: *Guidelines to the Practice of Anaesthesia* (Chapter 5). The work of three other committees exemplifies additional interests and issues of the Society in the 1970s. One issue was bilingualism, studied by an *ad hoc* Committee to Consider a Long-range Plan to Promote French and English Communications (1976). Another was the *ad hoc* President's Planning or Advisory Committee (1975), struck to consider a possible move of the central office and changes in the Society's Officers; third, the Publications Committee (1978), which reviewed the operation of the *Canadian Anaesthetists' Society Journal*.

AN AD HOC PLANNING COMMITTEE AND BILINGUALISM

There was no overt consideration of bilingualism in the 1940s and 1950s, no doubt because the Society had been founded in Montréal by a small group of anglophones and francophones who knew and respected each other. Not until the Quiet Revolution in Québec was bilingualism discussed by Council. At the 17 May 1962 Council meeting, Dr. Harold Griffith raised the question of publishing in English and French. His motion seconded by the retiring President, Dr. R.G.B. Gilbert, also of Montréal, merits reproduction in full:

> THAT Whereas Canada is a bilingual country with the English and French languages being accorded equal status for official purposes of a national nature and Whereas the Canadian Anaesthetists' Society is a national organization open to all qualified anaesthetists in Canada and Whereas French speaking anaesthetists in the interest of expediency and understanding have graciously not objected to carrying on the affairs of the Society in committees and in general sessions, in English, and are prepared to continue this courtesy provided their own language is accorded its proper official status, Be it resolved that it is the official policy of the Canadian Anaesthetists' Society, that so far as is practicable, all publications, reports, minutes, notices of meetings, programs and other official documents shall be issued in French as well as in English.

This resolution, which may be regarded as the basis of a policy of the Society, was welcomed by francophones. Dr. Léon Longtin of Québec City, while admitting that this

TABLE 4.4
Committees of the 1970s

Committee	Year of Formation	Comments
Finance	1970	See also 1957
CMA Administration of Inhalation Therapy Committee	1970	
Placement Bureau	1970	
Standards of Practice and Accreditation	1971	
Organizational Affairs	1971	From Constitution and Bylaws Committee
Physicians' Assistants Task Force	1971	
Allied Health	1971	An outcome of the Task Force on Physicians' Assistants
Liaison with Canadian Council on Hospital Accreditation	1971	
Past-Presidents' Club	1973	An informal once-yearly meeting
Future Annual Meetings	1974	
Working Party on Manpower (Requirements Subcommittee)	1973	A CAS committee that was one of 33 subcommittees of the Requirements Subcommittee of the National Committee on Physician Manpower
CAS Prize	1975	
Presidents' Advisory	1976	
Student (Resident) Representation on Council	1975	
Long-Range Planning Committee on Bilingualism	1976	
CAS Medal Guidelines	1976	
WFSA Office in Canada	1977	
Publications	1978	
Annual Meeting Format	1978	See also 1984
Task Force on Continuing Competence	1978	
Research Fund	1978	
CAS/Royal College Review of Aspects of Annual Meeting	1978	
Search, Editor of *CASJ*	1979	
Cardiopulmonary Resuscitation	1979	Disbanded 1980

Dr. Richard Gilbert, President, 1961–62.

gesture on the part of his English-speaking colleagues from Montréal caught him "unawares," (*pris au dépourvu*) also admitted that it gave him "great pleasure." To him "it signified ... not only the acceptance and support of the policy practised in the province of Québec, but also the wish to see this policy spread throughout the country."

Translation was expensive, and the Society appreciated financial assistance. In 1964 grants came from Abbott Laboratories, Poulenc Limited and Ayerst, McKenna and Harrison (see also Chapter 12). During the Council meeting of 11 May 1964, Dr. McAlpine asked what additional costs would be incurred if the annual meeting were held in western Canada. Dr. Campbell, the Secretary-Treasurer, estimated $400.00 or more. However, Dr. G. Cousineau suggested that translation services should be provided only when the Annual Meeting was held in Québec or Ontario. This opinion merged with policy in 1968, when Council generally agreed on "continuing the policy of providing translation services when the Annual Meeting ... (is) held in the province of Québec."[56] This policy was liberalized in 1974, when the federal government announced its readiness to assist national societies once a year by contributing as much as 85% of the cost.[57]

It remained necessary to monitor the policy of bilingualism, and during his presidency (1975–76), Dr. John H.A. Lawrence of Calgary and Saint John felt the need for advice from a committee, which was formed early in 1976. Dr. Lawrence's proposal was to appoint members, preferably from the same community, who would discuss long-range plans for communication with the membership in French and English. The committee, moreover, was to consider the requirements of applying for a grant from the Language Branch of the Secretary of State.

One of the requirements was the formulation of a plan on how to promote bilingualism among the membership. It therefore became necessary to refine the Society's stated policy of providing simultaneous translation service at the Annual Meeting, listing speakers and

their topics in both French and English, and striving to improve the preparation of other forms of communication in both languages. As of February 1977, the elements of this policy were as follows:

1 *The Canadian Anaesthetists' Society Journal* and *CAS Newsletter*. The bimonthly Journal had an Editorial Board, two of whose five members were French-speaking; the papers in English included an abstract in French; and French-language papers, which were encouraged, included an English summary. The first yearly Newsletter was published in both languages.

2 Publications. The Public Relations Committee had recently revised a brochure on the nature and scope of anaesthesia for distribution to the public, to patients, and to medical students, and had published it in both official languages. The Committee on Standards of Practice likewise had published its *Guidelines to the Practice of Anaesthesia* in both English and French. The Education Committee's self-evaluation program also was translated into French.

3 Meetings. Simultaneous translation of parts of the annual scientific meeting had been the policy since 1974. As far as the bi-annual meetings of Council were concerned, many of the members of Council were French-speaking, and the use of the French language was encouraged.

Although the Society has not yet achieved the degree of bilingualism as, for example, The Royal College of Physicians and Surgeons of Canada, it has endeavoured to keep the need for bilingualism in the forefront. However, Dr. Longtin's wish to see the policy of bilingualism spread "throughout the country" has not been fulfilled. While the *ad hoc* committee of 1976 facilitated the process, much remains to be done. For example, the absence of French in the programs of the Annual Meeting is "noticed."[58]

AN *AD HOC* COMMITTEE AND ADMINISTRATIVE CONCERNS

During the midwinter Council meeting in 1975, President Dr. J. Earl Wynands of Montréal expressed concern over the retirement, in the not too distant future, of the Honorary Secretary (Dr. S.L. Vandewater) and the Honorary Treasurer (Dr. D.W. Aitken), and, in the remoter future, of the Executive Secretary (Miss Campbell). Also of concern was the possibility of having to move the Society's office from 178 St. George Street, Toronto. These issues, though not weighty, deserved careful consideration, and an *ad hoc* committee was struck.

This committee achieved only qualified success, and its life was limited to a few months. Its significance is comparable to a scientific paper that reports negative results. The committee's single meeting explored issues and decided that nothing further need be done. But because these issues were not just of transient significance, they merit brief discussion here.

There were two important issues.[59] First was "possible structural changes in the Society in relation to duration of office of the President, Vice-President, Honorary Secretary, and Honorary Treasurer, and their implications." With Dr. Wyant chairing the committee, it raised for discussion the advantages of a longer, rather than a shorter, term for the President. Dr. Wyant had given a great deal of thought to the advantages of this.

The advantages were that a two-year term for the President would make it possible to achieve significant progress in any chosen programme, and also create opportunities to develop relations with government agencies. However, two years makes the position more demanding, time-consuming, and perhaps too expensive for an individual in private solo practice. After the committee members – Drs. Wynands, D.W. Aitken, F.G. Brindle, Gordon and Vandewater, and Miss Campbell – had debated the pros and cons, Dr. Wyant recommended altering Chapter 13 of the Constitution and Bylaws so that the terms of the President, Past President and Vice-President be two years, and the Second Vice-President, one year. Agreement could not be reached, and Dr. Wynands closed the discussion.

The second issue concerned changing the location of the central office and ensuring the Society's needs were addressed in a new site. This was raised because some considered Toronto a less desirable location than Ottawa, which would improve communication with the Canadian Medical Association and between francophones and anglophones. Upon reflection, this latter issue was felt to be "secondary to the necessity of improving communications" in the two official languages.

This issue also had been raised often enough to suggest that not all the Society's members favoured Toronto as the site of the Society's office. Indeed, some members were occasionally referred to as "the Toronto Mafia."

AN *AD HOC* PUBLICATIONS COMMITTEE

At the 1978 mid-winter Council meeting, Dr. Gordon noted a milestone in the Society's progress: publishing of the 25th volume of the *Canadian Anaesthetists' Society Journal*. Dr. Gordon had attained remarkable longevity as an editor, and could look back on his editorial efforts with considerable satisfaction.

In discussing the Journal, Dr. Gordon referred to concerns raised by members of the Association of Canadian University Departments of Anaesthesia (ACUDA). These concerns, according to Dr. Emerson A. Moffitt of Dalhousie University, amounted to a "widely held" apprehension concerning the health of the publication. ACUDA took an interest in the Journal because its members agreed that academic departments felt a responsibility, as leaders of academic anaesthesia, to support it. Dr. Gordon, however, wondered whether such observations were based in fact.

Dr. Douglas E. Crowell of Toronto explained that the Research Subcommittee's main concern was that the Journal's reviewing process should be more detailed and more specific. The subcommittee also suggested that a review of the Journal's format might indicate a place for clinical reports, review articles and multiple-choice questions.

The Executive Committee had already discussed these concerns[60] and wished to make

Presentation of Past-President's Gavel to Dr. Douglas Crowell (left) by the President, Dr. Germain Houle, Ottawa 1978.

a recommendation. Consequently, Drs. Crowell and John H. Feindel of Halifax resolved that a Publications Committee be struck to examine how best the *Canadian Anaesthetists' Society Journal* could serve the Society. Dr. Donald V. Catton of McMaster University was appointed Chairman, and Drs. M. Boulanger (Montréal), D.B. Craig (Winnipeg), D.E. Crowell, J.B. Forrest (Hamilton), R.L. Knill (London), E.A. Moffitt (Halifax) and Dr. Gordon were appointed members. Dr. Wyant was added as Assistant Editor at the next meeting of the Executive Committee, on 6 February 1978. At that meeting Dr. Catton referred to a consensus in communications he had received from the Editorial Board, as well as the Publications Committee, which augured well for a productive committee meeting, which was held on 26 May 1978 in Toronto.

The Publications Committee made 18 recommendations.[61] The most significant of these were the following:

3 The Editorial Board to give consideration to the publication of reviews, panels, proceedings, etc.

4 The Newsletter should be a separate Society publication, with a separate Editor apart from the Journal Editorial Board, mailed separately.

5 The Research Subcommittee of ACUDA be encouraged to continue their recent support for the Journal by the submission of papers and volunteering to be of service, as reviewers, to the Editorial Board.

6 The offer of the ACUDA Research Subcommittee to assist the Editor in the review of submitted papers be accepted.

9 Authors should receive explicit, detailed, constructive comments from both reviewers on all papers. The critical importance of this process to the development of the Journal and its authors should be recognized.

11 Memberships to be provided for the Editorial Board, by the C.A.S., in the Council of Biological Editors and the American Medical Writers' Association, upon request.

12 Members of the Editorial Board be individually provided with a copy of *Scientific Journal: Editorial Policies and Practices* by L. DeBakey, and the *Style Manual* of the Council of Biology Editors.

13 It should be an expectation of the Society that members of the Editorial Board attend all meetings of the Board.

14 The Executive Committee, with the Editorial Board (excluding the Editor and the Assistant Editor) act as a search committee for the position of Journal Editor.

15 The Editor should be initially appointed for a term of four years, with reappointment to be available upon the completion of a satisfactory review. It would be the expectation that two to three terms would be usual.

At its meeting of 18 June 1978 Council accepted the majority of these recommendations and referred those with financial implications to the Finance Committee. The only recommendation not acted on was that a Publications Committee become a standing committee.

The work of the Publications Committee clarified the responsibilities of the Editor and the Editorial Board, and provided ground rules for the future operations of the Journal.

Committees of the 1980s

Unlike earlier decades in the Society's history, committee activity in the 1980s reflected a loss of momentum. Reading between the lines of the reports of the Executive Committee and Council, one senses frustration among the Society's executive officers. The need for change was recognized, but the presence of obstacles created frustration. At the Council meeting of 17–18 June 1981, Dr. John B.R. Parker of Saskatoon made an astute diagnosis and prognosis:

> ... with the increase of size of the Society and its involvement in many fields of medicine, perhaps the Society should consider some form of professional management. In the future, Anaesthetic problems will certainly become more complex and will require a mechanism in order to react more quickly to these challenges.

As the Society entered the 1980s, its administrative staffing was neither qualitatively nor quantitatively much different from its first decade. Any association that, in 1983, had

TABLE 4.5
Committees of the 1980s

Committee	Year of Formation	Comments
Special Interest Groups (Sections)	1980	Stimulated by move to form Obstetric Anaesthesia Section
Search, Editor of *CASJ*	1981	
Search, Honorary Treasurer		
Long-Range Planning		
Office Relocation		
Parker Brief, and Search, Executive Director	1982	
Alternate Malpractice Insurance	1983	
Recommendation of Research Fund		
Bupivacaine	1984	
Search, Honorary Secretary		
Manpower		
Task Force, Allocation of Health Care Resources		
Review of Remuneration at Annual Meeting		
CASJ vis-a-vis Canadian Critical Care Society and Trauma Society		
Financing of Annual Meeting		See earlier committees of 1946 and 1965
Membership	1985	
Search, Executive Director		
Task Force, Annual Meeting		
Advisory Board, CAS Research Fund		
Bid, World Congress, 2000		
Awards		
Liaison with Canadian Critical Care Society		
Review, Editor		
Office Relocation		
Search, Editor of *CASJ*	1988	

a projected expenditure of nearly $200,000[62] yearly had to be business-like in its everyday operations and administration. Even as late as the mid-1980s, the Society was, as it were, using shoe boxes rather than computers for storage of and access to information.

Dr. Parker was instrumental in effecting the transition of the triad of positions of Honorary Secretary, Honorary Treasurer and Executive Secretary to the single position of Executive Director. Three committees are identified with Dr. Parker's leadership: an *ad hoc* committee to study a document on administration drafted by Dr. Parker himself (1982),

178 St. George Street, Toronto, The Society's head office from 1958 to 1982.

187 Gerrard Street East, Toronto. The Society's head office was located here from 1987 to 1991.

another to search for a chief administrative officer (1982), and a third (1985) after the first appointee had resigned.

Dr. Catton, the Honorary Secretary, likewise recognized a need for administrative change. He recognized a deficiency that was holding the Society back: slowness to react to situations as they arose. He therefore recommended the formation of a long-range planning committee (1981) which, he hoped, would "present the necessary information to guide our future decisions."

The formation of several other committees was further indicative of change in the 1980s. Search committees were struck for the positions of Journal Editor (1981), Honorary Treasurer (1981) and Honorary Secretary (1983). On a smaller scale, relocation of the Society's office in Toronto was considered and then executed, not once but three times in ten years: from 178 St. George Street to 94 Cumberland Street in 1982, to 187 Gerrard Street East in 1987, and then to 1 Eglinton Avenue East, in November 1991.

The formation of one other committee in the 1980s is important: the Committee on Membership in 1985.[63] The Society had grown from the five founders on 24 June 1943 to 1,971, including 1,334 active members, on 30 May 1985.[64]

The history of just three of the many committees will be discussed in order to illustrate aspects of the Society's development in the 1980s. These are the two search committees for an Executive Director and the Long-Range Planning Committee.

SEARCH COMMITTEES FOR AN EXECUTIVE DIRECTOR

In February 1982 Dr. Parker, in his report as the Immediate Past President, spoke of the "vast" amount of work accomplished over the years to nurture the growth of the Society.[65] For nearly four decades much of this work had been managed by two people, Dr. Gordon, as Secretary-Treasurer and later as Editor of the *Canadian Anaesthetists' Society Journal*, and Miss Campbell, the Executive Secretary.

The "Father" and "Mother" of Canadian anaesthesia – Dr. R. A. (Rod) Gordon and Miss E.R. ("Happy") Campbell, Montebello, June 1950. This was the first time the Society met separately from the Canadian Medical Association. For many years it was Dr. Gordon and Miss Campbell who ran the Society.

Charm personified. Dr. Jean-Claude Pouliot (President, 1981–82) with Miss E.R. Campbell, Québec City, 1982.

Dr. Arthur Dunn, Honorary Secretary from 1977–80, receives the Gold Medal in 1981. Dr. Parker (President 1980–81) presents the Medal, while Dr. Donald Catton (Honorary Secretary, 1980–84) looks on.

For years they steered the ship and prevented it from foundering. They rendered "yeoman service"[66] to Canadian anaesthesia in general and to the Society in particular.

But, as Dr. Parker pointed out to the Executive Committee in February 1982, these two individuals – sometimes dubbed the Father and the Mother of Canadian anaesthesia – would eventually retire. Dr. Parker considered the Society's future administrative needs and

drafted a brief summarizing his concept of the Society.

After discussing his ideas on this matter,[67] Dr. Parker identified two issues. First, the Society, 40 years on, had grown significantly and faced greater growth and increased interaction with other societies, lay organizations and governments. Second, managing the Society required two groups of people. One comprised elected Officers, chosen for their long-term commitment to organized anaesthesia and an ability to identify trends and developments, and provide creative leadership.

This group included the Society's philosophers and statesmen who understood how the specialty should develop. But these men and women had heavy professional and private commitments, and their time for decision-making and policy-forming was limited. Dedicated though they might be, there were limits to their contributions.

Hence, the Society required another group: a full-time staff led by an administrator skilled in modern business procedures and having the managerial expertise to supervise the central office and assist the Executive Committee and Council in developing and implementing policies. This group's task would be to make the office work and help the elected officers fulfil their assigned responsibilities.

Dr. Catton, supported by Dr. Parker in his plea for professionalization of the administration, emphasized the urgency of finding a solution. The Executive concurred and passed a motion by Drs. Ernest Michel (President-Elect) of Toronto and Gordon R. Sellery of London that an *ad hoc* committee be formed to consider the Parker document and to finalize its content.

Chaired by Dr. Parker and including Drs. Michel and D.B. Craig (the Editor-Elect) of Winnipeg, the committee appointed Frank Teepell to the position of Executive Director. He started with the Society on 1 February 1983. A congenial man remembered for his ability to order satisfying lunches, he lacked two important skills – computer literacy and the ability to lead. His appointment, wrote Dr. Lewis Hersey of London, marked "the beginning of disaster."[68] Dr. Hersey continued:

> I well remember coming on the scene for the first time at the Cumberland Street office. In its naive wisdom, the Society had been persuaded to buy, not lease, computer hardware at great expense. Also, a software company had been hired to develop appropriate software to run the Society's affairs. The new Executive Director turned out to know absolutely nothing about computers nor exhibited any leadership qualities. I remember the hardware sitting in the office unused – because no one knew how to – and the software company providing nothing useful. All that happened was the Society's financial position started to erode, because the hardware had been purchased and the software company sent monthly bills for two or three years. In short, the Society had been "had."

Dr. Hersey had identified the nub of the problem: "In that the central office is really run by absentee landlords, all that one knew was the office wasn't working and the bills were coming in."

Dr. James Beckstead,
Honorary Treasurer, 1982–1987.

Dr. Lewis Hersey,
Honorary Treasurer, 1987–1992.

Teepell's departure necessitated a search for a replacement. Lloyd Mayeda joined the Society on 1 February 1985 with credentials that seemed impeccable; his conduct as an office manager, however, was not. The preparation of minutes was slow and the cash flow was even slower.

The Honorary Treasurer, Dr. Jim Beckstead, lived in Winnipeg and, conscientious as he was, had an impossible task in monitoring the situation as an absentee landlord.[69] The finding of several thousand dollars' worth of stale-dated checks in the desk of a member of the administrative staff was cold comfort, but it was clear evidence of the need for efficient professional management. The result was that Mayeda, like Teepell, had to leave.

By this time, Ann Andrews, who had joined the Society's office staff in January 1987, was familiar with the Society's operations, and was promoted to Executive Director in 1988. Working at first in a house (187 Gerrard Street East), she modernized business management for the Society. Following the Society's move to a modern office late in 1991, she finally brought the Society's administrative procedures to a condition appropriate for the final decade of the 20th century.

The tumultuous events connected with the administration of the Society in the early to mid 1980s suggested to Dr. Hersey that there were three phases in the development of an administrative structure.[70] The first comprised "the good old days" under Dr. Gordon, Happy Campbell and her assistant, Sylvia Clark. The Society was "small, uncomplicated and

A happy quartet: Dr. Douglas Crowell (President, 1977–78) with (far left) Mrs. Sylvia Clark (long-time assistant to Dr. Gordon and Miss E.R. (Happy) Campbell (far right) and Miss Allison Bidwell.

Dr. Donald Catton, Honorary Secretary, 1980–84, receiving a presentation on completion of his term of office from Dr. Ronald Gregg, June 1984.

intimate." The years 1983–88 represented a transitional era of new leased offices, purchased real estate and less than successful management. The third era, the present, features the Society offices in a professional business environment employing sophisticated administrative and financial management procedures. The Society has been particularly well served by Andrews and her administrative staff in the latter 1980s and early 1990s.

THE LONG-RANGE PLANNING COMMITTEE

The Long-Range Planning Committee contributed to the re-animation of the Society in the 1980s. Its most significant contribution lay in its ideas concerning cost reductions, although its most tangible effect was the decision in 1983 to reduce the number of Past Presidents on Council to one.[71]

Dr. Catton originally envisioned a committee that would stimulate the "development of position papers on topics critical to anaesthetic practice in this country."[72] Council approved Dr. Catton's idea and he and Dr. Michel came to constitute the Long-Range Planning Committee. No topics "critical" to anaesthetic practice, however, seem to have been discussed by the committee, though two topics of some importance were discussed by Council.

The first was benefits members might expect from their membership dues. Table 4.6 provides the data on which Dr. Michel based his conclusion that the members in fact received a reasonable return for their contributions.

The second topic concerned principles that Council should adhere to if implementing cost-cutting measures. Dr. Catton initially listed these principles during the Council meeting of 13 November 1982, but expanded the list for an Executive Committee meeting on 4 February 1983:

1 The work of the Society's office, Council and Secretary must continue to be effective and not impaired.
2 Current level of office staff must be maintained.
3 Divisional delegates must realize that it is an honour to serve their colleagues when on Council or the Executive.
4 Members on Society business should not be out of pocket for expenses (hotel, meals, secretarial work).
5 The Society cannot attempt to compensate members for loss of income.
6 Membership dues must be increased.
7 The Annual Meeting must continue to be a consistent source of income.

The Executive Committee was particularly concerned with the cost of running the Society, especially the Executive Committee itself and Council. When Drs. Michel and Catton proposed two motions that would reduce costs, Council welcomed and approved them:

No. 4, 1983 Winter Council
The number of delegates to Council be altered from the current 1 per 100 members, or fraction thereof, to 1 per 200 members, or fraction thereof.

No. 5, 1983 Winter Council
THAT the following recommendation be made to the Annual Meeting of the Society, namely that Council eliminate (inclusion of the Past-Presidents, save the Immediate Past-President.

These changes were introduced in due course, and Dr. Catton calculated that they would save each member approximately $5.00 per year.

TABLE 4.6
Dues and Benefits in Six Canadian Speciality Societies, 1983*

	Society					
Variable	CAS	1	2	3	4	5
Membership	1,800	450	350	715	800	400
Dues ($)	155	170	250	250	350	150
Permanent Secretariat	Y	Y	Y	Y	Y	N
Journal	Y	Y	Y	N	N	N
Registration Fee for Annual Meeting	Y	Y	Y	Y	Y	Y

1 Canadian Otolaryngological Society
2 Canadian Ophthalmological Society
3 Canadian Society of Obstetrics and Gynaecology
4 Canadian Orthopaedic Society
5 Canadian Urological Society

*Source: Executive Committee Minutes, 13 November 1982 (Chart in Appendix to Council Minutes 5–6 February 1983)

TABLE 4.7
Committees of the 1990s

Committee	Year of Formation	Comments
Task Force, Environmental Issues in Anaesthesia	1990	
Performance Appraisal	1991	
Advisory, Fund Raising	1992	

Administrative staff, October 1989. From left to right: Ann Andrews, Christine Kofler, Jane Leckey, Cynthia Lank and Deanna MacDonnell.

Committees of the 1990s

Leaving a decade of turmoil and upheaval, the Society continued forming committees. However, the winds of change, which had attained gale proportions in the 1980s, helped these committees operate (Table 4.7).

With assistance from the Society's professional administrative staff, headed by Ann Andrews, the work of committee chairs and members became much easier and effective. One committee was struck to review the efficiency of the senior office staff – the Performance Appraisal Committee (1991).

Another was the Advisory Fund-Raising Committee (1992), which helped fund the R.A. Gordon Clinical Research Award, for presentation at the Society's 50th anniversary meeting in 1993. Finally, and in tune with the times, a Task Force on Environmental Issues in Anaesthesia (1990) was formed to raise the ecological consciousness of anaesthetists and to induce good practices appropriate for anaesthesia in the 21st century.

CHAPTER FIVE

Guidelines to the Practice of Anaesthesia

SINCE its founding in 1943, the Canadian Anaesthetists' Society has continually endeavoured to fulfil its Object "to advance the art and science of anaesthesia." In the early years the emphasis was placed on training for the trainee and on continuing education for the certified specialist; later, attention was given to research.

In 1973 the Society turned in a new direction. It introduced innovative and unique guidelines "aimed at improving the quality of anaesthetic practice."[1] No other specialty or other anaesthesia society had ever developed guidelines of this kind. The introduction of these guidelines was also significant in the evolution of the Society. By formulating guidelines "intended to provide a basis for a reasonable and acceptable standard of patient care,"[2] the Society came to influence the everyday practice of anaesthesia in Canada.

The movement to develop the guidelines goes back to 1971. Once they had been developed, the guidelines have been continually updated, mainly in response to technological aspects of anaesthesia. Three points can be made here. First, the Society has come a long way in developing guidelines and so influencing Canadian anaesthesia. Second, further development of guidelines will parallel advances in the art and science of anaesthesia. And third, the evolution of the guidelines illustrates the Society's commitment to the Objects drawn up on its founding in 1943.

This chapter focuses primarily on the development of the Society's *Guidelines to the Practice of Anaesthesia*. Some attention must first be given to the standards of the Canadian Council on Hospital Accreditation (CCHA) because, in the two years preceding the initial discussions of these Guidelines, the Society had more than a passing interest in CCHA standards proposed for anaesthesia.[3] To some members these were disturbing and the Society's interaction with the CCHA therefore needs to be addressed.

The Society and the Standards Proposed by the Canadian Council on Hospital Accreditation

The first phase of the development of the Guidelines was related to the Society's liaison with

the CCHA. This relationship was the responsibility of the Committee on Standards of Practice and Accreditation, which was formed at the midwinter Council meeting in February 1971. A discussion on approval of graduate training programs and training and examination included consideration of standards of practice and hospital accreditation. The committee's task was to contact the CCHA regarding standards of hospital practice.

The CCHA had developed its own standards of practice in the context of hospital accreditation. These standards included a section on Anaesthesia Services. Four specific standards that pertained to anaesthesia were as follows:

I The anaesthesia service shall be properly organized, directed and integrated with other related departments or services of the hospital;

II Staffing for the delivery of anaesthesia care shall be related to the scope and nature of the needs anticipated and the services offered;

III Appropriate precautions shall be taken to insure the safe administration of anaesthetic agents;

IV Practices employed in the delivery of anaesthesia care shall be consistent with the policies of the medical staff.[4]

Although the CCHA guidelines had been developed primarily for hospitals, they provided a model when the Society came to formulate its own guidelines. A number of statements in the CCHA document were of interest, and even concern, to Canadian anaesthetists. For example: "the qualified nurse anesthetist must be able to provide general anesthesia" (Standard II) – a statement in which the content and spelling clearly indicated an American context. Two other directives also concerned anaesthetists: "Decisions relative to the discharge of patients from any post-anaesthesia care unit should be made by a physician," and "the recording of post-anaesthetic visits that include at least one note describing the presence or absence of anesthesia-related complications" (Standard IV).[5]

The responsibility for developing a liaison with the CCHA first rested with Dr. Alan B. Noble, of Montréal. He established contact with Dr. L.O. Bradley, Executive Director of the CCHA, whose reception of Dr. Noble's overtures was "most cordial."[6] Dr. Noble noted that Dr. Bradley was "most anxious" to receive from the Society certain recommendations. These included: control of all types of operating room hazards; standards of practice for anaesthesia with specific reference to the community hospital, particularly the smaller hospital where only local family doctors were available to provide anaesthesia services; the objects of scrutiny for hospital inspectors during inspection of installations in operating rooms; and operating room construction, particularly concerning fire and explosion deterrents.[7]

Apart from Dr. Noble's expression of willingness to assist Dr. Bradley, no specific suggestions for change in the CCHA guidelines appear to have been made by the Society

at this stage. On 30 April 1971 Dr. Bradley wrote to Dr. Noble, stating that "we are getting on nicely with the revision of our Standards," adding that "we will send them out for your perusal shortly."[8] When the May 1971 revised edition of CCHA's standards was published, it omitted mention of nurse anaesthetists, but the two statements relating to discharge of patients from the anaesthesia care unit and the recording of post-anaesthesia visits remained.[9]

The new edition of the CCHA's standards was considered by Council in June 1971. Dr. Noble, referring to his contact with Dr. Bradley, stated that the committee had not been notified "as no urgent question had arisen." At this point, however, Dr. Noble, who was now unwell, gave over the responsibility of maintaining the Society's liaison with Dr. Bradley to Dr. R.A. Gordon of Toronto, who was appointed chairman of the committee in August 1971.[10]

Dr. Gordon was immediately disturbed by the evident lack of communication. His first observation was that, although Dr. Bradley had informed Dr. Noble on 30 April 1971 that the revised standards would be sent to him "shortly," this had never occurred.[11] Dr. Bradley replied to Dr. Gordon on 22 December 1971, regretting that the liaison between the Society and the CCHA "was not close enough for the Board to consider any representation which your Society had in mind."[12] However, he suggested that "your Society could or should take on the responsibility as the prime advisor to the CCHA on Anaesthesia Services." Dr. Bradley's letter is also of interest because of his statement that "in revising our Standards we have leaned heavily on the recent revision implemented this year for the Joint Commission on Accreditation of Hospitals in the United States."

Thereafter, relations between the Society and the CCHA deteriorated. Dr. Gordon felt compelled to reply to Dr. Bradley in forthright terms. The points Dr. Gordon made were the following:[13]

1 The draft standards that Dr. Bradley had forwarded to the Society were studied by the Conference of Heads of University Departments of Anaesthesia and by a committee of Council in June 1971. According to Dr. Gordon, Dr. Longtin was to have informed Dr. Bradley of the Society's views.

2 Two items in the CCHA's document, now ready for publication,[14] had been retained, although these had been "emphatically rejected by the senior people in the specialty as not only unnecessary but completely impractical." These items read as follows:

   a) "Following the procedure for which anaesthesia was administered, the anaesthetist, or his designee, shall remain with the patient as long as is necessary ... Decisions relative to the discharge of patients from any post-anaesthesia care unit should be made by a physician."

   b) "The recording of post-anaesthetic visits ... includes at least one note describing the presence or absence of anaesthesia-related complications."

In relation to the first item, Dr. Gordon suggested that, once the anaesthetist is satisfied with the condition of the patient, "responsibility from that point of view rests with the nurse and ... the nurse may on her own initiative remove the patient from the recovery room when his status is satisfactory." With respect to the second, Dr. Gordon held that it was impractical for a busy anaesthetist to make a postoperative note "because many patients do not remain in the hospital for a sufficient period of time," adding that "the idea of a busy anaesthetist making notes that there were no complications present related to anaesthesia borders on the absurd."

Dr. Gordon therefore asked that these two items be removed from the published standards. This, however, was impossible, for, as Dr. Bradley informed Dr. Gordon in his reply of 3 January 1972,[15] the *Guide to Hospital Accreditation – 1972* was already in press. Dr. Gordon then summarized for Council, at its midwinter meeting of 1972, what had happened. As expected, the discussion centred around the anaesthetist's responsibilities concerning immediate postoperative care and orders in the recovery room.

Council's reaction was summarized by Dr. Stuart L. Vandewater, of Kingston and then Honorary Secretary, in a letter to Dr. Bradley on 11 August 1972. The letter, in part, read as follows:

> ... while we agree with the principles regarding the discharging of patients from Post-Anaesthetic Care Units and the visiting of patients following Anaesthetics, and while we believe that Canadian Anaesthetists do accept the responsibility for discharging patients from Post-Anaesthetic Care Units and for visiting patients after Anaesthesia, we believe that the regulations of the Canadian Council on Hospital Accreditation regarding these matters are impractical.
>
> ... I trust that the Canadian Council on Hospital Accreditation will not withdraw accreditation from a hospital because of these particular clauses until a more practical plan can be devised to meet these requirements.[16]

The responsibility for facilitating the formulation of "a more practical plan" then devolved on Dr. J. Michael R. Campbell of Toronto, who was appointed chairman of the Committee on Hospital Accreditation (a subcommittee of the Committee on Standards of Practice) in July 1972.[17]

In light of current practice, in which it is customary for anaesthetists to take responsibility for immediate postanaesthetic care, the foregoing objection to the CCHA standards may perhaps be regarded as a storm in a teacup. However, in their relationships with other health care professionals, anaesthetists were sensitive to what they perceived as encroachments on their area of responsibility. This is illustrated by Dr. Campbell in a letter of 7 May 1974:

> ... we feel that anaesthetists, as members of a "mature" specialty, should not be told by a Hospital Accreditation Committee how they should practise their specialty.

> Surgeons, physicians in general, obstetricians, for example, have no such detailed instruction in the (CCHA) Guide. It may well be that a Guide of approved standards should be drawn up and, possibly, enforced by somebody, but we do not feel that the appropriate body for this is the Canadian Council on Hospital Accreditation. The appropriate body could well be the Canadian Anaesthetists' Society ... or the Provincial Colleges of Physicians and Surgeons.[18]

Dr. Campbell therefore suggested a "radical" change in the CCHA Guide's section on Anaesthesia Services. As Dr. Campbell explained to Dr. Vandewater, "what we suggest be placed in the Guide are the minimum standards which the 'hospital' should provide if anaesthetics are to be administered." Dr. Campbell's revision spelled out minimal standards on operating rooms, recovery rooms and anaesthetic equipment. The discharge of patients from recovery rooms, however, was addressed in general terms only: "all new hospitals where general anaesthetics are administered must provide a suitable post-surgical recovery area, of adequate size to contain a normal patient load, until they have adequately recovered from the acute effects of surgery and anaesthesia, and may be safely returned to a general nursing unit."[19] With minor changes, it was expected that the committee's revision of the section on Anaesthesia Services "should be word for word the new entry to the next edition of the (CCHA's) Guide."[20] Dr. Campbell had, after all, "made good contact with Dr. Bradley" and "he ... stated ... in writing that ... the Canadian Anaesthetists' Society is the appropriate body with which to deal on matters concerning anaesthesia.[21] Communication with the CCHA now seemed "cordial"; and the Society's proposed revision of the section on Anaesthesia Services, would, Dr. Campbell thought, "in all likelihood be mutually acceptable,"[22] although he did add the rider "unless anything should happen before then which would cause either side to suggest changes."

Dr. Campbell's added rider did not prepare him for the next development. Early in December 1975, he received word from the CCHA that the proposals for a revised section on Anaesthesia Services were unacceptable and that the CCHA "wished to add to it a considerable amount from the old section which we had previously agreed to delete."[23] Dr. Vandewater therefore wrote to the new Executive Director of the CCHA, Dr. A.L. Swanson, expressing the concern of the Society and the hope that "the Society would have the opportunity to review the final draft and have the privilege of offering amendments if deemed necessary."[24]

Since the CCHA expected to publish the new edition of their document in the near future, a meeting with the CCHA now became urgent. This meeting, attended by Drs. Vandewater, Campbell and Arthur J. Dunn of Toronto, then Assistant Secretary, was held on 9 February 1976; Drs. Swanson and J.H. Murray represented the CCHA. The meeting was for the most part "cordial," though "somewhat hard-nosed at times."[25] The tone of the meeting is evident from the following excerpts from Dr. Vandewater's account:

> – Dr. Swanson outlined the position of the C.C.H.A., and stated that they were more concerned with small hospitals where there are not organized Departments of

Anaesthesia, and the service is provided by the practitioner anaesthetist.

- Notwithstanding the above concern, Dr. Vandewater pointed out that 80% of the anaesthetics given in Canada were administered by certified specialists, and 40% of these anaesthetists were on the staff of University Hospitals. In addition, 90% or more of the certified anaesthetic specialists were Members of the C.A.S., and the C.A.S. did not appreciate the C.C.H.A. telling its members how to practise, unless the C.C.H.A. intended to write similar guidelines for surgeons and other physicians who practise in hospitals, large and small. The C.A.S. was of the opinion that the C.C.H.A. was interested in hospital accreditation, dependent on administrative practices and policies, and the Society and the provincial licensing authorities were concerned with the actual practice of the profession ...

- After the above introduction, it was agreed to review and amend Draft II by consensus. This was done in a meticulous manner over 3 1/2 hours from which emerged Draft III.[26]

Draft III was the basis for the new edition of the CCHA's guidelines, which were published later in 1976. It was the outcome of confrontation in part, but in larger part of compromise; the viewpoints of two sides had to be melded. It is therefore worth reproducing the two paragraphs dealing with Post-Anaesthesia Recovery Area, a topic that had caused so much concern originally:

1 All hospitals where general anaesthetics are administered must provide a suitable post-anaesthetic recovery area, of adequate size to contain the normal patient load until the patients have adequately recovered from the acute effects of surgery and anaesthesia, and may be safely returned to a general nursing unit or a day care surgery reception unit. These recovery rooms must be adequately fitted with an oxygen and suction supply, ideally, for each patient's space. They must also contain the supplies necessary for the treatment of patients in these areas. The P.A.R. area must be adequately staffed by properly trained nursing personnel. The anaesthetist must accompany the patient from the anaesthetic area to the post-anaesthetic recovery area and shall write such orders as may be necessary and give appropriate information to the P.A.R. personnel as necessary for the care of the patient during the recovery period.

2 The anaesthetist has the overall responsibility of the post-anaesthetic care of the patient during recovery from anaesthesia and for the assessment and order for discharge from the P.A.R. unless this responsibility is delegated to the nursing personnel. Such delegation must be under specific conditions which are written in the policy manual, and approved by the Medical Staff and the Governing Body.[27]

Such dictates go almost without saying today; when they were fought over and drawn up word for word in an atmosphere of confrontation, however, anaesthetists were sensitive about

their status. Only quite recently, for example, had The Royal College of Physicians and Surgeons of Canada abolished the dual standard of Certification and Fellowship, whereby anaesthetists who had passed their Royal College Examination could become, by joining the College as Fellows, equal in status with all other specialists, particularly Surgeons. This sensitivity is well illustrated by Dr. Campbell's stated desire that, in the CCHA's revised guidelines, anaesthetists should be regarded as qualified physicians and grouped as such rather than with non-medical personnel.[28]

The Development of the Society's Guidelines to the Practice of Anaesthesia

Although the initial concern of the Committee on Standards of Practice was the CCHA's proposed standards for anaesthesia, the committee soon became interested in several other aspects of anaesthesia that were topical in the early 1970s. The committee provided a forum for discussion on operating room pollution, electrical hazards in the operating room, and sterilization of anaesthetic equipment. Study of these topics occupied the committee in 1971, 1972 and 1973, though the liaison with the CCHA took up a great deal of time as well, and the reports of the subcommittee on hospital accreditation required frequent attention.

In these years the Committee on Standards of Practice was not primarily concerned with the clinical aspects of anaesthesia, and particularly the *quality* of clinical anaesthesia. This new concern, an important departure, came suddenly at the end of 1973. It was the outcome of the most serious of all anaesthetists' concerns: death associated with anaesthesia.

Ever since January 1848, when young Hannah Greener died just after the induction of anaesthesia with chloroform, "complications" and "accidents" have continued to bedevil the practice of anaesthesia. A tragic accident in Burlington, Ontario, in 1973 put pressure on the Society – and specifically the Committee on Standards of Practice – to address this problem, in the general context of the quality of anaesthetic practice in Canada. The Burlington incident, in which the death of a patient occurred after the anaesthetist had been called away from the operating room to attend an obstetric emergency elsewhere, greatly concerned Dr. Vandewater, the Society's Secretary. So did an inquiry from another community hospital, in Nova Scotia, on the same issue. What was the Society's opinion on an anaesthetist's being called away from the operating room to attend an emergency case elsewhere in the hospital?[29]

In looking for an answer, Dr. Vandewater invited Dr. F. Norman Brown, Secretary-Treasurer of the Canadian Medical Protective Association (CMPA), to address Council, and he requested the Committee on Standards of Practice to consider proposing minimum standards of anaesthetic practice.

Dr. Brown's remarks to Council on 8 December 1973 disturbed Council and demanded action. His central point was that, over a 14-year period, there had been a noticeable increase in medicolegal activities stemming from anaesthetic accidents. Some of these were minor but others had caused cerebral anoxia. Because action seemed urgent, Dr. Vandewater asked the chairman of the Committee on Standards of Practice, Dr. John H. Feindel

Dr. Donald Aitken (Honorary Treasurer, 1972–77) (left) receiving a presentation on concluding his term from President John Feindel, Saskatoon, 1977.

of Halifax, to take appropriate action. Some sort of guidelines would constitute "appropriate action" for, as Dr. Feindel pointed out to Council at the same meeting, "no formal guidelines on such matters have ever been prepared, or adopted by the Society." He assured Council that his committee would give this important topic their consideration.

No time was wasted in drafting proposed guidelines. The committee met in Toronto on 27 and 28 April 1974, in part to discuss the CCHA's Guidelines but, more importantly, to review Dr. Feindel's draft of proposals on what were then termed the *Minimum Guidelines for the Practice of Anaesthesia*, prepared for the Society (Table 5.1).

The draft was reviewed "one paragraph at a time," and the revised draft was presented to Council on 16 June 1974. Council would need time to study it, as would the CMPA and its legal counsel.

A meeting with Dr. Brown and the CMPA legal counsel on 17 January 1975 led to minor changes in the document. At the 1975 midwinter meeting, held on 1 and 2 February, Council discussed what was now the final draft. Further minor changes were made, and a motion was proposed by Dr. Feindel and seconded by Dr. William J. Farley of Calgary, as follows:

> THAT the final draft of the Minimum Guidelines for the Standards of Practice of Anaesthesia as amended by the Council ... be approved.

The motion was carried, and the Guidelines became part of the Society's policy. A statement of policy carried weight. As was pointed out during the Annual General Meeting on 20 June

TABLE 5.1
Draft of Proposals for the Minimum Guidelines for the Practice of Anaesthesia, as of April 1974*

OUTLINE:
Minimum Guidelines for the Practice of Anaesthesia

PREAMBLE:
Quality of care must be maintained.
Anaesthetic services responsibility of medical practitioners.
Continuing education to be emphasized and encouraged.
Qualified general practitioner anaesthetists needed in Canada to assist in providing anaesthetic services.

BASIC PRINCIPLES:

ORGANIZATION OF ANAESTHETIC SERVICES:
- Responsibilities and duties
- Privileges to administer anaesthesia
- Anaesthesia equipment
  - (1) Essential items
  - (2) Maintenance
  - (3) Disinfection
  - (4) Codes to be followed
  - (5) Safety Regulations
  - (6) Inspection

PRE-ANAESTHETIC PERIOD
- Pre-anaesthetic evaluation
- Documentation
- Essential investigations
- Preparation

ANAESTHETIC PERIOD
- Checking out and inspection
- Disposable equipment
- Obligations to patient
- Recording
- Positioning
- Intubation
- New techniques
- Draping of Patient

POST-ANAESTHETIC PERIOD
- Transfer of patient to recovery area
- Anaesthetist's role
- Discharge of patient
- Documentation
- Post-anaesthetic visit

*Source: Minutes, Executive Committee, 15 June 1974, Appendix 8.

1975, "a policy statement by a society has a greater implication than similar statements in published papers or (a) textbook, which reflect only the opinion of an author." Even so, individual opinions were of interest: Dr. J. Earl Wynands, then of Montréal and President of the Society, said that Dr. Feindel and his committee had produced "a major and definitive report that will have an impact on the practice and delivery of anaesthetic care in this country."[30]

But opinions varied, and there was, and still is, some criticism of the Guidelines. There

were some specific objections to content, such as "the stated responsibility of the anaesthetists in discharging patients from the Recovery Room."[31] But of more concern to some anaesthetists was the possibility that the Guidelines had set a standard that now had to be followed. There was some justification for this opinion, because, as Dr. Vandewater reported, failure to meet the standard set had led to a charge of professional misconduct.[32] This problem was discussed at some length by the Executive Committee on 21 June 1980, the diversity of opinion illustrating the points of a controversy.

The CMPA had a dual view. On one hand, suggested Mr. Tate, lawyer with CMPA solicitors McCarthy and McCarthy, it was not likely that in publishing the Guidelines the Society had exposed itself to liability, for it was clear that the Society's objectives were to educate and to improve the practice of anaesthesia. On the other hand, since it was counsel's opinion that judges appeared to be "overly hostile" to CMPA, juries might make the judgement decision of a standard of correct care versus the current judicial decision. The CMPA also was concerned that the Guidelines could become an instrument for the use of plaintiffs, for the relatively plain language in which the Guidelines were set out might purport to set a practice standard. The danger was that in setting standards in simple language the Society could indirectly harm a member.

Dr. Douglas E. Crowell of Toronto thought that the institution of Guidelines would enhance patient care, and that the Guidelines constituted an advance from which the Society could not go back. Dr. John Parker of Saskatoon pointed out that provincial government authorities had apparently endorsed the Guidelines, and Dr. Luc Perrault of Montréal noted that the Corporation of Physicians and Surgeons of Québec had published their own guidelines.

The consensus, therefore, was that the Guidelines represented the generally accepted standard of care. What was necessary was to revise the Guidelines rather than reject them, with legal advice provided by the CMPA.

With the passage of time, it is apparent that the introduction of the Guidelines served as a stimulus for improving the quality of anaesthetic practice, which was the original intent. Indeed, general opinion regarding the Guidelines supports the conclusion of Dr. Vandewater, who stated, simply, that the Guidelines were no less than a "milestone."[33]

One virtue of the Guidelines is their flexibility. This has allowed adaptation to new circumstances dictated by advances in anaesthesia. The remainder of this chapter reviews the different editions of the Guidelines (1977, 1981, 1987 and 1989) and reveals how the Society has responded to the development of anaesthesia in Canada in the past two decades.

The Guidelines from 1977 to 1989: A Comparative Review

The Guidelines were approved by Council in February 1975, and first published in booklet form in 1977, when Council approved the printing of 5,000 copies in French and English, to be distributed to members, hospitals, health care authorities and provincial licensing authorities.[34] Even before publication the need for revision and additions was recognized; for

example, guidelines for anaesthesia in dental practice outside the hospital were formulated as early as February 1975.

The practice of anaesthesia was developing steadily, and standards for anaesthetic equipment were constantly being revised and added to. Monitoring practices became more sophisticated through the years, and the changes in the 1987 and 1989 editions reflect this. Because it was important to keep abreast of legal opinion concerning the reception and use of the Guidelines, so legal advice, through the good offices of the CMPA, was regularly sought.

The structure set out in 1977 and maintained in 1981 was preserved as the basic organization in 1987 and 1989. With succeeding editions, the content of each section changed somewhat, but the message remained the same. Excerpts from the Preamble to each of the four editions exemplify this:

1977

The following minimum standards are intended to improve the quality of anaesthetic practice ... these guidelines are formulated to meet the needs for specific directives for the practice of anaesthesia in Canada. Although they represent the minimum accepted standard, it is recognized that there will be unusual, rare occasions when some of the instructions cannot be obeyed and some degree of flexibility should be employed in their application.

1981

The following guidelines are aimed at improving the quality of anaesthetic practice ... these guidelines are formulated to meet a perceived requirement for specific directives for the practice of anaesthesia in Canada. They are intended to provide a basis for a reasonable and acceptable standard of patient care and should be interpreted in that way, allowing for some degree of flexibility when conditions warrant.

1987

The following recommendations are aimed at providing basic guidelines for anaesthetic practice. They are intended to provide a framework for a reasonable and acceptable standard of patient care and should be interpreted so, allowing for some degree of flexibility to occur in different circumstances. The Guidelines are subject to revision as warranted by the evolution of technology and practice.

1989

The following recommendations are aimed at providing basic guidelines for anaesthetic practice. They are intended to provide a framework for a reasonable and acceptable standard of patient care and should be so interpreted, allowing for some degree of flexibility to occur in different circumstances. Each section of these Guidelines is subject to revision as warranted by the evolution of technology and practice.

The similarity in the stylistic organization of the Guidelines and in the essential

message of the Preamble, however, should not belie an important change of emphasis in the 1987 edition. In 1987 the title was phrased as "Guidelines for the Basic Standards of Practice of Anaesthesia." The word to note is *Standards*. In the two succeeding editions, this word was omitted because it was thought unwise to emphasize standards, with their medicolegal implications. Dr. Peter G. Duncan of Saskatoon, Chairman of the Committee on Standards of Practice, pointed out that the word 'guideline' was emphasized because it was seen as a "statement of principle, rather than a standard, or required level of conduct."[35]

Some sections, however, underwent considerable change. In the 1977 edition it was specifically stated that "all physicians applying for clinical privileges in anaesthesia must have completed at least six months' training in the specialty in a hospital which has a residency program approved by The Royal College of Physicians and Surgeons of Canada or its provincial counterpart." The six months' period was included in recognition of the perception, as stated in 1977, that "we will be dependent for many years on the general practitioner anaesthetist to assist in the provision of anaesthetic services to Canadians." A similar statement was made in the succeeding editions. However, it was also stated in the 1977 edition that "every effort should be made to ensure that anaesthesia care is provided by physicians who have the highest possible training and experience in this branch of medicine."

The statement that, for many years, Canada will be dependent on general practitioners to give a proportion of the anaesthetics that are administered in small communities throughout the country, raises an important question. It is also raised by the parallel and conflicting statement in the 1989 edition that "ideally physicians practising anaesthesia should have certification in this branch of medicine." The question, then, is this: Should all anaesthetics in Canada be given by specialist anaesthetists? If an ideal is recognized, should every effort indeed not be made to gain it? Henry David Thoreau knew this: "In the long run men hit only what they aim at. Therefore, though they should fail immediately, they had better aim at something high."[36]

The question of training general practitioner anaesthetists, and the relationship of the Society to them, has been discussed frequently in the history of the Canadian Anaesthetists' Society. Of much interest is the view of the Association of Anaesthetists of the Province of Québec (AAQ). The AAQ's view, as expressed in a meeting of the Executive Committee on 16 June 1979, is that the Canadian Anaesthetists' Society should not be in the business of giving approval for duration of training; moreover, since no other specialty supports less than full specialty training, the requirement for six months' training should be deleted from the Guidelines. The logic of this view was accepted, and the motion of Dr. G. Sellery of London and seconded by Dr. Farley that the wording on the duration of training requirement in the section on privileges was carried. The motion read as follows:

> THAT all physicians applying for clinical privileges should have completed postgraduate training in a Department of Anaesthesia which has a Residency Programme approved by The Royal College of Physicians and Surgeons of Canada or a provincial licensing authority.

The goal of practice in Québec is to have specialist anaesthetists give all anaesthetics in the province. While this may appear impractical, great strides have, in fact, been taken towards achieving this goal by establishing relationships, funded by the provincial government, between tertiary care hospitals and rural hospitals, so that specialist anaesthetists, in rotation, service the rural hospitals. If this can be the objective in Québec, can it not be the objective throughout Canada?

This question brings up a related issue, the "contentious" one of anaesthesia assistants (anaesthesia technicians) (Chapter 11). The Society had studied their role even before the Guidelines were drawn up, so it is not surprising that all editions of the Guidelines refer to the place of "qualified medical or paramedical personnel, or anaesthesia technicians." From the beginning their role seemed to that of rendering "certain ancillary assistance in providing anaesthetic, resuscitation and intensive care services." The emphasis was on the word "qualified"; that is, such personnel "must have received accreditation by an appropriate provincial authority where applicable." Their functions were specific, the anaesthetists delegating or assigning to anaesthesia technicians only "those tasks for which they are accredited."

Although concern may have been expressed that anaesthesia technicians might usurp the function of physician anaesthetists, or even facilitate the absence of the anaesthetist from the operating room, the Guidelines have always been clear on this point. Although the Guidelines have allowed that "under exceptional circumstances" – for example, to provide life-saving emergency care to another patient a physician anaesthetist may then delegate to a "competent" person the temporary care of an anaesthetized patient – the most recent edition of the Guidelines categorically, and in bold type face, states that "the anaesthetist must remain with the patient at all times throughout the conduct of all general, major regional and monitored intravenous anaesthetics." This may be considered a cardinal rule of anaesthetic practice whose importance was recognized from the very start. In his committee report of 19 November 1973, Dr. Feindel stated that "the anaesthetist is obligated to remain with the case in progress and is under no circumstances obliged to leave that patient to care for another."[37]

These two large issues – the training of general practitioner anaesthetists and the role of anaesthesia technicians – are not the only issues to have been considered controversial. The Guidelines have generated so much discussion over the years because the issues that have been addressed are fundamental. They are issues that have demanded the most careful thought before being addressed, on paper, in terms acceptable to the Society, to the specialty, to health care facilities and authorities, and to the CMPA.

Changes to the Guidelines have therefore been introduced slowly. The evolution of Guidelines on monitoring and monitoring equipment illustrate particularly well the conservatism necessary in preserving "a basis for a reasonable and acceptable standard of patient care" yet at the same time "allowing for some degree of flexibility when conditions warrant." Except for a statement in the 1977 and the 1981 Guidelines that "an adequate record of the patient's vital signs should be made during the course of anaesthesia," no

mention of specific monitoring techniques was made until 1987. In that edition, the introductory statement ran as follows:

> The only indispensible [sic] monitor is the presence, at all times, of an appropriately trained and experienced physician. Mechanical and electronic monitors are, at best, aids to vigilance. Such devices assist the anaesthetist to insure the integrity of the vital organs and, in particular, to insure that there is adequate tissue perfusion and oxygenation.

The guidelines defined monitoring equipment as basic or desirable, and required or immediately available. Basic and required guidelines defined monitoring requirements that were compatible with good anaesthetic practice. These include: a preanaesthetic checklist, sphygmomanometer, stethoscope (precordial, esophageal or paratracheal); electrocardiogram; thermistor; visualization of some part of the patient and a record of the anaesthetic. Other items classified as basic and immediately available were an electrocardiograph defibrillator, peripheral nerve stimulator, respirometer for total volume measurement, ventilator with low-pressure alarm, and drugs and equipment to manage emergencies (including dysrhythmias, malignant hyperpyrexia and cardiorespiratory arrest). An additional immediately available item, but desirable rather than basic, was a facility for measuring arterial blood gas concentrations.

In addition, the 1987 Guidelines included the following statements regarding continuous monitoring:

> During every administration of general anaesthesia the anaesthetist shall employ appropriate methods of continuously monitoring the patient's ventilation, cardiac function, and peripheral circulation. These included:
>
> - *Ventilation*: The possibility of palpation or observation of the reservoir bag and of auscultation of breath sounds. It was emphasized that "monitoring CO_2 and minute ventilation is an emergency standard and is strongly recommended." During automatic mechanical ventilation, a breathing system disconnect monitoring device, equipped with an audible alarm, was required. The concentration of oxygen in the "patient's breathing system," it was noted, "should" be measured by an oxygen analyzer.
> - *Cardiac function*: The possibility of auscultation of heart sounds together with continuous electrocardiogram display.
> - *Peripheral circulation*: Palpation of a pulse, visualization of a capillary bed, and frequent measurement of the blood pressure were regarded as mandatory, while monitoring of intra-arterial pressure, pulse plethysmography or ultrasonic peripheral pulse monitoring were recommended where appropriate.

The 1989 edition of the Guidelines simply classified monitoring equipment as *required* or *immediately available*, as follows:

Required	*Immediately Available*
Pulse oximeter	Peripheral nerve stimulator
Apparatus to measure blood pressure	Respirometer (tidal volume)
Stethoscope (precordial), esophageal or paratracheal	
ECG	
Capnograph (after June 1990)	
Temperature-measuring apparatus	
Lighting to visualize exposed portions of the patient	

These recommendations represent attempts to provide "basic guidelines to anaesthetic practice." Because they were made by the Canadian Anaesthetists' Society, they may be said to represent the Society's policy. Other aspects of anaesthetic practice, however, have been considered by the Society but not officially approved for inclusion among the basic guidelines to anaesthetic practice. Two that have received a measure of approval by being published in the CAS *Newsletter* are recommendations regarding *the epidural administration of local anaesthetics during labour* and *opioids for general use*.

The desirability of formulating directives on epidural administration of local anaesthetic agents for analgesia in labour was first discussed by the Committee on Standards of Practice on 8 May 1978.[38] The issue was raised by the recommendations of a coroner's inquest in Ontario:

> 1 A baseline blood pressure range, established during pregnancy by the attending physician on the chart.
> 2 If continuous epidural anaesthesia is to be administered, it should be administered in the delivery room where there is emergency equipment.
> 3 Where continuous epidural anaesthesia is used, the obstetrical staff should be trained to recognize warning signs should the local anaesthetic, following dural puncture, enter the subarachnoid fluid.
> 4 If continuous epidural anaesthesia is to be administered by a qualified anaesthetist, the anaesthetist should remain in the hospital.[39]

The key recommendation for the Committee on Standards of Practice and Council was whether an anaesthetist must be present throughout a continuous epidural anaesthetic. At the Council meeting of 22 June 1978, Dr. Sellery asked councillors to submit to him (or to Dr. Dunn, the incoming chairman of the Committee on Standards of Practice) their views on this specific question. As yet the Society had no policy on this, though Québec anaesthetists did. Caution and conservatism dictated that an anaesthetist should be present for the duration of the anaesthetic, though this caused some hardship for practitioners working alone in hospitals.

Dr. Peter Duncan, President, 1988–89.

A committee of members of the Obstetric Anaesthesia Section (Dr. Diane Bielh of Winnipeg, assisted by Drs. Richard Pahalniuk, Winnipeg, Stephen Rolbin, Toronto, and Desmond Writer, Halifax) studied this issue. Regarding the problem of 24-hour coverage, Dr. Biehl was forced to recommend "nothing less than the optimum,"[40] but a wide spectrum of opinion and practice was evident among the specialty at that time. Moreover, the Ontario College of Physicians and Surgeons had accepted the Ontario Division's recommendation that, provided certain guidelines were observed, an anaesthetist was not compelled to be present for the administration of reinforcing doses of local anaesthetic. On 2 May 1951 the Executive Committee therefore referred this matter to the Standards of Practice Committee.

The polarity of opinion remained evident. In 1981, for example, Dr. Parker held that the epidural administration of local anaesthetics was an anaesthetic procedure and should be so conducted, though others thought that "top-ups" given by "specially designated nurses" were acceptable.[41] The issue was debated at length during Council's midwinter meeting in 1982 as well. A motion by Dr. Parker and Dr. William B. MacDonald, both of Saskatoon, to the effect that where a continuous epidural service is provided a physician with anaesthetic privileges shall be in the hospital at "all times to respond to the complications" of epidural anaesthesia for obstetrics was passed, 13 votes for and 8 against, with 3 abstentions. This then became the Society's policy, at least for the time being.

Differences of opinion on the immediacy or relative immediacy of the anaesthetists responsible for epidural anaesthesia in obstetric practice were maintained over the next few years. More liberal guidelines were drawn up by the Committee on Standards of Practice for Council's opinion in 1985. Concerning the presence of the anaesthetist, these proposals recommended that an anaesthetist must be available to manage any complication that might occur.[42] However, at its meeting of 12–13 June, Council tabled a motion along these lines because the CMPA held that an anaesthetist should be present, and, besides, participation

by nurses should be permitted only if they were provided with "very specific guidelines."

Eventually, however, the careful work of Dr. Peter G. Duncan, then of Winnipeg and later of Saskatoon, the chairman of the Committee on Standards of Practice, paid off, and revised Guidelines were approved by Council at its meeting of 25–26 June 1986. Permission was given for these Guidelines to be published in the CAS *Newsletter* of September 1986.

These Guidelines were specific with respect to the management of the epidural anaesthetic. Concerning the presence of the anaesthetist, it was directed that "a physician who is capable of managing any of the complications associated with this technique, including respiratory or cardiac arrest, must be immediately available."

Even so, Dr. Richard J. Baxter of Kelowna pointed out that the phrase 'immediately available' was problematic; it was "neither clearly defined nor possible to always comply with (even in some teaching centres)."[43] The Committee on Standards of Practice continued to wrestle with the issue, concluding finally that the incidence of major complications associated with a continuous low-dose infusion of epidural analgesia was "extremely low." As a result, the committee's recommendation for a revised policy was accepted by Council in June 1991, and the new Guidelines were published as Appendix IV to the *Guidelines to the Practice of Anaesthesia*, as included in the Society's *Members' Guide* of 1991. The final version, in Dr. Baxter's words, "goes a long way in unfettering practising anaesthetists from the 'immediate availability' clause":

1 Experience since publication of the Guidelines in the September 1986 issue of the CAS Newsletter has shown that the incidence of major complications associated with continuous low-dose epidural infusion for obstetrical analgesia is extremely low.

   Consequently it is not necessary for an anaesthetist to remain physically present or immediately available during maintenance of continuous epidural analgesia provided:

   I An appropriate protocol for the management of these epidurals is in place;

   II An anaesthetist can be contacted for the purpose of advice and direction.

2 In contrast to continuous infusion epidural anaesthesia, bolus injections of local anaesthetic into the epidural space can be associated with immediate life-threatening complications. In recognition of this, the CAS recommends that:

   - When a bolus of local anaesthetic is injected into the epidural space, an anaesthetist must be available to intervene appropriately should any complications arise.
   - The intent of the phrase "available to intervene appropriately" is that individual departments of anaesthesia shall make their own determination with regard to availability and appropriateness. This determination must be made after each individual department of anaesthesia has considered the possible risks of bolus injection of a local anaesthetic and also the methods of dealing with any emergency situation that might arise from the performance of the procedure in their facility.

Although not debated at such length, guidelines on the use of narcotics administered by epidural injection also were published in the September 1986 Newsletter. Two key guidelines directed that a physician "should" be "readily available" to treat complications, and that, in case of "significant respiratory depression, normal methods of respiratory support must be instituted at once and consideration given to the use of intravenous narcotic antagonists."

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The Guidelines represent a cautious mix of conservatism and liberalism that has been formulated over the years to improve the quality of anaesthetic practice in Canada. They also represent a cautious blending of safety with flexibility, allowing for the fact that anaesthetic practice will continually develop and accepting that flexible guidelines are better than rigid rules. There is always room for further development of the Society's Guidelines, and a number of other topics that have been discussed by the Committee on Standards of Practice may well be incorporated into future editions. These include fatigue and maximum duration of periods on call, the impaired physician, quality assurance and peer review, intravenous sedation, minimum standards for continuing medical education, AIDS, and illness.

CHAPTER SIX

Standardization of Anaesthesia Equipment

In the spring of 1973 a new addition to a large hospital in northern Ontario was opened. On the ground floor within this new addition, medical gas pipeline systems were provided in an Emergency Treatment Room, and Out-patient Operating and Diagnostic Radiology rooms. In the next five months some hundreds of patients were treated, and in early September a young girl died during the attempted closed reduction of a supracondylar fracture of the humerus under general anaesthesia in one of the radiology rooms. This precipitated an investigation which subsequently involved another 22 deaths after the administration of medical gas in this area, and startling evidence was presented at the inquest into the 23 deaths that the oxygen and nitrous oxide pipeline systems within the new addition had been connected improperly to the pipeline systems in the existing building.[1]

IN commenting on this catastrophe, Dr. D.A. Pelton of Toronto wrote that "the evidence ... at the inquest made it very clear that those responsible for designing and constructing the new addition to this hospital were totally ignorant of, or had neglected to adhere to the principles of proper and safe installation of medical gas pipeline systems."[2] These mishaps were the most dramatic among catastrophes that have resulted from the failure to adhere to standards governing the use of anaesthesia equipment.

Over the years these standards have been developed, to quote Dr. G. Wyant of Saskatoon, "with the aim of arriving eventually at a point where the incidence of accidents due to mechanical failures can be greatly reduced, if not entirely eliminated."[3] Although the northern Ontario events originated in the pipeline system connected to the operating room, the goal has been to prevent flaws in all points in the system. The fundamental consideration is the provision of "absolute minimum requirements for the protection and welfare of patients."[4]

With the enthusiastic and committed support of the Canadian Anaesthetists' Society, Canadian anaesthetists have played a significant role in the development of standards governing the design and production of anaesthesia equipment. This chapter reviews the efforts of anaesthetists who have worked diligently and for the most part in relative obscurity

on developing national and international standards. These anaesthetists are the "unsung heroes" of Canadian anaesthesia.[5]

The development of standards for anaesthesia equipment has made the course of anaesthesia safer, and the work of all anaesthetists easier. In former times the anaesthetic environment was, according to Dr. I.A. Sloan of Toronto, a "morass" through which safe passage depended on much thought about, for example, the types and sizes of connectors for an endotracheal tube or a ventilator for a particular case.[6] Anaesthesia equipment completely lacked uniformity. This made life particularly difficult for anaesthetists working at more than one hospital. For example, Dr. Eric Webb of Vancouver pointed out in 1965 that it was necessary to carry much of his own equipment around with him, and a uniform and universal standard would solve these problems.[7]

Today this no longer applies; with steady progress towards uniformity of equipment through agreed standards, the "morass" has been replaced by much safer territory. The daily practice of anaesthesia in Canada and other countries is now relatively free of hazards due to problems with equipment.

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The Society's involvement in the evolution of standards began in the late 1940s. At a meeting of Council on 14 March 1948, Drs. R.A. Gordon of Toronto and Russell J. Fraser of Hamilton proposed that two official representatives of the Society be appointed to "investigate the desirability and possibility of periodic inspection of anaesthetic gas machines."

At the next meeting of Council, on 6 March 1949, a motion by Drs. Harold R. Griffith and Fraser led to the formation of a committee that on at least one occasion was referred to as a committee on standardization of anaesthetic gas machines. (See Chapter 4.) Although this committee never seems to have functioned, its objective was to develop standards for the maximum safety and proper functioning of equipment. Interest in the servicing of gas machines led to approval of a motion at the Annual General Meeting of 16 June 1949 that manufacturers be asked to catalogue replacement parts separately.

More germane to the evolution of standards of anaesthetic equipment in Canada was approval of a motion, introduced by Drs. Fraser and Gordon during the Council meeting of 26 February 1950, that the Society accept colour coding for compressed gas cylinders. Oxygen was to be indicated by green painted on the top of the cylinder to the depth of 4 inches (10 cm); nitrous oxide, dark blue (or blue-black); carbon dioxide, grey; and air, white. A copy of the motion was forwarded to the Federal Department of Health and Welfare and the Canadian Standards Association. Conformity with this practice was slow to come; at the Council meeting of 25 June 1951, Dr. Georges Cousineau (Montréal) and Dr. Gordon moved that the Secretary inform the Compressed Gas Association that some manufacturers were delivering gas cylinders, as though furtively, in "unmarked paper wrappers."

The Society's initiative was important, for it led the Food and Drug Division of the Department of National Health and Welfare to convene a meeting of "all interested parties"

on 10 January 1951.[8] Dr. Gordon was subsequently able to report that an interim legal standard would likely be adopted "in the foreseeable future." This standard became known as 24-GP-1.[9]

The universal adoption of standards of anaesthesia equipment was more difficult to attain. The International Convention of the Compressed Gas Associations had recommended an International Colour Code for the labelling of medical gases in 1951. In this respect Europe and Asia were ahead of North America. Canada, while favouring an international standard, had shown that colour-blind individuals might confuse some of the colours currently used.

Dr. Gordon, meanwhile, maintained his interest in Canadian conformity with practices in other countries. He understood the concern of the Association of Anaesthetists of Great Britain and Ireland that cylinders used by the US Armed Forces in Britain did not conform to the International Colour Code. On 4 March 1956, Council therefore directed Dr. Gordon to continue correspondence with the Department of National Health and Welfare that had earlier proved ineffective.

Dr. Gordon's role in developing an agreement on cylinder marking was most important: he kept alive the Society's interest in standards during the 1950s. He was a member of a national committee that had previously considered the problems, and represented Canadian anaesthetists when this committee was recalled under the auspices of the Canadian Government Specifications Board on 29 June 1956 and 16 November 1956. These meetings appeared to result in agreement that the standard colour code recommended by the International Standards Organization (ISO) be adopted, though with slightly different colour specifications conforming to the Canadian Paint Code and the recommendations of the National Research Council's consultants on colour vision. This standard was to be known as Canadian Government Specifications Board Code 24-GP-2, and included the pin-index system for flush-faced valves.

Despite apparent progress in the introduction of standards, obstacles remained. One was obtaining consensus on a draft code, which is necessary before a Standard can finally be introduced. With respect to colour coding of cylinders, for example, Ohio Chemical Canada Ltd., representing the Compressed Gas Association, and the Medical Branches of the Canadian Armed Forces both declined to accept the draft code. On 22 June 1958 Dr. Gordon pointed out to Council that this particular matter had by now been discussed for seven years, whereupon he was asked to "use every means within his power" to have all this finalized – but within six months.

Patience and persistence paid off. On 4 May 1959 Dr. Gordon was able to tell Council that Code 24-GP-2 had become official on 27 February 1959. The Society agreed to purchase copies of the Code for distribution to each active member.

Dr. Gordon's interest in the development of a standard for colour-marking medical gas cylinders ranks high in significance. In these early years he represented the Society in many lengthy discussions with other organizations. His election to membership in the newly formed Canadian Standards Association (CSA) in 1957 was important, for he then represented the

Dr. Roderick A. Gordon: Secretary-Treasurer, 1946–1961; Editor, 1954–1982; President, 1963–1964.

Society on committees dealing not only with the labelling of compressed gas cylinders but also with fire and explosion hazards in hospital operating rooms, and other issues.[10] For example, labelling of ampuls had presented a long-time problem since paper labels came off during sterilization. As the Society's Secretary, Dr. Gordon's representations to the Food and Drug Division of the Department of National Health and Welfare contributed to the replacement of paper labels by ceramic ("fast") printing on ampuls. In the 1950s, and many times in later years, Dr. Gordon acted as the Society's agent and beneficially influenced necessary regulations.

The Society, the Canadian Standards Association and the International Standards Association

The Society's official role in the development of standards for anaesthesia equipment in Canada began with Dr. Gordon's membership in the Canadian Standards Association. On 6 February 1961, Council approved a motion by Dr. Gordon and seconded by Dr. James M. Shapley of Toronto (also a Society delegate to CSA committees in due course) that the CSA be asked to set up a committee on the standardization of anaesthetic equipment in Canada. The time was ripe, not only for Canada but for many other countries. The Second World Congress had taken place in Toronto in September 1960, and there were then enough national standards organizations to make an impact on standardization in Canada as well as internationally.

Dr. G.M. Wyant, President, 1971–72, and a force in the development of standards for anaesthetic equipment, both in Canada and at the international level.

The CSA approved the formation of a committee on standardization of anaesthetic equipment on 23 August 1962.[11] Dr. Wyant was named chairman. For many years he also led a Canadian delegation to meetings of the International Standards Association (ISO) and chaired its committee on nomenclature. This "distinguished and erudite anaesthetist,"[12] who was the author of the standard work, *Mechanical Misadventures in Anaesthesia*,[13] made many contributions to the development of standards in Canada and internationally. The CSA recognized his contributions with an Award of Merit in 1980.[14]

The first meeting of the CSA committee took place on 14 May 1963, during the Society's annual meeting, thus setting a precedent for the close relationship between the Canadian Anaesthetists' Society and the CSA that would fruit each annual meeting. Many members of the Canadian Anaesthetists' Society were members of this original CSA committee: Drs. A. Drysdale of Halifax, E.A. Gain of Edmonton, R.A. Gordon of Toronto, A. Jacques of Québec, A.B. Noble of Montréal, H.T. Norry of London, S.L. Vandewater of Kingston, and E. Webb of Vancouver. Drs. T.J. McCaughey and M. Minuck, both of Winnipeg, attended as Visitors, while Drs. N.H. McNally and L.H. Edwards, Armed Forces anaesthetists, also attended. This distinguished group of Canadian anaesthetists, and their successors, shared their views and expertise with the representatives of the industry on the committee: J.K. Colwill, Ohio Chemical Canada Ltd.; C. Hoover, Medical and Industrial Equipment (Canada); E.R. Savidge, Canadian Oxygen Limited; and F. Sweatman, Canan Surgical Services Limited. J. Wordsworth, Canadian Oxygen Limited, and V. Schlitzer, Ohio

Chemical Company, attended as visitors, while K.O.J. Sidwell represented the CSA.

The minutes of this first meeting of the CSA Committee, some of which are reproduced here *verbatim*, give a fine sense of these original discussions.

- Dr. Wyant said that the Committee on Anaesthesia Equipment was established to prepare Canadian standards for anaesthesia equipment and to attempt to provide international standardization in the field of anaesthesia equipment.

- Mr. Sidwell briefly explained the structure of the CSA organization and the method by which proposed standards are processed through the Specifications Committee, the Sectional Committee and the Technical Council ... subsequent revisions to any published standard would be processed in the same way as the original standard.

- Mr. Sidwell stated that if the Committee wished to establish a subcommittee it would be setting a precedent ... and that many of the CSA committees establish such committees either to draft a proposed standard or to draft a particular section of a proposed standard.

- *Existing Standards on Anaesthesia Equipment*
  Dr. Wyant stated that the following two ASA standards had been adopted by the American Society of Anesthesiologists:
  1) Z79.1 – 1960 Endotracheal Tubes
  2) Z79.2 - 1961 Endotracheal Tube Connectors and Adaptors.
  Dr. Wyant further stated that the British Standard BS3487 Endotracheal Tubes was also available.

- *Endotracheal tubes*
  Dr. Wyant then suggested that the Committee would accept either the American or the British standards, and that the Committee should now discuss which of these standards is more acceptable to Canadian users.
  Dr. Webb suggested that since Canada is closer to American manufacturers of anaesthetic equipment it would be better for Canadian anaesthetists to support the adoption of American standards on endotracheal tubes.
  Mr. Savidge stated that he thought the opposite was true saying that he believed that most endotracheal tubes were manufactured in England.
  Dr. Wyant stated that there was a minor difference in tolerance between the American and British tubes and he felt that this was the only essential difference between the American and British standards.
  Mr. Sweatman asked if the German endotracheal tubes were similar either to the American or British tubes.
  Dr. Wyant stated that he felt that European tubes would be approximately the same regardless of whether they were Dutch, German or French make.
  MOTION (Drs. Gordon and Webb): that the CSA Committee on Anaesthetic Equipment adopt the British Standard BS3487-1962 as a Canadian standard.

– *Endotracheal-tube connectors and adaptors*

Dr. Gordon suggested that the American connectors were not generally acceptable.

Dr. Wyant said that the British connector used a metal to rubber connection while the American connector used a metal to metal connection.

Mr. Savidge said that he thought that most Canadian anaesthetists preferred a flexible connection.

Dr. Wyant said that there was no British standard on endotracheal tube connectors.

Dr. Gordon suggested perhaps the Canadian and British anaesthetists and anaesthesia equipment manufacturers could work together in the preparation of a standard which would be acceptable to both British and Canadian anaesthetists.

Dr. Minuck said that it would be more practicable to adopt American standards.

Dr. Gordon suggested that most Canadian anaesthetists would use American connectors.

Dr. Gain stated that he never used anything but American connectors.

Dr. Noble said that he used 15 mm (American Connectors).

Dr. Gordon said that he was concerned concerning the angle of curvature of the American connector and stated that as far he was concerned that the British connector was far more suitable than the American type.

Dr. Wyant suggested that since there appeared to be diverse opinions on endotracheal tube connectors ... the discussion for final adoption of the connector be deferred until the next meeting.

The "diverse opinions" continued to present the principal obstacle in many discussions of standards, both in Canadian and international forums. Dr. Wyant worked long and hard on developing international standards, and his name became synonymous with their development. It was he who recommended to the CSA committee at this first meeting that the ISO be approached to survey member nations regarding the need for international standardization. Mr. Sidwell explained how this would be done and indicated that if the ISO decided to establish a Technical Committee (TC) Canada might be asked to accept the Secretariat. Thus Canadian anaesthetists from Drs. Gordon and Wyant onwards came to assume a leading role in the development of international standards. The keyed filling device for volatile anaesthetic agents was of Canadian origin, for it was invented and patented by Fraser Sweatman, who donated it to Canada.[15]

Over the years a group of Canadian anaesthetists worked on standards under the auspices of the CSA, and with anaesthetists and others representing many different countries. Their work brought a new technological dimension to anaesthesia, one that members of the Canadian Anaesthetists' Society did much to advance.

The introduction of standards was vital to the safe care of anaesthetized patients. Unfortunately, the importance of such standards was sometimes only understood after disaster struck, as with the northern Ontario catastrophe, which could have been prevented if knowledge available in Canada had been tapped.[16]

The standards enabled anaesthetists to give safer anaesthesia. Numerous problems were solved over the years, although even an apparently straightforward one, such as the position

of the oxygen flow control knob on the right-hand side of the flow meter bank ("oxygen is right"), required a long time for agreement to be reached.

As well as Drs. Gordon and Wyant, a number of other Canadian anaesthetists have played key roles in the development of these standards. Society delegates to the CSA Health Care Technology Steering Committee (with their particular interest noted in parentheses) have included the following:

J.J. Benoit (anaesthesia equipment and respiratory technology)
A.W. Conn (Chairman, Respiratory Technology TC)
D.B. Craig
W. de Majo (respiratory therapy)
A.A. Drysdale
A. Dunn (breathing systems)
G. Edwards
L. Fournier
E. Gain
S. Galloon (anaesthesia equipment)
F. Haley (anaesthesia equipment)
A. Jacques
L. Longtin
J. McIntyre (oxygen analyzers)
I. MacKay
T.J. McCaughey (paediatric equipment)
H.T. Norry
J. Oulton
A. Pace-Floridia (oxygen analyzers)
D.A. Pelton (Chairman, Medical Gas Systems TC)
D. Reimer (anaesthesia equipment)
A.A. Scott (anaesthesia equipment and respiratory technology)
G. Sellery
J.M. Shapley (explosions, health facilities)
A. Sheridan
R.E. Simpson
I.A. Sloan (Chairman, Anaesthetic Equipment TC)
S.L. Vandewater
G. Van Vliet
E. Webb

Some of these individuals also contributed to standardization of equipment on an international level. When the ISO set up its Committee on Anaesthetic Equipment (TC/121) in 1965, Canada was represented initially by Drs. Wyant, Gordon and Sloan, and Messrs. C. Hoover and J.D. Wordsworth. Not surprisingly, consensus was even more difficult to reach in this international forum than in Canada. Of the first meeting of TC/121, held

TABLE 6.1
Canadian Standards for Anaesthetic Equipment

Z32.1 M1986	Safety in Anaesthetizing Locations (withdrawn)
Z32.2 M1989	
Z32.4 M1986	
CAN3-Z168.1 M83	Tracheal Tubes
CAN3-Z168.2 M82	Tracheal Tube Connectors
CAN3-Z168.3 M84	Continuous-flow Inhalation Anaesthetic Apparatus (Anaesthetic Machines) for Medical Use
Z168.351 Supplement No. 1-1992 CAN3-Z168.3	Continuous-flow Inhalation Anaesthetic Apparatus (Anaesthetic Machines) for Medical Use
CAN3-Z168.4 M83	Keyed Filling Devices for Anaesthetic Vaporizers
CAN3-Z168.5 M78	Lung Ventilators (a:1)
CAN/CSA-Z168.5.1 M87	Anaesthesia Ventilators
CAN3-Z168.5.2 M1991	
tZ168.5.2	Critical Care Ventilators
Z168.5.3	Neonatal Ventilators
Z168.5.4	Home Care Ventilators
CAN/CSA-Z168.6 M89	Oxygen Analyzers
CAN3-ZX168.6 M81	Oxygen Analyzers
CAN3-Z168.7 M83	Resuscitators
CAN-Z168.8 M82	Anaesthetic Gas Scavenging Systems
CAN/CSA-Z168.9 M86	Breathing Systems for Use in Anaesthesia
CAN/CSA-Z168.9 M92	Breathing Systems for Use in Anaesthesia
pZ168.10 M1988	Testing of Breathing Gas Interruption Monitors for Use During Anaesthesia
Z168.11	Suction Devices (New Standard under Preparation)
Z168.12	Monitors (New Standard under Preparation)
Z305.1 M1984	Nonflammable Medical Gas Piping Systems
Z303.2.1 M83	Low Pressure Connecting Assemblies for Respiratory Systems
Z305.1 M1992	Nonflammable Medical Gas Piping Systems
CAN/CSA-Z305.2 M88	Low Pressure Connecting Assemblies for Medical Gas Systems
CAN/CSA-Z305.3 M87	Pressure Regulators, Gauges and Flow Metering Devices for Medical Gases
CAN3-Z305.4 M85	Qualification Requirements for Agencies Testing Non-flammable Medical Gas Piping Systems
CAN/CSA-Z305.5 M86	Medical Gas Terminal Units
Z305.6	Oxygen Concentrators (New Standard in Preparation)

in London, England on 16–18 October 1967, Dr. Wyant reported that "it soon became evident that there were many differences of opinion and that only limited agreements could be achieved in such a large meeting."[17]

The Canadian delegation often served as mediators. As Dr. Wyant also noted of the initial work on endotracheal tubes and breathing bags (Study Group 2), "where disagreements existed, frequently the draft proposal of the Canadian Standard for Anaesthetic Tubes (CSA Standard Z168.1, revised 1967) was accepted as a suitable solution by the study group."[18] Because representation on the ISO by the United Kingdom and the United States delegates was so numerous, Canadian representation was important, not only in overcoming problems caused by differences in national usage and prejudice but also in safeguarding Canadian interests. Progress was slow, but in due course international agreement was reached on a number of standards.

Over the years standards have been introduced that govern the design of every piece of equipment that anaesthetists use. Table 6.1, which provides a list of the Canadian standards that have been developed and published, gives no indication of the enormous amount of work that has gone into the development of these standards, which the Canadian Anaesthetists' Society has done much to foster. Yet the significance of this work is still rarely understood or appreciated by most Canadian anaesthetists, even though it has greatly facilitated the daily practice of anaesthesia.

CHAPTER SEVEN

The Society and Research in Anaesthesia

ONE of the Objects for the Society set by the Founders was "to advance the art and science of anaesthesia." The *art* was advanced by the Society's efforts to encourage excellence in clinical practice and education in anaesthesia, but the *science*, until the latter 1980s, was less energetically pursued. Although a Committee on Clinical Research had been formed in 1947 (see Chapter 4), the committee never pursued its objective of fostering clinical research.

The next step was not taken by the Society but by British Oxygen (Canada) Limited, which granted funds in 1960 that eventually were used to establish the Canadian Anaesthetists' Society Prize (see Chapter 4). Another step was taken in 1967, when the Society initiated the Residents' Program and Competition. This, too, was funded by a commercial firm, Ayerst Laboratories (see Chapters 9 and 12).

Not until 1978 did the Society itself formally agree to support anaesthesia research in Canada, and a further seven years elapsed before funding of the Canadian Anaesthetists' Society Research Award began in 1985. Since then, several other research awards have been introduced under the auspices of the Society. Except for the R.A. Gordon Clinical Research Award, they have all been funded through the generosity of commercial companies.

This brief account of the Society's involvement in anaesthesia research is divided into three parts: 1947 to 1975, 1976 to 1985, and 1986 to 1992.

1947 to 1975: Development of an Interest in Research

On 3 March 1946 Council approved a motion by Dr. R.A. Gordon of Toronto and Dr. William Cody of Hamilton that a grant to support investigation be requested from the National Research Council. Nothing appeared to come of this request, and on 15 October 1946 Dr. Beverley C. Leech of Regina proposed that the Society strike a committee to foster research. With an established reputation in clinical research,[1] Dr. Leech recognized the need "to define problems for clinical investigation in anaesthesia, and to collect and correlate the

findings of members of the Society in these investigations." Although a committee was formed after Council had given its approval on 9 March 1947, it seems not to have taken any action to encourage clinical research in anaesthesia.

The idea of awarding a prize to encourage research was mooted in 1954, when Dr. Gordon suggested using the Society's funds for this purpose. The funds were eventually made available by British Oxygen Company (Canada) Limited, which contributed $1,000.00.[2] The company agreed that this might be used to fund a prize, which led to what became known as the Canadian Anaesthetists' Society Prize. Publication of the research results in the *Canadian Anaesthetists' Society Journal* indirectly stimulated research.

Since entries were not always of sufficiently high calibre, the Prize was not awarded every year: no awards were made in 1962 or in 1964. During the midwinter meeting of 1965, Council discussed the lack of research in Canada. Two years later Dr. Gordon reminded Council that the original purpose of the Prize was to stimulate research in anaesthesia *in Canada*, and the terms of reference were refined to clarify eligibility.

The Residents' Competition provided another stimulus to research. Introduced in 1967, the competition became a regular event at the Annual Meeting. It has encouraged residents to undertake research projects and, more importantly, planted the seed of research consciousness in their minds. The competition was generously supported by Ayerst Laboratories from 1967 to 1974, and by Astra Pharmaceuticals from 1975 to the present.

One of the participants in the 1967 Residents' Program was Dr. Gordon R. Sellery of London. His paper, entitled "A Review of the Causes of Post-Operative Hypoxia," won second prize, and it was he who became the catalyst whereby the Society finally came to fund research in Canada.

1976 to 1984: Initiatives of Individuals

A brief from the Saskatchewan Medical Association Section of Anaesthesia to the province's Advisory Committee on Medical Care noted that "the history of medicine, and particularly the history of Anaesthesia, is a combination of the life stories of a series of individualists. Every advance has been due to the unhampered action of an individual acting on his individual ideas."[3] Regarding the Society's involvement in research, this observation applies to few members as well as to Dr. Sellery, who convinced the Society to commit itself to anaesthesia research in Canada, and who developed the instrument by which funds for research were accumulated.

Having successfully competed in the Residents' Program in 1967, Dr. Sellery wished to encourage others to develop an interest in research, and to persuade the Society to raise money to support research. The former was not a difficult task; the latter seemed impossible. The Society was a group of working clinical anaesthetists, for whom supporting research was not a priority. For only a minority of Canadian anaesthetists was research, or support of research, of particular importance even though, as Dr. R.L. Knill of London, himself an active researcher, reminded the Society in 1992, "there can be no doubt that anaesthesia

The first Residents' Program and Competition was held in 1976. Judging the competition was Dr. Harry Churchill-Davidson, from London, England. The winners were ... (from left to right) Drs. Dale Zoerb (3rd), Gordon Sellery (2nd) and Marcos Viguera (1st).

research has been an instrument for beneficial change in the care of patients."[4]

Dr. Sellery proposed the establishment of a Research Fund. The Finance Committee accepted this and suggested a $1 million target to Council on 26 June 1976, to be reached by donations in a fund-raising campaign. The Research Fund developed slowly, but on 16 June 1979 Dr. Sellery, then the Society's Honorary Treasurer, was able to announce that the Canadian Anaesthetists' Society Research Fund had just been approved by Revenue Canada. Tax-deductible donations could be accepted "from now on."

The activities of the Research Fund were guided by three Trustees, Drs. Germaine Houle, Montréal, and Arthur J. Dunn, Toronto, as well as Dr. Sellery. They took note especially of three clauses in the Trust Document:

III Purpose for which established:
The C.A.S. Research Fund will be a vehicle to collect money from donations from bequests in order to support a Canadian (citizen or landed immigrant) who will carry out research in the field of Anaesthesia in a Canadian centre.

IV The administration of all monies received by the trust:
The money accumulated will be invested as the treasurer of the C.A.S. sees fit and will be used to award a grant and the interest earned will be used to award a grant to the most deserving applicant. The recipient of the grant will be chosen by a committee to be composed of the following:
1 The chair of the Scientific Affairs Committee C.A.S.
2 The chair of the Education Committee C.A.S.
3 The editor of the C.A.S. Journal
4 The president of the C.A.S.
5 The chairman of the A.C.U.D.A.

V The trustees agree that all monies received will be expended only for the purposes outlined above.[5]

Dr. David Mazer (centre) recipient of the David Sheridan Research Award in 1987, with Dr. David Skene (President, 1987–88) (left) and Mr. David Sheridan.

Once the Research Fund had been legally constituted, the task was to raise money over the next five years. The main consideration was that, at the end of the five-year fund-raising period, there should be sufficient money to award 80% of the Fund's donations yearly.[6] However, money was slow in coming. During the February 1983 Council meeting, the committee reported that only $31,347 had been contributed, which confirmed that support of research was not a high priority on the part of the Society or its members. Dr. Douglas B. Craig of Winnipeg did not wish the Society to be excused; he described the lack of response as "an atrocious commentary" on the Society, which, he emphasized, had a significant interest in research.

If Dr. Sellery was the prime mover in the struggle to build up funds for research, Dr. Craig was second. Like Dr. Sellery, Dr. Craig has his own ideas, which he customarily expressed in forthright terms. Moreover, he was interested in fund-raising and his research credentials were impeccable. He could also speak from a position of strength as editor of the Society's Journal, and his opinions on research and fund-raising made an impact on Council more than once. The presence on Council of academic anaesthetists with a strong interest in research – individuals like Dr. Sellery, Dr. Craig and Dr. Peter G. Duncan of Winnipeg and later Saskatoon – was important in reminding Council that research provided the basis for safe and sound anaesthesia. The Association of Canadian University Departments of Anaesthesia (ACUDA), whose reason for being was in part to stimulate research (see Appendix 8), had endorsed the Research Award project and encouraged the view that the Society should demonstrate to others in the scientific community that it was supporting research and promoting excellence in anaesthesia.

It therefore became necessary to intensify ways of building up the Research Fund. A compulsory donation from each of the Society's members was not favoured, even though Dr. Sellery's limited goal of $250,000[7] clearly would not be met by 1984, when the five-year period would end. Dr. Craig thought that the original goal of 1 million dollars should be

maintained as the target.[8] Dr. Sellery therefore requested, and was granted by Revenue Canada, an extension of the build-up period to 31 June 1985. He also proposed that the Research Award should be valued at $20,000, assuming that $12,000 to $14,000 could be obtained as interest on capital, plus donations and grants of $4,000 each from the Society's funds and the Journal account.[9]

Even though some councillors still expressed concern, a turning-point was now reached. A motion of Drs. Donald V. Catton of Hamilton and Terence Queree of Port Coquitlam that the Society and the Journal support the Research Award by each contributing up to $4,000 yearly was passed by the Executive Committee on 23 June 1984. At its meeting of 27–28 June 1984, Council approved a request by Drs. Sellery and Craig along the same lines, approved the formation of a new Advisory Committee to study the utilization of monies in the Research Fund, and took the historic step of establishing the Canadian Anaesthetists' Society Research Award.

1985 to 1992: The Expansion of Support for Research

The establishment of the Canadian Anaesthetists' Society Research Award was a milestone, though more in the history of Canadian anaesthesia than the history of the Society, whose interest in research seemed to be more honoured in the breach than the observance. It was a milestone, too, in the campaign to raise funds for the Research Fund. As noted by Dr. David R. Bevan of Montréal and later Vancouver, and Dr. Craig, "since the announcement that the first Research Award would be granted in 1985 and the publishing of the call for proposals, interest in the Research Fund blossomed."[10] The monies held in trust soon doubled. Members of the Society contributed more liberally; the Divisions of Ontario (twice), Newfoundland, Manitoba, Saskatchewan and Alberta made special contributions, and in 1985 the number of corporate donors increased from 3 to 17. In addition, at the 1985 annual meeting the International Anesthesia Research Society (IARS) generously donated $5,000 in recognition of past and current participation by members of the Canadian Anaesthetists' Society in IARS activities.

In 1985 the only research award was the Canadian Anaesthetists' Society Research Award. The balance of the Fund was by now respectable, although it was still necessary to attain the sum of $200,000 in order that an award of $20,000 be made annually solely on the investment income. More needed to be done to raise money.

From this point on, money appeared to come, manna-like. The first manifestation was an award made possible through the unsolicited generosity of Mr. David Sheridan, the equipment manufacturer, in honour of his wife, who had been born in Saskatchewan. He donated stock worth $100,000 to establish the David S. Sheridan Canadian Research Award, which is worth $10,000 in 1993. This was first awarded in 1987. The I.C.I. Pharma Research Award in Anaesthesia followed in 1988; like the Sheridan award, this came to the Society without being solicited and is worth up to $5,000 in 1993. Both awards enable an active member of the Canadian Anaesthetists' Society to conduct anaesthesia-related research in

A treasured moment for Dr. Rod Gordon as he receives a certificate of appreciation for his service to the Society and special recognition of his personal association with the R.A. Gordon Clinical Research Award, presented first in 1993. Dr. Gordon with Dr. Desmond Writer (President, 1989–90) in Vancouver, June 1990.

Canada. The next award was the Dr. Paul Janssen Canadian Research Fellowship Award in Anaesthesia. Introduced in 1989 and worth $40,000 in 1993, this award will provide a recent graduate in anaesthesia with funds to conduct research in anaesthesia.

The pharmaceutical industry's generous support of research has done much to strengthen a hitherto undeveloped area of anaesthesia. However, support for research in anaesthesia remains essential, for the lack of research will ultimately affect clinical practice. It has already been suggested that scientific research conducted by most anaesthetists has failed to keep up with the high standards of medical research in other fields, such that anaesthesia is in danger of seeing the rest of the academic world pass it by.[11]

The inauguration of three further awards is therefore a source of great satisfaction. The first of these is the R.A. Gordon Clinical Research Award. Plans for this were announced in 1987, and the first will be made during the Society's 50th anniversary meeting in Halifax in June 1993. This Award will enable a Canadian investigator to pursue a career in research and will honour a man who is more intimately associated with the Society than any other. The other two awards will be named the Burroughs Wellcome Award and the Syntex Award, after the sponsoring pharmaceutical companies.

The latter half of the 1980s evidently witnessed the recognition of the importance not only of research, but also its funding. Drs. Bevan and Craig have noted that there are very few career investigators and researchers in training because restrictions of funding for research projects limit investigation in Canada.[12] Furthermore, as Dr. Knill has observed, "perceptions of serious weaknesses in the innovativeness, significance and competitiveness of today's anaesthesia research ... indicate shortcomings which cannot be ignored."[13] The Society must therefore maintain its interest in supporting research, even though financial constraints will make liberal support difficult.

CHAPTER EIGHT

Training and Continuing Education in Anaesthesia

> It is true for Anesthesiology as for any other profession that *service* must be leavened with progressive thought.
>
> *W.T. Salter*[1]

THE educational aspect of the Society's endeavour to advance the art and science of anaesthesia was stressed in the Letters Patent of 1943. Like other activities in the Society's early years, this was slow to develop and attain momentum, but partly because other concerns predominated, particularly economic and political. Dr. Max Minuck of Winnipeg put it well in 1969: "we have, in the past, devoted so much time to the discussion of financial matters, health plans, fee schedules and economic policies that there was little time left to discuss problems relating to education in its broadest sense."[2] Dr. Ray L. Matthews of Toronto and then Kingston, the energetic chairman of the Education Committee from 1971 to 1978, said much the same thing in 1971 – that education was "an area which has been somewhat overlooked and neglected in the past."[3] This attitude, however, was not confined to anaesthetists; Dr. Matthews said the approach to continuing education in many specialties, including anaesthesia, had been "rather casual." This would have to change, for better patient care depended on anaesthetists' being informed of advances in their field.

The Executive Committee asked the Education Committee in 1972 to address a pertinent question about the Society and education in anaesthesia: "What is the educational role of the C.A.S., to whom should education be directed and by what means?"[4] The committee identified four aspects of this role: the continuing education of specialists; the education and continuing education of nonspecialist anaesthetists; the attraction of undergraduates into the specialty; and the education of the public as to the role of the anaesthetist on the health care team. This was consistent with the educational objects set in 1943.

There was no mention of the training of residents and the processes whereby they were

examined and certified as specialists, nor of the complementary roles played by other organizations, particularly The Royal College of Physicians and Surgeons of Canada, its specialty committee on anaesthesia, the Association of Canadian University Departments of Anaesthesia (ACUDA), and continuing medical education agencies in universities.

Three points should be made at the outset. First, though the Society has done much on its own, its work has been facilitated by, and often been made possible only through the activities of, other agencies involved in training and education in health care. Second, while the Society has been concerned primarily with the continuing education of the specialists, it has also been concerned with the training and education of a variety of members of the health care team. These include family practitioner anaesthetists, whose training is discussed in this chapter, and respiratory technologists and anaesthesia technicians (Chapter 11). And, third, with respect to the Society itself, the educational role has been discharged not by the "Society" as an organization but by those members, interested in training and education in anaesthesia, who have understood the importance of leavening service with "progressive thought."

In this chapter training and education of anaesthetists will be discussed in two parts: first, the specialist anaesthetist, and then the family practitioner anaesthetist.

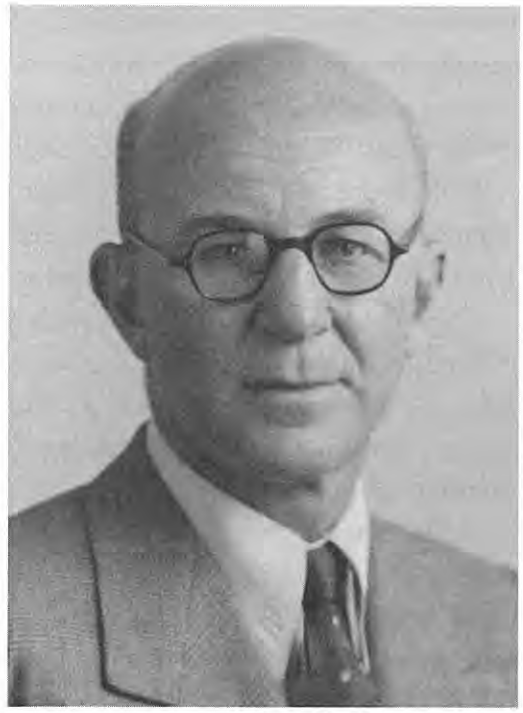
Training and Education of the Specialist Anaesthetist

The evolution of the Society's role in training and education may be followed by examining five phases of the period since 1943: 1943 to 1957; 1958 to 1962; 1963 to 1971; 1972 to 1980; and 1981 to 1992.

1943 TO 1957: TRAINING OF SPECIALISTS AND APPROVAL OF HOSPITALS

Before the Second World War, physicians interested in specializing in anaesthesia would learn appropriate skills by spending a year in an institution known for excellence in anaesthesia. Formal residency programs in anaesthesia did not exist, and in the United States a program that Dr. R.M. Waters started at the University of Wisconsin in Madison was the first of few. In Canada, the need for residency instruction became evident during the war, when the beneficial results of short courses in Montréal for doctors in the armed forces conducted by Drs. Wesley Bourne, Harold Griffith and Digby Leigh became apparent. Thus when the independent department of anaesthesia at McGill was established in 1945, some expertise in the training of residents already existed. The McGill department was the first in Canada, to be followed by the Universities of Laval, Toronto, Western Ontario and Montréal shortly thereafter.

The need for formal training of specialist anaesthetists, and the interests of the Society in this regard, were determined in this period by two developments in particular. First, The Royal College of Physicians and Surgeons of Canada approved anaesthesia as a specialty, and certification in anaesthesia, in 1942. Certification in anaesthesia was at first permitted under a "grandfather" clause without examination, but as of 1947 specialty certification could be



Two great anaesthetists, one from the United States and one from England, represent the influence of these two countries on Canadian anaesthesia. Dr. Ralph M. Waters of Madison, Wisconsin (left), introduced residency training into anaesthesia, while Dr. (later, Sir) Robert R. Macintosh stressed the elements of simplicity and safety. Dr. Waters befriended and encouraged Dr. Harold Griffith in his early years; Dr. Macintosh inscribed his photograph "To Wesley (Bourne), with affection and in admiration."

obtained only by passing the Royal College examination.

The second development was the return from wartime activity of a large number of trained and semi-trained anaesthetists who sought work as anaesthetists back at home. With demobilization in 1945 and 1946, it became necessary for the Society to monitor the situation. The formation of a committee on postgraduate education in 1947 enabled the Society to consider how all the returning physicians and Canadian hospitals might best be matched (see Chapter 4).

In Dr. Harold Griffith's presidential report of 1946, he addressed this problem.[5] Over 400 hospitals had been contacted by the Society, which advised them of an opportunity for hospital administrators and boards to improve their anaesthesia departments by appointing trained and experienced ex-Service anaesthetists. The Society's initiative was not only directed towards the assurance of good anaesthesia care; it provided an opportunity to emphasize "a policy regarding remuneration and the importance of proper training." It was, Dr. Griffith explained, "part of our general educational campaign regarding the status of modern anaesthesiology."

Dr. Griffith knew that "if anaesthesia (were) to progress in Canada properly organized training courses must be arranged in various centres of the Dominion." Much of the first

Education Committee's time was spent in determining the nature of training in hospitals and ensuring that these hospitals were indeed approved as training centres. In the latter 1940s and in the 1950s there were few university departments – the great increase came in the 1960s, when Sherbrooke, McMaster, Calgary and Memorial rapidly increased the number of such departments – and it was all too easy for a physician seeking to fulfil the time requirements of the Royal College's criteria for admission to the certification examination, to migrate from one peripheral hospital to another without coordinated training.

For their part, many hospitals made the most of this and were glad to have extra pairs of hands to do the service work that was required. Not until 1975 did all hospitals' training programs require affiliation with universities in order to gain Royal College approval.[6] Therefore in the 1950s and 1960s the Society's role was largely that of monitoring the suitability of training hospitals across the country.

Dr. Bourne, then chairman of the Royal College's Committee on Certification in Anaesthesia, summarized the Society's role vis-a-vis approval of hospitals: "With regard to approval of hospitals for training in Specialties ... any one hospital must be organized to give training in the Specialty ... (the) ... Committee (will) be asked to study and respectively report what is thought should be the Standards for the hospital to be approved for post-graduate training in the specialty."[7]

With the introduction of the Certification examination by the Royal College, the Society had to fulfil another monitoring role. The Royal College's Certification Committee, in evaluating the credentials of applicants for the examination, found that they were lacking in some respects and so rejected a number of them. The Society's Council discussed this situation on 3 March 1946 and concluded that "particularly some who have a long service in the armed forces ... (could be regarded as) properly qualified as specialists in anaesthesia." Dr. Bourne was directed to discuss the apparently justified applications with the Certification Committee, while Dr. Griffith, then the Society's President, agreed to discuss the situation with Dr. F.S. Patch, Chairman of the Royal College's Certification Committee.

The actions of Drs. Bourne and Griffith in the spring of 1946 were significant, for they marked the need for the Society to serve the interests of its members in relation to those of the Royal College. They also represented initial steps in forging a mutually satisfactory relationship between the Society and the Royal College. This relationship, with respect to both training of specialists and the continuing education of certified specialists, would become increasingly important as the years passed, and it is well that a satisfactory basis of this relationship was established in these early years. The value of this relationship was indicated on 16 June 1949 by Dr. Beverley C. Leech of Regina in his presidential report:

> During this first period in the history of the Society the problem of Certification in the Specialty of Anaesthesia by The Royal College of Physicians and Surgeons of Canada assumed an important place in its activities. The C.A.S. was recognized by the College as a National organization representing the views of the anaesthetists, and so was consulted and continued to be consulted in many matters relating to

certification and standards of qualification in the Specialty. In 1947 the Society applied to The Royal College of Physicians and Surgeons for recognition of Anaesthesia as a Specialty in which the Fellowship of the College might be obtained under the division of Surgery. This application has been renewed during this year, and we are hopeful that a favourable reply will be received from the College.

A favourable reply was received, although it was not until 1951 that the Fellowship in Medicine modified for Anaesthesia was introduced. There would now be two examinations and two levels of qualifications in anaesthesia. This "dual standard," and changes that the Royal College was considering in its training requirements and examination process,[8] led the Canadian Anaesthetists' Society to look more closely at training and examinations. This initiated the next phase of its educational role.

1957 TO 1963: REVISION OF TRAINING REQUIREMENTS AND SPECIALIST EXAMINATIONS

In the 1950s, those members of the Canadian Anaesthetists' Society who taught residents and examined candidates for Royal College Fellowship and Certification began to realize that the training requirements and examinations in anaesthesia of the Royal College were "inadequate in some respects and quite incorrect in others."[9] One had only to consider the pass rate for the Fellowship examination to realize that something was wrong. In 1942 the pass rate for all specialties had been 60% and in 1943 and 1944 even 100%, but by 1956 it had fallen to 37%.[10] Part of the problem was that the Royal College still envisaged its examinations as being primarily either medical or surgical in content, while the Society held that examinations should apply more specifically to the specialty of anaesthesia.[11]

In 1957, the Society struck a Special Committee on Examinations to study the problem and make recommendations for improvement (see also Chapter 4). Dr. Edward A. Gain of Edmonton was appointed chairman; the members were Drs. H.B. Graves (Vancouver), Stanley M. Campbell (Toronto) and Georges Cousineau (Montréal).

The Special Committee made a number of recommendations.[12] One concerned the time spent in medicine and surgery during the training period for the Fellowship examination. Another concerned the shorter period of training in clinical anaesthesia for the Certification as opposed to the Fellowship. But more important, and unanimously agreed on, was the conclusion that the Fellowship examination failed in its purpose because it was primarily an examination in Medicine and Pathology, with little emphasis on anaesthesia. The examination was a higher degree in medicine rather than in anaesthesia. The central problem was this: "the Internist and Pathologist dominated the examination with the result that little was ever learned of the candidate's knowledge of anaesthesia." What was needed was an anaesthetist as the senior examiner, and pathology replaced with physiology or pharmacology, or both.

In part, the stimulus to the Gain Committee's study was the Royal College's own uncertainty about specialty training and examinations. From 1953 to 1958 no fewer than

four committees studied the thorny issue that the dual standard imposed by having two examinations.[13] The final committee dealing with this problem was the Botterell Committee. Its report, which included a recommendation that the Certification examination be abolished, was approved by the Royal College Council in the fall of 1958. In May 1959 the Society's Special Committee was therefore asked by Council to study the Botterell Report and make appropriate recommendations.

The Gain Committee made its recommendations in a report to Council at the midwinter meeting in February 1960. These recommendations were based on correspondence with a cross-section of anaesthetists in the various regions of Canada. Two important questions had to be answered. First, should the training requirements for the Certification examination be made the same as those for the Fellowship? On this there was a surprising amount of agreement. However, the abolition of the lower level qualifications – the Certification – seemed to be inevitable because the Royal College had adopted the Botterell Report and anaesthetists reacted accordingly; besides, the "dual standard" of qualifications in Canadian anaesthesia seemed inherently bad.

The second question was this: could future needs for specialist anaesthetists be met by imposing only the Fellowship standards? On this there was much less agreement. The committee identified two "completely opposite" opinions, which reflected town-versus-gown perceptions of anaesthesia needs in Canada. University anaesthetists believed that if there were a demand for specialist anaesthetists, there would be no shortage of trainees; non-university anaesthetists believed that, as the needs in their areas would not be met if the Fellowship standard only were to be adopted, there would still be reason to preserve two standards of qualifications.

The committee endeavoured to be realistic. The principal recommendations were as follows:

1 the training requirements for Certification should be raised to those of the Fellowship examination commencing in 1961;
2 the Certification examination should be abolished after 1965;
3 the number of residents taking training should be reviewed before 1965, in order to determine the effect of the changes in the training requirements; and
4 the Fellowship examination should be made a more realistic examination.

The last recommendation was consonant with the conclusion that the committee had reached earlier concerning the omission of pathology as a separate subject in the Fellowship examination and the greater emphasis on physiology and pharmacology. In fact, in January 1960 the Royal College had accepted the Society's request that the Fellowship examination in Medicine modified for Anaesthesia be revised in accordance with the Gain Committee's recommendations of 1958. There would be three papers in the written examination, the former paper on pathology and bacteriology being dropped in favour of a more balanced examination in the basic sciences as applicable to anaesthesia.

This may all seem like a storm in a teacup in view of the standards of training and

examination results that have since been attained. But in the 1940s, 1950s and 1960s opinions regarding the dual standard were polarized among those Fellows of the Royal College who wished the college to be a small, elite academic group and those who favoured admission of all specialists. Fortunately, there were some Fellows who realized that, as Dr. R.I. Harris put it in 1953, "in certain fields of medicine the program of Certification is useless, futile and detrimental,"[14] for it set a dual standard of competence as well as a dual standard of specialist status.

The Royal College's decision to introduce a single standard (which did not come, however, until 1972) was, in retrospect, the right one. As Dr. R.C. Dickson, President of the Royal College from 1970 to 1972, wrote in 1979, "for the people of Canada no other solution could have provided the uniformly high standards of specialist training and identification that have now been achieved."[15]

The Society's insistence on realistic standards for training and examination in anaesthesia undoubtedly contributed to the momentum required to abolish the dual standard and attain the single high standard that Dr. Dickson referred to. The Society shared the Royal College's *desideratum* of a high standard of specialist training. In the words of Dr. R.G.B. (Dick) Gilbert of Montréal, "no hospital should be satisfied with poorly qualified anaesthetists possessing inadequate training and doubtful motivation."[16] Even so, it was not easy for some of the smaller provinces to accept the proposed changes.

An example of a regional viewpoint is provided in a brief prepared by the Atlantic Provinces Anaesthetists' Society in 1961.[17] The members of that Society were "very disturbed" by the Royal College's decision to introduce a single standard of training and examination and sought some means of setting up their own standards for certification on a provincial basis. In their region there was already a shortage of specialist anaesthetists and general practitioners with extra training in anaesthesia, and the move of the Royal College, supported by the Canadian Anaesthetists' Society, appeared to them to have been determined by "the intent of producing specialists of teaching calibre equipped to function in University Centres." However, since there was only one university centre in the Atlantic Provinces where such individuals could function fully, other individuals trained to that standard would move elsewhere in Canada or to the United States. Moreover, in many communities there was "little pressure" for the provision of specialists in anaesthesia, for many of the anaesthetics were given by general practitioners.

All in all, the logical solution, in the eyes of the Atlantic Provinces' Divisions, would be to set up a new standard of competence in anaesthesia, with a minimum of one year's rotating internship and two years' residency training. This would lead to a diploma from Dalhousie University, which could lead towards Royal College requirements for those who wished to proceed towards Fellowship. For those who did not it would serve as a second standard if there were insufficient Fellowship anaesthetists to fill manpower needs in the region.

Council considered this plan on 15 May 1961. There was much discussion, but the view of Dr. Campbell that the single-standard training should not be lowered because of

"local situations in outlying areas" prevailed. A motion proposed by Dr. Carl C. Stoddard, the alternate delegate to Council from Nova Scotia, and seconded by Dr. T.G. Stentaford, representing Newfoundland, that the Society reconsider the Royal College's new policy was defeated. An old era was ending; a new one, approved by a majority, was dawning.

1963 TO 1970: ACADEMIC INTERESTS AND SURVEYS

The regeneration of the Education Committee was the next stimulus to the evolution of the Society's educational role. An Education Committee had first been formed in 1947, but it was never very active (see Chapter 4). In May 1961, however, the formation of an unofficial group comprising the heads of the 12 University Departments of Anaesthesia inevitably led to consideration of education in anaesthesia in Canada. The predecessor of ACUDA, this group was formed "to exchange information and discuss mutual problems in University organizations, undergraduate and postgraduate teaching and research."[18] During their third annual meeting the group made a recommendation, accepted by Council on 13 May 1963, to establish a committee on education, "in order to further the interests of the Society and Canadian graduates at large in the specialty of Anaesthesia." Dr. Stuart L. Vandewater of Kingston was appointed chairman, and the heads of the university teaching departments of anaesthesia and the Executive Committee were appointed members.

This committee, and each of the succeeding committees, put their own stamp on the Society's educational role. The stamp of this committee was academic. Among its concerns were the definition of an anaesthetist[19] and the production of a handbook of anaesthesia for medical students by members of the university departments in Canada in 1967[20]; it also produced a pamphlet for the Society entitled *The Specialty of Anaesthesia* in 1964.

This committee may have been too academic; Dr. Vandewater told Council in February 1967 that it was difficult to wear two hats, and earlier, on 9 June 1966, he had said that some members of the Society had criticized the activities of the committee. At the 1967 midwinter meeting of Council Dr. Vandewater and Dr. Gordon M. Wyant of Saskatoon proposed that the committee be disbanded. Instead, a separate *ad hoc* committee, chaired by Dr. Gilbert, was struck to formulate terms of reference for an education committee.

The terms of reference of Dr. Gilbert's committee (comprising Drs. Graves, Iain MacKay, Toronto, Douglas F. McAlpine, Regina, and Max Minuck, Winnipeg) indicate the Society's educational interests in the 1960s:

1 To consider and make recommendations at the undergraduate and postgraduate level;
2 To review and report on examination requirements, standards and results;
3 To consult with the heads of university departments and to liaise with other organizations concerned with graduate education;
4 To plan and advise regarding paramedical programs;
5 To report on other relevant and pertinent matters.[21]

Among distinguished anaesthetists from outside Canada honoured by the Society was Dr. John S. Lundy, of the Mayo Clinic. Dr. Lundy was awarded the Society's Gold Medal in 1968, and receives it here from Dr. Stuart Vandewater (President, 1967–68).

The membership of the Education Committee should comprise the chairman; the chairman of the Royal College Specialty Committee in Anaesthesia; the chairman of the Manpower Committee; one university department, and two members at large. Dr. Graves accepted the chairmanship, but for one year, and Drs. Vandewater, McAlpine and Matthews were initially appointed members.[22] Later Dr. Leonard Jenkins of Vancouver replaced Dr. H. Barrie Fairley of Toronto, who left for California, and Drs. Paul E. Otton of Montréal and Alan A. Drysdale of Halifax were named to the committee.[23] Later still, Dr. J.M. Bergeron of Shaunigan South, Québec, and Dr. Léon Longtin of Montréal and chairman of the Royal College Specialty Committee, were added to the core committee. Drs. Jean-Paul Dechêne (Québec and Montréal), Douglas Ewart (Moose Jaw) and Tom J. McCaughey (Winnipeg) became corresponding members, with Drs. Minuck and Campbell as members ex-officio.[24]

If the previous committee had been academically oriented, the focus now turned to service. Dr. Graves held that it was essential to know how, when and where anaesthesia knowledge is being disseminated to medical students; consequently his committee conducted "extensive surveys associated with all branches of education related to anaesthesia."[25] The aspects of the education surveyed indicate what was of interest in the late 1960s:

1 Lectures, seminars and demonstrations to medical students (Dr. Dechêne).
2 Exposure of interns to anaesthesia (Dr. Matthews).
3 Refresher courses for family practitioners and facilities for family practitioners in-hospital training (Dr. Drysdale).
4 Refresher courses for specialists and for pre-specialist examinees (Dr. Otton).
5 Affiliation between university teaching programs and non-university teaching hospitals (Dr. McAlpine).
6 Provincial morbidity and mortality studies (Dr. Ewart).
7 Future role of "anaesthetic technicians" (Dr. Minuck).
8 Future role of inhalation therapy technicians (Dr. McCaughey).

Both the membership of this committee and their topics of study ranged wide. As well as medical students and residents and specialists, paramedical personnel entered the ken of those who were concerned with education and training in anaesthesia (see also Chapter 11). But, of greater significance, the medical profession had begun to take more seriously the needs for continuing education, which would be the focus of the next Education Committee.

1971 TO 1980: THE DEVELOPMENT OF CONTINUING MEDICAL EDUCATION

The need for continuing medical education was first felt in the 1950s: in 1950 the University of Toronto developed a program for specialists and in 1951 Dalhousie University did the same for general practitioners.[26] By the 1960s the serious problem that physicians had of simply keeping themselves informed was compounded by the public's knowledge of and insistence on the delivery of quality medical care. By the mid-1970s, the obsolescence of previous knowledge and the growth of current knowledge required "professional reorganization."[27]

Members of the Canadian Anaesthetists' Society felt this need. However, the Education Committee, Dr. Matthews concluded in 1971, was failing to meet the educational needs of anaesthetists.[28] Continuing education, he said, is like preventative medicine; one has to keep working at it. But the Education Committee had not met for two years. Dr. Matthews suggested that the efforts of Council and its committees should be redirected with these points in mind.

Dr. Matthews spoke to Council about this during the midwinter meeting of 1971. Dr. Vandewater then urged Council to consider "very seriously" the fact that a member at large had presented himself to Council to give his views on the lack of educational programs. Council asked the Education Committee to redirect its attention along the following lines:

1 The terms of reference and composition of the committee.
2 The feasibility of sponsoring a self-evaluation program.
3 Current trends in education as it related to training in, and the practice of, anaesthesia with special emphasis on the development of health-related professions.
4 Possible inter-relationship of the Committee with the Society's Program Committee and with the Specialty Committee of The Royal College of Physicians and Surgeons of Canada.

5 Other matters relating to continuing education in improving standards of anaesthetic care.

In July 1971, Dr. Matthews, now chairman of the Education Committee, put into effect some of his ideas on continuing education for anaesthetists. During his tenure as the chairman (for the next eight years), he was able to direct his efforts to education, which, it was thought, was emphasized in the new Constitution of 1971.

Dr. Matthews' efforts were successful. In a valedictory report he gave just before retiring from the chairmanship of the Education Committee he summarized the achievements of the committee in the 1970s.[29] Some of these were the following:

1 A survey of certificated anaesthetists in 1973 inquiring of them their views on monitoring of competence. This survey was prepared by the Education Committee and circulated with the cooperation of the Royal College. Of the 30% who responded, 95% favoured some form of *voluntary* recertification to be monitored by the Royal College, the Society or a provincial medical society.
2 A workshop on Electrocardiography for the Anaesthetists presented in 1973 in Toronto, Vancouver and Halifax.
3 A multiple-choice self-evaluation program in 1972 and another in 1976. Each was a "sell-out," about 15% of the membership subscribing to them.
4 Negotiations with the American Board of Anesthesiology, the American College of Anesthesia, and the American Society of Anesthesiologists regarding participation by Canadian residents. Beginning in 1975 this was managed by ACUDA.
5 Production of computer programs during the annual meetings in 1976 and 1977.
6 A workshop on Practical Regional Anaesthesia in 1979.

The Education Committee of the 1970s thus established the importance of continuing medical education for anaesthetists, which would be the focus of succeeding committees.

1981 TO 1992: MAINTENANCE OF COMPETENCE

In the 1970s continuing education was increasingly the focus of attention, with "CME" as the catch phrase; in the 1980s and 1990s maintenance of competence was increasingly the concern, with "MOCOMP" as the buzz word. This development was reflected in the change of name of the Committee on Education to the Committee on Continuing Education in 1990.[30]

CME (Continuing Medical Education) has been defined as "those activities undertaken by practising physicians to maintain and upgrade their professional competence and clinical performance."[31] Any CME program must be non-punitive and provide a course of action which allows individuals to fill their educational needs or deficits. This became the objective in this period. With intensifying concerns about quality assurance and malpractice litigation, maintenance of competence became significant to all anaesthetists, and the Society's task

was to find ways and means of facilitating it. The primary role of the Committee on Continuing Education was now clearly to provide a vehicle that would encourage members to maintain their professional competence.

The Royal College of Physicians and Surgeons of Canada had long been concerned with maintenance of competence, and in 1988 the Royal College held a workshop to explore aspects of encouraging interest and active involvement in maintenance of competence among specialists.[32] The Society was later invited to join with a number of other specialist organizations in launching a Pilot Project on Maintenance of Competence, and information sessions were held at the Royal College annual meetings in 1990 and 1991. The project was launched in 1991, and anaesthetists, like other specialists, were able to access a system whereby a variety of educational activities could be assigned MOCOMP values that would be recorded in a central office. Thus an individual anaesthetist could assign a numerical value to almost any educational activity. Evidence of maintenance of competence by an anaesthetist could be provided by a continuing record of attendance not only at Regional Refresher Courses (which the Education Committee began to develop in 1990) and the annual meeting, but also by participation in hospital rounds or even by reading of medical journals.

Whether the MOCOMP project will prove effective and efficacious is too early to say. Even as late as 1992 problems (e.g., the form for recording educational activities) were still being solved.[33] It is clear, therefore, that the Society's role in education continues to evolve, and that the Society must continue to find ways of encouraging its members to maintain their professional competence long beyond their period of specialist training.

Training and Education of the Non-specialist Anaesthetist

Although the Canadian Anaesthetists' Society is concerned primarily with the needs of specialists, the Society has long recognized a responsibility to family practitioner anaesthetists and their educational needs.* In 1960, Dr. David Power of Montréal (the chairman of a group named, quite remarkably, The Committee to Study the Problem of Recognition for the Non-Specialist Anaesthetists Who are Members of the Canadian Anaesthetists's Society, For Their Interest in the Specialty of Anaesthesia) concluded that "the Canadian Anaesthetists' Society might best advance 'the art and science of anaesthesia in its clinical and educational aspects' by arranging some formal training for those General Practitioners who must practice anaesthesia in a community that cannot support a specialist anaesthetist."[34] Council, in accepting the committee's report, concurred. Since then, on a number of occasions, the Society has adhered to this position.

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*Initially, any physician who was a member of the Canadian Medical Association or of L'Association des Medicine de la Langue Française could, if sponsored by a member of the CAS, join the Society. Because such members, on occasion, wished to use CAS membership as a specialist qualification, membership in the Society was later restricted to Certificated Specialists.

At its meeting on 6 June 1966, Council approved a motion by Drs. Vandewater and Gilbert to include anaesthesia in a training program for general practitioners that the College of General Practice of Canada was planning. The motion established the *desideratum* that the period of training be six months. This period would be made up of a) not less than two months in an approved department of anaesthesia in order to learn the principles of resuscitation, ventilation and care of the unconscious patient, and b) for those intending to administer anaesthesia while in practice, a further rotation of four months in a department of anaesthesia as an elective. The College of General Practice of Canada, which was enjoying a relationship of mutual respect with the Society, was informed of Council's decision.

The desirability of a six-month training period was confirmed two years later. On 3 February 1968 Council approved the following motion proposed and seconded by Dr. Ian E. Purkis of Halifax and Dr. MacKay:

> THAT all organizations concerned with the production of "recommended bylaws" be advised that the Canadian Anaesthetists' Society recommends a minimum of six months training in anaesthesia in a hospital approved by The Royal College of Physicians and Surgeons of Canada, or by the College of Physicians and Surgeons in Québec, for training in anaesthesia as a minimum requirement for a registered physician to administer anaesthesia in a hospital.

The Society's Education Committee also confirmed the Society's interest in the training and continuing education of non-specialist anaesthetists. In answering the question on the educational role of the Society, "the education and continuing education of the non-specialist anaesthetist" was one of the facets of the answer.[35] In December 1972, the Education Committee proposed that the Canadian Anaesthetists' Society seek the advice of the College of Family Practice of Canada "on ways and means of encouraging continuing education in Anaesthesia for its members who practise Anaesthesia,"[36] and Council approved this also. It is evident, therefore, that in the 1960s and 1970s the Canadian Anaesthetists' Society, though essentially a Society of specialist anaesthetists, was "stressing the positive aspects of continuing medical education ... for all Anaesthetists, both specialists and non-specialists."[37] Moreover, as associate members of the Society, general practitioner anaesthetists were always welcome at annual meetings and divisional meetings.

In the 1980s, however, the situation changed. The knowledge and practice of medicine had become ever more complex, and family medicine, like anaesthesia, had evolved as an independent specialty. At the same time, postgraduate funding and residency training positions were being cut back, and fewer Canadian medical graduates were attracted to some rural communities. In addition, a town-gown conflict became evident; as a Canadian Medical Association (CMA) report put it, there was evidence of "a perceived schism between the academic anaesthesia community and the family practitioners who provide anaesthesia services."[38]

This conflict, which fortunately was resolved in 1988, became apparent when members of the Society, and particularly of ACUDA, were apprised of two resolutions passed by the

Board of Directors of the College of Family Practice of Canada in November 1985.[39] These resolutions read as follows:

1 WHEREAS the additional and special training for education in areas of anaesthesia, obstetrics and surgical skills are often denied by university departments to the detriment of individuals, communities and their family physicians, BE IT RESOLVED that the College of Family Practice of Canada encourage provincial and territorial Ministries of Health, Deans of Postgraduate Education and Directors of Continuing Medical Education, to recognize and respond to the legitimate need of communities and their family physicians, by providing short courses for the development and maintenance of special skills in anaesthesia, obstetrics and surgery.

2 WHEREAS there is a need to maintain anaesthetic services in rural and isolated communities throughout Canada, AND WHEREAS rural family physician anaesthesia is a narrowly defined field relative to specialist anaesthesia, BE IT RESOLVED that the College of Family Practice of Canada make strong representation to the faculties of medicine, provincial licensing bodies and provincial funding agencies to continue good quality family practice anaesthesia training programs and specifically that:
   i) six month training programs continue to be available and
   ii) training in regional as well as teaching centres for the purposes of licensure in family practice anaesthesia continue.

Dr. R.L. Perkin, Executive Director of the College of Family Practice of Canada, together with the Board of Directors of that College, wished to "make strong representation," and they may have been surprised at the strength of the reaction that their representation induced. Neither the Canadian Anaesthetists' Society (represented by Dr. Ronald C. Gregg of Edmonton, the Society's President, to whom Dr. Perkin wrote on 27 March 1987[40]) nor ACUDA (represented by Dr. Charles E. Hope of Halifax, to whom Dr. Perkin wrote on 1 April 1987[41]) accepted the opinion of the College of Family Practice of Canada that six month training programs for family practitioner anaesthetists should continue.

Times had changed; the range and complexity of medical advances now demanded more than an apprenticeship of a few weeks. Dr. Hope suggested to Dr. Perkin, in a letter dated 5 May 1987, that "the specific requirements of ... an isolated physician may require a very specialized and detailed learning environment ... (and) that a six month training program is totally inadequate."[42] Moreover, in litigiously conscious times, "even the teacher is liable to be sued for the quality of his product," and a six-month product in the 1980s was an immature one. Nor could Dr. Hope refrain from asking Dr. Perkin, "would your colleagues be comfortable with me practising family medicine part-time following a six month program?"

Dr. Gregg was equally forthright. "With the continuing improvement in practice and increasing knowledge about anaesthetic care," he wrote back to Dr. Perkin, "we must con-

Immediate Past President Dr. Jean Taillefer presenting the Chain of Office to the Incoming President, Dr. Ronald Gregg, in 1986.

tinually improve anaesthesia training for the specialist and non-specialist alike. Staying with the six-month course, and especially one centred in a regional hospital rather than a teaching hospital, would not be doing anyone a service, but especially not those in rural areas requiring anaesthetic care."[43] Dr. Gregg also touched on a crucial point, which raises the question of who, under ideal conditions, should give anaesthetics in Canada. "As a Canadian," Dr. Gregg emphasized, "I do not feel that some citizens in this country should get inadequate anaesthesia because they happen to live in rural areas."

These views were representative of many anaesthetists, and in order to resolve the contentious problem of a training period for family practitioner anaesthetists, the CMA sponsored two invitational meetings on 20 November 1987 and 15 February 1988. These two meetings explored "the issues involved in the provision of anaesthesia services and the appropriate training to provide these services," and facilitated the process whereby "recommendations were then developed by a consensus building process."[44]

The Canadian Anaesthetists' Society and ACUDA were represented at these meetings, as were the Association of Canadian Medical Colleges (ACMC), the Canadian Association of Internes and Residents, the College of Family Practice of Canada (CFPC), the CMA, the Federation of Provincial Medical Licensing Authorities of Canada, and The Royal College of Physicians and Surgeons of Canada (RCPSC). The meetings generated much discussion and many interesting data, but in particular they resolved various aspects of the problem of training for family practitioner anaesthetists. The most significant facets of the deliberations are summarized here.[45]

- In 1985–86, family practitioners provided 26.51% of anaesthesia services in Canada. Certified anaesthetists provided 68.16% of the anaesthetics. The remainder of the services were provided by "other physicians."

- Analysis of the CMA's 1986 Physician Manpower Survey indicated that of those respondents who worked primarily as general or family practitioners, 71.1% reported providing nine hours or less of anaesthesia services per week, while 92.4% reported providing 20 hours or less. This underlined concern about the maintenance of necessary skills and limits below which physicians would be expected to refer patients to larger centres.

- Even in urban settings, 48% of practitioner-anaesthetists provided eight hours of care or less per week.

- To provide anaesthesia it was agreed that the Family Practitioner Anaesthetist must have certain skills. A Family Practitioner Anaesthetist must be able to:
  - select a safe and effective anaesthesia technique
  - use appropriate invasive as well as non-invasive monitoring methods
  - effectively manage complications of anaesthesia
  - apply the skills necessary to manage the trauma patient (e.g., airway control, cardiorespiratory stabilization, identification and management of life-threatening emergency situations)
  - administer epidural anaesthesia for obstetric anaesthesia, and manage the complications of pregnancy requiring an anaesthetic and those affecting the newborn
  - appropriately manage patients in the post-operative period.
  - respond to the needs of other groups of patients, especially newborns, children, the elderly and ambulatory patients
  - Know when it is appropriate to transfer the care of the patient to someone else.
  - Respond to the situations demanding other urgent anaesthesia (when the safety of the patient might be compromised during transportation) and emergency anaesthesia (when the risk of further illness or death would increase during transportation).
  - Treat a number of other acute or chronic medical conditions (e.g., cardiac arrhythmias and respiratory abnormalities).

- There is suggestive evidence that lower death rates relating to anaesthesia and surgery may be attributed to an increase in the number of specialists rather than non-specialists providing anaesthesia. The literature was reviewed and summarized.

- Among the recommendations, the following are of note:
  - "... where possible, anaesthetic services should be provided by certified anaesthetists."
  - "... if the services of the family practitioner anaesthetist are required, (the participating organizations) support the practice of anaesthesia by appropriately trained family practitioners."

- "... when volume is sufficient and where indicated, the preferred model for the delivery of anaesthesia services by family practitioners would be at least one Royal College of Physicians and Surgeons of Canada certified anaesthetist working with family practitioners with appropriate training in anaesthesia."
- "... family practitioner anaesthesia training (should) take place in university programs and facilities accredited by The Royal College of Physicians and Surgeons of Canada."
- "... the training programs for the family practitioner anaesthetist include a minimum of 12 months of core anaesthesia-related training. The anaesthesia training program should be tailored to meet the individual requirements of the trainee, taking into account the candidate's previous training, level of skill and competence. These would be assessed by the Department of Anaesthesia with reference to the educational objectives developed by the Association of Canadian University Departments of Anaesthesia and the College of Family Practice of Canada."
- "... the Canadian Anaesthetists' Society and the Association of Canadian University Departments of Anaesthesia (should) coordinate programs to encourage certified anaesthetists to make periodic visits to those non-urban centres providing anaesthesia services, particular institutions that do not have a certified anaesthetist on staff."
- "... the Canadian Anaesthetists' Society and the Association of Canadian University Departments of Anaesthesia (should) encourage anaesthetists in urban communities to provide locum tenens for their colleagues in non-urban communities."

– The Report concluded with the statement that "the endorsement of the recommendations arising from the meetings by a variety of medical organizations represented assures continued efforts to achieve the desired outcomes in Canada's unique medical geography."

This last statement raises a question for the future: how far will the Canadian Anaesthetists' Society go in achieving the ideal that the CMA meetings agreed on: "to have all anaesthesia services provided by certified anaesthetists?" Great progress in this regard has been made, particularly in Québec. As Dr. Jacques Samson of Québec City wrote on 8 April 1988, "maybe ... we are stubborn in the Province of Québec but we really believe that anaesthesia should be exercised by specialists only and we also believe that our National Society has to fight to attain this goal as soon as possible even if the pressures coming from the CMA, the ACMC, the RCPSC and even the CFPC are tough to support."[46]

CHAPTER NINE

The Annual Meeting and Regional Meetings

THE first annual meeting of the Canadian Anaesthetists' Society was held on 24 May 1944, just a year after the Society was founded. As the Society has grown, so too has the annual meeting, in terms of organization, content and composition.

The 1944 meeting was organized for the Society's 300-odd members chiefly by the President and the Secretary-Treasurer. This was made easy because in the earliest years the Society met with the Canadian Medical Association (CMA), which made all the arrangements. In contrast, the 50th anniversary meeting in 1993 was the end-result of several years of planning by a professional central office staff, including a meeting coordinator, working together with a large Scientific Affairs Committee and a dedicated Local Arrangements Committee for a society membership that has increased sevenfold.

There is no record of the budget for that first meeting, though the 2-line financial statement of 7 December 1944 did include the sum of $427.00, some of which covered "initial organizing expenses." By 1951 the meeting had become large enough for exhibitors' dues to amount to $440.00, but it was not until 1956 that a line entry of $1,408.96 designated disbursements specifically for the annual meeting. The budget for the 1993 meeting is of the order of $333,000.

The growth of the annual meeting over four and a half decades is most obvious by comparing its content and composition in 1950 and 1990 (Table 9.1). In 1950, the meeting was a leisurely 3-day affair held at the Seigniory Club in the resort area of Montebello, Québec. Only 13 topics were presented on the program, and only 10 exhibitors had booths. In 1990, the meeting was a frenetic 5-day forum at which a myriad of topics were discussed within distinct segments: the concurrent Refresher Courses, workshops, a breakfast seminar, section lunches, free papers, symposia, a clinical forum, poster discussion presentations, poster display presentations, the Royal College Lecture, the Residents' Competition and a residents' seminar. All this served up an educational feast. The 1990 meeting is also memorable for occurring jointly with the Japan Society of Anaesthesiology. No fewer than 66 commercial firms exhibited their products; financial assistance by 10 offset some of the meeting costs.

TABLE 9.1
The Annual Meeting: A Comparison of the 1950 and 1990 Programs

	1950	1990
Dates	26–28 June	15–19 June
Location	Seigniory Club Montebello, PQ	Hyatt Regency Hotel Vancouver, BC
Special Registrants	Dr. H.R. Griffith	Members, Japan Society of Anaesthesiology
Scientific Sessions	Free papers (10) Round-table sessions (2) Panel (1)	Free papers (36) Symposia (2) Clinical form Refresher course lectures (2 tracks) Workshops (2) Section lunches (2) Breakfast seminar Residents' papers (12) Residents' seminar Royal College Lecture Poster discussion presentations (58) Poster display presentations (52)
No. of Commercial Exhibitors	10	66

Like the Society's Journal, the annual meeting serves a valuable purpose in linking the members to each other and to the "Society." Like the Journal, it also serves as an educational vehicle and reflects the changing scene in anaesthesia. However, the annual meeting adds another dimension that enhances the collegiality among Canadian anaesthetists: it provides a setting and an opportunity for person-to-person contact with its infinite spectrum of communication among peers and others who attend the meeting.

The development of the Society's annual meeting is complex and is discussed in relation to three time periods: 1944 to 1966, 1967 to 1978, and 1979 to 1993.

In the earliest years there were advantages to holding the Society's annual meeting where and when the CMA held its annual meeting. The overall arrangements were made by a larger organization; anaesthetists had an opportunity to meet with physicians of other specialties from other parts of Canada; the meeting was held in different regions (see Table 9.2); and the CMA Section of Anaesthesia, of which the Society's members had been a part since 1943, held *its* meeting in conjunction with the parent body.

Meeting with the CMA had its disadvantages, too: independence and autonomy were lacking, as was simple physical space to accommodate the increasing numbers of anaesthetists attending each year. At the annual general meeting of 16 June 1949 it was decided, therefore, on a motion of Drs. E.H. Watts of Edmonton and M.K. Belton of Montréal, that the annual meeting of the Society in 1950 would be held "separately from and in addition to the meeting of the Section of Anaesthesia of the Canadian Medical Association."

Holding the meeting in the Seigniory Club in the pleasant setting of Montebello was a significant change. The Society now had to make its own arrangements, but the Society was still small, the membership as of 27 June 1950 numbering only 449. The meeting was successful, for almost 100 physicians registered – one quarter of the membership – though only a handful were from centres outside Québec or Ontario. A notable name from far afield was Dr. Edgar A. Pask, of Newcastle-on-Tyne in England.

Montebello was the site of the Society's annual meeting on eight further occasions (1953 and 1958–64), while the resort settings of Murray Bay and Mont Tremblant, also in Québec, were selected in 1951 and 1956. Throughout this period, the only annual meetings not held in eastern Canada were Banff (1952), Vancouver (1954), where the CMA also met, and Saskatoon (1957).

The 1950 meeting also saw the inauguration of Guest Lectures, now a tradition. The 1950 meeting honoured Dr. Harold Griffith, who was also the after-dinner speaker at the annual dinner. Until 1975, the lectures were supported financially by grants from commercial firms; for example, the Burroughs Wellcome Lectures in 1968, 1969 and 1970. At that point, The Royal College of Physicians and Surgeons of Canada initiated the Canadian Anaesthetists' Society Annual Royal College Lecture (Table 9.3).

Annual lectureship and the separation of the Society's meeting from the CMA were important, from an educational and a collegial viewpoint. The Annual Meeting has served to foster a sense of professional identity among Canadian anaesthetists. The very existence of the Society provides the matrix in which this sense of identity grows, while the various activities during the meeting shape the sense of this professional identity. Important though it is, the social purpose of the annual meeting is secondary to its educational purpose.

How is this reflected in the earliest annual meeting, and how did it change? To answer these questions, the Annual Meeting in 1950 is compared with the Annual Meeting in 1966 (Table 9.4).

The most obvious change was the size of the meeting. In 1950 the scientific program

TABLE 9.2
The Annual Meeting: Locations

Year	Location	Year	Location
1944	Toronto	1969	Toronto
1945	Montréal	1970	Winnipeg
1946	Banff	1971	Québec
1947	Winnipeg	1972	Halifax
1948	Toronto	1973	Vancouver
1949	Saskatoon	1974	St. John's
1950	Montebello, Québec	1975	Kingston
1951	Murray Bay, Québec	1976	Montréal
1952	Banff	1977	Saskatoon
1953	Montebello	1978	Ottawa
1954	Vancouver	1979	Edmonton
1955	Toronto	1980	Toronto
1956	Mont Tremblant, Québec	1981	Halifax
1957	Saskatoon	1982	Québec
1958	Montebello	1983	Vancouver
1959	Montebello	1984	Winnipeg
1960	Montebello	1985	Toronto
1961	Montebello	1986	Montréal
1962	Montebello	1987	Calgary
1963	Montebello	1988	Halifax
1964	Montebello	1989	Ottawa
1965	Charlottetown	1990	Vancouver
1966	Banff	1991	Québec
1967	Montréal	1992	Toronto
1968	Ottawa	1993	Halifax

was built around 13 topics, 10 presented by individuals and 3 by small groups. As well, 10 commercial firms exhibited "many new things ... of interest to Anaesthetists."

In 1966, 37 topics were presented, and each of the 30 papers by individuals was formally commented on by a discusser. There was a qualitative change in the topics with greater emphasis on the science rather than the art of anaesthesia. Aspects of a new era in anaesthetic practice were evident. Invasive monitoring, measurement, open-heart surgery, physiological responses to anaesthesia and surgery, artificial ventilation, renal transplantation, the search for new induction agents and legal problems were all discussed. By the 1966 meeting the number of registrants had doubled, and 188 persons (or one-sixth of the membership) attended the meeting in Banff. (Two years earlier, however, when the meeting had taken place in Montebello, 282 attended.) The number of exhibitors (26) had more than doubled.

TABLE 9.3
The Annual Meeting: Royal College Lectures

Year	Lecturer	Lecture
1975	E.I. Eger II (San Francisco, California)	Uses of MAC
1976	M.B. Laver (Boston, Massachusetts)	Controlled Intraoperative Myocardial Depression: An Idea Whose Time Has Come
1977	D.G. McDowall (Leeds, England)	Monitoring and Intensive Care of Severe Head Injuries
1978	R.D. Miller (San Francisco, California)	Recent Developments with Muscle Relaxants and their Antagonists
1979	K. Rehder (Rochester, Minnesota)	Anaesthesia and the Respiratory System
1980	W. Kalow (Toronto, Ontario)	Pharmacogenetics and Anaesthesia
1981	J. Wade (Winnipeg, Manitoba)	Foetal Anaesthesia – Past, Present and Future
1982	R. Melzack (Montréal, Québec)	Current Concept of Pain
1983	G.M. Wyant (Saskatoon, Saskatchewan)	Chronic Pain
1984	D.J. Roy (Montréal, Québec)	Hippocrates Redivivus? Values and Judgements in the 1980s
1985	M.J. Cousins (Bedford Park, South Australia)	Severe Pain Management: Opioids, Neural Blockade or What?
1986	H.B. Fairley (Stanford, California)	Physiology and Applications of Positive Airway Pressure
1987	E.A. Moffitt (Halifax, Nova Scotia)	Myocardial Oxygenation – A Critical Matter in Anaesthesia
1988	C.R. Stiller (London, Ontario)	Multi-organ Transplantation – Oversold or Under-utilized?
1989	J.F. Nunn (Harrow, England)	Evolution and Toxicity of Oxygen
1990	A.C. Bryan (Toronto, Ontario)	Stability of the Lung
1991	M.L. Boulanger (Montréal, Québec)	Image of the Profession
1992	D.R. Bevan (Vancouver, British Columbia)	50 Years of Relaxation
1993	D.A.E. Shephard (Regina, Saskatchewan)	Retrospect and Prospect: Reflections on the History of the Canadian Anaesthetists' Society, 1943–1993

TABLE 9.4
The Annual Meeting: Topics of Presentations 1950 and 1966

1950	1966
Decamethonium Bromide	Central Venous Pressure Monitoring in Anaesthesia
Muscle Relaxants: Dangers in Use	The Relationship of Nasal Mucosal Temperature to System Blood Pressure
The Endotracheal Tube: Use and Abuse	Neuroendocrine and Metabolic Effects of General Anaesthesia and Graded Haemorrhage
Anaesthesia for Transurethral Resection	Effects of Nitrous Oxide on Myocardial Function of Dogs
Trichloroethylene (Round Table)	Haemodynamics of Selective Cardiac Sympathetic Denervation by Extradural Analgesia
Anoxia	L'anesthésiste-réanimateur et la circulation extra-corporelle
Anaesthesia for Thoracic Surgery: Physiological Factors	The Effects of Anaesthesia and Cerebral Ischaemia in Rabbits
The Oximeter: Clinical Impression and Evaluation	Basal Narcosis in Paediatric Anaesthesia (Film)
Spinal Anaesthesia: Complications (Panel)	Relaxant Techniques for Adeno-tonsillectomy
Therapeutic Nerve Block	Another Anaesthetic Technique for Tonsillectomy in Children
Sodium Thiopental in Obstetric Anaesthesia	Prolonged Nasotracheal Intubation in Children
	Artificial Ventilation Using a New Ventilator in Neonatal Anaesthesia
	Further Experience with Fentanyl and Droperidol in Clinical Anaesthesia
	Further Studies of Inspired Oxygen Concentration Delivered by the Bird Respirator
	Effect of Hyperventilation on Arterial Oxygen Tension
	Renal Transplantation (Panel)
	Anaesthetic Management of Phaeochromocytoma
	Premedication Including a Study of Chlordiazepoxide
	Clinical Experiences with PLV2 (Octapressin) as a Local Haemostatic Agent
	Comparison of Propanidid and Pentothal as Induction Agents to General Anaesthesia
	Continuous Intercostal Block Anaesthesia (Film)
	Long-acting Citanest
	The Significance of Methaemoglobinaemia Produced by Prilocaine (Citanest)
	Diabetes 1966 (Guest Lecture)
	Modern Anaesthesia (Film)
	Orthopedic Surgery and Anaesthesia (Panel)
	Progrès dans le traitement des patients gériatriques

TABLE 9.4 continued
The Annual Meeting: Topics of Presentations 1950 and 1966

1950	1966
	Recent Legal Problems Associated with Anaesthesia and Surgery
	Some Observations on the Use of Mannitol in Open-heart Surgery
	The Use of Low Molecular Weight Dextran (Rheomacrodex) for Haemodilution in Open-heart Surgery
	Anaesthesia for Revascularization Procedures of the Heart – Vineberg's Procedure
	Closures and Coring under Magnification
	Report on the State of Curarization in an Unanaesthetized Observer
	Atypical Cholinesterases in Anaesthesia
	Diazepam for Dilution of Anaesthesia
	Prostatism and Anaesthesia
	A Look into the Future

At the 1966 meeting, Dr. Edward A. Gain of Edmonton presented an interesting topic, "A Look into the Future." Dr. Gain asked "What do you think will happen?" in connection with the following aspects of anaesthetic practice: spinal anaesthesia; cyclopropane, halothane, penthrane; electronarcosis; hypothermia; hypotensive techniques; and intravenous barbiturates. These subjects illustrate the topics of interest then and reflect the changes in anaesthesia over the years.

During this period two meetings in Canada permitted Canadian anaesthetists to meet anaesthetists from other countries. In 1955, the Society met in Toronto at the same time as the CMA held a joint meeting with the British Medical Association. That year the Society benefitted from the presence of Sir Robert Macintosh, who gave a paper on "The Design of Anaesthetic Inhalers." Sir Robert was also one of two after-dinner speakers; the other was Wesley Bourne. Other well-known contributors from the United Kingdom included Ronald Jarman, "The Place of Pentothal in Modern Anaesthesia," Geoffrey (later Sir Geoffrey) Organe, "Reflexions on the Muscle Relaxants," Andrew R. Hunter, "Ketosis in Anaesthesia" and a panellist on induced hypotension, and R.W. Cope, "Contamination with Phenol."

The other notable international meeting was the Second World Congress of Anaesthesiologists. This was held at the Royal York Hotel in Toronto from 4 to 10 September 1960. Canadian anaesthetists had an opportunity to present themselves and Canadian anaesthesia in an international forum. The Chairman of the Congress was an

Sharing a moment at the Seigniory Club during the annual meeting in May 1959 are Dr. Gladys Munroe and Dr. Ernie Watts (President 1951–52).

anaesthetist who was by now respected around the world, Dr. Harold Griffith. The Chairman of the Organizing Committee, also active in the World Federation, was another well known Canadian, Dr. R.A. Gordon. Others active in the planning and execution of the Congress were the following: Dr. Stanley M. Campbell (Scientific Program); Dr. J.S. Heron, the Deputy Secretary (Publicity, Registration and Housing); Dr. R.H. Meredith (Social Events and Tours); Dr. Iain M. MacKay (Translation Services); Drs. Stuart L. Vandewater and James M. Shapley (Finance); Dr. Alan W. Conn (Commercial Exhibits); Mrs. H.W. Boyes (Ladies' Committee); and Mrs. Helen Junkin (Ladies' Program) and Miss Edna Campbell, R.N. (Secretary).

The cost of organizing and conducting the World Congress was borne in part by members of the Society, each of whom was assessed $10.00, yielding a total of $5,300. The Council for International Organizations of Medical Science (CIOMS) provided a refundable grant of $1,000; the Ministry of Health of Ontario, $2,500; the Department of Health and Welfare, Canada, $10,000. More than 2,000 registrants attended. Active membership (entitling attendance at all scientific and social sessions) cost $30 and associate membership (for attendance at the Opening Ceremony, the reception and the Congress Ball) cost $15, while residents in training were enrolled for $10. The Congress was a financial as well as a scientific and social success: revenues exceeded expenditures by more than $27,000. The grants from CIOMS, the Government of Canada and the Government of Ontario were repaid and a handsome profit of $8,573.21 was returned to the World Federation of Societies of Anaesthesiologists. The money obtained from the Society's members was not returned but held in a separate account for use on special projects.

The 1967 annual meeting was held in Montréal. The big event in Canada that year was Expo '67, and the Society, like many other organizations, tied its annual meeting to this enormously popular event. The meeting drew anaesthetists from all over Canada and the United States and Europe. As a result, more than 500 anaesthetists registered, the largest number up to that time. It was an international as well as Canadian meeting. Some of the more prominent names on the scientific program were the following: André Soetens of Antwerp, "le Métabolisme de l'eau et des Electrolytes en Neurologie et en Neurochirurgie"; Lou Orkin of New York, the panellist with Dr. Soetens, and Canadians G. Wyant, L. McLean and Dr. C. Finlayson, all of whom discussed "Shock – Concepts and Treatment"; R.A. Theye and C.J. Restall of Rochester, Minnesota, "Oxygen Levels and Hemodynamics During Anesthesia and Nitrous Oxide, Thiopental and Curare"; G. Vourch'h, of Paris, "Study of the Action of Drugs on the Electrical Activity of the Brain and Thalamus – Clinical Implications"; H.C. Churchill-Davidson of London, England, "Some Problems in the Use of Muscle Relaxants"; R. Frey of Mainz, "Resuscitation at the Place of Accident and During Transportation"; and E. Nillson of Lund, "A Review of Neurolept Analgesia." Other internationally known anaesthetists included A.B. Dobkin of Syracuse, formerly of Saskatoon; J. Parkhouse, previously of Oxford and the first Professor of Anaesthesia at the University of Manitoba; and H. Zauder of New York, who became President of the American Society of Anesthesiologists in 1987.

The 1967 meeting inaugurated the Residents' Program, a part of the scientific program that has continued to the present. The program got off to a good start. It was chaired by Dr. Gilbert and judged by five experts of international repute (Drs. Churchill-Davidson, Frey, Nillson, Soetens and Vourch'h). Ayerst Laboratories donated $1,000 to fund three prizes. Details of the program and names of the participants are given in Table 9.5.

The Residents' Program attracted competition to such a degree that its title became the Residents' Competition. This unique aspect of the Society's annual meeting has continued to stimulate entries and interest in research in anaesthesia in Canada. Since its inception, the Residents' Program has attracted 226 presentations, 53.5% of which have been published; of the presentations by first prize winners, 76% have been published.[1] A list of all Residents' Prize winners appears in Appendix 12.

The 1968 Annual Meeting was a special occasion, for it was the Society's 25th anniversary. The meeting was to have been held at the Seigniory Club, Montebello, which had so many happy memories for the Society. At the last moment, however, a strike by club employees put the meeting in jeopardy, and only the readiness of the Chateau Laurier in Ottawa, together with last-minute planning by Miss Campbell, saved the day. Thus, the 1968 meeting was held in an urban centre rather than a resort, a custom that has continued ever since.

Another feature of the annual meeting that year was the presentation of two Scientific Exhibits: one on Neuroleptanalgesia for Cardiac Surgery, by Drs. J.W.C. Fox, E.J. Fox and

TABLE 9.5
The Annual Meeting: Residents' Program, 1967

Author	Topic	Author's Present Location
G.H. Hodgson	Respiratory Unit Management of Acute Head Injury – A Retrospective Study	Bowmanville, Ontario
O.H. Hippolyte	Toxéurie de la grossesse et anesthésie	Unknown
A.K. Lawes	The Management of Functional Residual Capacity During Intermittent Positive-Pressure Ventilation	Toronto, Ontario
P.R. Ramachandran	The Usefulness of Central Venous Blood Samples as an Index of Arterial Acid Base Balance and Oxygenation	Don Mills, Ontario
G.R. Sellery[2]	A Review of the Causes of Postoperative Hypoxia	London, Ontario
M.G. Viguera[1]	Fluid Therapy During Surgery	Williamsville, New York
D.L. Zoerb[3]	Atypical Cholinesterase Activity – A Review and the Presentation of Two Cases	Saskatoon, Saskatchewan

Superscript numerals indicate place in Residents' Competition.

J.E. Coppen of the State University of New York; and the other by Dr. André McClish of Hôpital Laval, Québec. These exhibits were the forerunners of the Poster Presentations in 1987.

The chairman of the Program Committee was Dr. H. Barrie Fairley, then of Toronto. He and his committee took the view that the annual meeting should be held primarily for scientific purposes.[2]

The committee enhanced the scientific standard of the annual meeting, while Dr. Fairley deplored the "nihilistic" attitude that the Canadian meeting might not be an adequate forum for the presentation of one's best material.[3] Ironically, he almost immediately moved to California, but the innovative meeting of 1969 bore his stamp – and evidence of his professional interests – for a symposium on respiratory care was held the day before the annual meeting. Thus became a custom of holding an attractive educational scientific event immediately prior to the main part of the annual meeting.

Although the scientific content of the annual meetings in the 1970s increased, attendance did not. The Montréal meeting in 1967 had marked a high point in the number of registrants (510), and a disturbing characteristic of the following decade was a levelling

Dr. David Bevan, Chairman of the Scientific Affairs Committee, presenting Dr. H. Barrie Fairley with a certificate recognizing his Royal College Lecture in 1986. Dr. Fairley, of Stanford University, was himself chairman of the Scientific Affairs Committee before he left for California in 1970.

The President and Past President with winners of the Residents' Competition, Ottawa, 1978. From left to right: Drs. Germain Houle, Douglas Crowell, Susan Bright, Richard Lee and Keith Rose.

off at smaller numbers of registrants, even though the Society's membership in this period steadily increased (Appendix 7).

These statistics were of great concern to Dr. Emerson A. Moffitt of Halifax, who asked, "Is it whither goeth, or wither goeth, the annual meeting of the Canadian Anaesthetists'

The Royal College Lecture in 1978 was Dr. R.D. Miller of San Francisco. To his left are Dr. Douglas E. Crowell, the President, and Dr. Gilles Hurteau, representing the Royal College.

Dr. Emerson Moffitt, Winnipeg, June 1984. Dr. Moffitt was awarded the Society's Gold Medal in 1990.

In conversation during the pre-dinner reception at Saskatoon's Bessborough Hotel in 1977 are Drs. Nancy Ironside (Orillia) and Iain MacKay (Toronto; President 1973–74).

TABLE 9.6
The Annual Meeting: Refresher Courses, 1979

Track I		Track II	
Topic	Lecturer	Topic	Lecturer
Preoperative Assessment of Patients with Pulmonary Disease	A.W. Scott (Toronto)	Pharmacokinetics of the Commonly Used Agents	C. Hug (Atlanta, Georgia)
Management of Respiratory Failure	K. Rehder (Rochester, Minnesota)	The Anaesthetic Machine and Its Circuits – How Do They Work?	C. Hope (Halifax)
Perioperative Management of Fluids, Electrolytes and Acid-Base Balance	J. Hewson (Hamilton)	The Anaesthetic Machine and Its Circuits – What Can Go Wrong?	G. Wyant (Saskatoon)
Preoperative Assessment of the Patient with Cardiac Disease	E.A. Moffitt (Halifax)	A Look at Paediatric Anaesthesia in 1979	D. Pelton (Toronto)
Anaesthetic Management of the Cardiac Patient for Non-Cardiac Operations	G. Houle (Montréal)	A Look at Obstetric Anaesthesia in 1979	R. Pahalniuk (Winnipeg)
Identification and Management of Arrhythmias	E. Wynands (Montréal)	Anaesthetic Management of the Patient with Head Injury	J. Wade (Winnipeg)

Society?"[4] From 1974 to 1978, attendance at the annual meeting averaged only 307; Dr. Moffitt's interest in cardiac anaesthesia moved him to remark that "there was a slide down the failure side of the curve, to analogize with ventricular function." The numbers told the story: in the opinion of Dr. Moffitt and others involved in planning the annual meetings, members did not perceive the program to be sufficiently attractive and useful. It was essential to revitalize the Society's annual meeting.

Accordingly, new features were introduced at the 1979 meeting in Edmonton. The principal innovation, attributed to Dr. Moffitt himself, was a 2-track series of concurrent

A group of hard-working volunteers take a break during the Annual Meeting in Montréal, June 1976. From left to right: Mme Lise Lamarche, Mme Louise Boulanger, Mrs. Mary Wynands, Leslie Vandewater, Mrs. Mary Vandewater, Mme Rose-Marie Houle, Denis Houle and Micheline Houle.

refresher courses.[5] The topics were practical and the lecturers were acknowledged experts (Table 9.6). In the main program there was one panel on monitoring and another on the outpatient facility. The Residents' Competition, numerous free papers, 10 scientific exhibits and a session on Computer-based Patient Management Problems completed a full program.

The treatment worked: 349 persons registered for the Edmonton meeting. The annual meeting, considered by Dr. Moffitt in 1978 to have been "moribund and in need of advanced life support," seemed in 1979 to be "alive and recovering: not well yet, but well on the way to renewed vigour and life."[6]

Dr. Moffitt also detected an "intangible but unmistakable air of enthusiasm and satisfaction." This seemed to confirm that the process of recovery had begun.

1980–1992: The Continuing Need for Review

By 1980 a basic organizational structure for the annual meeting had been established. The Program Committee recognized the need to add new elements to avoid entropy and, more importantly, to continue attracting anaesthetists to continuing education. (The Program Committee was originally an *ad hoc* committee, but after 1972 the responsibility for planning and conducting the scientific part of the program was entrusted to the Scientific Affairs Committee.) From 1950 to 1992 a basic matrix evolved, into which elements, many old and tried but some new and to be tested, were added as seemed appropriate. The Annual Meeting (both the scientific part and the social part) became an increasingly rich and complex kaleidoscope of offerings (Table 9.7).

TABLE 9.7
The Annual Meeting: Chronological Development of Principal Elements

Element	Year Introduced
Scientific Component	
Free papers (separate)	1950
Round-table Session	1950
Panel	1950
Guest Lecture	1950
Work in Progress Report	1958
Debate	1959
Residents' Program	1967
Scientific Exhibits	1968
Symposia	1969
CME Session	1975
Clinical Forum	1976
Refresher Courses	1979*
BLS Course	1980
Section Meeting	1980
Audiovisual Exhibits	1981
Free Papers (concurrent)	1985
Section Luncheon	1985
Poster Discussions	1987
Breakfast Seminar	1987
Poster Displays	1988
Residents' Seminar	1991
Medical Grand Rounds	1992
Section Breakfast	1992
Period	
Monday–Wednesday	1950
Monday–Tuesday	1952
Monday–Thursday	1959
Sunday–Friday	1965
Sunday–Thursday	1966
Saturday–Wednesday	1979
Friday–Tuesday	1990

* The first Refresher Course was, in fact, held in 1945. This ran for 2 weeks, immediately preceding the annual meeting.

In June 1989 the Society met in Ottawa with The Association of Anaesthetists of Great Britain and Ireland. Shown here are Drs. Rod Gordon (Toronto), John Dundee (Belfast), Max Minuck (formerly of Winnipeg) and Gordon Wyant (Saskatoon).

It was further enriched when the Society invited societies from other countries to join the program in 1985 (The Australian Society of Anaesthetists), in 1989 (The Association of Anaesthetists of Great Britain and Ireland) and in 1990 (The Japan Society of Anesthesiology).

Despite the best efforts of program committees, attendance at the annual meetings in the 1980s remained more or less constant. In 1980, 505 individuals registered; in 1987, 495. In the same period, however, membership increased from a little over 1800 in 1980 to almost 2100 in 1987 (Appendix 7). Clearly, the Society had to review the timing and location of the meeting, its duration and its increasing cost. Accordingly, in May 1985 a Task Force was struck[7] "to examine all aspects of the Annual Meeting."[8] Dr. John Price of Fredericton was appointed chairman; Drs. James E. Beckstead (Winnipeg, and Honorary Treasurer), David R. Bevan (Montréal), Douglas E. Crowell (Toronto), Germaine Houle (Montréal, and Honorary Secretary), Kenneth Turnbull (Vancouver) and W. Desmond R. Writer (Halifax) were named members. (Dr. Ian E. Purkis of Halifax replaced Dr. Turnbull in June 1986.)

The Task Force solicited submissions from the provincial divisions, university departments of anaesthesia and individual members. A questionnaire also elicited the opinions of 2,035 active and associate members. Although the mandate called for an examination of all aspects of the annual meeting, the questionnaire solicited views "on specific aspects of the annual meeting not related to the Scientific Programme."

Dr. John Price (President, 1983–84) in conversation with Dr. Ian Purkis (President, 1966–67), June 1984.

The Vancouver meeting in 1990 was notable because of the presence of the Japan Society of Anaesthesiology. Here the President of the Canadian Society of Anaesthetists, Dr. Desmond Writer stands with Dr. Fujimori, the President of the Japan Society, together with Mrs. Marijke Crosby and Dr. John Crosby, co-chairs of the Local Arrangements Committee.

A comprehensive set of guidelines had been drawn up in 1974,[9] when Dr. Vandewater was the Honorary Secretary, which the Task Force could draw on. While these guidelines principally concerned the planning of the annual meeting, they provided a great deal of information about the structure and the *desiderata* for the annual meeting as they had been developed until that time.

The Task Force's study was useful in focusing ideas about the annual meeting. It stated that the purpose of the meeting was to encourage participation in continuing medical education, provide a forum where research results could be presented, and enable anaesthetists from different parts of the country to make social and personal contact with each other and see different parts of Canada.

A total of 745 questionnaires (36.5% of those sent out) were returned. This enabled the Task Force to gauge the membership's views and wishes. Some were consistent with changes that had already been introduced. The Task Force's recommendations included:

1 *Meeting dates and days.* The Society should continue to meet in mid-June, but the meeting should start on a Friday rather than a Saturday. Conflicts with dates of meetings of surgical specialty societies should be avoided. The Society's Annual Meeting would not be held in conjunction with that of the Royal College. Conjoint meetings with anaesthesia societies from other countries would continue to be held periodically.

2 *Location.* The meeting should be held in different parts of the country, in cities that could host it. Specifications should be drawn up and met in deciding the locations.

3 *Budget.* The overall meeting budget should be designed to bring "a modest surplus" to the Society. Costs of social events, except the annual dinner, should be separate from registration costs. Commercial sponsorship for all social events and for light meals and beverages could be solicited. Payment of honoraria to various participants should be reviewed, but honoraria should be paid from the Treasurer as a single source.

4 *The annual dinner.* This should be the premier social event. At this event, for which "black tie" dress should be suggested, a guest speaker or an after-dinner entertainment should replace the annual dance and the Society's awards, honours and prizes; only the Gold Medal should be presented at the dinner.

5 *Presentation of awards, honours and prizes.* Some of these should be presented immediately before the Royal College Lecture: the CAS Research Award, the Sheridan Research Award, the CAS Prize, and the Residents' prizes. Prizes for audiovisual and scientific presentations and posters should be presented at the annual business meeting.

The only meeting of the International Anesthesia Research Society held in Canada was in 1947, and was hosted by Québec. The group shown here comprises, from left to right and from rear to front: Mr. Kim Hallamore, Dr. Wesley Bourne, Mrs. Florence Guedel, Dr. Arthur E. Guedel, Dr. Brian Sword and Mr. Richard Foregger; Dr. Harry Lapp, Maude Lapp, Dr. Digby Leigh, Dr. Kathleen Belton and Mrs. Micci Foregger.

6 *Scientific Program.* Certain aspects should continue unchanged: publication of the abstracts of free papers ("regardless of the commercial sponsorship available"), selection of the free papers by the Scientific Affairs Committee, the general format, "hands on" workshops, and evaluation of the meeting by the registrants. Certain features might be added: poster presentations, cracker-barrel sessions at the end of the day, and moderated luncheons. Guidelines defining the duties of chairs of the scientific sessions should be drawn up, and judging criteria should be formulated for scientific exhibits and audiovisual presentations. Terms of reference for the judges in the Residents' Competition should be defined.

7 Co-sponsorship by the *International Anesthesia Research Society (IARS).* For many years American anesthesiologists had attended the Annual Meeting, but it had not been possible for them to receive educational credits. This became possible when the Society and the IARS reached agreement whereby the IARS became a co-sponsor of the meeting, being represented on the Scientific Affairs Committee by two IARS members who happened to be Canadians. (Over the years, Drs. E.A. Moffitt, D.B. Craig and D.R. Bevan served in this capacity.) The relationship between the Canadian Anaesthetists' Society and the IARS should continue, albeit with a periodical review of the implications of the arrangement for the Canadian Society.

The annual dinner, Seigniory Club, 1964. Dr. Stuart Vandewater (wearing lifejacket) initiates Dr. "Horky" Graves into the "Queen's Pool Dippers' Club." Other head table guests were (left to right) Drs. S.M. Campbell, J. Payne (England), R.A. Gordon, F. Hudon and L. Longtin. Drs. H.R. Griffith and G. Cousineau can be spotted near the head table.

Awaiting dinner during the annual meeting in Québec City in 1971 were members of the Head Table. An honoured guest from Boston was Dr. Leroy Vandam (second from left). Drs. Alan Conn (sixth from left) and Jean-Paul Dechêne and Miss E.R. Campbell (right, foreground) were also present.

The annual dinner, Winnipeg, 1970.

The Kingston meeting in 1975 was full of ceremony. Here, pipes and drums from the Royal Military Academy lead in the Head Table to dinner.

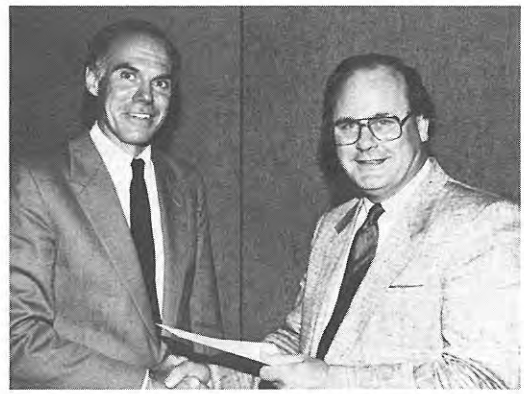
Dr. Germain Houle (President, 1978–79) not so subtly alters the meaning of the Society's motto, "We watch closely those who sleep." A lighter moment during the annual dinner, Montreal, 1976.

Enjoying the conviviality of the annual dinner in Ottawa, 1978, was this group from Québec: standing, from left to right, Drs. Marcel Boulanger, Claude Lepage, Rosario Jenis and Yves Lamarche and their wives.

In 1978 the annual meeting was held in Ottawa. Present at the annual dinner was this distinguished group, from left to right and rear to front: Drs. Norman McMillen (President, 1970–71), Melvin Bowering (1956–57), Rice Meredith (1960–61) and Rod Gordon (1963–64), and Mmes Ardath McMillen, Ruth Gordon, Marion Bowering and Suzanne Power.

Sharing a table at the annual dinner in Ottawa, 1978, were, standing from left to right, Drs. Gordon Wyant (President, 1971–72), Jean-Paul Dechêne (1972–73), Donald Aitken (Honorary Treasurer, 1971–77) and Norman McMillen (1970–71), and seated, from left to right, an unidentified guest and Mmes Anne Wyant, Betty Aitken and Therèse Dechêne.

Dr. E. W. Lunney (President, 1957–58) addressing the annual dinner at the Seigniory Club, June 1958.



Dr. Bob Byrick receives the CAS Prize for 1988 from Dr. David Bevan. Both Dr. Byrick and Dr. Bevan at different times chaired the Scientific Affairs Committee.

Dr. John Price, outgoing President, installs the new President, Dr. Terence Queree, June 1984.

The Royal College Lecture is a high point of the annual meeting. In 1980 the Lecturer was Professor Werner Kalow, of the University of Toronto (far right). Representing the Royal College was Dr. Robert Salter. To his right are Dr. David Steward, then Chairman of the Scientific Affairs Committee and Dr. William Farley, outgoing President.

The Task Force's report was useful as an assessment of the direction that the annual meeting should take. It also indicated that the annual meeting, like the Society itself, was always changing, and that such an important event should be examined from time to time to ensure its continued usefulness to the membership.

Regional Meetings

Meetings held regularly by the divisions have always attracted attention. Indeed, as Dr. Moffitt pointed out, they are sometimes proportionately better supported than the annual meeting itself.[10] In 1978 the Atlantic Division meeting attracted 55 registrants, the Québec meeting, 196; the Ontario, 160; and the Western, 193. In other words, twice as many persons attended divisional meetings as attended the annual meeting.

This is not surprising because the distances to be covered by most members to attend a divisional meeting are not so great. Divisional members have much in common to discuss with each other, and the expenditure of time and money is less of a concern.

TABLE 9.8
Regional Meetings: The Western Division Meeting, Calgary, 1958

Topic	Speaker
Mechanical Ventilators in Thoracic Surgery	C.R. Stephen (Durham, NC)
Risks of Anaesthesia in the Patient with Coronary Heart Disease	R.W. Milnes (St. Boniface)
The Effect of Chlorpromazine on the Pulmonary and Systemic Arterial Pressures in Dogs	A.K. Bradshaw (Edmonton)
Resuscitation	C.R. Stephen (Durham, NC)
Comparative Study of Neraval	G.M. Wyant (Saskatoon)
Anaesthetic Problems in Infants	C.R. Stephen (Durham, NC)
A Report on Trilene Anaesthesia in The Royal Alexandra Maternity Hospital, Edmonton, Alberta	R.D. Scragg (Edmonton)
Cardiac Resuscitation, Defibrillation, etc. (accompanied by a film)	W.A. Dodds (Vancouver)
Induced Hypothermia	E.T. Thomas, C.J. Kilduff (Saskatoon)
Anaesthetic Considerations in the Use of Hormones	H.R. McPhail (Calgary)
Controlled Apnoea with Relaxants and Respirator for Laryngoscopies and Bronchoscopies	G.E. Sleath (Vancouver)

TABLE 9.9
Regional Meetings: The Ontario Division Meeting, Kingston, 1964

Topic	Speaker
Preoperative Preparation and Sedation	
– NPO	D.J. Delahaye (Kingston)
– Barbiturates vs Analgesics	R.M. Smith (Boston, MA)
– Atropine, Hyoscine or Nothing	T.J. McCaughey (Winnipeg)
– Discussion	F.J. Wright (Hamilton)
Fluid Balance and Blood Replacement	
– Fluids and Electrolytes	D.S. Alexander (Kingston)
– Blood Volume and Transfusion	A.W. Conn (Toronto)
– Discussion	A.B. Noble (Montréal)
Intubation for Tonsillectomy	
– Views of an Otolaryngologist	G.B. MacPherson (Kingston)
– We do!	T.J. McCaughey
– We don't!	A.W. Conn
– Discussion	L.E. Simonsen (Port Arthur)
Hyperbaric Oxygen	R.M. Smith (Toronto)
Ether Anyone	
– Advantages	R.M. Smith
– Other Inhalation Agents	T.J. McCaughey
– I.V. Barbiturates	A.W. Conn
– Discussion	J.W. Fyfe (Sudbury)
Relaxants in Children	
– Advantages	T.J. McCaughey
– Hazards	A.W. Conn
The Cardiovascular and Respiratory Effects of Hypoxia	J.D. Hatcher (Kingston)
– Discussion	H.B. Fairley (Toronto)
Present Organization for the Training and Registration of Inhalation Therapy	A.B. Noble
– Discussion	R.I. Probert (Hamilton)
Role of the Anaesthetist in Oxygen Therapy	
– Discussion	W.E. Spoerel (London)
	H.W. Boyes (Kingston)
Tents, Masks, Catheters, Theory	R. Neill (Kingston)
– Discussion	M. Tousignant (Ottawa)

The regional meetings have provided an excellent source of continuing education, and their scientific value is undoubted. To illustrate this, Tables 9.8 and 9.9 summarize the content of two regional meetings: the Western Divisional Meeting in 1958, and the Ontario Divisional Meeting in 1964. Canadian anaesthetists now have to consider which of the numerous meetings in all of North America offer the best value for time and money, and the termination of the biennial western provinces' meetings as of 1990 may be an indication of the surfeit of available meetings.

CHAPTER TEN

The Society's Journal

BY R.A. GORDON, D.B. CRAIG AND D.R. BEVAN

> "I, Norman Alexander McLarty, Secretary of State of Canada ... do constitute ... THE CANADIAN ANAESTHETISTS' SOCIETY ... to advance the art and science of anaesthesia and to ... *edit and publish a journal of anaesthesia.*"
>
> *(Letters Patent, 21 June 1943)*

THE goal of the Society's founders to produce a journal of anaesthesia showed remarkable foresight. In 1943, there were no specialist medical journals in Canada. The profession was served largely by the *Canadian Medical Association Journal* (1911) and by regional, general journals such as *L'Union Médicale du Canada* and the *Nova Scotia Medical Bulletin* (1922), *Ontario Medical Review* (1934), *Manitoba Medical Association Review* (1934) and the *Saskatchewan Medical Quarterly* (1937). Indeed, the *Canadian Anaesthetists' Society Journal* (*CASJ*) was only the second specialty medical journal in Canada, having been preceded by the *Journal of the Canadian Association of Radiologists* in 1950.

Internationally, the first independent anaesthesia specialist journal, *Current Researches in Anesthesia and Analgesia*, had evolved from a section in *The American Journal of Surgery* in 1922. Other countries were slow to follow, although progress was more rapid in Europe than in North America (Table 10.1).

The first issue of the *CASJ* was published in July 1954 and contained summaries of papers presented at the 1954 annual and regional meetings of the Society. For two years previously, the publication of the *Proceedings* of the Society was sponsored by Squibb Pharmaceuticals, and it was their success that encouraged Council in March 1954 to recommend the publication of a quarterly journal. Dr. R.A. Gordon was appointed Editor and arrangements were made for printing by University of Toronto Press. It was agreed that articles would be published in either English or French with Summaries or Abstracts in the other language. It was hoped that the Journal would provide "a suitable Canadian medium for the presentation of original work by Canadian anaesthetists."[1]

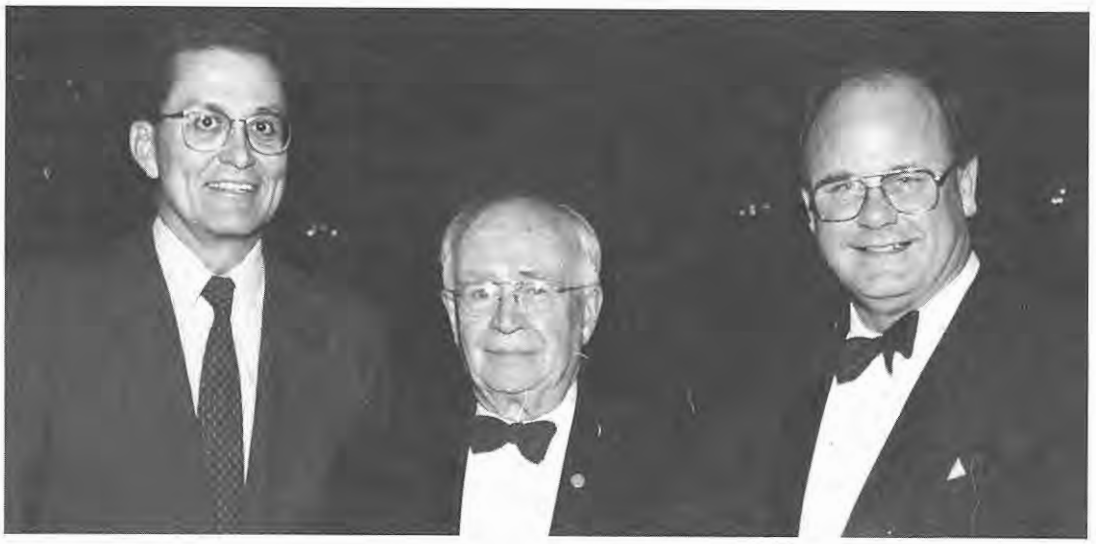
TABLE 10.1
Anaesthesia Journals Published 1922–1954

First Issued	Original Title	Country
1922	*Current Researches in Anesthesia and Analgesia*	USA
1923	*British Journal of Anaesthesia*	UK
1928	*Narkose und Anaesthesie*	Germany
1928	*Der Schmertz*	Germany
1935	*Anesthésie et Analgésie*	France
1935	*Minerva Anestesiologia*	Italy
1939	*Revista Argentina de Anestesiologia*	Argentina
1940	*Anesthesiology*	USA
1946	*Anaesthesia*	UK
1950	*Acta Anaesthesiologica Belgica*	Belgium
1950	*Acta Anaesthesiologica Italia*	Italy
1951	*Revista Brasileira de Anestesiologia*	Brazil
1952	*Der Anaesthesist*	Germany
1952	*Japanese Journal of Anesthesiology*	Japan
1952	*Revista de la Sociedad Mexicana de Anestesiologia*	Mexico
1953	*Cahiers d'Anesthésiologie*	France
1953	*Indian Journal of Anaesthesia*	India
1954	***Canadian Anaesthetists' Society Journal***	**Canada**

The Editors

The first Editor, R.A. Gordon, held the position for 28 years (1954–1982). It was he who established the format of the Journal: bilingual presentation, Editorial Board composition, arrangements for publication, and in-house management of the advertising. Too often, he was also responsible either for writing or canvassing manuscripts from the university departments of anaesthesia. It should be remembered that, in 1954, the Society consisted of only 500 members. Nevertheless, the early issues contained approximately 100 pages of editorial material. Inevitably, these issues consisted of reviews and papers presented at regional and national meetings in Canada and were written by Canadians. Gradually, both the style and origin of the manuscripts changed. Reviews, Case Reports, and descriptions of new drugs gave way to reports of original scientific studies, and more articles were received from outside Canada.

During the early years, the cooperation of Dr. Ralph Tovell, Editor of *Anesthesiology*, and Dr. Harry Seldon, Editor of *Anesthesia & Analgesia: Current Researches*, was invaluable.



Three generations of editors, Toronto, 1992. Dr. Rod Gordon (Editor, 1954–1982) flanked on the left by Dr. Doug Craig (1983–1988) and on the right by Dr. David Bevan (1989 to present).

These editors frequently had more acceptable papers available than they could accommodate, and referred authors to the *CASJ*. Gradually, contributions from outside Canada increased so that, by 1961, 25% of the contents originated from American universities. Dr. Gordon's long-term efforts as founding Editor are recognized by his continuing appointment, since 1983, as Editor Emeritus.

The second Editor, Douglas B. Craig of Winnipeg (1983–1988), undertook a major reorganization of the presentation and functioning of the Journal. The Editorial Board was expanded with the goal to include a representative from each university department (never quite achieved) and a community anaesthetist, Andrew Davies, North Bay, Ontario. The business affairs of the Journal were moved from the editorial office, at this point based in Winnipeg, to the Society's head office in Toronto, and the advertising sales were contracted to an advertising agency. The Journal was totally redesigned, the cover changing from the traditional beige to deep green in 1983, and the title to the *Canadian Journal of Anaesthesia/Journal Canadien d'Anesthésie* (*CJA*) in 1987. The title change was intended to communicate unequivocally that the Journal was truly international in its source of manuscripts and its readership. Although this had been the case virtually from the outset, the inclusion of the Society name in the Journal title had created misunderstanding by individuals not directly aware of the contents of the Journal.

There was a complete text design change in 1983. Each manuscript submitted was reviewed by a member of the Editorial Board and at least one other reviewer, usually from one of the university departments of anaesthesia. Such changes reflected the growing confidence and maturity of the Canadian academic anaesthetic community, and the Journal allowed them to become involved with a highly regarded international publication. Thus, the *CJA* became a unifying focus for Canadian academic anaesthesia. The membership and

subscriber base allowed the Journal to develop without financial constraints.

David R. Bevan (Montréal and then Vancouver), the third Editor (1989–present), was, like Doug Craig, a member of the Editorial Board of *Anesthesia & Analgesia*. Thus he came under the influence of the latter's Editor-in-Chief from 1977 to 1991, Nicholas Greene, the dean of North American editors of anaesthesia journals and who had previously been Editor-in-Chief of *Anesthesiology*. During these years, the rapidly increasing number of contributions, both from Canada and the rest of the world, led to a need for expansion. By 1986 only half the manuscripts were from Canadian investigators and clinicians. The remaining half were from the United States and elsewhere. In the 1990s the major change has been an increase of submissions from Japan.

Initially, the Journal had been published four times a year, increasing to six in 1961, eight in 1990 and ten in 1991 before becoming a monthly publication in 1993. Again, an increasing subscriber base and considerably augmented advertising revenue allowed this to be achieved without increased cost to the Society.

Editorial Board

The Editors have been assisted by Editorial Boards of varying size and geographic representation. The early Editorial Boards were small (three to four members during the years 1954 to 1968), with later expansion to six to ten members from 1969 to 1982, and 13 to 15 members since 1983. These expansions were dictated in part by increasing numbers of manuscripts received for review and were similar in nature, if not timing, with the growth of the Editorial Boards of *Anesthesiology* and *Anesthesia & Analgesia*.

There was remarkable continuity of Editorial Board service from a small number of individuals. Of the 45 members of the Canadian Anaesthetists' Society who have served on the Editorial Board to date, seven deserve special recognition for terms of service exceeding 10 years: Dr. E.A. Gain, Edmonton (21 years); Dr. Léon Longtin, Montreal (18); Dr. Alan B. Noble, Montréal (15); Dr. Gordon Wyant, Saskatoon (15); Dr. Alan W. Conn, Toronto (12); Dr. Kenneth M. Leighton, Vancouver (12); and Dr. André Jacques, Québec (11).

A separate Regional Board was established in 1960 at a time when the Journal was rarely receiving an adequate supply of acceptable manuscripts to meet its publishing commitments. The object was for the members of the Regional Board to serve as representatives for the Journal in their regions, to determine what publishable information might be available, and to recruit manuscripts for consideration for publication. This Regional Board of 11 to 12 members continued through 1968.

The position of Associate Editor was created in 1969. It was held for one year by Dr. Noble until his retirement due to ill health. Dr. Wyant assumed the responsibilities of Associate Editor in 1973, continuing in this capacity through 1982. The Associate Editor assisted the Editor-in-Chief in editing accepted manuscripts and in-house proof reading.

These editorial service functions had been provided from 1954 to 1969 by University

of Toronto Press, but the retirement of the incumbent and the absence of a satisfactory replacement led to these new roles for the Editor and Associate Editor.

The Associate Editor position was reestablished in 1991 with the appointment of Dr. Yves Lamarche (Sherbrooke). As Associate Editor Dr. Lamarche has had total responsibility for the management of French-language manuscripts. In addition, he has overseen the translation of Abstracts and Editorials.

With the expansion of the Editorial Board coincident with the appointment of the new Editor in 1983, there were also major changes in the manuscript review process. The new review forms and procedures were a blend of what the Editorial Board felt to be the best of the systems then in use by *Anesthesiology* and *Anesthesia & Analgesia*. These new processes and patterns of communication between the Editor and authors of both accepted and rejected manuscripts appeared to encourage a growing number of manuscript submissions, both from Canada and world-wide.

Key Articles

The Journal provides a glimpse not only of those involved in its production, but also of the practice of anaesthesia and clinical research over 40 years. The chosen "key articles" represent those which, in the view of the authors of this chapter, were important because they marked original contributions first reported in the Journal, recorded current practice that was ahead of its time, or marked particular contributions of Canadian anaesthetists. Space limitations prevent the inclusion of literally hundreds more articles worthy of recognition.

- Ruston FG. Epidural anaesthesia in infants and children. (1954)[2]
  A report of epidural anaesthesia with procaine or lidocaine in 77 paediatric patients undergoing abdominal surgery. Forty years later, this reminds us that our current interest in regional anaesthesia is not new.

- Lucas GHW. The discovery and pharmacology of cyclopropane. (1960)[3]
  Although popularized by Waters in Wisconsin, cyclopropane was first prepared for experimental use in Toronto by Lucas in 1928. This paper recalls the origins of the drug and its later acceptance into anaesthesia practice.

- Virtue RW, Lund LO, Phelps McK, Vogel JHK, Beckwitt H, Heron M. Difluoromethyl 1,1,2- trifluoro-2-chloroethyl ether as an anaesthetic agent: results with dogs and a preliminary note on observations with man. (1966)[4]
  The first description of the use of enflurane in humans. Anaesthesia was induced by mask with enflurane and found to be pleasant. However, this was followed by decreases in blood pressure and cardiac output and 3 of the 8 subjects were nauseous during recovery.

- Oyama T, Shibata S, Matusmoto F, Takiguchi M, Kudo T. Effects of halothane anaesthesia and surgery on adrenocortical function in man. (1968)[5]
  The first of several studies by this group to examine hormonal responses to anaesthesia and surgery. In this study, halothane anaesthesia induced small but measurable increases in circulating 17 hydroxycorticosteroids, but the increase was much greater at the start of surgery.

- Britt BA, Locher WG, Kalow W. Hereditary aspects of malignant hyperthermia. (1969)[6]
  This report by the group which had so much influence on the understanding of malignant hyperthermia and which demonstrated that at least in some situations the syndrome was inherited.

- Craig DB, Wahba WM, Don HF. Airway closure and lung volumes in surgical positions. (1971)[7]
  One of a series of reports by this group examining the clinical implications of overall airway closure. In this study, they found that closing volume increased with age and exceeded functional residual capacity in the seated position at the age of 49 yr and in the supine condition at 36 yr.

- Keeri-Szanto M. Apparatus for demand analgesia. (1971)[8]
  Acute Pain Services originated in Canada with this simple apparatus. The analgesic was placed in a motor syringe and the motor was driven through a switch-box triggered, by the patient, via a push-button. Keeri-Szanto showed that using the device after abdominal or thoracic operations reduced pain considerably.

- Bain JA, Spoerel WE. A streamlined anaesthetic system. (1972)[9]
  Although the search for a light-weight, valveless anaesthetic circuit continues, this modification of the combined Mapleson D and E systems found great popularity particularly in paediatric anaesthesia and especially for head and neck surgery.

- Gelb AW, Knill RL. Subanaesthetic halothane: its effect on regulation of ventilation and relevance to the recovery room. (1978)[10]
  Meticulous assessment of ventilation and the ventilatory response to isocapnic hypoxemia revealed that low doses of halothane (0.05 and 0.1 MAC) markedly reduced ventilatory responses to hypoxemia. These data and later reports from the same laboratory established that patients may have a significant impairment of the ventilatory response to hypoxemia persisting for some time after patients regain consciousness.

- Noble WH, Kay JC, Fisher JA. The effect of PCO_2 on hypoxic pulmonary vasoconstriction. (1981)[11]
  Noble and his colleagues provided a large volume of important information that aided the understanding of the origin and therapy of the adult respiratory distress syndrome (ARDS). This article described the use of a sophisticated model to isolate factors influencing hypoxic pulmonary vasoconstriction (HPV).

- Mallampati SR, Gatt SP, Gugino LD, Desai SP, Waraksa B, Freiberger D, Liu PL. A clinical sign to predict difficult tracheal intubation: a prospective study.(1985)[12]
An observation by Mallampati published two years earlier in the Correspondence section of the Journal was here subjected to careful scrutiny. The demonstration that the preoperative ability to visualize upper airway anatomy is a valid means of predicting the degree of difficulty in laryngeal exposure during tracheal intubation has proven useful clinically.

- Cohen MM, Duncan PG, Pope WDB, Wolkenstein C. A survey of 112,000 anaesthetics at one teaching hospital (1975–83). (1986)[13]
This initial paper from this group reported the results of the epidemiologic analysis of a huge data base in a tertiary care hospital. The analysis provided both useful information with respect to methodology and also an introduction to the more detailed analyses of clinical care issues published subsequently by the same authors.

- Byrick RJ, Kay JC, Mullen JMB. Pulmonary marrow embolism: a dog model simulating dual component cemented arthroplasty. (1987)[14]
The development of a sophisticated and reproducible model of pulmonary marrow embolism allowed the careful investigation of the etiology of the cardiopulmonary changes associated with cemented arthroplasty procedures. Therapeutic interventions that may detect and prevent the marrow microembolism syndrome intraoperatively were also examined.

- Plumley MH, Bevan JC, Saddler, Donati F, Bevan DR. Dose-related effects of succinylcholine on the adductor pollicis and masseter muscles in children. (1990)[15]
This report is symbolic of a large number of reports by the same group demonstrating, using meticulous measurement techniques, the clinical effects of various neuromuscular blocking and reversal agents. This article raised the possibility that masseter muscle rigidity is a normal response, of variable intensity, to succinylcholine, rather than being pathognomonic of malignant hyperthermia.

- Maltby JR, Lewis P, Martin A, Sutherland LR. Gastric fluid volume and pH in elective patients following unrestricted oral fluid until three hours before surgery. (1991)[16]
The demonstration by this group that traditional fasting regimens both lacked logic and may even be less desirable then the administration of limited oral fluids until 3–4 hours preoperatively in healthy patients successfully challenged traditional beliefs and led to revisions of clinical practice.

Special Issues/Supplements

Abstracts of papers presented at the Society's annual meeting have always been presented in the Journal. Since 1983, they have appeared, together with the annual meeting Refresher

Course summaries, as a separate Supplement: Part II of the May issue. As the number of Abstracts increased, so too did the size of the Supplement. It was anticipated that in this format the Supplement would provide greater educational importance. This matched a similar presentation by *Anesthesia & Analgesia*.

Special issues and Supplements also brought together several studies concerned with the introduction of new drugs. The July 1957 issue included nine articles about halothane and marked the first international coordination between Canadian and American anaesthetists.[17] This was circulated to the whole subscriber list of *Anesthesia & Analgesia*, which was provided by Dr. Harry Seldon. This had the effect of increasing circulation dramatically. The second, for isoflurane, published in 1982, was the report of a multi-centre evaluation of the new inhalational agent. This report was remarkable for its ability to coordinate a multicentre clinical evaluation of the drug in 165 university teaching hospitals throughout Canada and the United States.[18]

The contribution of Harold Griffith to the development of anaesthetic practice was celebrated with a Supplement in 1992, edited by Drs. J. Roger Maltby and David A.E. Shephard.[19] This was a tribute on the 50th anniversary of the introduction of curare into anaesthetic practice. The editors grouped several of Griffith's publications into sections – endotracheal intubation, cyclopropane, curare, WFSA, etc. – and each was accompanied by a commentary by a currently practising anaesthetist.

Support of Research

The existence of the Journal provided a means of publishing the work of Canadian anaesthetists. Commencing in 1960, an annual prize was awarded to the authors of the "best" manuscript published by Canadian anaesthetists in the Journal, but this was rolled over into the Canadian Anaesthetists' Society Research Fund in 1985 after the presentation of its first Canadian Anaesthetists' Society Research Award. The Editorial Board decided that the $1,000 was better spent establishing research projects than celebrating their completion.

The first Canadian Anaesthetists' Society Research Award in 1985 to Dr. Howard J. Nathan of Ottawa was a symbolic and practical contribution to increase the number of career investigators and researchers in training in anaesthesia in Canada. The Trustees of the Research Fund had the foresight to establish it in 1979, and constant promotion by Dr. Gordon Sellery encouraged Council, Society members, divisions, and corporate donors to join the cause. For the first time, money was available to support anaesthetists who had acquired, through special training and experience, skills that would allow them to begin research careers in anaesthesia as Canadian researchers in Canadian research programs.[20] The Journal played its part by contributing to the first award from its profits. It seems only appropriate that the next award established by the Society, should, as the Dr. R.A. Gordon Clinical Research Award, honour the Journal's first editor.

Continuing Medical Education Role

It might be argued that the entire scientific content of the Journal can be considered as filling the continuing medical education (CME) needs of the reader. The Journal has, through the years, made special efforts to address the CME needs of its readers, through the inclusion of Review Articles and, from 1983 to 1986, a specifically designated CME Section. The CME Section was prepared on a rotating basis by the 16 Canadian university departments of anaesthesia and was intended to include timely and authoritative summaries on clinically relevant subjects, followed by a series of self-assessment questions. Although this format was popular with Journal readers, it was impossible to sustain on an every-issue basis and has continued in the form of occasional CME articles, without a direct university departmental role.

Publication of Society News Within the Journal

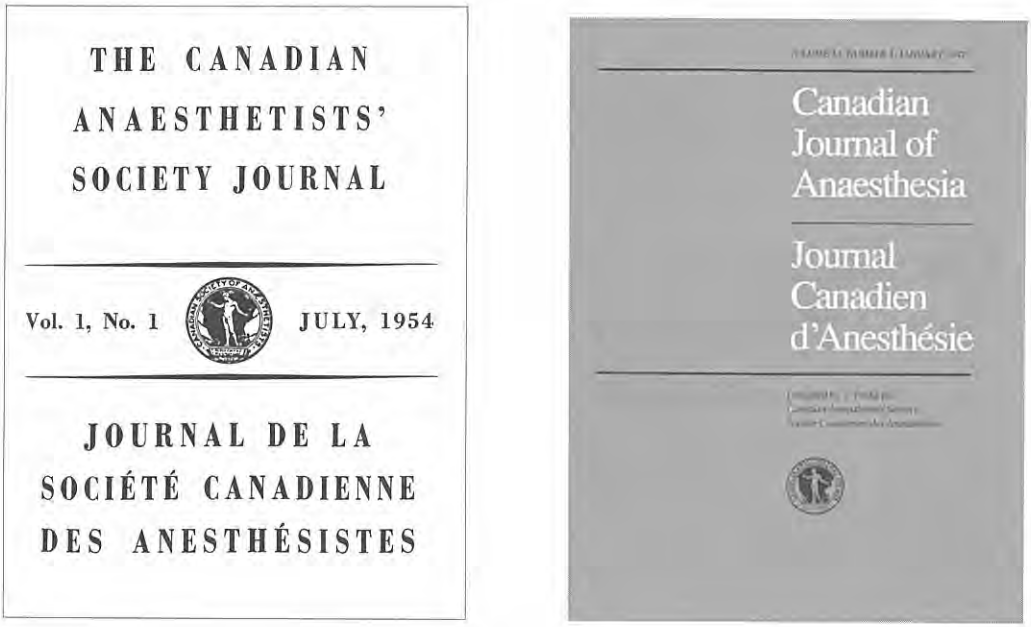
The *CAS Newsletter* has been a separate Society publication since 1950, designed to provide information to members on activities of the Society and its divisions. From 1955 to 1968 the Newsletter was incorporated with the *CASJ*. The Society's Membership List was also published in the Journal from 1957 to 1966. These practices were discontinued because it was considered inappropriate for Society news to be included in a journal that had a wide international distribution. Notwithstanding this earlier conclusion, including the Newsletter within the Journal was tried again in 1983 and 1984. On this occasion the Newsletter was part of the non-indexed commercial advertising section. This trial was discontinued when it became clear that the rigidity of the publication schedule associated with a scientific journal was incompatible with the separate needs of a newsletter.

Journal Production and Distribution

The Journal has always been produced by a single printer, University of Toronto Press. The Press has consistently provided a high quality pre-press process and final product. The Press also arranges the delivery of the Journal to the Canadian and United States postal systems.

Although concern had been expressed about possible difficulties in managing the scientific content of the Journal from editorial offices remote from Toronto, significant problems in this area have not occurred, despite editorial offices located in Winnipeg (1983 to 1988), Montreal (1989 to 1991), and Vancouver (since 1992).

From 1954 to 1982 the dimensions of the Journal were 6.5 x 10 inches, with text printed in a single column from 1954 to 1969, and double columns thereafter. The size was increased twice, first in 1983 to 7 x 10 inches and then in 1987 to 8 x 11 inches. The changes were driven by text-design factors in the first instance and by commercial adver-



A comparison of Journal covers (1954 and 1987).

tising copy size considerations later. One of the reasons for the financial success of the Journal in recent years has been the adoption of the most common North American journal size and the resulting ability to employ, without modification, advertising copy and inserts prepared for inclusion in other journals.

Although the initial circulation base was primarily the membership of the Canadian Anaesthetists' Society, a broad international circulation developed within several years. This pattern has continued, with the result that well over one half of the Journal circulation is outside Canada. The total paid circulation in 1992 was approximately 5,500.

Journal Finances

The Journal has always been available as a right of membership to Society Members. A portion of each member's annual dues has been paid by the Society to the Journal. The relationship of this payment to the standard non-member subscription rate has varied through the years, but has approximated one half of the full rate. The large size of the non-member individual and institutional subscription base, plus the income from commercial advertising, have permitted this preferential rate for members.

Commercial advertising page and income volumes have increased substantially in recent years, in common with the experience of other North American-based anaesthesia journals, and these increases have provided further stability to the Journal financial base.

The financial stability of the Journal has allowed it to contribute to the overall finances of the Society, with a return of profit to the Society in recent years exceeding the members' subscription payments.

CHAPTER ELEVEN

The Society and Allied Health Professionals: Respiratory Technologists and Anaesthesia Technicians

FOR the Society's founders, ethical aspects of the practice of anaesthesia were important enough to be distinguished as identifying objects for the Society. The founders were particularly concerned with two aspects of the practice of anaesthesia. They first insisted on the principle that the administration of anaesthesia was part of the practice of medicine and was, therefore, a medical act.[1] Consequently, in Canada the Society objected strenuously to the administration of anaesthesia by nurses,[2] or even to the implication, as in a cartoon, that anaesthesia was ever administered by nurses.[3] The founders also insisted that it was unethical for an anaesthetist to enter into a relationship with an "agency" that takes it upon itself to offer anaesthetic services for a fee, instead of the anaesthetist charging the fee.[4]

If ethics is regarded broadly as implying rules of conduct, then the Society's relationships with other "agents" may be considered as part of the ethical aspect of anaesthetic practice. It has always been necessary for the Society to develop and maintain relationships with other organizations, either to facilitate its own interests or those of its members, or to provide the organizations with advice and information. Therefore the content and execution of such relationships have an ethical basis.

In some instances, it is the collegial nature of the relationship that has governed the Society's actions; the Society's relationships with The Royal College of Physicians and Surgeons of Canada, the Canadian Medical Association and the Association of Canadian University Departments of Anaesthesia are examples of such relationships and need not be amplified further here, for their significance is evident elsewhere in this book. In other instances, the morality of the nature of the relationship has governed the Society's actions; an example is the Society's relationship with the pharmaceutical and equipment industries (Chapter 12).

In this chapter two other examples of ethical relationships are discussed. Both are with allied health professionals, and representative of the Society's liaison with paramedical personnel. The first is the Society's relationship with respiratory technologists, or inhalation therapists. The relationship demonstrates the Society's willingness to share professional

expertise with members of an allied health profession and indicates how the Society facilitated the development of respiratory technology in Canada. It is a relationship in which the Society can take both pleasure and pride.

The second example is the Society's relationship to a less well defined group of allied health professionals who have been referred to as physicians' assistants, anaesthesia assistants or anaesthesia technicians. This relationship is of interest because of its manpower implications, and, more importantly, because over many years it has generated strong feelings and differences of opinion among Society members.

The Canadian Society of Respiratory Technologists

One of the Society's more unusual committees served as obstetrician at the birth of a new paramedical organization, originally known as the Canadian Society of Inhalational Therapy Technicians (CSITT) and, later, the Canadian Society of Respiratory Technologists (CSRT). Although the Society's involvement with respiratory technologists was not directly related to the development of anaesthesia in Canada, its relationship to the CSITT illustrates how the Canadian Anaesthetists' Society advanced the cause of respiratory technologists even though their role was then not appreciated in many hospitals.

On 4 September 1960 Council discussed a letter from the Québec Division concerning the question of sponsorship of inhalational therapists in Canada. Interest in the role of inhalational therapists had originated in the desire to have some type of paramedical professionals look after oxygen therapy. The Québec Division had passed a resolution recommending that the Canadian Anaesthetists' Society take appropriate action, including forwarding the matter to the Canadian Medical Association (CMA) so that regulations governing inhalational therapists might be formulated. Council duly approved the motion of Drs. H.B. Graves and W. Esdale, both of British Columbia, that the Society sponsor the formation of an organization for inhalation therapists. The Québec Division's resolution was, as well, passed on to the CMA.

Inhalational therapists in Canada were anxious to form their own society, as their counterparts had done in the United States and United Kingdom. Responding to the action taken by the Canadian Anaesthetists' Society, the CMA had advised that, if a committee were set up to deal with this matter, the Society would be asked to appoint personnel.[5] Accordingly, Council approved a motion by Dr. James Wishart of Vancouver and Dr. David Power of Montréal that led to the formation of a committee to facilitate the creation of a Society of Inhalation Therapists. Dr. Alan B. Noble of Montréal was named chairman, and Dr. Alan W. Conn of Toronto and Dr. Guy Fortin of Québec, members. Drs. Noble and Conn acceded to a request of some Canadian members to attend the annual meeting of the American Association of Inhalation Therapists in Buffalo in November 1961. This enabled them to gain further insight into an aspect of medical practice in which they were already interested.

Meanwhile, the CMA's Executive Committee arranged a meeting of interested parties

Two Presidents of the 1950s: Dr. Alan Noble (President, 1955–56), left, and Dr. Melvin Bowering (President, 1956–57).

in Montréal on 22 June 1961, at which the Canadian Anaesthetists' Society and the Canadian Thoracic Society, as well as the CMA, were represented.[6] This meeting recommended that a committee make a pilot study of educational requirements for a training program for inhalation therapists.

This committee was established by the CMA at the Executive Committee meeting in December 1961;[7] Dr. Noble was appointed chairman, Dr. Fortin was appointed a member, and Dr. Conn, a corresponding member. Also included were a thoracic surgeon (Dr. D.D. Munro), an internist (Dr. M. Aronovich), a pulmonary physiologist (Dr. F. Gregoire), and an otolaryngologist (Dr. M. Belisle).

This committee's work initiated the professionalization of inhalational therapy in Canada, but also set in train complex and often confusing interrelationships among individuals of different specialities and organizations. The end result was positive, but at times it seemed to prove that too many cooks indeed spoil the broth.

Dr. Noble reported the recommendations of his "pilot committee" to Dr. Arthur Peart, Assistant Executive Secretary of the CMA, in a letter dated 7 May 1962 and to the Society's Annual General Meeting on 15 May 1962.[8] The recommendations concerned aspects of training for inhalation technicians, but also suggested that the teaching and training programs be supervised and approved by a joint committee composed of appointed members of the Canadian Anaesthetists' Society and the CMA, with "nominations from the inhalation therapists" at their discretion. As a result of the pilot committee's recommendations, the Society was asked to inaugurate a training program.[9] The work of the committee was approved by the Society's Annual General Meeting in 1962, which initiated a long and close relationship between the Society and the CMA in this context. However, Council also made clear that the Society would only administer the project until such time as the administra-

Postprandial thoughts: Dr. Rod Gordon (standing) with Drs. Alan Conn and David Steward to his right.

tion might reasonably be undertaken by the inhalation therapy technicians;[10] there was never any intention that the Society would do other than guide and advise.

By May 1963, the pattern of future developments had been formed.[11] First, although the committee represented the Canadian Anaesthetists' Society and the CMA, members additional to the anaesthetists (Drs. Noble, Fortin, Conn, H. McCartney, J. Boucher and F.R.H. Wrigley) included representatives from the Canadian Thoracic Society (Dr. R.N. Cherniak) and the Canadian Society of Internal Medicine (Dr. B. Sproule). A representative from the Canadian Otolaryngological Society remained to be appointed. Thus the Canadian Anaesthetists' Society was required to work with representatives of several other specialties.

Second, the committee established a subcommittee on training and a curriculum, and another on accreditation. Yet another committee would be struck to deal with examinations. Third, although the Royal Victoria Hospital, Montréal, was the only hospital at that time to offer complete training facilities, the Hospital for Sick Children, Toronto, had applied to the Ontario Hospital Services Commission to form a second school, and other institutions would follow. And fourth, the organization then known as the Canadian Society of Inhalation Therapy Technicians had already applied for incorporation. Dr. Noble, emphasizing the need for inhalation therapy technicians, stated that "a group of enterprising and capable young men are anxious for our moral support and educational assistance," and he and his colleagues were justifiably pleased when these inhalation therapists received their charter, and the diploma that was first presented to successful candidates, both in 1964.[12]

Dr. Noble had always stressed the importance of CMA affiliation in order to provide a channel for nomination of specialists on the committee other than anaesthetists, and to facilitate a more effective approach to government should financial support be sought. He therefore protested the CMA's statement in July 1964 that the inhalation therapy project

was "solely a program of the C.A.S."[13] Thereafter the CMA made no nominations, although a representative of the CMA did attend meetings of the joint committee. The Canadian Anaesthetists' Society continued for many years to nominate the majority of members on the committee. Thus Dr. Tom J. McCaughey, of Winnipeg, Chairman of the committee in 1969, was quite justified in claiming that "Inhalation Therapy is our creation.[14] The growth of CSITT, which had a membership of 285 by 1969,[15] was indeed a creditable reflection on the interest that the Canadian Anaesthetists' Society had taken in inhalation therapy since 1960.

However, the efforts of interested anaesthetists in this period – notably Drs. Noble, Conn and McCaughey – was a considerable burden in terms of time, effort and money. Besides, there was some confusion in the minds of many regarding the relationship of the joint CMA/CAS committee to each body. An *ad hoc* committee chaired by Dr. Ian E. Purkis of Halifax was therefore struck to dispel this confusion and make recommendations concerning such aspects of the Joint Committee as its name, composition and role.[16]

The *ad hoc* committee's report was presented to Council at its midwinter meeting in 1970. The committee made a number of recommendations: that the committee be referred to as the CAS Advisory Committee on Inhalation Therapy; that the members include three representatives from specialties other than anaesthesia – one from the CMA Council on Education and two from the CSITT, as well as a chairman, five regional representatives and three members at large (chairs of the subcommittees on examinations, accreditation and approval of schools); that the appointment of future members be made by the Council of the Canadian Anaesthetists' Society; and that financial support include 30% from the CMA and 10% from the CSITT.

Council then approved a motion that another *ad hoc* committee be struck, this time in order to prepare a brief to request that the CMA assume the administrative and financial support for the Advisory Committee.[17] At the next meeting of Council, however, Drs. McCaughey and Conn expressed their disagreement that administration of the committee should be taken over by the CMA. Their view was understandable, for they must have been proud of what the Canadian Anaesthetists' Society had achieved in their relationship with the inhalation therapists over the years, and they did not like to see the role of the Society diminished or diluted.

This concern may have been heightened early in 1971 when Dr. McCaughey resigned the chair of the Joint Committee, and Dr. Brian Sproule, an internist, replaced him.[18] Dr. Sproule, a member of the Advisory Committee of the American Association of Inhalation Therapists, knew a great deal about inhalation therapy – now becoming increasingly frequently known as respiratory technology – and his appointment, suggested by an anaesthetist, Dr. Arthur Scott,[19] was illustrative of the areas of medical practice that utilized the services of respiratory technologists. For his part, Dr. Sproule always spoke favourably of the work of the Canadian Anaesthetists' Society. However, he did cause some consternation when, independently and without the prior approval of Council, he nominated another Edmonton internist, Dr. Patricia Lynne-Davies, to the subcommittee on accreditation of schools.[20]

Meanwhile, the CMA's response was made known to Council on 26 June 1970, when Dr. Alan A. Drysdale of Halifax reported on the discussions that had occurred during the CMA's annual meeting. The CMA was sympathetic but did not wish to become involved in financial or administrative aspects. The Association did, however, approve a motion that a committee, from the Canadian Anaesthetists' Society and the Canadian Thoracic Society, be convened to produce a basis for approval of training programs for respiratory technologists. On the other hand, it was agreed, at a meeting of yet another new committee – the CMA-CSRT Committee on Approval of Training Programs for Respiratory Technologists – that the old CAS/CMA Committee would be dissolved, though it should continue to be convened whenever the new committee met, and that the same physician representatives could be members of this new committee. This added to the complexity of the relationships now between the Canadian Anaesthetists' Society and the several different organizations.

But the work of the Society in launching the inhalation therapy program in Canada had been done. There was, moreover, evidence of change in the air, whereby guidance to respiratory technologists of a different nature was more appropriate. For example, the Society had to take note of the trend towards training respiratory technologists in community colleges, under control of provincial departments of education. There were many such institutions: in Québec, the transfer of the School of Inhalation Therapy of the Hôpital de St. Joseph de Rosemont into a CGEP system, followed by CGEPs at Vanier, Sherbrooke, Sainte-Foy and Chicoutimi; in Ontario, the Toronto Institute of Medical Technology (in association with Toronto General Hospital, Toronto East General Hospital, Sick Children's Hospital and St. Joseph's Hospital), Fanshawe College (Victoria General Hospital and St. Joseph's Hospital, London) and Algonquin College (Ottawa General Hospital and Ottawa Civic Hospital); in Manitoba, several Winnipeg hospitals; in Alberta, the Northern Alberta Institute of Technology (University of Alberta Hospital) and the Southern Alberta Institute of Technology (Foothills Hospital, Calgary General Hospital, Rocky View Hospital and Holy Cross Hospital). Even so, as late as 1971 a general understanding of the role of respiratory technology in medicine was still limited. Dr. McCaughey, for example, was constrained to say that "we felt we were crying in the wilderness to some extent because the majority of the medical profession were still ignorant of the potential of inhalation therapy."[21]

The Canadian Anaesthetists' Society recognized this, and eventually responsibility for the Society's relationship to respiratory technologists was placed under a new committee of the Society, the Committee on Allied Health Professions, which was formed in 1971. Meanwhile the Society's involvement with respiratory technology continued, for Dr. Scott later took on the chairmanship of the CAS/CTS Committee on Respiratory Technology, and Dr. F.R.H. (Deric) Wrigley, also of Toronto, took over in his turn.

The participation of the Canadian Anaesthetists' Society in the activities of Canadian respiratory technologists had originated in an initiative from the Québec Division. It is therefore appropriate to include in this survey of the development of respiratory technology in Canada some reference to the growth of the discipline in Québec.[22]

Late in the 1960s, Dr. Léon Longtin, Chairman of the Department of Anaesthesia at

A towering trio: Drs. Léon Longtin, Fernando Hudon and Rod Gordon. This was the occasion of the presentation of the Gold Medal to Dr. Hudon (centre) in 1964. Each of these three men was President of the Society and each received the Society's Gold Medal.

Dr. Luc Perrault (right) receiving second prize for his audiovisual exhibit from Dr. Kenneth Turnbull.

the University of Montréal, and Roméo Soucy, PhD, Chief of the Pulmonary Function Tests Laboratory at Rosemont Hospital, initiated a two-year course in respiratory technology. The course began with four months of lectures on physics, respiratory and cardiovascular physiology and pathology, and techniques of respiratory therapy. This was followed by 20 months of clinical training in hospitals. Because of his interest in the role played by technicians in the treatment of respiratory disease, Dr. Luc Perrault, in Dr. Longtin's department, also took part in the teaching of respiratory technologists. In 1970 Dr. Perrault,

together with Mme Paule Duplantis, the coordinator of the school of respiratory technology developed by Dr. Longtin, facilitated the transfer of training responsibilities to the college environment under the provincial Department of Education. College teaching was first effected in the Rosemont CGEP; later CGEPs at Vanier, Sherbrooke, Sainte-Foy and Chicoutimi participated in the training of respiratory technologists. By this time, respiratory technology had become part of the official teaching program of the Québec Department of Education, just as it had elsewhere in Canada through programs in colleges and institutes.

Dr. Perrault served another useful purpose, for, besides being a member of the Society's Committee on Allied Health Professions, he co-chaired, with Dr. Arthur A. Scott of Toronto, the Joint Advisory Committee on Respiratory Technologists of the Canadian Anaesthetists' Society and the Canadian Thoracic Society. He was therefore often called on to give the perspective of respiratory technology developments in Québec which, with Ontario (which Dr. Scott, in particular, spoke about) were in the vanguard of educational developments in respiratory technology in Canada. Regional representation was particularly important on the Committee on Allied Health Professions, for the desirable goal of an overall standard to which all provinces could subscribe had yet to be reached. In this respect, the Canadian Anaesthetists' Society had a useful part to play.

The Controversial Role of Anaesthesia Technicians

A role for paramedical personnel in the provision of anaesthesia services in Canada appears to have been mentioned first within the Society by Dr. Graves in a 1968 report to Council.[23] One of the terms of reference for the Survey Committee that he chaired was "to report on the possible role that non-physician paramedical personnel might assume in the future practice of anaesthesia in Canada." The committee recommended employing such individuals, though it did not specify their qualifications and only suggested that they assist anaesthetists by setting up and cleaning and maintaining anaesthetic equipment.

During the Executive Committee meeting of 17 and 18 April 1971, the President of the Society, Dr. Norman R.J. McMillen of Vancouver, referred to statements made by the Federal Minister of Health about physician assistants in medicine. These individuals had long played a useful role in various medical-assistant activities, and it was reasonable to suggest, as the Executive Committee did, that their role in anaesthesia be considered. In one sense, some kind of role in anaesthetic practice was quite logical, as the following viewpoint of the Québec Division indicated:

> More and more, in the practice of medicine, are we becoming familiar with the concept of auxiliary help in the health services, of paramedical personnel and of health professionals. In the day-to-day practice of medicine the physician always has recourse to the service of these professionals. The orientation of modern medicine and the lack of medical manpower, in an era where there is an increasing number of patients, has progressively forced physicians to confer part of their tasks to auxiliary personnel trained for that purpose. This phenomenon has already existed for a

> number of years in certain specialties such as the medical laboratory, radiology and physiatry. Recently cardiovascular surgery has developed "pump technicians," and even more recently, we have noticed the appearance of inhalation therapy technicians. Some of these paramedics work in the para-clinical field, but many perform their duties at the bedside.[24]

This statement had a sting in the tail for some anaesthetists. "Technical services" would be acceptable; "direct patient care services" would not. Some members of the Society thought that employment of anaesthesia assistants represented the "thin end of the wedge," and anaesthetists in Nova Scotia rejected this because acceptance of anaesthesia assistants might be the first step towards a generation of nurse anaesthetists in Canada.[25] A fear of being replaced by anaesthesia technicians was another source of apprehension, as was the fear that governments might reduce anaesthetists' fees because of the assistance they were receiving from others.[26]

How did the debate on anaesthesia technicians evolve over the years?

As a result of the Executive Committee's discussion in April 1971, a Task Force was appointed to enquire into and report on all aspects of Physicians' Assistants in the practice of anaesthesia. Dr. John Wade, of Winnipeg, was appointed chairman, Dr. Jean-Paul Dechêne, then of Québec, as vice-chairman, and Dr. McMillen and Dr. Drysdale, as members.

Dr. Wade knew much about anaesthesia technicians because a pilot project in Winnipeg had examined their role. This project had shown that their assistants could improve anaesthetic efficiency but not necessarily lighten the workload. Although it did appear that the role of anaesthetic technicians would become "a reality" in Québec, and even be granted some responsibility for patient care, the British Columbia College of Physicians and Surgeons had recently ruled that it was unethical for a physician to hire a nurse to monitor an anaesthetic.[27] The Committee, too, took the view that if anaesthetic technicians were to become a reality in more than one or two places they should certainly be allowed no responsibility for patient care.

Meanwhile, the Association of Anaesthetists of Québec (AAQ) had recommended to the Québec government that inhalation therapy technicians, who had well-defined training requirements, become the core group for anaesthesia technicians. Dr. Perrault explained the reasoning of the AAQ, which had appointed a committee to develop proposals for the development of anaesthesia technicians:

> My strong feeling, which was also the feeling of the members of the Committee, was that the future anaesthesia technicians should be respiratory technologists. The members of the Committee knew exactly what was the training program of the Respiratory Technologists: they had a specific training in technical support of respiration and circulation. More, they had an extensive training in respirators and technical devices related to respiratory and circulatory diseases. It was clear in our mind that we could not make any other recommendation. The only other group of

The four in the foreground are Gold Medallists of the Society and two are Past-Presidents. From left to right: Dr. Rod Gordon (President, 1963–64, and Gold Medallist 1969); Dr. Fred Parney, Chief of Anaesthesia, Foothills Hospital, Calgary; Dr. Gordon Wyant (President, 1971–72 and Gold Medallist, 1984); Dr. John Wade (Gold Medallist, 1987); and Dr. Wolfgang Spoerel (Gold Medallist, 1986). Winnipeg, June 1970.

> personnel was the nurses but their training was much less specific and they would have to be trained for a much longer period to become as competent as the respiratory technologists in this field.[28]

Two groups were now studying the question of anaesthesia technicians. One was the Québec Division of the Society; the other was the Society's own task force. Each group prepared reports. Council called a special meeting to study and discuss these two reports on 19 June 1972. The Chairman of Council, Dr. Arthur Dunn of Toronto, delegated chairmanship of the meeting to Dr. Wade, who also attended as the Manitoba representative.

Dr. Wade first asked Dr. McCaughey, present by invitation, to review recent events in Québec. The points he made were the following:

- Because of the worsening shortage of anaesthetists in Québec, operating-room nurses had been asked to assist anaesthetists, to the extent of monitoring the condition of patients. The Federation of Nurses objected to this. The special committee of the AAQ, after considering this issue, then recommended that Inhalation Therapy Technicians be the paramedical group from which anaesthesia technicians would be developed. Their curriculum and training made it appropriate for them to be trained as anaesthesia technicians; also, anaesthetists could retain some control, as it did with Inhalation Therapy Technicians.

- The Québec anaesthetists appeared to be committed to the development of anaesthesia technicians, even though the appropriate allied health group, the role itself, their responsibility and remuneration had not been settled.

- Education would be at the junior college (CGEP) level. Inhalation Therapy Technology and Nursing currently were trained in three-year courses at this level.

- It was presumed that there would be no effect on anaesthetic fees, because of the physician shortage.

- The Québec College of Physicians and Surgeons and the Minister of Social Affairs (C. Castonguay) had read the AAQ's White Paper on anaesthesia technicians and a Resolution considered by the AAQ Executive on 13 April 1972 proposed that "the technicians in inhalation therapy become assistants to anaesthetists in all the duties which anaesthetists are called upon to carry out in hospital departments."

- One point causing confusion concerned the word *Assistant*. In Québec this suggested a person who could work alone, without direct supervision.

The AAQ's position was spelled out in its White Paper.[29] This introduced the rationale for anaesthesia technicians and their evolution from respiratory technologists, and described their training and duties. A translation of the White Paper summarizes this position.

> Briefly, it is well established that there is a shortage of anaesthetists and that they require some help to assure a more equitable distribution of their services. After having circumscribed the problem, the Association of Anaesthetists of the Province of Québec has come to the conclusion that inhalational therapy technicians possess the best training to assure these new tasks that we would confer provided there is a small modification in their education programme. The provincial committee of inhalation therapy technicians was enchanted by this project and does not see any objection to these modifications which would open up a whole new field for its technicians. By using this auxiliary help, one prevents the creation of a new category of health professionals.

That was the position of anaesthetists in Québec. Dr. Wade then discussed his own report to summarize for Council the Task Force's position.

First, regarding the lack of manpower, Dr. Wade was concerned that data on manpower shortages were lacking. He then asked if the quality of anaesthesia could definitely be maintained by the appointment of anaesthesia technicians. Other solutions had to be considered: the redistribution of specialists, the provision of anaesthesia services by better trained general practitioner anaesthetists, and a smaller volume of surgery. In any event, since health care came under provincial jurisdiction, the final decisions and negotiations would have to be considered provincial responsibilities.

Dr. Wade then listed six recommendations:

1 Provincial studies on anaesthesia manpower should be conducted to determine whether Physician Assistants were necessary.

2 If Physician Assistants were thought to be necessary, data on the quality of care should be attained on the value of these paramedical personnel. Pilot projects should be set up in each province.

3 Physician Assistants and technicians for anaesthesia should have a similar core curriculum, length of training, and national certification as other Physician Assistants in other specialties. Anaesthetists should be directly involved in their training.

4 The Canadian Anaesthetists' Society must insist that all Physician Assistants and technicians in anaesthesia work under the direct supervision of consultant anaesthetists.

5 Medicolegal implications might require changes in provincial Medical Acts.

6 Funding, either federal or provincial, or both, would be required to further study these issues for remuneration of anaesthesia assistants.[30]

Council then approved these recommendations and directed that the President of the Society (Dr. Gordon Wyant, of Saskatoon) write to federal health authorities and to provincial ministers of health and education.

The question of anaesthesia technicians remained under review over the next two years. Meanwhile, the Québec government decided to introduce courses for anaesthesia technicians as part of the Inhalation Therapy Technicians program, and in Alberta a pilot project was introduced at the University Hospital in Edmonton to train small groups of nurses to become anaesthesia technicians. Clearly, matters were moving ahead and the Society would have to formulate a policy.

During the Council meeting on 8–10 December 1972 Council approved a motion, proposed by Dr. Douglas F. McAlpine of Regina and Dr. Lemuel E. Prowse of Charlottetown, to the effect that:

- all anaesthesia technicians must work under the direct supervision of a specialist anaesthetist
- the role of anaesthesia technicians must be confined to monitoring of the vital signs and the patient's condition
- exercise of clinical judgement must be excluded from the area of responsibility of such technicians.

Another motion, proposed by Dr. McAlpine, seconded by Dr. J. Earl Wynands of Montréal, and approved by Council on 24 June 1973, indicated that Council was opposed to the principle and practice of anaesthetic adminstration by unsupervised non-physician personnel.

Yet a third motion indicated the "very guarded" position[31] taken by the Society on a "contentious" matter.[32] This motion, introduced by Drs. Donald Aitken of Peterborough and Iain MacKay of Toronto, proposed that "the Society will continue to support measures which encourage recruitment into the specialty of anaesthesia, continuing education of physician anaesthetists whether specialists or not, and the raising of anaesthesia standards and minimum requirements for anaesthesia privileges in all hospitals throughout the country."

Meanwhile, Council encouraged the preparation of a draft statement of policy on anaesthesia technicians. This was prepared in large part by Dr. Wade and by Dr. Purkis, for the Committee on Public Relations. On 20 June 1974, Council approved the following statement that represented the Society's policy:

> In those areas of Canada where anaesthesia services are not available from qualified specialists in anaesthesia, and the need for such service can be clearly demonstrated, the responsible provincial anaesthetists' organization should clearly act. Their priorities in seeking a solution to provide the best quality of care for the people of the province should be in the following order:
>
> 1) To increase the recruitment and training of qualified specialists in the field of anaesthesia.
>
> 2) To encourage the further training of general practitioners through special continuing education, internship and "on-site" training programs.
>
> 3) To develop a group of physician assistants and/or technicians in anaesthesia only if increased effort in priorities 1 and 2 are still inadequate to meet the need to improve the quality of care.
>
> - The assistants should come from one of the existing health fields.
> - The responsible anaesthetic body provincially shall clearly define the scope of practice of assistants and/or technicians, their curriculum of training, and set the standards for their evaluation.
> - The degree of supervision must be clearly defined to insure the safety of the patient and to avoid abuses of the system.

Interest and concern kept the question of the desirability of employment of technicians in anaesthesia alive. It was raised again in 1975 and 1976 by events in Saskatchewan. There, a Board of Inquiry into the Practice of Anaesthesia in Saskatchewan[33] had been commissioned to inquire into the practice of anaesthetists being responsible concurrently for more than one anaesthetic (even though a nonspecialist anaesthetist was responsible for one of the patients). One of the Board's recommendations was the introduction of anaesthesia

technicians in Saskatchewan. As Dr. Perrault reported to Council on 19 June 1977, this practice was already in effect in Québec, although the AAQ was attempting to establish the policy of one specialist anaesthetist to each patient. At the next meeting of Council Dr. Perrault, together with Dr. E. Daigle of New Brunswick, introduced a motion that firmly established this policy for the Canadian Anaesthetists' Society:

> In accordance with accepted Standards of Practice, it is proposed that the Canadian Anaesthetists' Society reaffirm the principle of one anaesthetist per patient during anaesthesia and surgery, to insure that the quality of anaesthesia takes precedence over productivity.

Council then approved this motion.

This, however, was not the end of the matter. Concern extended into the 1980s. "Wide" differences of opinion[34] persisted, particularly over the possibility that anaesthesia technicians might have "direct patient care" responsibility rather than simply technical support responsibility. The latter was considered acceptable; the former, as Council made clear at its meeting on 17–18 June 1981, was not.

The most acute difference of opinion, however, did not surface until the latter 1980s. It was most evident in the polarized views of the Québec and Nova Scotia Divisions. The Québec viewpoint was that anaesthesia technicians provided an infrastructure in a department of anaesthesia that permitted smooth and efficient functioning of the department. The chairman of the Committee on Allied Health Professions was now Dr. David Whalley of the Department of Anaesthesia at the Royal Victoria Hospital, Montréal, and he knew how useful anaesthesia technicians were. His committee was "encouraged," and, at the midwinter meeting of Council in 1988, Dr. Whalley requested a mandate from Council to develop a draft job description for anaesthesia technicians.

During the midwinter meeting of 1989 Council approved a description of the duties for anaesthesia assistants prepared by the Committee on Allied Health Professionals, on a motion by Dr. Desmond Writer of Halifax and Dr. Lewis Hersey of London. Four votes were cast against the motion, 21 in favour. A second motion, proposed and seconded by Dr. Writer and by Dr. Andrew Davies of North Bay, to the effect that Council approve the draft curriculum on the training of respiratory technologists in anaesthesia was also approved, with one vote cast against it. A third motion was tabled, by 11 votes to six, with five abstentions. This expressed Council's reservation in endorsing the ability of anaesthesia assistants "to discharge primary elements of patient care without the direct and immediate supervision of a specialist anaesthetist."

Opposition became critical the summer of 1989. Three paragraphs taken verbatim from the Minutes of the Executive Committee meeting of 9 June 1989 indicate the strength of feeling expressed by the Nova Scotia Division.

> A contentious issue brought forward from the Mid-Winter Council meeting (of 4–5 February 1989) was the subject of anaesthesia assistants and the concern of the Nova

> Scotia division of the CAS in this regard. Dr. Writer reviewed with the Executive the specific concerns of the division, and the threat of the division, in the form of a motion, to withdraw from the Society should the "tabled" motion from Mid-Winter Council be passed.
>
> Dr. (Jacques) Samson commented on the situation in Québec where anaesthesia technicians have been present and active for 15 years.
>
> It was felt that much confusion arises from using the term "assistant" as opposed to "technician."
>
> The tabled motion was then amended by the Executive Committee as follows:
>
> The CAS Council directs the Standards of Practice Committee to amend the Guidelines to the Practice of Anaesthesia to recognize the role of anaesthesia technicians, while emphasizing that the physician anaesthetist retains full responsibility for individual patients.

The key words in this amended motion were clearly these: "The physician anaesthetist retains full responsibility for individual patients."

The issue was discussed next during the Council meeting of 13–14 June 1989. The discussion brought to the fore a principle that has always been fundamental to good anaesthetic practice: in fulfilling his or her responsibility for patient care, the anaesthetist *must* remain with the patient regardless of the presence of an assistant.

Dr. Crawford Walker, chairman of the Committee on Standards of Practice and from Kentville in Nova Scotia, made this clear when he pointed out that the Guidelines did not clearly specify whether the physician anaesthetist must be present with the anaesthesia technician during maintenance of anaesthesia. This was the ideal, but in small hospitals, as Dr. Richard Baxter of Kelowna pointed out, sometimes an anaesthetist had to leave the operating room, for example to go to the Recovery Room. Then it would be safer to leave the patient with a technician than with an untrained person. In this respect Dr. Jacques Samson of Québec agreed with Dr. Baxter.

After much discussion, in part concerning the lack of clarity on where the Society really stood on this issue, the following motion proposed by Dr. Davies and seconded by Dr. Samson was put before Council:

> THAT the Canadian Anaesthetists Society Council direct the Standards of Practice Committee to amend the *Guidelines to the Practice of Anaesthesia* to recognize the role of the anaesthesia technicians while emphasizing the physician retains the full responsibility for individual patient care.

The motion was carried with two abstentions.

Dr. Richard Baxter, President 1991–92.

Two Presidents of the 1990s: Dr. Desmond Writer, Immediate Past President (left) and Dr. Jacques Samson, Incoming President, Vancouver 1990.

One other motion requires emphasis. This was proposed by Dr. Keith Hamilton of Nova Scotia and seconded by Dr. Baxter during Council's midwinter meeting of 1990. It proposed the following:

> THAT Council direct the President to inform the membership of the actions of the Committee on Allied Health Professions and Council, clearly stating the position of the CAS that the anaesthetist's primary responsibility is to the patient under his care, and that he must remain with his patient at all times during the provision of general anaesthesia, major regional anaesthesia and monitored anaesthesia care.

This made quite clear the Society's position. Writing in the CAS *Newsletter* in 1990, Dr. Writer summarized this position in a single paragraph:

> The final position of the Society is that the specialist has ultimate authority. His or her primary responsibility is to the patient, with whom he or she must remain at all times during the provision of general anaesthesia, major regional anaesthesia and monitored anaesthesia care. Technicians may not provide independent anaesthesia care, nor may they act except under the explicit guidance of the specialist.

CHAPTER TWELVE

The Society and the Pharmaceutical Industry

THE practice of anaesthesia, except for the rare instances of hypnosis or acupuncture, is unique in being totally dependent on the use of pharmaceutical products. The reverse is also true. The sale of anaesthesia-specific substances is almost entirely dependent on administration by anaesthetists. The relationship between anaesthetists and pharmaceutical companies is a symbiotic one, perhaps closer than that between any other medical specialists and the industry. For the most part it has been congenial and fruitful, but, as in any close relationship, it calls for defined areas of responsibility and ethical conduct.

The relationship between the Canadian Anaesthetists' Society and the pharmaceutical industry also has been close. It is, not surprisingly, almost as old as the Society. The first reference in the Minutes concerns the Society's appreciation to Winthrop Chemical Company for sponsoring a cocktail party before the annual dinner on 25 June 1947.[1] Thereafter, various aspects of this relationship regularly became evident in the Minutes. Apart from references to the content and labelling of ampuls over the next decade[2–4] (see Chapter 5), the next reference of note was made in 1960 to the offer of research support by British Oxygen Company (Canada) Ltd.[5] Other references in the Minutes through 1968 concerned the following: support for the cost of translation during the 1964 annual meeting provided by Abbott Laboratories, Ayerst, McKenna and Harrison Ltd., and Poulenc Laboratories;[6] the beginning of a long period of funding prizes for the Residents' Competition by Ayerst Laboratories in 1967;[7] payment of travel expenses of the two recipients of the CAS Gold Medal by Abbott Laboratories in 1968;[8] and the offer of money to support an annual award and presentation of a scientific paper at the Annual Meeting of 1968 by McNeil Laboratories.[9]

In those years the industry supported scientific as well as social activities at the annual meetings. A review of the programs of annual meetings in the latter 1960s, however, indicates that pharmaceutical companies were also interested in *sponsoring* many of the social events on the programs. While welcomed by the Society, this aspect became a source of concern, and the ethics of accepting support for social rather than scientific activities was questioned.[10] This led Council to formulate a policy on the relationship between the Society and the pharmaceutical industry.

The Need for a Policy

The relationship between the Society and pharmaceutical companies in the Society's first quarter-century appears to have been straightforward, based as it was on the needs of each party. In fulfilling its goal of enhancing the standard and practice of anaesthesia, the Society always endeavoured to organize a satisfying national meeting each year, and it appreciated the many and varied contributions of the pharmaceutical companies. As manufacturers of anaesthetic agents, pharmaceutical companies took this opportunity to bring their products before the membership.

While each party ultimately desires the same end result – the best of anaesthesia care for all Canadians – each has its own purpose in pursuing the relationship. This has led to the risk of debasing what should be a pristine relationship. Consider for the moment members of the Society, on the one hand, and representatives of pharmaceutical companies, on the other, attending the Society's annual meeting.

Anaesthetists attend primarily to learn, and secondarily to socialize with colleagues; the Society endeavours to keep the registration costs down, and so welcomes – and solicits – pharmaceutical companies' subsidies. For their part pharmaceutical companies pay a fee to display products during the meeting, and many sponsor educational sessions and social events.

How far should the Society allow the relationship between physicians and pharmaceutical companies to develop without crossing the ethical line to become, as it has done outside anaesthesia circles, "too close for comfort?"[11] How far should the Society go in protecting itself from the charge levelled at the medical profession "that, in many of our dealings with the industry, we have become corrupt; that in return for needlessly (and sometimes recklessly) prescribing their expensive products, we accept (or even demand) rewards on a breathtaking scale?"[12]

Similar questions were asked by Council during the midwinter meeting of 1969. A sense of the discussion is given in the following excerpt from the Minutes:

> SOCIAL PROGRAMME
>
> Dr. S.M. Campbell brought forward a problem of having two companies who wished to sponsor a "Wine and Cheese Party" at the time of the Annual Meeting, namely, Astra Pharmaceuticals and Hoffman-LaRoche. He further stated that Astra had offered to sponsor the reception before the Annual Dinner and Dance.
>
> The question of having commercial firms sponsor cocktail parties and other social events brought forward a great deal of discussion.
>
> Moved by Dr. S.L. Vandewater
>
> Seconded by Dr. G. Wyant

"THAT the President of the Society form an *Ad Hoc* Committee to consider and develop a policy as to the relation of Industry to the Society in matters of gifts, prizes and social contributions at Annual Meetings."

Carried.

Moved by Dr. J.D. St. Clair

Seconded by Dr. R.G. Gilbert

"THAT Hoffman-LaRoche be allowed to sponsor a Wine and Cheese Party on Monday evening, June 16, (1969) and that Astra Pharmaceuticals be allowed to sponsor any other social function except the Reception before the Annual Dinner."

...

Dr. Campbell further informed the meeting that Baxter Laboratories would be sponsoring a Cocktail Party for delegates and their wives on Tuesday, June 17 (earlier, Dr. Campbell had informed council that McNeil Laboratories had offered money and this might be used to tape symposia and panel discussions).

Council then decided that it must define ethical limits not to be transgressed by either party to the relationship. Dr. Lucien E. Morris of Toronto was appointed chairman of the *ad hoc* committee.

Dr. Morris presented a preliminary report to Council on 14 June 1969. An excerpt from this report indicates the thinking of the committee:

The Committee members (Drs. E.A. Gain, N.R. McMillen, G. Sirois and J. Wade) are agreed that there is reason to be concerned about the relationship of the Society with the Industry, and the possible misunderstandings which may arise from the lack of specific ground rules governing donations and sponsorship by the manufacturers and drug houses.

We recognize that such contributions to the Society activities have been most helpful, and we have enjoyed the hospitality provided. However, it seems neither the sponsors nor the Society should feel an obligation to continue and, therefore, some specific guidelines should be provided. Constraints should be placed upon solicitation of funds, purposes for which funds may be accepted or used, and the manner of acknowledging such assistance publicly (if at all) be clearly spelled out in an effort to avoid future misunderstanding.

The Annual Meeting on 18 June 1969 gave the committee an opportunity to discuss the issue further, and it made the following recommendations to Council:

1 The formation of a permanent committee to review Society policy concerning relationships with the pharmaceutical and manufacturing industry. The committee should control and coordinate solicitations, manage disbursements and executive acknowledgements.

2 The formulation of policy along the following lines:
   a) Prohibition of public acknowledgement of sponsorship of social or nonscientific activities financially supported by others than the Society.
   b) Interdiction of Company sponsorship of Society advertised cocktail parties.
   c) Funds and gifts obtained for Educational and Scientific purposes – such as prizes, travel expenses, and speakers' honoraria – shall be placed in a separate bookkeeping account of the Society. Cheques should be paid by the Society out of such funds as are donated to the Society from whatever source.
   d) In general the following format for acknowledgement should be used:
      we gratefully acknowledge the assistance of
      A ... Company
      B ... Company
      C ... Company
      to the Scientific and Educational program"
      without further specific specification.
   e) Such policy provisions as are approved should be communicated to C.P.M.A. (Canadian Pharmaceutical Manufacturers Association) ...
   f) The above policy should be applied to Provincial Divisions as well as the National Society.

Council, at its meeting the next day, approved all these recommendations except for 2(f), which was referred to the provincial divisions for eventual resubmission to Council. These recommendations served as the basis for a policy.

Five of the divisions accepted all or most of the recommendations; Nova Scotia and New Brunswick thought that if any steps were taken "to reduce the generosity of contributors" their regional meeting might become too expensive; and Alberta agreed that support at cocktail parties was acceptable if the funds obtained for them were not publicly acknowledged. (Québec and Saskatchewan did not respond.) As well as questioning the divisions, Dr. Morris questioned companies that had sponsored events at annual meetings. Four appreciated "the steps taken to relieve them of pressures which ... (had) been in many instances embarrassing." McNeil Laboratories, however, objected to the recommendation that there be no specific designation of support. This company had wished to sponsor a named award on an annual basis; it had made clear that its wish was based on "enlightened self-interest," and that, in the absence of a specific listing of a designated award, they would have little incentive to become involved in "academic pursuits" of the Society.[13]

At the next meeting of Council, Dr. Morris added three other recommendations to his previous ones:

- That further quiet effort be made to make all members aware of the impropriety of solicitation and use of funds from commercial sources for Society entertainment functions.

- That sponsorship of lectures be accepted on an annual basis – and that a proper name designation and specific acknowledgement of sponsorship be allowed.

- That sponsorship of awards and prizes be accepted on an annual basis and that a proper name designation and/or specific acknowledgement of sponsorship be allowed.[14]

Drs. Norman R.J. McMillen of Vancouver and Alan A. Drysdale of Halifax then proposed "THAT all Divisions be notified of the present policy and recommendations and ... that Divisions be asked to use their own discretion in this area." This motion was carried. Its work completed, the *ad hoc* committee was then disbanded.[15]

The Society now had a policy concerning its relationship to pharmaceutical and allied companies. The only modification to it was made on 17 June 1972, when Council agreed that the phrase "without further specification" be deleted. The policy was then entered into the Society's Rules and Regulations.

The formulation of a policy on commercial donations was a wise step because it clarified ethical conduct for both the Society and the industry. It preceded an expression of concern by the medical profession at large in the 1980s and 1990s, in the United States and United Kingdom as well as Canada. As late as 1987 Goldfinger, in the *New England Journal of Medicine*, advised that, "if for no other reason than self-interest, the time has surely come for us to develop a set of guidelines for our participation, as faculty and as audience, in continuing-medical-education programs funded by industry."[16] Nor was it until 1990 that the American College of Physicians formulated its own policy on the relationship with industry, reminding its members that "it is a fundamental tenet of the medical profession that physicians should make their clinical decisions on the basis of medical knowledge without commercial influence."[17] Likewise, it was not until 1991 that the American Medical Association published its policy, noting that "the giving of a subsidy directly to a physician by a company's sales representative may create a relationship that could influence the use of a company's products."[18]

In Canada, the Canadian Medical Association approved its *Guidelines for an Ethical Relationship Between Physicians and the Pharmaceutical Industry* in August 1991.[19] The Society's policy was therefore well ahead of its time. That is not to say that it will remain so, for the relationship between physicians and the industry is likely to be affected by future changes in society, with respect particularly to legislation affecting not only the pharmaceutical industry but health care costs and the general economy. For this reason, this relationship has been under review in 1992.

The Industry's Continuing Support of the Society's Activities

The anaesthetic pharmacopoeia does not vary greatly across the country, and competition among pertinent pharmaceutical companies is not as fierce as it is among those who manufacture tranquilizers, antihypertensive agents or antibiotics. Even so, pharmaceutical companies do recognize the desirability of penetrating a captive market for induction agents and muscle relaxants. These companies are also aware of the phenomenon of "the non-

pharmacological basis of therapeutics,"[20] and will continue to work the market provided by some of the Society's activities, particulary the annual meeting. In general, however, the industry's conduct has been ethical, and the contributions that pharmaceutical companies and equipment manufacturing companies have made to the Society's professional activities over the years have been much appreciated. Some of these are summarized here.

The offer of $1,000 by British Oxygen Company (Canada) Ltd. in 1960 to fund research was the earliest of many contributions. While the Society was most appreciative of the offer, it also requested that this money be used to support a new venture, the Canadian Anaesthetists' Society Prize. (See also Appendix 11.) The company courteously agreed to this request.[21] Furthermore, the company (later, the Canadian Oxygen Company) agreed in 1963 to continue donating money even when the lack of worthy papers in the Journal led the Society to withhold the award.[22] In both of these instances this company's conduct was admirably ethical.

This support was continued in 1977, when Ohio Chemical announced its offer, of $1,000 yearly for five years, to fund the Prize.[23] Indirectly, the offer by British Oxygen (Canada) Ltd. in 1960 also enabled the Society, in 1962, to fund its premier award, the Gold Medal.[24] (See also Appendix 10.)

A review of the programs of the Society's annual meetings in the second 25 years identifies numerous other contributions by pharmaceutical companies. In 1968, for example, Abbott Laboratories funded the travel expenses of two Gold Medal recipients (Drs. J.S. Lundy and R.R. Macintosh) so that they could receive their medals at the 25th Annual Meeting. Abbott Laboratories subsidizing the cost of translation services in 1963 and in 1964; in the latter year Poulenc Limited and Ayerst, McKenna and Harrison Limited made contributions for this purpose, and Hoechst Pharmaceuticals also provided support in 1967. These companies offered essential support before the Language Branch of the Secretary of State provided a grant towards the cost of translation services in 1975.

Two pharmaceutical companies funded prizes for the Residents' Program. Ayerst Laboratories did so from 1967 to 1975, after which Astra Pharmaceuticals continued the much appreciated support for this increasingly important part of the Society's annual meeting.

The financial support of guest speakers at the annual meeting constitutes another aspect of the contributions of pharmaceutical companies. In 1967, Hoechst Pharmaceuticals funded a group of speakers from overseas. Burroughs Wellcome (Canada) Limited offered similar support from 1968 to 1970 in connection with the Burroughs Wellcome Lecture, and Abbott Laboratories, likewise. Halocarbon (Ontario) Limited and Ohio Chemical also did so in the latter 1970s. Named lectureships recognizing a particular pharmaceutical company do, however, single out an individual company, and the practice was discontinued after 1971.

The policy formulated by the Morris Committee in 1969 dictated that specific designations should be eschewed, which is the possible reason why the offer by McNeil Laboratories in 1968 of $500 to fund an annual award for a paper presented at the annual meeting did not bear fruit.[25] Janssen Laboratories (which took over McNeil), however, did

not object to funding a prize for audiovisual entries beginning in 1982.[26]

The cost of printing programs and lectures also has been facilitated by industry support. Two examples are the printing of the annual meeting program in 1967 (Wyeth) and the Electrocardiography Workshop in 1973 (Baxter Laboratories). Greatly appreciated have been the generous and regular contributions of Ohio Chemical, and later, Anaquest, which have reduced the Society's costs for publishing in the Journal the Refresher Course Lectures and the Scientific Abstracts for the meeting. The subsidy from Anaquest in the 1980s and 1990s was extremely generous, the total being of the order of $150,000.

These are just some of the many contributions that have been made and continue to be made to the Society's educational activities over the years, particularly at the annual meeting. Pharmaceutical companies have made similar contributions to divisional meetings, which likewise have benefitted from the industry's assistance in continuing-education endeavours.

More recently the Society has received generous contributions that have facilitated the establishment of major research awards. As of 1993 these include the David S. Sheridan Canadian Research Award (applications for up to $10,000 are invited); the Dr. Paul Janssen Canadian Research Fellowship Award in Anaesthesia (for the total value of $40,000); and the I.C.I. Pharma Canadian Research Award in Anaesthesia (for which applications of up to $5,000 are invited). The Society inaugurated its own Research Award in 1985, and was initially supported by three pharmaceutical or equipment companies: Glaxo Laboratories, Winthrop Laboratories and Cook (Canada) Inc. Two other research awards beginning in 1993 will be sponsored by Burroughs Wellcome (up to $10,000) and Syntex (up to $10,000). All these contributions set the seal on the industry's participation together with the Society, in enhancing the quality of the research base of Canadian anaesthesia. They also reaffirm the fruitful relationship between the Canadian Anaesthetists' Society and the pharmaceutical industry in Canada.

Three Problems

It would be surprising if this relationship had been wholly free of problems, but there have, in fact, been few negative aspects to it. Three examples illustrate different aspects of such problems.

The first is taken from the Society's Minutes in 1984 and 1985. A company that had previously subsidized an activity at the annual meeting informed the Society that it would no longer do so.[27] This was "deplored" by the Executive Committee,[28] even though the Morris committee of 1969 had observed that neither the sponsors nor the Society should feel an obligation to continue the relationship,[29] and even though this particular company had facilitated continuing-medical-education programs. Each pharmaceutical company has a right to decide what to do with its promotion, especially in hard financial times, and, as Dr. Douglas B. Craig of Winnipeg advised, the Society's demands should be moderate in times of economic restraints.[30] The Society may hope for financial contributions from pharmaceuti-

cal companies, but it cannot demand them; that would be as unethical as the physician who threatened to stop prescribing a particular company's products unless his request for funding of a foreign trip by that company was granted.[31]

Where should the Society draw the line in such instances? Waud has suggested that "we simply not be on the take, whatever the amount or context."[32] His frame of reference for appropriate action is that part of the Hippocratic oath that adjures, "in every house where I come I will enter only for the good of my patients." In other words, the question to be asked is this, "Will a particular action benefit the patients we watch over or not?"

The second example concerns the marketing and availability of a drug to hospitals. How far may the sole manufacturer of a drug dictate this? This question was asked in an editorial in the Journal, with respect to Dantrolene and the manufacturer's limiting the availability of the drug to packages of 36 vials. As Dr. Peter G. Duncan of Saskatoon, observed, "it is indeed a unique situation when the sole producer of a commodity sets the price, tells the purchaser he must buy, and exactly how much as well."[33] The Society made its objections known,[34] but the manufacturer persisted in the practice, although it permitted hospitals to make subsequent purchases in units of only 12 vials.

The third example concerns the withdrawal of isobaric 0.75% bupivacaine in 1983, on the initiative of the manufacturer. This action concerned the Society, principally because the drug was withdrawn, not after consulting with the Society, but, as Drs. W. D.R. Writer, J.M. Davies and L. Strunin pointed out, "essentially on anecdotal evidence from a foreign country." The unilateral action of the manufacturer meant the loss of the opportunity in Canada to evaluate the safety of a drug that had been used in Canada without ill-effect since 1975. Communication between pharmaceutical companies and the Canadian Anaesthetists' Society, it was suggested, would be appropriate in such instances.

❦

Noble has summarized the essence of the relationship between medical educators and the pharmaceutical industry as follows: "the pharmaceutical industry must promote and sell its products. Medical education must educate and avoid promotion."[35]

In the same vein, the Canadian Anaesthetists' Society must concentrate on education and avoid promotion. This does not appear to have been a problem, but Noble's point should be considered: "we are in a quandary of our own making because we have decided that we cannot afford to educate ourselves without industry's support."

Over the years the Society has benefited from the contributions made to its activities by pharmaceutical and equipment companies. However, organizations such as the Canadian Anaesthetists' Society must remain true to their nonprofit status and discourage commercial influences from unduly influencing the thinking and prescribing practices of its members, influences whose potency may be underestimated by physicians' organizations.[36] The Society's principal interests are those of continuing education and the quality of anaesthesia care. While there is no evidence that these have been compromised by commercial sponsorship,

the Society must ensure that it continues to adhere to the policy it laid down in 1969. The position recommended by the American College of Physicians is worth noting: "Professional societies should develop and promote guidelines that discourage extensive industry-sponsored gifts, amenities, and hospitality to physicians at meetings,"[37] because "it is a fundamental tenet of the medical profession that physicians should make their clinical decisions on the basis of medical knowledge without commercial influence."

In light of the experience over the years and the more recent concern on commercial influences, it appears that the Society's policy of 1969 has served well. It may, however, be wise to remember the significance of the observation that "in the absence of a drug company to pay for lunch most doctors still eat."[38]

CHAPTER THIRTEEN

The Society and Economic and Political Aspects of Anaesthesia

ONE of the Society's four original objects was to promote the economic aspects of anaesthetic practice, and attainment of this object has consistently concerned the Society. As Dr. Beverley C. Leech of Regina put it in his presidential address to the membership on 16 June 1949, "the economic concerns of Anaesthesia have always been the concern the Society."

The Society's Minutes abound with references to economic matters, either alone or linked to political topics. Despite the continual attention to economic matters, however, the Society, as a *national* organization, has been able to play only a limited role in influencing negotiations on fees for anaesthetists. The reason is that health care comes within the jurisdiction of the provinces, and since the introduction of Medicare in the 1960s provincial governments have acted as the paying agencies. Dr. Leech, who had a ready grasp of the economic aspects of anaesthesia, and whose opposition to salaried employment facilitated the early acceptance of a fee-for-service method of remuneration, realized this when he summarized the Society's role in his presidential report of 1949. "The Canadian Anaesthetists' Society," said Dr. Leech, "has been prepared to collect and forward relevant information, to deal directly with the Canadian Medical Association or through it with Government agencies, and to provide advice and all possible assistance when requested." The Society struck a Committee on Economics in 1949[1] (and another in 1958[2]) so that it would be possible, as Dr. Leech also indicated, "to collect information on economic matters in order that the Society may have this available and correlated (and) ... to provide advance information on impending developments in each Province." This is a succinct and still relevant explanation of the Society's role in economic matters.

Before specific aspects of the economics of anaesthesia in Canada are discussed, the history of the Society's activities in this respect will be summarized. In the early postwar years the Society tried to have a tariff applied across the country and to ensure that the fee-for-service method of remuneration prevailed. Only in the second of these two goals did the Society succeed. In the 1950s, as the introduction of national health care insurance became

increasingly likely, the Society, through committee study, sought to understand the implications of this radical new system of primary health care.

After universal health care insurance had indeed been introduced – in Saskatchewan in 1962 and in Canada as a whole over the next 10 years – the whole approach to economic matters in anaesthesia changed, for the primary responsibility for negotiation rested with the provinces. Physicians, trying to improve their economic condition, frequently became frustrated and disenchanted. Members in the divisions could do little to alter the new circumstances. At the Annual General Meeting of 16 May 1961, Dr. Vivyan Morton of Saskatoon was forced to conclude that "our reaction is limited to complaint."

Even so, as a national body, the Society still had a role to play, for its clearing-house activity provided provincial divisions with cross-Canada economic information that was helpful in the development of provincial fee schedules. This role was summarized by Dr. W.J. Farley of Calgary, chairman of the Economics Committee in 1976, when he said "In essence we would develop a 'bank' of current anaesthesia economic statistics which would then be available to all provincial divisions as negotiation time nears – not only with government but with the individual provincial medical associations."[3]

The development of the Society's concerns with economic matters may be understood more fully in relation to specific topics: the earliest fee schedules and the Society's economic policy; interest in a national fee schedule; the advent of Medicare; and the concerns of the divisions.

A National Tariff and the Society's Economic Policy

For some years after its founding, the Society favoured a tariff of fees based on that used by the Ontario Medical Association and the Manitoba Medical Association.[4] A document dated 20 March 1943 lists numerous operations and relates the anaesthetic fee to one or other of four categories of operations:

> VERY MINOR ANAESTHETIC – $5.00 and up – surgical fee, $15.00 or less. Only the simplest anaesthetic should be provided for this $5.00 fee which must be compared with the following tariff rates for visits to a patient's home in ordinary sickness: – Day, $3.00; Night, $5.00; Emergency, $5.00; Sunday, $5.00; (less .50 in communities of less than 50,000).
> (Operations in this category included myringotomy, cystoscopy, cauterization of cervix, excision of venereal warts, etc.)
> ...
>
> MINOR ANAESTHETIC – $10.00 and up for first hour – Surgical Fee, $50.00 or less.
> (The 1943 tariff lists 90 operations for which the fee is between $15.00 and $50.00.) The upper limit of $50.00 represents a compromise in that it will entail a $10.00 anaesthetic fee for 32 operations which, because of the unusual age of the patient or

site of operation, present unusual difficulties to the anaesthetist (but not necessarily to the surgeon). Since the operating time is almost always less than one hour, the anaesthetist will be accepting a complete fee of $10.00 for a procedure which should more properly be classed as a major anaesthetic and $15.00.
... (These operations included simple mastectomy, needling of cataracts, bronchoscopy, fulguration of bladder tumor, correction of fractured hip, etc.)
The remaining 58 operations as a rule require relatively simple anaesthetics, for which the $10.00 fee is reasonable and in keeping with average private practice ...
...
(These operations included removal of a mass from the breast, skin graft, tendon suture, orchidectomy, haemorrhoidectomy and reduction of Colles' fracture.)

MAJOR ANAESTHETIC – $15.00 an hour for first hour – Surgical fee in excess of $50.00.
To commence anaesthetic at a higher level (between $50.00 and $100.00) would force the inclusion of 20 common procedures for which a $10.00 fee would be grossly inadequate ...
(These operations included, among others, correction of harelip, enucleation of eye, tracheotomy, rhinoplasty, external urethrotomy, excision of pilonidal cyst, etc.)
These eye, ear, nose and throat operations require special techniques of administration. The urological procedures are almost always on patients in poor condition. Each merits a $15.00 fee. The remaining 15 operations listed at $60.00 or $75.00 are almost all amputations and fractures. Under certain circumstances a fee of $10.00 might be adequate but in view of the frequency with which these anaesthetics are administered at inconvenient hours immediately following an accident, to patients with full stomachs and varying degrees of shock, the full major fee of $15.00 is justified for the entire group.

PROLONGED OPERATIONS – Beyond one hour, irrespective of Surgical fee – $2.50 per quarter hour ... the time of the anaesthetic is invariably longer than that of the operation, and in calculating the elapsed time, the following regulations should apply:

a) "commencement" shall mean,

in a general anaesthetic	the time at which the anaesthetist starts actual administration
in a spinal anaesthetic	the time at which the anaesthetist starts to scrub
in an intravenous anaesthetic	the time at which the anaesthetist starts to prepare the solution

b) "completion" shall mean the earliest moment at which the anaesthetist can safely leave the patient to the care of an interne or nurse having regard to the danger of shock, asphyxia due to aspiration of blood, mucus or foreign material, laryngeal spasm, relaxed tongue, etc.

Evidently anaesthetists of 1943 took into consideration the procedural and time elements and some modifiers (e.g., time of day) that became part of later fee schedules in different provinces. They also included modifiers for procedures that presented "unusual difficulties," such as bronchoscopy in a tuberculous patient or those fraught with danger of aspiration.

Originally, therefore, the Society advocated a fee schedule for anaesthetists across the country. This "Five and Ten" Schedule was simplicity itself and, had political developments not come to play the large role they did, would have provided the basis for a straightforward method of remuneration to doctors by patients or their insurance agencies.

Very early on, however, it became clear that political developments were going to change the face of medicine in Canada. In a letter of 24 June 1944, Dr. Harold Griffith, the Society's President, wrote to Major R.A. Gordon, then President of the Society of Anaesthetists, Canadian Army Overseas, a short-lived division of the Society that was recognized by Council on 7 December 1944. Two paragraphs of this letter illustrate Dr. Griffith's views on the future of medical practice in Canada:

> The future of the practice of medicine in Canada is quite uncertain. No one knows how much socialization of the medical services will be attempted. It appears that whatever plan of national health insurance is adopted the system of remuneration of the doctors and the administration will be on a Provincial rather than a Federal basis. We do not view this development with any particular apprehension because we feel that the doctors' interest in the varying Provinces can probably be better looked after in a Provincial set-up than if we became servants of a Federal bureaucracy.
>
> In the meantime, we are doing everything we can to have anaesthesiology and fees for anaesthesia service recognized on a proper professional level. The (CAS) ... tariff, which you have probably already seen, has been accepted by numerous medical bodies, and we are now working strenuously to have it, or some similar tariff, accepted by the Compensation Commissions of the various Provinces, by the D.N.P.H., and by other hospitalization and insurance schemes. We feel that the tariff is a fair one to both patient and anaesthetist and will not exploit anyone. Our principal difficulty seems to be with certain hospitals who want to keep anaesthetists on a low salary basis and make money out of their services.[5]

During his presidential report to the membership on 12 June 1946, Dr. Griffith referred to the advent of national health insurance, and he spoke of the need to make "every effort ... to put the anaesthesia tariff on a satisfactory basis." There were two aspects to be considered. One was the need for an increase in fees for certified specialists, with fees that would reflect, as Dr. Leech emphasized to Council on 9 March 1947, "recognition of the greater skill and training of the Specialist Anaesthetists." The other aspect was a schedule of fees for nerve blocks, which was approved by Council on 26 June 1947.

One other problem for the Society in its first decade and a half was having the fee-for-service method of remuneration prevail over the salary method, for a significant number of

anaesthetists were in effect hospital employees. This was abhorrent to the founders of the Society, but the practice was common in certain centres, particularly Montréal, Winnipeg and Vancouver. To leaders of the specialty, notably Drs. Bourne, Griffith, Rochette and Leech, an important principle – that anaesthetists are independent physicians, equal in status to other specialists and to be remunerated accordingly[6] – had to be upheld.

The principle underlay a motion, proposed and seconded by Dr. Griffith and Dr. Stanley M. Campbell, of Toronto, that was carried during the Council meeting of 6 March 1949:

> THAT the Canadian Anaesthetists Society deserves to emphasize the principle that the administration of anaesthesia is part of the practice of medicine and that therefore Anaesthetists are entitled to remuneration comparable with that of other members of the medical profession. The scale of remuneration should be on the same basis as that of other doctors working in similar circumstances.
>
> We commend especially the efforts of our members in British Columbia and in Manitoba who have recently been endeavouring to uphold this principle.

It was at this same meeting that, on a motion of Dr. Campbell and of Dr. Alan Noble of Montréal, a committee was struck "to obtain information from each province on tariff and economic questions." This was the Committee on Economics.

Recognition of the principle that the administration of anaesthesia is part of the practice of medicine was particularly important when some anaesthetists – and some nurses – were employed by hospitals to give anaesthesia rather than working as independent physicians and charging their own fees. Working as a hospital employee was in conflict with the official policy of the Canadian Anaesthetists' Society. An illustrative statement came from the Society of Anaesthetists of the Canadian Army Overseas, in the form of a paragraph from a Memorandum dated 17 May 1944 and which was accepted by the Executive of the Society on 7 December 1944:

> The Society of Anaesthetists of the Canadian Army Overseas is of the opinion that the interests of all concerned in the operation of a Health Insurance Plan would best be served in (1) individual practice as opposed to full-time salaried appointments (2) that (the) method of payment should be fee for service plus salary for teaching (3) that the practice of anaesthesia in hospitals should be conducted by certified an(a)esthetists – this must be subject to modification in smaller hospitals and rural communities (4) that in the event that (the) method of payment were by salary, then the minimum yearly fee should not be less than six thousand dollars ($6,000.00) for a full-time salary.

This opinion was shared by the specialty's leaders, who sought to make it known to other members of the health care professions whenever they could. A motion of Drs. Griffith and Gordon, which was approved by Council on 26 February 1950, further emphasized the principle being upheld:

> THAT it is the policy of the Canadian Anaesthetists' Society that before accepting new hospital appointments Members have a moral obligation to inquire into all circumstances surrounding the vacancy, and that before accepting any such appointment they should receive the approval of the terms of the contract by the Provincial Division of the Canadian Anaesthetists' Society.

By 1950, therefore, the basic elements of an economic policy were in place. While the advent of a health insurance plan for Canada was recognized, it was emphasized that anaesthetists should continue to work as independent physicians rather than as hospital employees. All this was incorporated into a second statement of policy, on a motion by Dr. Griffith and Dr. E.H. Watts of Edmonton:

> THAT the overall policy of the Canadian Anaesthetists' Society shall be that it is unethical for any corporation or agency whether or not organized for profit, to furnish or to make available medical services for a fee. It is unethical for any practising physician-anaesthesiologist to enter into a relationship with any corporation or agency which enables it to offer his services for a fee. In insurance or other prepayment programs, the hospital service branch should provide for hospital services only, medical service plans should provide for medical and surgical services. Hospital services shall not include the administration of anaesthesia, which is the practice of medicine.[7]

That the Secretary was directed by Council to write to "the Heads of Departments of Anaesthesia and all other members of the C.A.S. in those hospitals where anaesthetists are still on salary" indicated that this practice was in operation as late as 2 March 1952, when Council made this directive.

A National Fee Schedule

The fee-for-service principle was held to be fundamental, and it is likely why the Society worked hard to develop a tariff that could be used in all parts of the country. For several years this was one of the main concerns of the Economics Committee, but by 1956 it was obvious that a national fee schedule both was obsolete and could not be agreed on.[8] This had, in fact, been suggested much earlier, for Dr. H.J. Shields of Toronto had said in his presidential report to the membership on 23 June 1948 that, "as economic conditions vary from province to province it seems logical for each Division to modify the C.A.S. tariff to meet their own particular needs." However, at the Council meeting of 20 June 1956 it was agreed that Dr. John Carroll of Vancouver be approached to undertake a study of the economic factors related to anaesthesia *vis-a-vis* the other segments of the profession and to the economy as a whole. With the expected advent of a national health care insurance program in the near future, it was hoped that his findings would yield a formula on which schedules of anaesthetists' fees for various regions across the country could be developed.

Dr. Carroll reported to Council during the winter meeting of 1958. Several points are of interest. First, he wrote his report "with the realization that the era in which the medical fee was the concern of the physician and the patient only, is rapidly drawing to a close." Second, he believed that "the advent of the third party; the prepaid schemes, indemnity insurance and the Government into this relationship, as the payer of medical bills, necessitates a fixed schedule of fees." Third, "in the past schedules of fees have acted mostly as a guide. In the near future they will be only a basis for the remuneration of our services." The task before the Society now was to ensure that "a fair relative value is placed on our service ... (and) decide on what basis a portion will be paid to us."

In setting up a fee schedule the principal factors would be time and the surgical procedural fee, but three principles were important. First, no schedule should be considered final or permanent. Provision had to be made for periodical reassessment.

Second, provision had to be made for means of arbitration when agreement could be reached between anaesthetists and the third party paying the bills. This was thought to be *most* important, because it was one of the causes of dissatisfaction among physicians in Britain.

Third, the unit value should vary from province to province. The Government seemed to have recognized this principle as demonstrated by the latest schedule of the Department of Veterans' Affairs.

Dr. Carroll also recommended that each division set up a permanent economics committee to make recommendations to the chairman of a new national committee, which would correlate the reports of all the divisions. He noted that the CMA was studying the California Medical Association's Relative Value Schedule. The schedule places a relative value on all medical services, and these values were expressed in units rather than in dollars. The value of the unit varied in different areas and might be adjusted according to a rise or fall in the cost of living. However, the relative value remained constant.

Council nominated Dr. Melvin W. Bowering of Regina as chairman of the new national Economics Committee. The task of this committee was different from earlier years; as Dr. Carroll observed, the era in which the medical fee was the concern only of the patient and the physician was drawing to a close. The new era would bring very different factors to the forefront.

The Advent of National Health Care Insurance (Medicare)

The Society's need to understand universal health care insurance was recognized officially on 4 March 1956 when, on a motion of Drs. Griffith and Carroll, the President was requested to appoint a committee "to investigate the implications of a State Medical Scheme in relation to the Specialty of Anaesthesia." There was some urgency, for Saskatchewan, having introduced the Saskatchewan Hospital Services Plan in January 1947, was moving rapidly towards universal health care insurance. In addition, the advent of national Medicare raised the "grave possibility that attempts were undoubtedly being made to make Anaesthesia

a Hospital Service under presently proposed Government Health Insurance Plans."[9] At first chaired by Dr. M. Dubeau of Québec, the State Medical Schemes Committee was later energetically chaired by Dr. Vivyan Morton of Saskatoon. With Drs. Peter Percheson (Vancouver) and Roger Gagnon (Québec), Dr. Morton immediately set to work and, over the next three years, produced several useful reports.

Dr. Morton's preliminary report illustrates the reactions among anaesthetists generated by the spectre of Medicare. Some are illustrated by quotations from her report:

- "The Doctor becomes the servant of the people, not of the patient."

- "Administration of anaesthetic practice under such a scheme would probably become a duty of *hospital administration* since all these services are performed in hospital. The employment of the Anaesthetists by the hospital on any contractual basis carries serious implications: decisions are made by individuals and boards who may or may not be aware in any way of anaesthetic problems; the Anaesthetists will be remunerated as part of a large organization where he is in financial competition with everything from the laundry to the eaves-cleaners and since he has no union affiliation he has no guarantee that his ever-increasing workload will result in any reward whatsoever. In addition the personal satisfaction gained from work well done will be denied him as his greater load prevents a high standard of individual care to the patient."

- "A highly qualified and conscientious Anaesthetist under this arrangement is liable to retreat (if he is lucky) to an office where in the name of better care he can deal with administrative problems and deny the patient his own skill. In so doing he sells his professional soul and those of his brothers to some accountant (a political appointment no doubt) behind the frosted glass door."

- "It is important for us in the Society to realize how vulnerable we are at present to whatever change the respective Provincial Departments of Health may have in mind for us. We are agreed that we are not a hospital service, but how can we demonstrate to an unwilling officialdom that this is so?"

- "We are agreed that fee for service is the only manner in which we can receive proper reward for professional services rendered – but no administrative authority finds anything but fault with this principle. The reasons for this are that (a) it is expensive (... Doctors are stretchable, but they don't stretch so far on fee for service) (b) in some branches of medical practice it is open to abuse by the Doctors and it is foolish to contend that this is not true in anaesthesia, however, we have little opportunity – had we the will – to practise such abuse."

- "Only by being completely unanimous in our belief in the fee for service principle and in wishing to remain apart from hospitals can we have the strength to negotiate and therefore the time to elaborate and emphasize the importance of these principles in our good care of our patients."[10]

Dr. Morton presented a further report to the annual general meeting on 23 June 1958. By this time she and her committee (Drs. P. Percheson, R. Gagnon and M. Levitz) had been able to "crystallize their resolution to hold fast to the advantages of our former practice (and) reform the disadvantages and abuses." She emphasized the following "FACTS":

1 Any agency sponsoring a scheme financially, lawfully and perhaps reasonably expects to control the expenditure of the contributed monies.

2 Any government sponsored scheme works under a ceiling which will be as low or as high as the economy of the country and/or the will of the people – in this country the Parliament – dictates.

Consideration of this fact reveals how far this sort of scheme becomes divorced from any traditional responsibilities and ethics of the medical profession. We must appreciate that this divorce is a necessary and immediate effect of virtually all third party schemes.

3 A government has sovereign powers and can offer terms without a legal need for bargaining. This means that negotiation by persuasion becomes the only effective instrument.

4 In Canada at present it is from the economic standpoint entirely feasible for the government to assume a financial liability equal to the recorded costs for health care.

5 All such matters under the terms of the BNA Act are an entirely provincial affair in this country and all negotiations with professional groups will occur at this level.

6 Constant resolute negotiations by informed and experienced representative bodies are a necessity for all branches of the profession. The place of young men in these bodies has obvious advantages.

The committee then recommended that members of the Society, "freely and unanimously," affirm their belief in the following principles:

- A direct doctor-patient relationship, including the financial aspect of a fee for each service, will provide conditions of incentive and reward, both professionally and financially, which will guarantee a continuing high standard of service to the patient.

- Remuneration by any method other than a fee-for-service ultimately defeats this aim if adopted as a general rule.

- An anaesthetist is a professional, rendering professional service and that anaesthesia in no way can be considered a hospital service or facility.

Dr. Morton concluded her report with words that are still worth pondering today:

> If we fail to remain constant to the principles in which we believe, in every province and in every hospital, we are possibly choosing a role leading to production line care for the patient and frustration and indifference for ourselves. It may be that it is a road which, due to political expediency, the country will find itself following with a heavier economic burden than it wishes to carry. As doctors, citizens and anaesthetists we have a continuing responsibility to the patient, to the people and to the future of Anaesthesia.

Dr. Morton's recommendations were duly approved by the membership. Adherence to words and principles, however, was not enough to stem the tide that would change the nature of medical practice. A comprehensive health insurance plan was introduced in Saskatchewan in 1962 and across Canada by 1971. The rules of the game now changed. It was the provincial divisions and the provincial medical associations, rather than the national Society, that had to deal with the government paymasters.

The Burden Shifts to the Provincial Divisions

At the midwinter Council meeting in 1966, the President, Dr. Douglas F. McAlpine of Regina, emphasized that "the future of anaesthesia depends on the economics, the specialty and on the supply of sufficient suitably trained anaesthetists to provide a satisfactory service." Many physicians believed that the involvement of government in medicine could not be reconciled with the principles that Dr. Morton had defined and that this would inevitably continue to create conflict. The question for anaesthetists, like other physicians, was how to deal with these new circumstances, and, moreover, in their own provinces.

There was no easy answer to this question. The Society, as a national organization, was impotent in solving problems that lay in the realm of the provinces. Indeed, during the Executive Committee meeting of 31 January 1975, the President, Dr. J. Earl Wynands of Montréal pointed out that the Society had made no policy statement about fee schedules "to be of value to any or all divisions during their respective negotiations with Provincial Medical Associations or governments."

The story of the divisions' dealings with their governments and even their own medical associations was more often depressing than inspiring. The reports to Council in the 1960s, 1970s and 1980s sometimes carried cries of woe and frustration. Consider, as examples, the report submitted to the midwinter meeting of Council in 1961:

- *From British Columbia:* "the B.C. Division has been signally unsuccessful so far this year in getting a sympathetic hearing from the Tariff Committee of the B.C. C.M.A ... Because of the animosity of the prepaid plans to schedule increases and because of the lack of sympathy from the Tariff Committee of the B.C. C.M.A., our current brief, for a very modest raise, which in reality we have been attempting

to secure for the past 11 years, appears to have little chance for acceptance at this or any other time."

- *From Saskatchewan*: "On February 1, 1960, our Fee Schedule was changed with regard to Anaesthesia to provide 'that there shall be no Anaesthetic Fee when surgery is cancelled for reason other than anaesthetic unsuitability.' At the request of a number of our members a protest was submitted to our Tariff Committee based on the fact that a large number of such surgical cancellations occurred after the patient was assessed, and sometimes premedicated by the Anaesthetist, and frequently the Anaesthetist was unable to obtain another booking to utilize this time. However, in accordance with an apparently fixed policy of the Tariff Committee our protest was rejected on the grounds that the principles of 'no fee – no service' pertains in such cases."

- *From Manitoba*: "In the matter of fees a relative value schedule based on the one used in California is being considered by a committee of the Manitoba Medical Association. It has been accepted by the Association and a committee is ironing out a few controversial details before its final acceptance."

- *From Ontario*: "The Ontario Division Tariff Committee ... have had a busy time as they prepare the new tariff. This is a change from the time basis to procedural tariff and includes as well a differential between specialists and general practitioners tariff for performing the same procedures. A special meeting was held on February 11 to make final revisions in the presentation to the O.M.A. Tariff Committee ... There was the feeling among the members that the tariff should be as high as possible in anticipation of a possible freezing of tariff or even a proration of tariff in the near future."

- *From Québec*: "Our efforts to have the College of Physicians and Surgeons of the Province of Québec to accept a procedural tariff have not met with success but are being continued. This effort is directed to make easier our negotiations in the advent of a compulsory prepaid Medical Insurance Scheme being enacted in the Province. Personal contact with individual Governors is being made to present our case in a better light. It was recommended by the division that the National Council be asked to consider if a procedural tariff should not be instituted in all provinces to make easier discussions with Governments in the case of the institution of some form of State medicine.
... The Committee on Economics points out that if better financial rewards are not available to anaesthetists, recruitment into the Specialty is likely to suffer greatly. Canadian graduates are few among the trainees and reliance has to be made on immigrants to meet the demands of hospitals."

- *From New Brunswick*: "A schedule of fees was submitted to the New Brunswick Tariff Committee as an amendment to our 1956 schedule. The schedule is $15.00 for the first half hour and $10.00 for each subsequent half hour. This has recently

been accepted by the N.B. Medical. This fee is for Specialist Anaesthetists only and does not as previously apply to all men doing Anaesthesia."

Of the divisions that submitted reports on that occasion, only Nova Scotia failed to express concern about economic issues. The Nova Scotia Division's report was concerned solely about the issue of a shortage of anaesthetists, and the effect that the substitution of a single certifying examination for the current Royal College Fellowship and Certification examinations would have on this shortage.

Nor did the situation change in the next decade. Consider this extract from a report by the chairman of the Economics Committee to Council in December 1973:

> Dr. Finlayson gave a verbal report on the current status of the negotiations in Québec and Ontario. There does not appear to be a significant increase in utilization of anaesthetic services, but the relative position of anaesthetists' income is at the bottom end of scale, shared with Psychiatry (Ontario). Recent statistics have shown that the once-thought low level of general practice is not so. One suburban hospital department in Toronto has negotiated a single monthly payment, adjusted by units of service, with no billing (this arose from previous mis-billing practices). The future prospect for an increase in the medical dollar is not hopeful, but possibly there could be some internal redistribution, which occurred in Québec.
>
> B.C. reported a 12% increase in the medical dollar last year, 6% being used in increased utilization, and the B.C.M.A. is negotiating for an over-all increase of 7.5% in 1974. In 1973, their increase included a government paid disability plan of $400.00 per month, increasing to $800.00 per month in 1974, and currently they are negotiating a percentage of total health dollar to be for continuing education purposes.
>
> Québec reports that there are plans afoot to charge doctors using hospital O.P.D. facilities to see their patients, and the government is looking closely at the geographical full time staff financing.
>
> In Saskatchewan, the Tariff Committee is examining the tariff in terms of earning capacity per hour (Anaesthesia is the lowest paid and works the longest hours). This may become the basis of income redistribution.
>
> Alberta anaesthetists received a 15% increase in fees in 1972, mainly by redistribution, but this year their average income has dropped back to second from the bottom.
>
> Manitoba reported briefly on the deteriorating state of negotiations between the government and the M.M.A. If withdrawal of services occurs, there may be a need for neighbouring provinces to offer assistance. Any requests for assistance should be channelled through the Central Office of The Society.

Although the national body, through the Economics Committee, was unable to be of

direct assistance to the divisions in their negotiations, the Economics Committee did try to provide information that would be useful. The report of the Economics Committee for November 1977, for example, opened by stating that "since fees are a provincial matter, then we as a national committee can only compile interesting and relative information and pass this on to you." Several concerns that anaesthetists had at this time – and, indeed, still have – become evident when this information is considered. Many of these problems fall under the single rubric of disparity. Disparity may shape the economics of anaesthetic practice in various ways: anaesthetists' earnings in the different provinces, anaesthetists' earnings versus other specialists' earnings within the same province, and physicians' earnings versus the earnings of other professionals outside medicine. Some of this information is summarized in Tables 13.1 to 13.6.

Not surprisingly, there was considerable unhappiness among some anaesthetists. Some left Canada for apparently greener pastures. The following comments from emigrés indicate some of their reasons:

- "Rampant socialism – Government's approach to medicine will affect both the economics and conditions of practice both in private practice and universities – adversely in my opinion, and will bring about a greater and more uniform degree of mediocrity."

- "I would not have look [sic] except for political reasons – due to political incompetence, low fees, high taxation, inflation – no dialogue – no end in sight!"

- "I was chronically uncomfortable with the high degree of hostility that existed between the medical profession and the provincial government – all of it due in my opinion, to the efforts made by government to produce the adversary position."

- "... the people, climate and geography are just lovely – the taxes are not too terrible and the country might just last another hundred years. In fact maybe you should petition to be admitted to the 51st state."[11]

Since 1977 little has changed. Anaesthetists continue to bemoan their lot. Brief reports published in the Newsletter in the fall of 1991 (Vol. 7, No. 3) continue to indicate discontent resulting from the economic and political aspects of the practice of medicine in Canada. Some excerpts:

- *From Newfoundland*: "The Newfoundland medical profession's financial concerns have further worsened ..."

- *From Prince Edward Island*: "With permanent and semi-permanent bed closures beginning in July 1991, waiting lists for elective surgery are already growing longer. In addition, money for much needed equipment is becoming less available, and requests for some items are being refused by hospitals ..."

- *From Nova Scotia*: "Economic issues continue to be at the forefront. The provincial government has announced a wage freeze for all public servants, including physicians, for the next two years. In addition, all departments have been given a 2% cap on their funding growth."

- *From New Brunswick*: "A government freeze has held up efforts ... to achieve favourable fees for anaesthetists, which include a unit value increase and renewal of the specialist/non-specialist fee differential ..."

- *From Québec*: "The government has imposed a freeze on all salaries of civil service employees, which is also applied to doctors' incomes. This freeze is to last approximately six months, but it might last up to eighteen months for specialists."

- *From Ontario*: "... The agreement provides for effective capping of physicians' incomes and describes specific financial penalties for increases in utilization beyond predetermined values ..."

- *From Manitoba*: "There has been dissatisfaction with the fee-for-service arrangement for specialist anaesthetists in the province ..."

- *From Alberta*: "... The progress of the Alberta Medical Association toward the development of a provincial relative value guide continues to move slowly ..."

- *From British Columbia*: "The much-publicized pension plan for physicians is still uncertain. Legislative changes to balance RSP/pension plan contributions may wipe out any real gain there might have been in negotiating a defined benefits plan ..."

❦

In his valedictory presidential report to the annual general meeting on 12 June 1946, Dr. Griffith urged members to "face the future with confidence and enthusiasm." He believed that for the "satisfying work" that anaesthetic practice provides there would be "adequate reward." He also correctly suggested that "we may have our worries as to the changes in organization and economic status which may come to the medical profession." This would appear to be an understatement, and it is unlikely that the ever-optimistic Dr. Griffith thought that these "worries" would persist for the next five decades. Such, however, appears to be the case. It is a moot question as to whether, as the Canadian Anaesthetists' Society enters its second half-century, the situation will change.

TABLE 13.1
Methods of Payment

1. Relative Value		Net ($)
	BC	5.70
	MB	3.95
	ON	5.04
	PQ*	4.95
	NS	5.29
	NB	5.33
	NFLD*	5.30
2. Procedure with time rider		
	AB	
3. Tied in loosely with surgical fee		
	SK	
4. Straight time		
	PEI	23.00 for first 1/2 hr 15.00 for each subsequent 1/2 hr, or part

* Base value + time

Source: Council 4–5 February 1978, Report of Committee on Economics

TABLE 13.2

Net Professional Income (Indexed) 1975

(Physicians netting more than $15,000 per annum)

	BC	ALTA	SASK	MAN	ONT	PQ	NB	NS	PEI	NFLD	CAN
F.P.	100	100	100	100	100	100	100	100	100	100	100
Psychiatry	130	101	140	106	125	97	97	104	00	165	112
Paediatrics	119	115	125	95	121	105	106	81	00	138	113
Internal Medicine	136	124	120	109	136	116	128	120	140	155	127
Anaesthesia	**137**	**117**	**132**	**108**	**143**	**128**	**103**	**123**	**00**	**112**	**133**
General Surgery	136	109	123	100	142	129	120	136	134	141	133
Urology	159	113	115	131	156	131	103	151	00	133	141
Neurosurgery	148	118	00	00	156	121	153	185	00	00	141
Ob & Gyn	137	134	129	111	161	145	126	142	130	150	147
Pathology	174	162	00	00	176	124	00	130	00	00	147
Ophthalmology	138	149	134	119	170	146	152	217	00	222	155
Radiology	169	168	147	177	167	145	163	160	00	164	160
Orthopaedics	163	157	194	108	192	168	153	180	00	174	171
Plastic Surgery	198	269	219	00	180	149	206	199	00	00	180
CVS & Thoracics	295	135	00	269	181	174	00	00	00	00	192
Anaesthesia	11	11	6	8	11	10	12	11		10	11
	—	—	—	—	—	—	—	—		—	—
Ratio	16	16	13	13	16	16	14	15		11	16

Source: Department of Health and Welfare, 1975 Income Tax returns

TABLE 13.3
Ontario Physicians' Net Incomes (Indexed) vs Consumer Price Index, Wages and Salaries Index (1971-77)

	Physicians' Net Income	CPI	WSI
1971	100.0	100.0	100.0
1972	100.2	104.8	108.3
1973	92.2	112.7	115.8
1974	93.1	125.0	126.8
1975	99.6	138.5	143.2
1976	106.9 (Est)	148.9	159.9
1977	112.8 (Est)	159.6 (Est)	173.5 (Est)

This table shows that Ontario physicians' net incomes have fallen by 41.5% relative to the CPI and by 53.8% relative to the WSI since 1971. To restore the physicians' purchasing power to the 1971 level (CPI) would require a catch-up fee schedule increase of 25%. To restore the physicians' economic position relative to the WSI would require a catch-up fee schedule increase of 32%.

Source: Council, 4–5 February 1978, Report of Committee on Economics

TABLE 13.4
Index Changes in Net Incomes of Other Selected Ontario Fee for Service Professionals (1971-74)

	Lawyers	Dentists	Engineers	Accountants
1971	100.0	100.0	100.0	100.0
1972	109.6	111.5	97.8	108.5
1973	132.6	117.2	125.1	148.0
1974	150.1	133.7	168.3	163.6

Source: Council, 4–5 February 1978, Report of Committee on Economics

TABLE 13.5
Net Incomes for Different Specialties (1972-75)

Section	Net Incomes (000)	
	1972	1975
Orthopaedic Surgery	$66.1	$68.6
Plastic Surgery	62.5	66.2
Otolaryngology	63.0	63.0
Cardiovascular & Thoracic Surgery	55.5	63.8
Ophthalmology	59.6	63.2
Diagnostic Radiology	56.3	60.7
Obstetrics and Gynaecology	55.4	58.7
Urology	59.8	57.4
Neurosurgery	59.7	54.9
General Surgery	54.7	53.2
Anaesthesia	45.5	51.2
Internal Medicine	49.2	50.7
Paediatrics	46.1	47.1
Psychiatry	42.3	45.6
General Practice	41.0	39.5
All doctors	47.4	47.2
All specialists	53.1	55.0

Source: Department of National Health and Welfare, income tax data for fee-for-service physicians with incomes exceeding $15,000 per annum

TABLE 13.6
An "Ideal" Fee Schedule

1. A relative value system in which 100% of the fee is paid by the paying agency.

2. The right to "extra-bill" in certain cases and still remain in the scheme, i.e., cosmetic surgery, therapeutic abortions, etc.

3. A fee differential between F.P.s and specialists.

4. An increased fee for cases done after 1800 hours, on weekends, and statutory holidays.

5. Modifiers used
   - over age 74
     under age 1
     insertion of arterial line
     controlled hypotension
     pump oxygenation

6. More pay for longer cases, i.e., number of units per hour to increase after 2 hours.

7. Perhaps some fringe benefits:
   a) Disability insurance
   b) Education fund
   c) Prepaid medical and dental plan
   d) Malpractice fees paid
   e) Standby
   f) Group life insurance
   g) Professional dues
   h) Pension plan
   i) Canada Pension Plan

8. The right to incorporate as in Alberta.

Source: Council, 4–5 February 1978, Report of Committee on Economics

CHAPTER FOURTEEN

Manpower in Anaesthesia: The Society's Perspective

THE concern regarding anaesthetic manpower is virtually as old as the Society. As the Second World War was drawing to a close, the membership supported a plan presented at the annual meeting on 13 June 1945 to survey conditions under which anaesthesia was being practised in Canada. This was in part related to concern about the economic status of anaesthetists, but a year later President Harold Griffith told the annual meeting that rapid demobilization had made it necessary to give "considerable thought" to integrating returning military anaesthetists into civilian hospitals.

Council's approval on 3 March 1946 of the formation of Committee on Anaesthetic Services should have facilitated this process, but records suggest the committee never functioned. It was, however, the first of four committees to study manpower problems over the years. (See also Chapter 4.)

The need to study manpower and to act accordingly is frequently referred to in the Society's Minutes and in the Canadian medical and anaesthetic literature in the 1960s, 1970s and 1980s. This chapter is based on this source material and emphasizes the principal problems of anaesthesia manpower in Canada from the Society's perspective.

The 1960s

The first clear note of concern in the 1960s regarding anaesthetic manpower was sounded in an editorial published in the *Canadian Anaesthetists' Society Journal* in 1961.[1] Appropriately entitled "A Matter for Concern," the editorial stated that, unless solutions were found to some of the pressing problems of manpower, "we will find ourselves unable to provide the anaesthetists which will be required by the Canada of 1970."

There were three main problems. One was that, since the end of the Second World War, the increase in numbers of physicians required to provide anaesthesia services to a growing Canadian population had been met only through the immigration of anaesthetists from other countries. A second allied problem was that a significant proportion of trainees

were also immigrants. This immigrant source, however, was not inexhaustible, and it was not wise for Canada to rely so heavily on that source. It was therefore necessary – and this was the third problem – to draw trainees from Canadian medical schools into anaesthesia residency training programs.

This was not easy, and the editorialist noted "our failure ... to attract a larger number of bright young men (and, he might have added, young women) to the study and practice of anaesthesia." A tall order was required: more adequately paid teachers of anaesthesia, "adequately compensated to permit them to make teaching a vocation rather than a spare time avocation"; and adequate facilities for clinical investigation and laboratory facilities, "not only to seek answers to the endless procession of problems in anaesthesia, but at the same time to demonstrate to the student and interne the interest and challenge of the specialty."

Soon after this editorial had been published, an informal group comprising the heads of the university departments of anaesthesia was formed.[2] This group was founded after discussion among university anaesthetists had shown "much divergence of opinion on the matter of postgraduate training for anaesthetists and how we should face the future as University teaching centres."[3] This group, the forerunner of the later, more formal Association of Canadian University Departments of Anaesthesia (ACUDA), was established in 1961. It was formed after Dr. Stuart L. Vandewater, of Kingston, wrote to his fellow university heads (Drs. S.M. Campbell, Toronto, E.A. Gain, Alberta, R.G.B. Gilbert, McGill, H.B. Graves, UBC, F. Hudon, Laval, L. Lamoureux, Montréal, W.E. Spoerel, UWO, C. Stoddard, Dalhousie, and G. Wyant, Saskatchewan) suggesting that "it would appear that it would be worthwhile for the heads of University Anaesthetic Departments to meet regularly ... and ... discuss problems of mutual interest in both undergraduate and postgraduate teaching." One of Dr. Vandewater's points addressed precisely the main problem that the 1961 editorialist had identified. Dr. Vandewater was customarily direct in his opinion: "I believe that it is obvious to all that as yet we are not attracting our own graduates into the specialty of Anaesthesia and this should be our main supply. I am sure the fault lies with us."

The formation of this group, and of ACUDA in later years (see Appendix 8), did a great deal for training and education in anaesthesia in Canada – and indeed for the Society – but in terms of manpower its importance lies in the questions it asked and the solutions proposed. A key question was this: how could Canadian graduates be attracted into anaesthesia? The answer proposed in 1961 was the following:

- "Sell" anaesthesia for the undergraduates.
- Glamorize anaesthesia for students, interns and general practitioners through the regional medical societies.
- Extol the living and working conditions.
- Go after the honours graduate.
- Encourage general practitioners to come back.
- Since anaesthesia is an honourable and satisfying specialty, equal to any other – preach it, practise it.[4]

The existence of the Heads of Canadian University Departments of Anaesthesia stimulated interest in anaesthesia manpower in a second way. During the inaugural meeting of this group, which was held in Montebello, Québec on 14 May 1961, members discussed the practice of foreign medical graduates applying for training to several Canadian centres simultaneously. Out of this discussion emerged the concept of a central agency that could assess all applications from foreign medical graduates and coordinate their appointments. Dr. H.B. Graves agreed to take on this arduous task, which he continued to perform most diligently over the next decade. Dr. Graves was inspector as well as coordinator; department heads would forward to him their list of accepted appointments each year, so that "if a name occurs on more than one list, it will be spotted immediately and the respective departments informed."[5]

Dr. Graves pursued the trail with dogged determination, which was just as well, because at the next meeting of the group, on 13 May 1962, he agreed to extend this service by collecting data on all accepted trainees, Canadian graduates as well as foreign medical graduates. The task was no small one: the data would include, for each trainee, the place of graduation, stage of training, reappointment or new appointment, year of completion of training, and the country where anaesthesia would be practised. These data, though concerning only residency training positions, at least provided some manpower statistics.

Information about requirements for specialists rather than trainees was, of course, of interest to the Society. During the midwinter meeting of Council in 1965, Dr. R.A. Gordon asked if the Society's office could be kept informed of requirements for specialists across the country. Dr. Graves then suggested that a committee be established "to go further into future needs for Specialists in Anaesthesia for Canada." The committee was "to study and analyze the present situation of anaesthesia services in Canada, to project the needs of and provision for competent anaesthesia for the various geographical areas of Canada." Knowing Dr. Graves' interest in and knowledge of anaesthesia manpower, the President, Dr. Léon Longtin of Québec, appointed Dr. Graves as chairman, with Drs. Max Minuck of Winnipeg and A. Stuart Wenning of Halifax as members.

By February 1966 Dr. Graves was able to present Council with a thoughtful report on anaesthesia manpower in Canada. His basic tenet was that "safe" anaesthesia must be provided for "all the peoples of Canada" and that "acceptable" anaesthesia must be provided for the practising physicians and surgeons in Canada. This, however, was not easy, for the stock of anaesthetists increased insufficiently to compensate for the loss by attrition. He concluded that the additional yearly requirement could be averaged as follows: for Nova Scotia, New Brunswick, Manitoba, Saskatchewan, Alberta, British Columbia and Yukon Territory, 30; and for Ontario and Québec, 40 each. Since only 60 to 65 new specialists were starting to practise at this time, there would be a shortage of about 10 specialists yearly or 50 over the next five years. Dr. Graves saw no need to increase the number of training facilities because too few candidates were applying for positions. Therefore, to meet requirements for safe and acceptable anaesthesia in the 1960s it would be necessary to provide three types of anaesthetists:

- Competent general practitioner anaesthetists, appropriately trained for a period from 3 to 12 months.
- Trained specialist anaesthetists willing to combine specialist practice with general practise. (According to Dr. Graves, "there are a number of such individuals still available.")
- Certified trained anaesthetists for "closed" hospital staffs.[6]

By 1967 the work of Dr. Graves and his committee was seen to relate to manpower as well as training. Consequently, on 29 June 1967 Council approved the renaming of the Survey Committee to "The Committee to Study Manpower in Anaesthesia in Canada." This was an appropriate step because of the interest of the Canadian Medical Association (CMA) in medical manpower.

The following year Dr. Graves was able to add the data to make further projections for the provinces not previously considered,[7] and in May 1968 he submitted a final and complete report.[8] The principal aspects of the report were the following:

- *Terms of Reference of the Committee.* Dr. Graves had defined these terms of reference for his committee. (They are of interest of themselves, but also in comparison with those of the 1984 Manpower Committee [see page 225]). The terms of reference were the following:
  1 To assess the status of the practice of anaesthesia in Canada as provided by physician specialists, and general practitioners.
  2 To study and project the future requirements for safe and acceptable anaesthesia for all Canadians, and how this goal may be attained.
  3 To report on the possible role that non-physician paramedical personnel might assume in the future practise of anaesthesia in Canada.

- *The Shortage of Trained Anaesthetists.* To Dr. Graves' committee it was apparent that there was indeed a shortage of trained physician anaesthetists in Canada. The shortage was "acute" in certain areas of the country (particularly, as Dr. Graves had reported to Council on 25 June 1967, in Nova Scotia, New Brunswick, Manitoba, Saskatchewan and Alberta) and "not so alarming" in others (e.g., Ontario, BC).

- *Workload for Anaesthetists.* The committee suggested that 1200 anaesthetics per year was a reasonable workload, that the active anaesthetist would spend 45 hours in the hospital each week, and that 30 of those hours would be spent in the actual administration of anaesthesia.

- *Factors Contributing to the Shortage of Anaesthetists.* These included: a general shortage of physicians in all fields of medicine owing to the inevitable number of medical schools and graduates; increasing nonoperating room activities of anaesthetists; building of new hospitals; and geographic and climatic preferences of physicians.

- *Possible Solutions to the Problem of the Shortage of Anaesthetists.* Encouragement of medical students and interns through exposure to anaesthesia was a starting point. Family practitioners, too, should be encouraged, and training programs for them supported. Recruitment of physicians from other countries would be expected to continue. Surveys had shown that about six fully trained anaesthetists emigrated from Commonwealth countries and became established in Canada each year in this era. Also, an average of 40 graduates of British medical schools had enrolled in Canadian postgraduate training program in the previous four years.

- *Use of Paramedical Personnel.* The committee's report is of interest in recommending the employment, by the hospital, of paramedical personnel (registered nurses, orderlies or inhalation therapy technicians [respiratory technologists]) who would assist anaesthetists by setting up and cleaning and maintaining equipment. (See also Chapter 11.)

- *Recommendations.* Actions that would ease the manpower shortage were the following:
  1 An increase in the exposure of medical students and interns to the principles of anaesthesia in medical schools.
  2 Encouragement of postgraduate training of general practitioner anaesthetists by refresher courses and short-term residency programs in universities. This had led the committee earlier to present a motion to Council to the effect that the minimum requirement for a physician administering anaesthesia in a hospital should be six months. Council approved this motion on 3 February 1968.
  3 Recognition of the qualification of trained, immigrant anaesthetists and easing of their licensing requirements. A motion recommending that anaesthetists from the British Commonwealth holding the FFARCS (England) or FFARCS (Ireland) be admitted to the Royal College Certification examination without further training was approved by Council on 3 February 1968. It was also recommended that the Canadian Anaesthetists' Society make appropriate recommendations to provincial licensing authorities that such physicians be granted temporary licenses.
  4 Adequate publicity regarding postgraduate training and the practice of anaesthesia in Canada.
  5 Assumption of "a more positive and active role" on the part of specialist anaesthetists so that the trained anaesthetist's time could be more advantageously used.

The 1970s

Dr. Graves had tried to give some attention to statistics. In his final report he had stated that, as of 1 April 1968, the presence of 1,017 active specialists provided Canada with a specialist anaesthetist-to-population ratio of 1:20,000, which meant an extra requirement for specialists of 328. However, he emphasized solutions as much as statistics.

In the 1970s there was a greater emphasis on statistics. The principal study was mounted by the National Committee on Physician Manpower, which published a three-volume report in 1976.[9] This included data on anaesthesia that were provided by a Working Party of Society members, which presented its final report in July 1975.[10] Two other studies contributed data. One concerned Ontario, and was presented by the Manpower Study Group for Anaesthesia, which submitted a report to the Postgraduate Committee of the Council of Ontario Faculties of Medicine in January 1975.[11] A third study was less formal and concerned manpower in the Maritime Provinces.[12]

The manpower situation in Canada (the analysis and reporting of which must have provided many person-years of employment in the 1960s, 1970s and 1980s), presented problems that were extremely difficult to solve. In Dr. Minuck's presidential address to the Annual General Meeting in 1969, he likened the situation to "a picture that is as difficult to interpret as any abstract or surrealistic painting"; he added that "the author of such a painting tends to be deeply personal and restricted in his view and therein lies the difficulty in assessing the national picture." Avoiding a restricted view was what the National Committee on Physician Manpower attempted to do by enlisting the aid of working parties from 33 specialties, including anaesthesia. However, even after this committee had conducted its study, the answers to the central questions about manpower remained unclear.

The Requirements Subcommittee of the National Committee on Physician Manpower had three main objectives in conducting its study: to determine the present status of physician manpower in each specialty; to determine the requirements of physicians for each specialty in the immediate future; and to improve methods by which physician manpower requirements could be established. After distilling the various working parties' reports, the Requirements Subcommittee reached the following conclusions:

- In 1981 there should be from 37,427 to 38,818 full-time, fee-for-service physicians in Canada.

- The desirable physician-to-population ratio in 1981 would be 1:665.

- To achieve these *desiderata*, 1,796 physicians would have to be produced each year.

What contributions did the Working Party on Anaesthesia make to this study?

The members of the Working Party were appointed in December 1973 by the Society President, Dr. Iain M. MacKay of Toronto. This group comprised Dr. MacKay himself, and Drs. Vandewater, Ian E. Purkis (Halifax), Gordon M. Wyant (Saskatoon) and J. Earl Wynands (Montréal), all of whom were Presidents of the Society at one time or another. Dr. Vandewater chaired the committee. The Working Party met four times, twice with the Requirements Committee and twice on its own. Dr. Vandewater also met with personnel of the Department of National Health and Welfare and consulted with heads of university departments of anaesthesia. A summary of the Working Party's report follows:

- *Sources of Information.* The principal data originated with 10 provincial medical care insurance plans. Data were either for fiscal 1971–72 or 1972–73. A second source of data comprised the annual reports of Dr. Graves' central registry of residents, which had been in operation since 1962.

- *Objectives.* The Working Party was invited to use the data to determine an anaesthetist's workload and to estimate both the present requirement for anaesthetists and the requirements for 1981.

- *Principal Findings.* Selected findings are summarized in Tables 14.1 to 14.5.

- *Estimate of Current Requirement.* Several different factors had to be taken into account in arriving at this estimate. The actual number of full-time anaesthetists was 1,115 (650 in community hospitals and 465 in teaching hospitals). The number of anaesthetic services per full-time anaesthetist was 1,266 (Table 14.1) and the total number of services provided by all full-time anaesthetists was 1,411,882. Taking the suggested yearly workload of 45 weeks (including weekends and statutory holidays and leaving two weeks for continuing medical education and five for vacation and illness), it was concluded that the actual number of full-time anaesthetists could have been expected to provide 819,000 anaesthetics in community hospitals (at 1,260 anaesthetics per year per anaesthetist) and 481,275 anaesthetics in teaching hospitals (at 1,035 anaesthetics per year). Based on the evidence that some 70% of anaesthetic services were provided by full-time anaesthetists in community hospitals and 30% in teaching hospitals, the difference between the actual services (1,411,882) and the appropriate workload (1,300,275) should have been provided by 94 additional anaesthetists (62 in community hospitals and 32 in teaching hospitals). In addition, since the Working Party identified 133 full-time equivalent practitioner-anaesthetists, most of whom worked in small cities or larger towns, the total shortage of full-time fee anaesthetists was 227 (94 + 133). Therefore the total requirement for full-time anaesthetists in the period under review was 1,342 (1,115 + 227), or one full-time anaesthetist per 16,077 population as opposed to the actual supply of 1,115 (1:19,350). As well, there were some non-full-time fee-for-service anaesthetists, representing 14.5% of all fee-for-service anaesthetists; an additional 39 anaesthetists were therefore required, for a total of 228 (189 + 39). Consequently, the total requirement for this period was 1,570 (1,342 + 228), or one anaesthetist per 13,742 population. The actual supply was 1,304 fee-for-service anaesthetists (1:16,545).

- *Estimate of Future Requirements.* Factors taken into account included the increase in the population of Canada, from 21.5 million in 1971 to 24.5 million in 1981 (or 14%), the changing roles of anaesthetists outside the operating room, and the use of anaesthetic technicians. By maintaining the required recommendation for current specialist to population ratio constant at 1:13,742, the required number in 1981 would be 1,781. Therefore, the number of additional full-time anaesthetists required by 1981 would be 1,017 (477 – for the future requirement of 1,781 less

the current supply of 1,304 – plus 540 to replace the estimated loss through attrition over the decade). With further calculations on training and certification, it was concluded that 105 newly certificated specialists in anaesthesia would be needed between 1971–72 and 1981–82 to reach the actual number of 1,781 anaesthetists in 1981. However, between 1970 and 1974 there was an average yearly output of only 82 new specialists, and in the 1974–75 examination year only 54 new certificates were issued.

- *Reconciliation of Supply and Requirement.* Because the supply situation did not appear to be "overly stable," it would be necessary to monitor the supply of anaesthetists on a continuing basis. Meanwhile, the Working Party made the following recommendations:
  1 Encouragement of recruitment of Canadian graduates into anaesthesia. "Clinical anaesthesia must be an attractive experience to all senior students."
  2 Re-examination of remuneration of anaesthetists. ("Anaesthetists are concerned over the degree of disparity of incomes between anaesthetists and other specialists.")
  3 Encouragement of "appropriately qualified" graduates of non-Canadian medical schools to enrol in Canadian anaesthesia residency programs. (However, "any restriction of foreign medical graduates as a source of manpower, at least until recruitment of Canadian graduates improves, could have a serious effect on the delivery of high quality anaesthetic care.")
  4 The requirement for general practitioner anaesthetists to have not less than six months' training in anaesthesia. ("In order to improve anaesthesia care for patients in localities where it is impractical [although ideal] to have anaesthetists.")
  5 Regionalization and rationalization of health care facilities. (To reduce the requirement for anaesthetist's services.)
  6 Consideration of employment of suitably trained anaesthesia assistants, with monitoring of their training and activities. ("The training of technicians or nurses for anaesthesia is problematical ... yet to materially increase the workload of an anaesthetist by the use of assistants could lead to an abuse of the system and, of more importance, jeopardize the quality of patient care, through unsupervised activities.")

The two other studies of manpower by anaesthetists in the 1970s led to similar conclusions. The Ontario report found that in 1973 there were 451 full-time-equivalent anaesthetists in the province, and that, ideally, 603 were required; by 1982, 713 would be required. The Ontario report was similar in many ways to the national one, which is not entirely surprising, because this too was principally authored by Dr. Vandewater.

The study of manpower requirements in the Maritime provinces also indicated a shortage of anaesthetists. Drs. Emerson A. Moffitt (Halifax), David Rideout (Saint John) and Douglas A. MacDonald (Charlottetown) sought to answer questions germane to all manpower studies: Who was providing the services? Were there sufficient anaesthetists?

What was their level of training? And how many anaesthetists should be trained in the foreseeable future?

As far the Maritime Provinces were concerned, the answers were similar to those in other areas. In 1978, 78 physicians were practising anaesthesia regularly in Nova Scotia, New Brunswick and Prince Edward Island, of whom 76 were full-time anaesthetists. In the next three decades, 76 present specialists would require to be replaced on grounds of age; in addition, a 3% attrition rate per year due to other conditions seemed reasonable (approximately 68). Therefore, 184 anaesthetists (30 + 10 + 76 + 68) should be trained for the Maritimes in the next 30 years, or approximately six trainees finishing each year over the next three decades.

The message in all these studies in the 1970s was essentially the same: there was a shortage of anaesthetists; it would be unrealistic to rely on immigration as a solution to the manpower shortage; therefore, Canadian anaesthetists must attract graduates from Canadian medical schools into the specialty of anaesthesia if a shortage of anaesthetists was not to become more serious.

To clarify these issues for the Society, a Conference on Health Economics was held on 11 November 1977.[13] The conference was the idea of Dr. John H. Feindel, of Halifax, when he was President of the Society (1976 to 1977). Participants concentrated on both the economic problems confronting the specialty and the anaesthesia manpower requirements. The conclusions regarding the former have been considered in Chapter 13; the latter are summarized below, in the form of excerpts from the conference report.

- "There is increasing evidence that we have reached a crisis state in our specialty. Six of 16 Canadian University Departments of Anaesthesia are currently without effective Chairmen. Several provinces are having difficulty obtaining the required specialists in anaesthesia. At least four internationally known anaesthetists capable of heading University Departments of Anaesthesia have recently immigrated [sic] to the United States."

- "Will we, in the future, be able to maintain the academic status of our specialty or will we become mere technicians completing operating room lists? The Canadian Anaesthetists' Society must respond to the challenges and provide leadership."

- (Apart from methodological problems identified by the Requirements Committee of the National Committee on Physician Manpower in 1975) "other factors which affect future manpower requirements are:
  1 An aging population will require an increasing number of services. An increase in female population will be significant as they require about 50% more medical services than the males.
  2 The future demand for services whether physician or patient generated is not entirely predictable and the effect of other factors such as a rise in litigation is unclear.
  3 The implications of biomedical progress and improved medical technology cannot be fully predicted.

4 The future definition of "good medical care" has not been established.
5 The advent of changes in disease states cannot be fully predicted.
6 The effect of social ills on the requirements for physicians; for example, unemployment and alcoholism cannot be fully predicted.
7 The effect of changes in medical care insurance.
8 The effect of changes in the methods of remuneration for physicians.
9 Future changes in physicians' working hours.
10 The number of female physicians is also relevant as the lifetime productivity of a female will be approximately 20 to 30% less than the lifetime productivity of a male physician.
11 Future use of allied health personnel for the provision of services not provided by physicians. This is likely to have little effect in Canada.
12 The bureaucratization of medicine.
13 The introduction of jurisdictional boundaries; that is, who does anaesthesia? Will general practitioners continue to provide anaesthesia services?
14 The effect of changes in patterns of practice; that is, new evolving specialties, overlapping functions, patterns of delivery of primary care.

- "It is likely that there will continue to be a flow of Canadian graduates to the United States as long as there is a shortage of fully qualified anaesthesiologists in that country."

- "Some of our present manpower shortage may be due to a poor distribution of available physician anaesthetists. It is highly likely that, as regionalization and rationalization of hospital services continues to be implemented and as more efficient scheduling of operating room time is introduced, more effective use can be made of the present complement of certified anaesthetists."

- "There is no question that there is a severe shortage of anaesthetists at the present time. Each year we seem to fall further behind the actual manpower requirement and as we do, those that are left put in longer hours of work and thus falsely inflate their incomes. Because of longer hours spent in the operating room, there is less time for non-operating room activities. It is specifically the latter activities which seem to most impress the medical students with a wide range of responsibilities offered by the specialty of anaesthesia. Our fee schedules must be raised to a level which will allow anaesthetists to spend more time outside the operating room and hence exert a wider influence in hospitals. This may be the only way we can attract new people into our specialty in great numbers. It will be necessary to explain our role and functions to the public, government and undergraduate students."

- "Based on the projected future requirements for anaesthetists, there is indeed a crisis in the production of qualified anaesthetists. There are, however, an adequate number of medical graduates being turned out ... (by) Canadian Medical Schools to meet all of Canada's physician manpower requirements. Therefore, every means

must be utilized to persuade medical students to choose anaesthesia as a career. Most experts agree that the present standards of the Royal College Examinations in Anaesthesia are *not* too high and that the level of competence demanded of candidates should be maintained or perhaps even elevated."

- "The following steps can be taken immediately to improve or at least maintain the present viability of the specialty:
  - Take steps to assure better distribution and more efficient use of the present supply of certified anaesthetists.
  - We must maintain or even raise the present standards of proficiency and competence in the specialty.
  - We must accept and upgrade those practitioners in primary and secondary areas.
  - We should recognize a place for anaesthesia technicians in Canada.
  - The fee for service system of remuneration of anaesthetists should be maintained and preserved. Guidelines for an ideal fee schedule as set down by the Economics Committee of the Canadian Anaesthetists' Society should be endorsed and promoted as a basis for the future development of fee schedules.

    As a general principle the annual incomes of specialists in anaesthesia should be based on an annual workload of 1,200 cases per year and should be equal to the annual income of other specialists with similar duties, training and responsibilities.
  - The recommendations made in this report pertaining to the ideal funding of University Departments of Anaesthesia should be endorsed and promoted by the Canadian Anaesthetists' Society.
  - Every effort must be made to enhance the attractiveness of the specialty of anaesthesia for potential candidates. Anaesthetists as individuals must project a better image of their specialty and promote the concept of job satisfaction as they carry out their duties."

The 1980s

The 1980s opened with relatively encouraging statements from two anaesthetists on opposite coasts. Both Drs. Moffitt and Graves had given much thought to this perennial problem. Writing in the *Canadian Anaesthetists' Society Journal* in January 1980,[14] they wrote that "our efforts to attract enough people of high quality are succeeding." They believed that the sense of discouragement that had pervaded Canadian anaesthesia for the previous decade need no longer continue. In their opinion, anaesthesia was now a more attractive career choice, and more Canadian graduates were entering the 16 training programs and succeeding in obtaining their Royal College specialty certificates. The evidence is summarized in Table 14.6.

These data appeared encouraging, but other data were less so. Responding to the claim by Drs. Moffitt and Graves, Dr. Vandewater felt constrained to temper their optimism.[15] Dr.

Vandewater's argument ran as follows. First, little had changed except the gender distribution of residents in training: in 1965, of the 270 residents, 229 were men and 41 were women; in 1979, of the 320 residents, 260 were men and 94 were women. Dr. Vandewater thought that the shortage of specialists, as defined by the Working Party report of 1975, was of the same magnitude in 1980. Second, the total numbers of graduates of Canadian medical schools having a documented interest in Royal College specialty training for the graduating years from 1966 to 1975 had decreased from 50.4% to 35.6%. During that period there were 11,771 graduates, and 3,855 became certified in a specialty, of which only 6% were anaesthetists. Thus, concluded Dr. Vandewater, less than 2% of Canadian medical school graduates became certified in anaesthesia. The ideal addition to the stock of specialists still was not being achieved.

Dr. John B.R. Parker of Saskatoon also was less than enthusiastic.[16] He was replying to what appeared to be an overly optimistic review of manpower planning by Charlotte Gray in 1980.[17] She had said that, in terms of the requirements projected by the National Committee on Physician Manpower for specialists per population unit, "the one specialty which achieves the desired ratio is anaesthesia." Gray's conclusion was based on the belief expressed by Dr. W.A. Mennie, of the Department of National Health and Welfare, that for anaesthesia the desired ratio of 1:13,742 had been reached.[18]

However, Dr. Parker noted, Dr. Mennie had based his calculations on misleading assumptions. He had added to the total number of specialist anaesthetists the estimated number of nonspecialist physicians devoting 50% or more of their time to anaesthesia. Nor had Gray allowed for the attrition rate due to emigration and retirement, the latter being especially important since the average age of physicians in the specialty exceeded 48 years. Furthermore, the National Committee on Physician Manpower had based its estimate for a desirable ratio on a workload of 55.5 hours weekly (excluding on-call time) and had allowed a yearly caseload of 1,260 cases per anaesthetist in community hospitals and 1,035 in teaching hospitals. In Dr. Parker's experience this desirable workload still had not been achieved; in his own department, for example, the average annual caseload per anaesthetist had long averaged 1,600 to 1,800.

It was all too evident that there was a shortage of anaesthetists. In Ontario alone, Dr. Parker continued, 39 specialist anaesthesia positions were vacant, and the situation was the same across Canada in proportion to the numbers of practising anaesthetists. How could this be reconciled with the Society's long-term goal of providing specialist anaesthetists to Canadians needing this service? (The revised Constitution of 1971, in the expanded section on Objects of the Society, included the statement that "the Society shall aid the furtherance of measures designed to improve the delivery of health care for the people of Canada through the promotion of research, education and practice of anaesthesia, and medical services in general, however rendered.") This goal of the Society could not be met for many years. However, Dr. Parker added, that time would never come unless more anaesthetists were trained "now." In his final paragraph he gave this advice:

> It is essential that governments realize the need to expand residency programs in anaesthesia and provide additional funds so that programs in other specialties are not reduced. This has been accomplished in Saskatchewan and other western provinces. It is required even more in the major population centres. It will be unfortunate indeed if the comments on anaesthesia manpower in Ms. Gray's article were to deter medical students or recently qualified doctors from seeking a career in anaesthesia. The resulting reduction in both the quality and quantity of anaesthetic care would be unacceptable to Canadians.

Dr. Parker's words were echoed in Québec, where the Professional Corporation of Physicians of Québec, together with the University Departments of Anaesthesia, had conducted their own study of anaesthesia manpower.[19] Dr. Laurent Marceau, in a letter to the Deans of the Québec medical schools and to the chairmen of the Québec departments of anaesthesia, made the following specific points:

- The present manpower shortage was of the order of 25% of the normal level. To the 442 anaesthetists registered with the Corporation, another 100 should be added to satisfy the needs of hospitals for adequate anaesthesia services.
- The mean age of anaesthetists was 49.8 years, as opposed to the mean age for all specialists of 46.6 years.
- The recruiting figures of residents for the period 1975–1979 showed a 36% increase compared to the period 1960–1965. Furthermore, more and more anaesthetists were leaving to practice outside Québec.
- There were shortages both in urban areas and in remote areas such as Rouyn-Noranda, Sept-Iles, Baie-Comeau/Hauterive and Maniwaki.
- There were currently 115 residency positions in Québec. When all of these were filled, there would be 29 positions per year of training. At least 40 positions per year should be filled to meet future manpower needs.[20]

In a letter to Mme Paule Leduc, President, Council of the Universities, on 23 January 1981, Dr. Marceau, who was then President of the Association of Anaesthetists of Québec, made some other points concerning the lack of interest in the specialty by medical students.[21] These points would have to be accepted in any efforts to attract medical students into the specialty:

- Anaesthesia was a relatively young specialty which was still not well known by students.
- As a service specialty it was vulnerable to such events as strikes, bed closures and admitting problems.
- Emergency work was more pronounced in anaesthesia than in other specialties.
- Anaesthetists must be available on a "practically immediate" basis. In no other speciality was on-site, on-call requirements so widespread.
- Teachers were insufficient in both quantity and quality. An anaesthetist administering anaesthesia could not concentrate wholly on teaching. Funds would have to be found to remunerate teachers.

- Similarly the quantity and quality of research activities suffered.
- The specialty had suffered from "a chronic lack in manpower," which was aggravated by the advent of Medicare, due to the increase in the number of surgical cases. In Québec (and in Saskatchewan[22]) this situation had fostered "a doubtful type of practice characterized by the administration of two simultaneous anaesthetics, without always providing adequate supervision."

The manpower message was being stated over and over again. The situation was no different in the 1980s from earlier. The majority of those practising in the field believed there was an acute shortage of anaesthetists. This, and the need for an increase in the number of residency positions, had to be impressed upon governments.

As President of the Canadian Anaesthetists' Society, Dr. Parker therefore wrote to all provincial ministers of health and education, and to the deans of medical schools.[23]

The CMA also repeated its concern about the shortage of anaesthetists. The 1976 study by the National Committee on Physician Manpower had recommended the establishment of a national "functional" inventory of physicians in Canada, and this was initiated by the CMA in 1981. A report on the findings obtained by analyzing this inventory, published in 1985, confirmed what practising anaesthetists had been saying. Anaesthesia was one of the specialties (together with surgery, obstetrics and gynaecology, and radiology) in which "within the next decade the numbers ... may be too few to meet the demand as more than 20% of the current practitioners reach retirement age."[24]

Despite this continuing activity regarding manpower in the 1980s and 1970s, a specific and separate standing manpower committee had not been active in the Society. This was corrected in 1984 when the President, Dr. John Price of Fredericton, proposed to the Executive Committee on 3 February 1984 the formation of a manpower committee. Dr. Charles E. Hope of Halifax was appointed chairman. The primary objective of the committee would be a continuing study of manpower, with the information being retained in computer data bases.

The terms of reference for this Manpower Committee, which may be compared to those of the 1965 Survey Committee, were the following:

1 To establish a data collection mechanism to identify the present status of anaesthesia manpower in Canada.
2 To establish a data collection mechanism which would permit regular updating of anaesthesia manpower statistics on an ongoing basis in order to identify trends in all aspects of manpower and activities of physicians administering anaesthesia in Canada.
3 To establish a mechanism for analyzing and interpreting the data collected in a manner which would permit the Executive and Council of the Canadian Anaesthetists' Society to obtain the best possible assessment of any aspect of the status of anaesthesia in Canada as and when required.

This large task would occupy the committee for the remainder of the 1980s and early

1990s. The committee sought to do what the Economics Committee had done: collect data for all provinces on a continuing basis so that there would be available an overall view of statistics across the country. So far this has been possible except for Ontario, because of its large data base.

The Manpower Committee in the 1990s has also tried to study other issues as they arise. The Barer-Stoddart Report of 1992,[25] with its implications for the numbers of physicians graduating in the future, is an example of such an issue. The changing profile of anaesthetists is another; what will be the effect of changes in age and gender ratios among physicians who are added to the stock of anaesthetists? A third area of interest has been generated by the approach hospitals have taken with respect to regionalization and rationalization of services.

The wheel had come full circle. The Canadian Anaesthetists' Society has been concerned with manpower for half a century. In 1945 the Society struck a committee to survey conditions under which anaesthetists were practising and how they operated in the hospitals. In 1993 this concern still exists. The complexity of the issues has, however, increased enormously, as has the methodology of the instruments used to measure the problem. Burning questions remain, however. How can sufficient anaesthetists be found to provide a comprehensive anaesthesia service for Canadians, and how can the Canadian Anaesthetists' Society play an appropriate role in achieving this objective?

TABLE 14.1*
Selected Indices: Anaesthetic Services by Anaesthetists in Canada
Data for 10 Provinces, Fiscal 1971–72 or 1972–73

	Index					
Province	Service per 1000 Pop.	Service per FT Anaesthetists†	All Fee Anaesthetists per 100,000 Pop.	Pop. per Fee Anaesthetist	FT Anaesthetists per 100,000 Pop.	Pop. per FT fee Anaesthetist
1	36.6	1,666	3.8	29,250	2.9	35,000
2	43.5	1,374	3.8	26,333	2.8	35,111
3	44.1	1,428	3.4	29,067	3.1	32,296
4	53.9	1,308	4.4	22,794	4.0	25,000
5	52.2	1,332	4.6	21,822	4.0	25,179
6	69.4	1,390	5.8	17,330	5.1	19,626
7	78.0	1,213	7.4	13,460	6.1	16,373
8	79.8	1,336	6.7	14,953	5.8	17,266
9	65.1	1,180	6.2	16,138	5.3	18,860
10	45.5	1,183	5.3	18,833	3.5	28,250
10 Provinces	67.6	1,266	6.0	16,545	5.2	19,350

Notes:

1. No. of fee-for-service anaesthetists: 1,340.
2. No. of full-time (FT) fee-for-service anaesthetists: 1,115.
3. Insured population: 21,575,000.

* Source for Tables 14.1 to 14.5: Report of Working Party in Anaesthesia, Requirements Subcommittee of the National Committee on Physician Manpower, 1975.

† Excludes Workers' Compensation Board, Dept. Veterans' Affairs, Cancer Services in Saskatchewan.

TABLE 14.2
Anaesthetic Services in One Year, Canada
Data for 10 Provinces, Fiscal 1971–72 or 1972–73

	Anaesthetists	Practitioners	Other MDs	Total
Nerve blocks (and %)	11,181	24,700	20,270	56,152
	(19.9)	(44.0)	(36.1)	(100.0)
All other procedures (and %)	1,447,128	661,436	13,825	2,122,389
	(66.2)	(31.2)	(0.6)	(100.0)
All fee physicians	1,304	2,726		
Services per physician	1,118	243		
FT fee physicians	1,115	445		
Services per FT fee physician	1,266	1,486		

Note:

1. "Other MDs": Surgeons occasionally giving anaesthetics (local nerve blocks).
2. Nerve blocks were included in total services rendered by anaesthetists, but excluded from services rendered by practitioners.
3. "All other procedures" excluded Workers' Compensation Board, out-of-hospital dental, and other services not covered by provincial care insurance.
4. The FT fee anaesthetists (1,115) provided 10,800 nerve blocks and 1,401,082 other anaesthetic services for a total of 1,411,882, representing roughly 96.8% of the total workload of all fee anaesthetists, which was 1,458,310 (i.e., 1,447,128 + 11,182 services).

TABLE 14.3
Average Anaesthesia Times (Min), Canada

Anaesthetic Services	Anaesthetist	Practitioner
All types of anaesthesia*	61	51
Anaesthesia time, case >35 min*	66	55
Excluding tonsillectomy*	70	59
All types		
Winnipeg General Hospital†	78	
University Hospital, Saskatoon§	81.8	–

* Dept. National Health and Welfare, based on services in Québec, 1971–72.

† Data provided by Dr. J. Wade.

§ Data provided by Dr. G.M. Wyant.

TABLE 14.4
Average Working Week for Anaesthetists, Canada*

	Type of Hospital	
	Community	Teaching
O.R. time for anaesthesia (hr)	28.4	30.0
Waiting, set-up time (hr)	5.0	4.0
Other professional (hr)	18.0	18.0
Administration, records, committees (hr)	2.0	2.0
Teaching (hr)	1.0	3.0
Total	54.4	57.0
Working year	2448	2565
Anaesthetics (no./yr)	1260	1035

* Working weeks include weekends, statutory holidays.

† For average anaesthesia times, see Table 14.3.

TABLE 14.5
Demographic Characteristics of Anaesthetists, Canada*

Year of Graduation			
1910–29	34	1950–54	273
1930–34	33	1955–59	277
1935–39	76	1960–64	212
1940–44	144	1965–69	43
1945–49	165		

School of Graduation†			
Memorial	0	Toronto	178
Dalhousie	44	McMaster	0
Laval	190	Western Ontario	45
Sherbrooke	0	Manitoba	56
McGill	64	Saskatchewan	64
Montréal	113	Calgary	0
Ottawa	13	British Columbia	17
Queen's	79	**Total**	812

Average Age			
1969	45.89	1972	46.48
1970	46.23	1973	46.72
1971	46.45	1979	46.79

* Principal Source of information: Dept. National Health and Welfare

† Anaesthetists resident in Canada, Jan. 1, 1973.

TABLE 14.6
Anaesthesia Training and Specialist Certification Data, Canada, 1963-80*

Training					Examination Success			
		Graduation Medical School (%)				Graduation Medical School (%)		
Academic Year	Nos. of Residents	Canada	UK	Other	Nos. of Candidates	Canada	UK	Other
1963–71					532	56	20	25
1964–65	258	54	11	35	–	–	–	–
1965–66	270	51	13	36	–	–	–	–
1966–67	270	50	14	36	–	–	–	–
1967–68	247	48	15	37	–	–	–	–
1968–69	263	40	15	45	–	–	–	–
1969–70	292	36	12	52	63	43	27	30
1970–71	266	41	13	46	70	46	24	30
1971–72	266	42	14	44	66	44	24	32
1972–73	276	49	8	43	56	34	85	36
1973–74	315	48	8	44	51	55	14	31
1974–75	269	48	10	42	54	59	15	26
1975–76	302	49	13	38	58	62	12	25
1976–77	283	50	12	38	49	51	18	31
1977–78	280	57	13	30	60	66	18	16
1978–79	313	65	10	25	60	53	20	27
1979–80	336	72	11	17	–	–	–	–

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2 Minutes, Council, 6 March 1949.
3 Minutes, Council, 26 February 1950.
4 Minutes, Council, 1–2 March 1958.
5 Minutes, Council, 27–28 February 1960.
6 Minutes, Council, 11 May 1964.
7 Annual Meeting Program, 1967.
8 Minutes, Council, 2–4 February 1968.
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25 Minutes, Council, 12 May 1968.

26 Minutes, Executive Committee, 6 February 1981.

27 Minutes, Executive Committee, 23 June 1984.

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Chapter 13

1 Minutes, Council, 6 March 1949.

2 Minutes, Council, 1–2 March 1958.

3 Minutes, Council, 31 January – 1 February 1976, Appendix 7.

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5 Letter, HR Griffith to RA Gordon, 24 June 1944. Canadian Anaesthetists' Society Archives.

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8 Minutes, Council, 20 June 1956.

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10 Minutes, Council, 1–2 March 1958, Appendix 2.

11 Minutes, Council, 5–6 February 1977, Appendix VIII.

Chapter 14

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2 The group was known as the Heads of Canadian University Departments of Anaesthesia. The purpose, as given in the Minutes of the group's first meeting in Montebello, PQ, on 14 May 1961, was to "Exchange information, and discuss mutual problems in relation to undergraduate and postgraduate teaching in Anaesthesia." It was a loosely structured association of department heads, much

smaller than the later Association of Canadian University Departments of Anaesthesia (ACUDA) (Appendix 8), to which members of academic departments as well as the heads belonged.

3 Letter, SL Vandewater to Heads of Departments of Anaesthesia, 8 February 1961. (File, courtesy of Dr. Vandewater.)

4 Minutes, Meeting of Heads of Canadian University Departments of Anaesthesia, 14 May 1961. (File, courtesy of Dr. Vandewater.)

5 Minutes, Meeting of Heads of Canadian University Departments of Anaesthesia, 14 May 1961. (File, courtesy of Dr. Vandewater.)

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9 See Korcok H, Geekie DA. Report issued by Requirements Subcommittee of the National Committee on Physician Manpower. *Can Med Ass J* 1976; 115: 265–73.

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13 Minutes, Council, 4–5 February 1978. Attachment, Canadian Anaesthetists' Society Conference on Health Economics, 11 November 1977.

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21 L Marceau. Letter to Mme Paule Leduc, 23 January 1981.

22 Report of Board of Inquiry on Anaesthetic Practices in Saskatchewan (DT Anderson, Chairman). Regina, Queen's Printer, 1976.

23 These letters were dated 21 November 1980 and emphasized the need for more residency positions. Dr. DV Catton, then President of ACUDA, emphasized the same point in letters he wrote to the same groups on 1 October 1980.

24 C Woodward, O Adams. Physician resource data bank: numbers, distribution and activities of Canadian physicians. *Canad Med Ass J* 1985; 132: 1175–87.

25 ML Barer, GL Stoddart. *Toward Integrated Medical Resource Policies for Canada.* Vancouver, Centre for Health Services and Policy Research, University of British Columbia, 1992. This report was serialized in the *Canadian Medical Association Journal* in 1992.

Appendices

APPENDIX 1

Selected Chronological Outline of Events, 1943–1993

Year	CAS Event	Miscellanea, Comments
1943		
27 May	Memorandum of Agreement incorporating Bylaws signed by H.R. Griffith, R. Rochette, M. Digby Leigh, W. Bourne, G. Cousineau.	
21 June	Letters Patent granted, incorporating Society.	
24 June	Provisional Directors meet, elect H.R. Griffith as President, M. Digby Leigh as Secretary, R. Rochette and W. Bourne as Vice-Presidents.	The five founders "being all the members of the Society," membership total is 5.
	CAS office: residence of Digby Leigh, Montréal (386 Grosvenor Avenue, Westmount).	
9 October	First meeting of "Executive." Dues set at $5.00.	"Executive" equivalent to Council.
1944		
24 May	First Annual Meeting (Royal York Hotel, Toronto)	NDP platform includes proposal for "universal" health care insurance for Saskatchewan.
7 December	Membership organized in nine provincial Divisions.	
1945		
24 May	Membership total: 310	End of World War II
15–19 June	First Refresher Course	Held prior to Annual Meeting.

1946 3 March	Committee on Survey of Anaesthetic Services formed. R.A. Gordon elected Secretary-Treasurer; CAS office moved to Toronto (Medical Arts Building).	The first CAS committee.
1947		Saskatchewan Hospital Insurance Plan introduced
Fall	First exam for Royal College Certification.	
1948 23–24 April	Western Canadian Divisions' Meeting, Regina	
1949 16 June	Newfoundland approved as Society's tenth division.	
1950 27 June	First Annual Meeting held separately from CMA's.	Meeting held in Seigniory Club, Montebello, PQ.
1951	First Newsletter published. Examination for Royal College Fellowship in Medicine Modified for Anaesthesia inaugurated.	
1952	Society's *Proceedings* published.	
1954	Inaugural issue of *Canadian Anaesthetists' Society Journal* published.	R.A. Gordon named Editor.
1955 June	CAS participates in joint CMA-BMA meeting in Toronto.	WFSA founded; H.R. Griffith elected as Founder-president.
1957	Canadian Anaesthetists' Mutual Accumulating Fund established.	
1958	CAS office moved to 178 St. George Street, Toronto.	
1960	Research grant of $1000 offered by British Oxygen Co. (Canada) Ltd.	
1961	British Oxygen Canada Prize inaugurated.	Becomes CAS Prize in 1965.

	Heads of Canadian University Departments of Anaesthesia form informal group. S.M. Campbell becomes Secretary-Treasurer.	
1962	First presentation of Society's Gold Medal.	Gold medallists were W. Bourne, H.R. Griffith and H.J. Shields. "Universal" health care insurance plan introduced in Saskatchewan.
1964		Justice Emmett Hall presents report of Royal Commission on Health Services.
1967	First Residents' Program inaugurated at Annual Meeting.	Known later as Residents' Competition.
1968		Medicare inaugurated in Canada, 1 July (not truly universal in Canada until 1 April 1972).
1969	Post of Secretary-Treasurer split into those of Honorary Secretary and Honorary Treasurer.	For officers, see Appendix 5.
1971 12 October	Supplementary Letters Patent granted.	Embodies revised Constitution and Bylaws, with establishmentof formal Executive Committee.
1972	Single-standard examinations introduced by Royal College.	Certification now the sole standard for specialty qualification.
1974	Past-Presidents' Club formed.	
1975	Council approves Guidelines for the Standards of Practice.	The first such Guidelines by any anaesthesia society.
25 June	First CAS/Royal College Lecture at Annual Meeting; inaugurates new tradition.	Lecturer: E.I. Eger II, on "Uses of MAC."
1976	Association of Canadian University Departments of Anaesthesia (ACUDA) approves Constitution for this new group.	ACUDA supersedes former Annual Conferences of Departmental Chairmen.
1978	CAS Research Fund established.	

1980	First special-interest section formed – the Obstetric Anaesthesia Section.	Followed by Regional Anaesthesia, Pediatric and Cardiothoracic Sections, 1984–1992
1982	CAS office moves to 94 Cumberland Avenue, Toronto. IARS proposes co-sponsorship with CAS of the Annual Meeting.	
1983 1 January	D.B. Craig appointed Editor.	
1 February	Appointment of F. Teepell as Executive Director. Regional Anaesthesia Section approved.	First non-physician administrative officer (succeeded by L. Mayeda in 1985 and A. Andrews in 1988).
1985	CAS Research Award presented for first time.	Awardee: H. Nathan.
1987	*CASJ* renamed *Canadian Journal of Anaesthesia*. Office relocated to 187 Gerrard Street E., Toronto.	
1988	D.R. Bevan becomes Editor. Bid for World Congress in year 2000 to be held in Canada (Montréal) approved by WFSA.	
1991 November	Office relocated to 1 Eglinton Avenue E., Toronto.	
1992	Membership total: 2214.	
1993	Dues set at $317.79.	
4–8 June	CAS' 50th Anniversary Meeting, Halifax.	

APPENDIX 2

Letters Patent, 21 June 1943 and Constitution and By-laws*

By the Honourable Norman Alexander McLarty
Secretary of State of Canada

To all to whom these presents shall come, or whom the same may in anywise concern,

GREETING:

WHEREAS in and by Part II of The Companies Act, 1934, it is amongst other things, in effect enacted that the Secretary of State of Canada may, by Letters Patent, under his Seal of Office, grant a charter to any number of persons, not less than three, who having complied with the requirements of the Act, apply therefor, constituting such persons, and others who thereafter become members of the Corporation thereby created, a Body Corporate and Politic without share capital, for the purpose of carrying on in more than one province of Canada, without pecuniary gain to its members, objects of a national, patriotic, religious, philanthropic charitable, scientific, artistic, social, professional or sporting character, or the like, upon the applicants therefor establishing to the satisfaction of the Secretary of State of Canada, due compliance with the several conditions and terms in an by the said Act set forth and thereby made conditions precedent to the grantings of such Charter.

AND WHEREAS, HAROLD RANDALL GRIFFITH and GEORGES COUSINEAU, both of the City of Montreal, in the Province of Quebec, ROMEO ROCHETTE, of the City of Outremont, in the said Province of Quebec, MORTON DIGBY LEIGH and WESLEY BOURNE, both of the City of Westmount, in the said Province of Quebec, all Physicians, have made applications for a Charter under the said Act, constituting them, and such others as may become members in the Corporation thereby created, a Body Corporate and Politic, under the name of

The Canadian Anaesthetists' Society

for the purposes hereinafter mentioned, and have satisfactorily established the sufficiency of all proceedings required by the said Act to be taken, and the truth and sufficiency of all facts required to be established previous to the granting of such Letters Patent, and have filed in the Department of the Secretary of State a duplicate of the memorandum of Agreement executed by the said applicants in conformity with the provisions of the said Act.

NOW KNOW YE, that I, the said NORMAN ALEXANDER McLARTY, Secretary of State of

*Principal amendments are noted in Chapter 3.

Canada, under the authority of the hereinbefore in part recited Act, do, by these letters Patent, constitute the said

HAROLD RANDALL GRIFFITH, GEORGES COUSINEAU, ROMEO ROCHETTE, MORTON DIGBY LEIGH AND WESLEY BOURNE,

and all others who may become members in the said Corporation, a Body Corporate and Politic without share capital, by the name of

The Canadian Anaesthetists' Society

with all the rights and powers given by the said Act and for the following purposes and objects, namely:

To advance the art and science of anaesthesia and to promote its interests in relation to medicine with particular reference to the clinical, educational, ethical and economic aspects thereof, to associate together in one corporate body members in good standing of the Medical Profession who have specialized in this particular science, to promote the interests of its members, to maintain a society library and bureau of information, to edit and publish a journal of anaesthesia, to acquire and own such property and real estate as may be necessary to effectively carry out the purposes of the Society, and to do all such lawful acts and things as may be incidental or conducive to the attainment of the above objects.

The operations of the Corporation to be carried on throughout the Dominion of Canada and elsewhere.

The head office of the said corporation will be situate at the City of Montreal, in the Province of Quebec.

And it is hereby ordained and declared that, if authorized by by-law, duly passed by the directors and sanctioned by at least two-thirds of the votes cast at a special general meeting of the members, duly called for considering the by-law, the directors may from time to time:

(a) borrow money upon the credit of the corporation;
(b) limit or increase the amount to be borrowed;
(c) issue debentures or other securities of the corporation;
(d) pledge or sell such debentures or other securities for such sums and at such prices as may be deemed expedient;
(e) mortgage, hypothecate, charge or pledge all or any of the real and personal property, undertaking and rights of the corporation to secure any such debentures or other securities or any money borrowed or any other liability of the corporation.

Nothing in this clause contained shall limit or restrict the borrowing of money by the corporation on bills of exchange or promissory notes made, drawn, accepted or endorsed, by or on behalf of the corporation.

And it is further ordained and declared that the business of the said Corporation shall be carried on without the purposes of gain for its members and that any profits or other accretions to the Corporation shall be used in promoting its objects.

That the said HAROLD RANDALL GRIFFITH, GEORGES COUSINEAU, ROMEO ROCHETTE, MORTON DIGBY LEIGH and WESLEY BOURNE,

are to be the first directors of the said Corporation.

Given under my hand and Seal of Office, at Ottawa, this twenty-first day of June, 1943.

(Sgd.) E. H. Coleman (Seal)
Under Secretary of State

Dated 21st June 1943
Recorded 24th June 1943
Lib. 404 Fol. 544
W.P.J. O'Meara Acting Dep. Registrar General of Canada
Ref. No. 111859
WMC
[Earlier, a Memorandum of Agreement set out the Founders' concept that was formalized by the Letters Patent.]

Memorandum of Agreement

1 We, the undersigned, do hereby severally covenant and agree each with the other and each of them to become incorporated under the provisions of Part II of The Companies Act, 1934, as a corporation without share capital under the name of

The Canadian Anaesthetists' Society

or such other name as the Secretary of State may give to the corporation, for the purpose of carrying on in more than one province of Canada, without pecuniary gain to its members the objects following: To advance the art and science of Anaesthesia and to promote its interests in relation to medicine with particular reference to the clinical, educational, ethical and economic aspect thereof, to associate together in one corporate body members in good standing of the medical profession who have specialized in this particular science, to promote the interests of its members, to maintain a society library and bureau of information, to edit and publish a journal of anaesthesia, to acquire and own such property and real estate as may be necessary to effectively carry out the purposes of the Society, and to do all such lawful acts and things as may be incidental or conducive to the attainment of the above objects.

2 We, the undersigned, do further severally covenant and agree each with the other and each of them that the corporation shall be carried on without pecuniary gain to its members and that any profits or other accretions to the corporation shall be used in promoting its objects.

3 The subscribers hereto shall be the first members of the corporation which shall consist of the subscribers and of those who shall hereafter duly become members of the corporation in accordance with the by-laws from time to time in force.

4 The first directors of the corporation shall be as set out in the petition herein.

5 The following shall be the by-laws of the corporation:

TITLE

1 The Corporation shall be known as "THE CANADIAN ANAESTHETISTS' SOCIETY."

OBJECTS

2 To advance the art and science of Anaesthesia and to promote its interests in relation to medicine with particular reference to the clinical, educational, ethical and economic aspects thereof, to associate together in one corporate body members in good standing of the Medical Profession who have specialized in this particular science, to promote the interests of its

members, to maintain a Society Library and Bureau of Information, to edit and publish a journal of Anaesthesia and to do all such other lawful acts and things as may be incidental to and conducive to the attainment of the above objects.

MEMBERSHIP

3 Members of the Society shall be Medical Practitioners duly qualified and registered in the country in which they practise their profession who fill the requirements hereinafter outlined. If practising in Canada, they must also be members in good standing of the Canadian Medical Association, L'Association des Medecins de la Langue Francaise de L'Amerique du Nord, or of a local or provincial Medical Society approved by the Council of the Society.

Subject to the foregoing, membership in the Society shall be divided into four classes:-

(a) Active Members
(b) Members Elect
(c) Associate Members
(d) Honorary Members

(a) *Active Members:-* These must have devoted the major part of their time to the practice or study of Anaesthesia for a period of not less than three years. They shall be entitled to attend, take part in and vote at all meetings of the Society, shall be eligible for membership on the Council and entitled to propose or second candidates for admission to the Society.

(b) *Members Elect:-* These shall comprise graduate physicians who are in training in the Specialty of Anaesthesia. They shall not vote at meetings or hold office in the Society. No person may remain a member-elect who is not in training, or, in any event, for more than three years.

(c) *Associate Members:-* These shall be those surgeons, physicians, dentists or other scientists who have rendered special service to, or have shown special interest in anaesthesia and its allied subjects and who have been invited by the Council to apply for such membership. Associate members pay the same due as active members. They may not vote at meetings or hold office in the Society.

(d) *Honorary Members:-* These shall be such distinguished persons who have rendered services to Anaesthesia as the Society may desire to recognize. They shall be nominated by the Council and their names submitted to election at the next meeting of the Society. They may neither vote at meetings nor hold office in the Society.

Before a Medical practitioner may be elected an Active Member of the Society, the Council must approve of his or her training and experience.

The Certification in Anaesthesia of the Royal College of Physicians and Surgeons of Canada, the Diploma of Anaesthesia of the Royal College of Physicians and Surgeons of England [sic], the Diploma of the American Board of Anaesthesiology [sic], or other diplomas which in the opinion of the Council are considered sufficient qualification, may be accepted by the Council as adequate qualification for Active membership in the Society.

MODE OF ELECTION

4 Candidates for the Active membership and membership Elect, shall be nominated, in writing, by two members of the Society in good standing, who shall vouch that the candidates fulfil all the conditions of the membership. Such nominations in writing shall be sent to the Secretary-

Treasurer, who shall submit the same to the Council without undue delay. The Council shall recommend for election at a General Meeting of the Society those candidates whom they may deem eligible. The election of new members shall be the first item of business on the agenda at General Meetings of the Society, and subject to Article 5 hereof. New members elected at such meetings shall be entitled to vote in connection with any business that may be transacted at such Meeting following their election.

PRIVILEGES DEPENDENT ON PAYMENT OF SUBSCRIPTIONS

5 No member shall enjoy any of the privileges of membership until he has paid annual dues and is not in arrears in respect thereof.

LOSS OF MEMBERSHIP

6 A member shall cease to be a member:-

(a) If by notice in writing to the Secretary-Treasurer of the Society he resigns his membership;
(b) If he is expelled under Article 7 hereof;
(c) If his name shall be removed for misconduct from the medical register of the Province or Country in which he practises;
(d) If his annual dues are in arrears for more than twelve months and he has been duly notified in writing of the delinquency by the Secretary-Treasurer of the Society. In such cases he may be reinstated with the consent of the Council on payment of arrears.

7 If at any time they shall be of the opinion that the best interests of the Society so require, it shall be the duty of the Council, by notice in writing, to invite any member to withdraw from the Society within the time specified in such notice, and in default of withdrawal within the specified delay, to submit the question of his expulsion to a Special General Meeting of the Society duly called for considering such an expulsion. At such Meeting the member whose expulsion is under consideration shall be allowed to offer an explanation of his conduct verbally or in writing. If three-fourths of the members present at such meeting shall vote for expulsion of such member, he shall thereupon cease to be a member of the Society, and his name shall be struck from the Register.

GENERAL MEETING

8 The Annual General Meeting of the Society shall be held at such time and place as may be fixed by the Council. Special General Meetings may be held from time to time at the call of the President. The President shall, at the request in writing of at least 20 Active Members of the Society, call a Special General Meeting, provided that the request of such members specifies the nature of the business to be transacted thereat.

OFFICERS

9 The Officers of the Society shall be a President, two Vice-Presidents and a Secretary-Treasurer. They shall be elected at Annual General Meetings by a plurality of those voting. They shall hold office for a period of one year or until their successors are duly elected, and shall be eligible for re-election. The President shall not hold office for more than three consecutive years. The terms of the newly elected officers shall commence at the close of the Annual General Meeting at which they are elected. Officers elected to fill vacancies shall assume office immediately upon election. The officers shall be nominated by the Council, the nominations to be specified in the notice of the Annual General Meeting. Nominations may also be made by any two Active members prior to the date of notice calling the Meeting. Officers shall be elected by ballot, by plurality vote. Voting shall be by mail. Ballots will be sent to Active Members in good standing one month prior to the date of the meeting.

DUTIES AND POWERS OF THE OFFICERS

10 (a) *President:*

The President shall be and have the power of the Chief Executive Officer of the Society. He shall preside at all meetings of the Society and of the Council and shall have a casting vote in all proceedings thereat.

He shall submit an annual report of the business and affairs of the Society to the Council as soon as such report may conveniently be prepared after the close of each fiscal year, and to the members of the ensuing Annual Meeting; and, from time to time, he shall report to the Council all matters within his knowledge which the interests of the Society may require to be brought to their notice.

He shall be ex-officio a member of all Committees, and shall have the general powers and duties of management and supervision usually vested in the office of the President.

(b) *Vice-Presidents:*

The Vice-Presidents shall assume the duties of the President during the latter's absence or incapacity and shall, in the event of the death or retirement of the president, become the President of the Society, provided that in the event of a dispute as to which Vice-President shall act in any of the said events, the decision shall rest with the majority of the Council.

(c) *Secretary-Treasurer:*

The Secretary-Treasurer shall:–

1) Keep the Minutes of the Society and of the Council in books provided for the purpose;
2) See that all notices are duly given in accordance with the provisions of these by-laws or as required by law;
3) Be custodian of the records of the Society and of the seal thereof;
4) Have charge and custody of, and be responsible for all funds and securities of the Society and deposit such funds in the name of the Society in such banks, trust companies or other depositories as shall be selected by Council;
5) Exhibit at all reasonable times his books of account and records to any of the officers or members of the Council upon application during business hours at the place where such books and records are kept;
6) Render a detailed report of the finances of the Society whenever called upon by the Council or by the Auditor of the Society and an annual report to the Society at the Annual General Meeting;
7) Receive and give receipts for moneys due and payable to the Society from any source whatsoever;
8) In general perform all duties necessary or incident to the office of Secretary-Treasurer and such other duties as may from time to time be assigned to him by the Council.

COUNCIL

11 The affairs of the Society shall be conducted by a Council consisting of the President, Vice-Presidents, the Secretary-Treasurer and ten (10) other Active Members to be selected [sic] annually by the Active Members of the Society. At least two of the members of the Council shall reside in and represent each of the four Divisions of the Society (Maritime Provinces, Quebec, Ontario, Western Provinces).

The Council shall have general management, supervision and direction of the affairs of the Society. They shall adopt at all times the best possible measures for the advancement of the Society's interests, and shall be entrusted with the maintenance and care of the property of the Society. They shall be the Executive and Administrative body of the Society and shall have charge of all arrangements for the Annual Meetings of the Society.

CASUAL VACANCIES

12 Whenever any vacancy shall occur in the office of President, Vice-President or Secretary-Treasurer or in the membership of the Council by reason of death, resignation or otherwise, such vacancy or vacancies shall be filled by the remaining members of the Council, but any person so appointed to fill a vacancy shall hold office only until the next Annual General Meeting of the Society.

DIVISIONS

13 (a) To fulfil the objects of the Society and to facilitate the organization of the Anaesthetists within Canada and to permit reasonable freedom of action among sectional groups which may be formed from time to time, the membership of the Society may be divided into four Divisions, as follows:-

Division 1: Comprising members residing in the Provinces of Nova Scotia, New Brunswick and Prince Edward Island.
Division 2: Comprising members residing in the Province of Quebec.
Division 3: Comprising members residing in the Province of Ontario.
Division 4: Comprising members residing in the Provinces of Manitoba, Saskatchewan, Alberta and British Columbia.

(b) Each Division shall be presided over by a Divisional Chairman, who shall be a member of the Council of the Society. Divisional Chairmen shall be appointed by Divisional members.

(c) The business of a Division shall be conducted by the members of the Division presided over by the Divisional Chairman. The members shall meet at the call of the Chairman.

(d) Subject to these By-laws and subject also to the approval of the Council of the Society, a Division may deal with the provincial and other governing bodies regarding matters strictly provincial or sectional in character.

(e) Scientific sessions of the Divisions may be arranged at any time according to the wishes of the Divisional members.

(f) Divisional Chairmen shall keep or cause to be kept Minutes of all proceedings at Divisional Meetings and shall forward copies thereof to the Council without undue delay.

DUES

14 Members shall pay such annual dues as shall be determined and fixed from time to time by the Council of the Society.

15 (a) All proceedings of the Society shall be accurately recorded and may be distributed to all members.

(b) A Journal may be published by the Council of the Society, which may appoint an Editor and other officers for that purpose.

AMENDMENTS

16 These By-laws may be amended or repealed by Resolution of the Council and proposals for the amendment or repeal thereof may be made by individual members of the Society, provided always that in no event shall any such resolution be deemed to have been passed unless and until approved by a majority of at least two-thirds of the votes cast at a General Meeting of the Society and provided also that in no event shall any such repeal or amendment be acted upon until after the approval of the Secretary of State has been obtained. Voting may be done by mail ballot of the active membership, under the signature of such members. Notice of any proposal to repeal, amend or add to these by-laws must be sent to the Secretary-Treasurer in writing, signed by at least two active members, not later than six weeks before the date fixed for a General Meeting, and must appear on the Agenda of the said meeting in the form of a motion, which shall be mailed to the active members not less than one month before the date fixed for such General Meeting.

QUORUM

17 Ten active members personally present shall constitute a quorum for any General Meeting of the Society, and no business shall be transacted at any General Meeting unless the requisite quorum be present at the commencement of business. The quorum for a meeting of the Council shall be five.

AUDITOR

18 At each Annual General Meeting of the Society, the members shall appoint an Auditor who shall make an annual audit of the books and accounts of the Society and shall report thereon at each such Annual Meeting. The Auditor may be a member of the Society and may be paid such remuneration commensurate with services rendered as the Council may from time to time determine.

SEAL

19 The Society shall have a seal, which shall have inscribed thereon the name of the Society and the year of incorporation.

The President of the Society and/or the Secretary-Treasurer shall have the custody and care thereof.

SALARIES AND REMUNERATION

20 All officers shall render their services to the Society gratuitously, provided always that the Council may pay reasonable salary or remuneration to the Auditor and to the Secretary-Treasurer commensurate with the value of the services rendered as it may from time to time deem fit, and provided also that the Council may pay travelling expenses and other expenses reasonably incurred by its officers and/or members in the interests of the Society.

NOTICES

21 (a) Notices of Annual or Special General Meetings of the Society shall be given to all Active members in writing by mailing the same in a prepaid wrapper to the registered address of the members at least one month prior to the date fixed for such meetings.

(b) Notices of meetings of members of the Council may be given by mail, by telegraph or by telephone at least three days prior to the date fixed for such meeting, provided always that such meetings may be held without notice if all members of the Council are personally present.

A Resolution or Resolutions signed by all members of the Council shall be as effective and binding as if passed at a meeting duly called and constituted.

(c) Meetings of Divisional members may be held on such notice as the Chairman of such Divisions may determine in the circumstances.

SIGNING OF DOCUMENTS

22 All bills of exchange, cheques, documents, deeds or other papers required to be executed by the Society shall be signed by the President or, in his absence, by one of the Vice-Presidents of the Society and by the Secretary-Treasurer or, in his absence, by such member or members of the Council of the Society as the Council may be resolution determine.

All documents requiring certification shall be certified by the Secretary-Treasurer of the Society.

RULES AND REGULATIONS

23 The Council may from time to time make such rules and regulations, not in any way inconsistent with these by-laws, for the internal management of the Society as the Council may deem advisable.

FISCAL YEAR

24 The fiscal year of the Society shall end on the 31st day of December in each year.

IN WITNESS THEREOF we have hereto set our hands and affixed our seals.

Dated at Montreal, this 27th day of May, 1943.

	WITNESS		NAME
(Sgd.)	A. Smyth	(Sgd.)	Harold R. Griffith, M.D.
"	A. Smyth	"	R. Rochette, M.D.
"	A. Smyth	"	M. Digby Leigh, M.D.
"	A. Smyth	"	Wesley Bourne, M.D.
"	A. Smyth	"	Georges Coucineau, M.D.

APPENDIX 3

*Supplementary Letters Patent, 12 October 1971 and Revised Constitution and By-laws as Amended to 26 September 1975**

Chapter 1
TITLE, HEAD OFFICE AND LANGUAGES

1.1 The Society shall be known as the Canadian Anaesthetists' Society and when the French language is used, it shall be known as the Société Canadienne des Anesthésistes.

1.2 The headquarters and office of The Society shall be at 178 St. George Street, Toronto, Ontario, Canada, or wherever designated in Canada by the Council from time to time.

1.3 French and English may be used in the conduct of the business of the Society.

Chapter 2
THE SEAL

2.1 The Seal of the Canadian Anaesthetists' Society as depicted on the cover of this document shall be the Seal of the Society and shall be in the custody of the Honorary Secretary and be affixed by him to all documents that require to be sealed.

Chapter 3
OBJECTS OF THE SOCIETY

3.1 The Society shall promote the medical and related arts and sciences of Anaesthesia and maintain the honor and the interests of the medical profession.

3.2 The Society shall aid the furtherance of measures designed to improve the delivery of health care to the people of Canada through promotion of research, education and practice of anaesthesia, and medical services in general, however rendered.

3.3 The Society may publish periodic journals or publications as may be authorized from time to time and which promote the objects of The Society.

*Principal amendments are noted in Chapter 3.

3.4 The Society shall assist in the promotion of measures designed to improve the standards of hospital and related anaesthetic services.

3.5 The Society shall promote the interests of the members of The Society and act on their behalf where appropriate, in the promotion thereof.

3.6 The Society shall form a liaison and affiliate with The Canadian Medical Association.

3.7 The Society shall grant sums of money out of funds of The Society for the furtherance of these objects.

3.8 The Society shall do other lawful things as are incidental or conducive to the attainment of the above objects.

Chapter 4
RULES AND REGULATIONS

4.1 The Society may make such rules and regulations, not contrary to law, or to the provision of these By-laws, as it may deem necessary for the government and management of its business and affairs and especially with respect to qualification, classification, admission and expulsion of members, the fees and dues which it may deem advisable to impose, and the number, constitution, powers and duties of its Council, Executive Committee and Officers, and may, from time to time, amend or repeal all or any of such rules and regulations as it may see fit.

Chapter 5
DIVISIONS

5.1 The Society shall be considered as composed of ten (10) Divisions, namely, as follows:

- 5.1.1 The Newfoundland Division shall comprise the members of The Society who reside in the Province of Newfoundland.
- 5.1.2 The Nova Scotia Division shall comprise the members of The Society who reside in the Province of Nova Scotia.
- 5.1.3 The Prince Edward Island Division shall comprise the members of The Society who reside in the Province of Prince Edward Island.
- 5.1.4 The New Brunswick Division shall comprise the members of The Society who reside in the Province of New Brunswick.
- 5.1.5 The Quebec Division shall comprise the members of The Society who reside in the Province of Quebec.
- 5.1.6 The Ontario Division shall comprise the members of The Society who reside in the Province of Ontario.
- 5.1.7 The Manitoba Division shall comprise the members of The Society who reside in the Province of Manitoba.
- 5.1.8 The Saskatchewan Division shall comprise the members of The Society who reside in the Province of Saskatchewan.
- 5.1.9 The Alberta Division shall comprise the members of The Society who reside in the Province of Alberta.
- 5.1.10 The British Columbia Division shall comprise the members of The Society who reside in the Province of British Columbia.

5.2 The Division shall be known as the Canadian Anaesthetists' Society (one of the above mentioned) Division.

5.3 Any Division may affiliate with the provincial division of the Canadian Medical Association by agreement, and where their constitution and by-laws are in keeping with the Constitution and By-laws of This Society.

5.4 Any geographic group of Divisions, on the approval of two-thirds of the Active Members within each Division concerned, may amalgamate for the purposes of The Society.

Chapter 6
MEMBERSHIP

6.1 The Society shall be composed of duly qualified Medical Practitioners or other recognized Scientists, designated as Active, Associate, Student, Senior and Honorary members as hereinafter set out.

6.2 *Active Members*

6.2.1 shall be Medical Practitioners resident in Canada who are accredited specialists in Anaesthesia by The Royal College of Physicians and Surgeons of Canada or by the College of Physicians and Surgeons of Quebec;

6.2.2 shall be accorded all the privileges of The Society.

6.3 *Associate Members*

6.3.1 Associate Members (Resident)

shall be Medical Practitioners, resident in Canada, engaged in the practice of Anaesthesia not otherwise qualified for Active Membership but showing evidence of experience and interest in Anaesthesia, or be Medical Practitioners or Scientists resident in Canada not engaged in the practice of Anaesthesia who profess an interest in Anaesthesia whom The Society deem worthy of membership.

6.3.2 Associate Members (non-Resident)

shall be Medical Practitioners not resident in Canada, engaged in the practice of Anaesthesia, or Scientists not resident in Canada who profess an interest in Anaesthesia, whom The Society deem worthy of membership.

6.3.3. Associate Members, whether resident or non-resident, shall be accorded all the privileges of The Society but may not vote or hold office in The Society.

6.4 *Student Members*

6.4.1 shall be Medical Practitioners who are currently registered in Anaesthesia training programmes in Canada approved by The Royal College of Physicians and Surgeons of Canada, or by The College of Physicians and Surgeons of the Province of Quebec;

6.4.2 shall be accorded all the privileges of The Society but may not vote or hold office in The Society with the exception outlined in Section 8.4 below.

6.5 *Retired Members*

6.5.1. shall be those Medical Practitioners who have retired from the active practice of Anaesthesia, and have been either an Active or Associate Member of The Society, ordinarily for a period of twenty (20) years;

6.5.2 shall be accorded all the privileges of The Society, at a reduced fee, but may not vote or hold office in The Society.

6.6 *Senior Members*

6.6.1 shall be those Medical Practitioners who have retired from the active practice of Anaesthesia and have been an Active Member of The Society ordinarily for a period of twenty (20) years, and at the discretion of The Society shall be so honored;

6.6.2 shall be accorded all the privileges of The Society, without fee, but shall not hold office in The Society.

6.7 *Honorary Members*

6.7.1 shall be those distinguished Medical Practitioners or Scientists who have rendered conspicuous services to the Medical Profession, and whom The Society desires to recognize;

6.7.2 shall be accorded all the privileges of The Society, without fee, but shall not hold office in The Society.

6.8 *Nomination and Election*

6.8.1 Nomination for membership shall be on the prescribed forms for consideration by the Membership Committee and election shall be at the Annual Meeting of The Society.

6.8.2 Notwithstanding the provisions of Section 6.2 above, all Active Members at the time these By-laws are adopted shall continue in this category. This is not be construed as a precedent nor an abrogation from the terms of these By-laws.

6.9 *Termination of Membership*

6.9.1 An Active, Associate, and Student Member shall cease to be accorded the privileges of The Society if he has not paid the annual dues within three months of final notice, or has submitted his resignation to the Honorary Secretary of The Society or whose name has been erased from the Register of a licencing authority or gives cause to The Society that membership should be withdrawn.

Chapter 7
FEES

7.1 *Annual Fee*

7.1.1 The annual fee for each category of membership shall be determined by the Executive Committee and be submitted for approval by the Council.

7.1.2 The annual fee shall apply to the ensuring calendar year and shall be due on January first of each year.

Chapter 8
THE COUNCIL

8.1 The governing body of The Society shall be the Council of The Society, and the members by virtue of office, or elected annually, shall be as hereinafter defined.

8.2 *Personnel*

8.2.1. The Council shall consist of the following members:

a) the officers of The Society, that is to say, the President, the First Vice President, the Second Vice President, the Honorary Treasurer, the Honorary Secretary, the Immediate Past President, as well as the two Past Presidents who held office immediately before the current Immediate Past Present;

b) Active Members at Large elected by each Division of The Society as outlined in Section 8.3.1 below;

c) Student Members at Large may be elected as outlined in Section 8.4 below;

d) one representative from the Conference of Heads of Canadian University Departments of Anaesthesia, non voting;

e) the Editor of The Canadian Anaesthetists' Society Journal, non voting.

8.3 *Election of Divisional Representatives*

8.3.1 Each Division shall be entitled to elect annually Active Members to the Council in

proportion to the number of Active Members in that Division, by a formula to be determined from time to time by the Active Members at an Annual Meeting of The Society.

8.3.2 The method of election of Active Members to the Council as Divisional representatives to sit on Council shall be at the discretion of each Division.

8.3.3 Each Division shall elect an alternate for each member of Council who shall attend meetings of Council if the elected member of Council is unable to attend.

8.3.4 Divisional representatives to the Council shall hold office for a period of one year and shall be eligible for re-election.

8.4 *Election of Student Members*

8.4.1 Student Members may be elected annually to the Council from within their respective membership in a number and formula that may be determined from time to time by Council.

8.4.2 Student members who sit on Council shall be full voting members and shall be eligible for re-election for a total term not to exceed three (3) consecutive years.

8.5 *Duties and the Powers of Council*

8.5.1 The Council shall act for The Society in all matters not otherwise reserved, and more specifically, shall as far as possible, deal with and dispose of all matters relating to:

a) the reports of the Executive Committee;
b) any matters relating to the general health and welfare of the public, the specialty of Anaesthesia and The Society;
c) the Nomination of the Officers of The Society, the election of the Chairman of Council, and representatives to the Executive Committee;
d) the proposal of By-laws not contrary to this By-law, subject to the provision of section 16, below.

8.5.2 The Council may make rules and regulations, and revise them from time to time and it may perform such other acts not elsewhere excluded as shall make for the welfare, order, and good government of The Society. Any rule or regulation so made, or any revision thereof shall become effective when adopted by a majority of the Active Members present and voting at any Annual or Special Meeting of The Society as provided in Chapter 15 of these By-laws.

8.5.3 The Council shall approve of all financial matters related to The Society, and cause to have published an annual record of receipts and expenditures of all funds.

8.5.4 The Executive Committee shall act for the Council between meetings in the approval of all financial matters.

8.5.5 Ten (10) members of Council shall constitute a quorum.

8.5.6 The Council may meet from time to time during the course of the year but in no event shall it meet less than once during each calendar year. Special meetings of Council may be called by the Chairman of Council at the written request of at last six (6) Divisional representatives on Council.

8.5.7 The Council may authorize the payment of specified travel and maintenance expenses of members of Council and others when engaged in business of The Society.

8.6 *Chairman of Council*

8.6.1 A Chairman of Council shall be elected from and by the members of Council and shall have the following duties:

a) The Chairman shall preside at all meetings of the Council and enforce due observance of the By-laws of The Society according to established procedure.
b) He shall not hold other office in The Society.
c) He shall determine the order of business to be presented to Council and shall rule on procedure as currently observed by the Parliament of Canada.

d) He shall remain in office until the conclusion of the Annual Meeting of The Society.

8.6.2 Upon election the Chairman's position on Council shall be filled by an alternate from his Division.

Chapter 9
EXECUTIVE COMMITTEE OF THE COUNCIL

9.1 The day-to-day affairs of The Society shall be managed by the Executive Committee of the Council hereinafter referred to as the Executive Committee.

9.2 *The Composition of the Executive Committee*

9.2.1 The following shall be the members of the Executive Committee:

a) the elected officers of The Society; President, First Vice Present, Second Vice President, Immediate Past President, Honorary Secretary, Honorary Treasurer;

b) two representatives from the Council, not officers, elected by the members of the Council, and Chairman of Council.

9.3 *Duties and Powers of the Executive Committee*

9.3.1 The Executive Committee, between meetings of the Council, shall exercise the right and powers of the Council and may delegate this responsibility at its discretion.

9.3.2 The proceedings of the Executive Committee, including proposals, recommendations, and details of reports of committees shall be reported in full to the Council.

9.3.3 These reports in the form of Reports to Council shall be in the hands of the members of the Council at least twenty-one (21) days prior to a regular meeting of Council.

9.3.4 The Executive Committee shall be responsible for the selection and appointment of the appointed officials of The Society. It shall designate their job descriptions and fix their salaries.

9.3.5 In the event of a vacancy occurring in an office or appointment, the Executive Committee shall have power to appoint a successor. In the event of a vacancy occurring amongst the Divisional representatives elected to the Executive Committee, the vacancy shall be filled by an official nominee from the Council.

9.3.6 Unless otherwise specifically provided for in these By-laws, the Executive Committee shall nominate the Chairmen of the Statutory and such special committees as are required from time to time and shall nominate the representatives of The Society to outside bodies.

9.3.7 The Executive Committee shall have charge on behalf of Council of all publications of The Society and of all published proceedings, transactions, memoirs, essays, papers and programmes of The Society.

9.3.8 The Executive Committee, on the recommendation of the Honorary Treasurer shall prepare a budget of the anticipated revenue and disbursements of The Society for the ensuing calendar year.

9.3.9 The Executive Committee shall approve the programmes and budgets of each of the Committees of The Society for the current year.

9.3.10 The Executive Committee shall be responsible for:

a) The nomination of Senior and Honorary Members;

b) The consideration of applications for Active, Student and Associate Membership;

c) The supervision of arrangements for the Annual and any Special Meetings of The Society.

9.4 *Meetings of the Executive Committee*

9.4.1 The Executive Committee shall hold one or more meetings annually, and shall meet at the call of the President.

9.4.2 On the request, in writing, by any three members of the Executive Committee, the President shall call a Special Meeting.

9.4.3 Five (5) members of the Executive Committee shall constitute a quorum.

9.4.4 Notice of a meeting of the Executive Committee may be given by mail, by telegraph or by telephone at least three days prior to the date fixed for such meeting, provided always that such meetings may be held without notice if all members of the Executive Committee are personally present.

9.5 *Liaison*

9.5.1 The Executive Committee shall maintain close liaison with the Divisions and the Statutory and Special Committees of The Society.

9.5.2 The Executive Committee may request interim reports from the Statutory or Special Committee Chairmen at any time and shall review all reports prior to their submission to the Council. It may invite the Chairman of any committee to attend meetings of the Executive Committee.

9.6 *Liability*

9.6.1 The Society will not hold members of the Executive Committee, the officers or any member acting on their behalf, individually or collectively, liable for decisions and/or actions taken in good faith on behalf of The Society.

9.6.2 The legal description of this section entitled "For the Protection of Officers, Council Members, Committee Members and Officials of the Society" is attached as Appendix I and is to be considered part of these By-laws.

9.7 *Travel and Maintenance Expenses*

9.7.1 The Executive Committee may authorize the payment of specified travel and maintenance expenses of the members of the Executive Committee, officials, Chairman and members of Committees, and others engaged in business of The Society.

9.8 *Bonding*

9.8.1 The Executive Committee shall make arrangements for suitably bonding all officers, officials or other persons handling funds of The Society.

9.9 *Signing Officers*

9.9.1 The Executive Committee shall name the signing officers of The Society and indicate the term of office and limits of their authority.

9.10 *Auditor*

9.10.1 The Auditor shall be appointed by the members of The Society at each Annual Meeting.

9.11 *The Auditor Shall*

9.11.1 Examine annually the Financial Statement of the Honorary Treasurer, including such tests of accounting records and other information as will enable him to give an opinion on the financial statements.

9.11.2 File his reports with the Honorary Secretary not less than sixty (60) days before the Annual Meeting of The Society. The report shall be submitted to the Annual Meeting of The Society at which meeting it shall be read and shall be opened to inspection by all Active Members of the Society.

9.11.3 Examine and report on other financial affairs of The Society at any time during the year upon the request of the Executive Committee.

Chapter 10
OFFICERS

10.1 *The Officers of The Society*

10.1.1 The elected officers shall be the President, the First Vice President, the Second Vice President, the Immediate Past President, the Honorary Secretary, the Honorary Treasurer.

10.2 *The President who shall*

10.2.1 be the Chief Officer of The Society;

10.2.2 perform such duties as custom and parliamentary usage require;

10.2.3 preside at the Annual Meeting of The Society;

10.2.4 preside at all official functions of The Society or delegate some other member of the Executive Committee to do so;

10.2.5 be ex-officio a member of all committees of The Society;

10.2.6 act as Chairman of all meetings of the Executive Committee or appoint a member of the Officers to act as Chairman in his absence;

10.2.7 appoint the Committee on Nominations.

10.3 *The First Vice President who shall*

10.3.1 assist the President in the performance of his duties and in his absence, or at his request, preside or perform such other functions as are the duties of the President;

10.3.2 be ex-officio a member of certain Committees that may be determined from time to time by the Executive Committee;

10.3.3 serve as Acting President in the event that the office of President becomes vacant prior to the election and in that capacity shall assume all the powers and duties of the President during the unfinished portion of that presidential term.

10.4 *The Second Vice President who shall*

10.4.1 assist the First Vice President and the President in the performance of their duties;

10.4.2 be ex-officio a member of certain committees that may be determined from time to time by the Executive Committee.

10.5 *The Immediate Past President who shall*

10.5.1 be a member of the Executive Committee for the year immediately succeeding the termination of his presidency.

10.6 *The Honorary Secretary*

10.6.1 The Honorary Secretary shall be responsible for all communications, minutes of meetings of The Society, the Council, and Executive Committee, applications for membership and liaison between The Society and its several Divisions and between the Society and other national and international organizations or governments, on matters pertaining to the purposes of The Society.

10.7 *The Honorary Treasurer shall*

10.7.1 a) be the custodian of all monies, securities and deeds which are the property of The Society and be accountable for the safekeeping of all funds derived from whatever source, belonging to The Society;

b) undertake the payment of all bills, monies, etc., as directed by the Council or the Executive Committee making all payments of any kind whatsoever by cheque;

c) prepare the annual financial statement audited by the Auditor appointed by the members of The Society;

d) be suitably bonded;
e) be Chairmen of the Committee on Finance.

Chapter 11
APPOINTED OFFICIALS

11.1 *Appointed Officials*

11.1.1 An Executive Secretary and such other officials as are required to carry out the activities of The Society shall be appointed by the Executive Committee.

11.1.2 The officials shall attend meetings of The Society, Council and Executive Committee and other committee meetings when required or invited. The appointed officials shall not vote at any of these meetings.

11.1.3 The appointed officials shall serve at the pleasure of the Executive Committee.

11.2 *The Executive Secretary who shall*

11.2.1 give general supervision to the administration of The Society including the Secretariat and shall be responsible to the Honorary Secretary.

11.3 *The Editor who shall*

11.3.1 be the Editor of the Society publications, including the Canadian Anaesthetists' Society Journal or any successor thereto and shall be responsible to the Executive Committee for all editorial policies in the production of these publications;

11.3.2 present reports to the Executive Committee as required.

Chapter 12
COMMITTEES

12.1 The Committees of The Society shall be Statutory and Special.

12.2 *The Statutory Committees*

12.2.1 The Statutory Committees, otherwise known as Standing Committees are as herein stated and may be altered, removed or added to as may be desirable and necessary from time to time.

a) Committee on Archives
b) Committee on Allied Health Professions
c) Committee on Education
d) Committee on Finance
e) Committee on Medical Economics
f) Committee on Nominations – See Chapter 13
g) Committee on Organizational Affairs
h) Committee on Public Relations
i) Committee on Scientific Affairs
j) Committee on Standards of Practice

12.2.2 The membership, chairmen, terms of reference, programmes, and budgets of the Statutory Committees shall be as determined by the Executive Committee on behalf of the Council.

12.2.3 Shall report through their Chairmen to the Executive Committee and where desirable to the Council at least once annually.

12.3 *Special Committees*

12.3.1 Shall be short-term committees, appointed by the Council or the Executive Committee and shall be appointed for a specific task and be dissolved automatically on the completion of its task and submission of a report.

Chapter 13
NOMINATIONS AND ELECTIONS

13.1 *Nominations*

13.1.1 The Nominations Committee shall be appointed by the President, and shall consist of the Immediate Past President and two Active Members of the Council, not officers.

13.1.2 The Nominating Committee shall prepare a list of nominations for the offices of President, First Vice President, Second Vice President, Honorary Secretary, Honorary Treasurer and transmit this through the Honorary Secretary to Council for consideration.

13.1.3 The Honorary Secretary shall submit the final list of proposed officers to the Active Members of The Society at least sixty (60) days prior to the Annual Meeting of The Society, inviting further nominations for these offices in a manner to be prescribed, to be returned to the Honorary Secretary within ten (10) days.

13.2 *Election of Officers*

13.2.1 Where necessary, ballots shall be issued with the Notice of the Annual Meeting of The Society to be returned to the Honorary Secretary in the sealed envelope provided, within ten (10) days.

13.3 *Nomination and election of Representatives to the Executive Committee*

13.3.1 The Honorary Secretary shall invite nominees for the elected members and Chairman of Council from members of Council at the time of the Annual Meeting of the Society.

13.3.2 The Honorary Secretary shall submit this list of nominees to Council, and where necessary, a ballot vote shall be taken.

13.4 *Re-election of Officers and Representatives to the Executive Committee*

13.4.1 The President, the First Vice President, the Second Vice President shall hold office for one year and each may be re-elected once to that office.

13.4.2 The Honorary Secretary may be re-elected for a total term not to exceed five consecutive years.

13.4.3 The Honorary Treasurer may be re-elected for a total term not to exceed five consecutive years.

13.4.4 The Council members elected to the Executive Committee and the Chairman of Council may be re-elected for a total term not to exceed two consecutive years.

Chapter 14
CANADIAN ANAESTHETISTS' SOCIETY PUBLICATIONS

14.1 *Editor and Editorial Board*

14.1.1 The Executive Committee shall nominate an editor for a term of four years, which appointment may be renewed for such further four year periods as the Executive Committee in its discretion sees fit.

14.1.2 The Editor shall be responsible to the Council through the Executive Committee for all publications of The Society.

14.1.3 On the recommendation of the Editor, the Executive Committee may nominate an editorial board to assist in the duties pertaining to publications.

14.2 *Publications Committee*

14.2.1 A Publications Committee may be appointed by the Executive Committee. This Committee shall be available for consultation with the Editor on the day-to-day management of The Society publications. The Committee, through its Chairman, shall

recommend general policy to the Executive Committee and to the Council with regard to the management of publications by The Society.

Chapter 15
MEETINGS

15.1 *Annual Meeting*

15.1.1 An Annual Meeting of The Society shall take place in every calendar year, at a time and place to be determined by the Executive Committee.

15.1.2 A Special General Meeting may be held from time to time at the call of the President, or the President shall call a special General Meeting at the written request of at least twenty (20) Active Members of The Society, representing not less than two (2) Divisions, providing the request specifies the nature of the business to be transacted thereat.

15.1.3 The Annual meeting of The Society shall be open to all members of The Society excepting that members other than Active Members, may address the Annual Meeting only with the prior approval of the President.

15.1.4 A quorum at an Annual or Special Meeting of The Society shall be ten (10) voting members present.

15.2 *Notice*

15.2.1 Notice of an Annual or Special Meeting of The Society shall be given to all Active Members in writing by mailing the same in a prepaid wrapper to the registered address of the member at least four (4) weeks prior to the date fixed for such meeting.

Chapter 16
AMENDMENTS

16.1 Proposals for amendments to the By-laws or repeal thereof may be submitted to the Executive Committee by one or more Active members of The Society, the Council, Executive Committee or a Committee on By-laws. The proposed amendment should be in the hands of the Honorary Secretary twelve (12) weeks before the date of the Annual Meeting of The Society for consideration by the Executive Committee. Any proposed amendments to the By-laws or repeal thereof shall be transmitted by the Honorary Secretary to the members of Council at least four (4) weeks before the next Meeting of the Council.

16.2 Amendments which have been proposed, published, and circulated as in 16.1 above may be adopted by a two-thirds majority vote of the members present and voting at a duly advertised Annual or Special Meeting of The Society.

16.3 No repeal or amendment or a by-law may be acted upon until the approval of the Minister of Corporate and Consumer Affairs has been obtained.

Chapter 17
CERTIFICATION OF DOCUMENTS

17.1 All documents requiring certification shall be certified by the Honorary Secretary of The Society.

Chapter 18
FISCAL YEAR

18.1 The fiscal year of The Society shall end on the 31st day of December.

Appendix I

FOR THE PROTECTION OF OFFICERS, COUNCIL MEMBERS, COMMITTEE MEMBERS AND OFFICIALS OF THE SOCIETY

No officer, director, official or other member of The Society for the time being of The Society shall be liable for the acts, receipts, neglects or defaults of any other directors, officer, member or employee or for joining in any receipt or act for conformity or for any loss, damage or expense happening to The Society through the insufficiency or deficiency of title to any property acquired by The Society or for or on behalf of The Society or for the insufficiency or deficiency of any security in or upon which any of the moneys or belonging to The Society shall be placed out or invested or for any loss or damage arising from the bankruptcy, insolvency or tortious act of any person, firm or corporation with whom or which any moneys, securities or effects shall be lodged or deposited or for any loss, conversion, misapplication or misappropriation of or any damage resulting from any dealing with any moneys, securities or other assets belonging to The Society or for any other loss, damage or misfortune whatever which may happen in the execution of the duties of his respective office or trust or in relation thereto unless the same shall happen by or through his own wrongful and wilful act or through his own wrongful and wilful neglect or default. The officers, directors, officials or other members of The Society for the time being shall not be under any duty or responsibility in respect to any contract, act or transaction whether or not made, done or entered into in the name or on behalf of The Society, except such as shall have been submitted to and authorized or approved by the Executive Committee.

APPENDIX 4

Rules and Regulations of the Canadian Anaesthetists' Society

[First drawn up in 1972 and 1973, "the Rules and Regulations ... are the working rules and terms of reference of The Society, the Executive Committee, Council, and Standing Committees." They serve to interpret the Constitution and are of particular value to those who are concerned with the workings of the many aspects of the Society's organization. Section A concerns those elements of the organization other than those related to the committees, which are dealt with in Section B. They are always subject to amendment – by amendment to the Constitution, by action of Council, or by appropriate action of the membership – and are updated periodically.

The material in this Appendix is an abridged and edited version of the Rules and Regulations as of 1980.]

Section A

A2 – Membership

1 *General*
Membership categories in the Society shall be deemed to be either regular or special.

2 *Applications*
The application form for the various categories of membership shall be approved by the Council, and may be subject to change from time to time.

Application forms will be available from the central office of the Society and from Divisional representatives, and will be published regularly in the Canadian Journal of Anaesthesia.

3 *Nominations: Regular Categories*
These categories include Active, Associate (in Canada) and Associate (out of Canada). Nominations for regular membership should be required in support of applications.

Residents (in training) require written nomination by two Active members, one of whom shall be the respective University Department Head or a designate.

4 *Nominations: Special Categories*

All nominations for these categories should be considered by the Committee on Membership and Awards before submission to Council

(a) Senior membership shall require written nomination by two Active members, with details to support this nomination and a copy of the nominee's current curriculum vitae. This nomination should also have the written support of the Division.

(b) Retired membership may be considered upon application from an Active member, and should include reasons for seeking a change in status.

(c) Honorary members may be nominated by any Active member for consideration by the Council, and the written nomination shall include the reasons supporting the nomination and a copy of the nominee's curriculum vitae.

5 *Processing*

All completed applications shall be referred by the Honorary Secretary to the Council and to the Annual General Meeting for approval. Applications for special categories shall be referred to the Officers of the appropriate Division for advice before reference to the Council.

6 *Fees*

Annual fees for the various categories of membership shall be determined by the Council of the Society, and may be altered from time to time, as recorded in the Minutes.

Members who join the Society up to and including 30 September of any year shall be required to pay the annual fee of that year. Members who join the Society on or after 1 October of any year shall pay the annual fee of the following year only.

A member who neglects to pay his/her annual fee before the 1st of May of the year in which it is due shall forfeit his/her membership.

A member's status shall not be affected by a transfer from one Division to another.

Members are responsible for notifying the Society office of any change in address.

A3 – Divisions

1 *Representative(s) to Council*

The representative(s) to Council of the various Divisions of the Society shall ordinarily be the Chair of the respective Division (and other Officers of the Division if there is to be more than one representative). However, a Division may elect or select representation to Council in an alternate manner.

2 *Alternates*

Divisions, in electing or selecting their representatives(s) to Council, shall also designate alternates for this purpose, and so inform the Honorary Secretary.

3 *Divisional Fees*

Any Division, amalgamated Division, or group of Divisions may request that the Society collect an annual levy from its membership. This request must be forwarded to the Honorary Treasurer and the Society office prior to 15 September for inclusion in the following year's invoices.

Statements of annual dues shall contain provision for statement of Divisional dues, where requested. Monies collected for the Divisions shall be remitted to the Divisions by the Honorary Treasurer on a regular basis.

Council may levy an administrative charge for collecting Divisional fees.

Failure to pay Divisional dues with payment of Society dues will not exclude a member from the privileges of the Society.

A4 – Council

1 *Membership*

Each Division or group of Divisions shall select or elect its Council representation as deemed appropriate. Each Division or amalgamated Division shall be represented on Council by one Active member for each one hundred Active members, or part thereof, residing in that Division or amalgamated Division. The Honorary Secretary shall be informed of the names of the Divisional representatives and alternates at least 30 days prior to the Annual Meeting. Failure to notify the Honorary Secretary of these names shall imply that there has been no change in Divisional representation.

The Association of Canadian University Departments of Anaesthesia (formerly known as the Conference of Heads of Canadian Departments of Anaesthesia) shall determine who shall represent it to the Council, and so inform the Honorary Secretary prior to the first meeting of Council for the said year. For each Council meeting, the Honorary Secretary shall select two resident (in training) members to act as observers.

2 *Notices of Meetings*

Notices of Council meetings shall ordinarily be sent by the Honorary Secretary to all members of Council by first-class mail and not less than 28 days prior to the date of the meeting. An agenda, as well as Committee, Divisional and other reports shall ordinarily be sent by the Honorary Secretary to all members of Council not less than 21 days prior to the meeting. Reports submitted to the Honorary Secretary too late for inclusion with the agenda shall be presented to the meeting only if time allows for their printing and distribution, and at the discretion of the Chair.

3 *Minutes*

The Honorary Secretary shall be responsible for taking the Minutes of meetings of Council and for distributing them within 60 days of a meeting. The Honorary Secretary may have the aid of a recording secretary and may use tape recording equipment. The use of a tape recorder by individual members of Council, other than the Honorary Secretary, shall be subject to the prior approval of the Chair of Council.

4 *Meetings*

Ordinarily, Council shall hold its first regular meeting at the close of the Annual Meeting. Council shall meet again approximately half-way through the year (historically known as the Mid-Winter meeting), and as called by the Chair.

5 *Chair*

A nomination for Chair of Council shall be made at the Mid-Winter Council meeting and shall be the first item of business of the succeeding Council at its first meeting. A special ad hoc committee consisting of the Society President, Immediate Past President and the current Chair of Council shall act as a nominating committee.

The first meeting of a new Council shall be called to order by the Honorary Secretary, who shall read the recommendation of the previous Council, call for further nominations and conduct an election by closed ballot, if required. The new Chair shall then conduct the remaining portion of the meeting.

6 *Election to Executive*
At the first regular meeting of the Council, two members of Council, not otherwise Officers, shall be elected to the Executive for the year.

7 *Expenses*
Members of Council and others requested to attend Council meetings shall be reimbursed for travel expenses. During the Mid-Winter Council meeting and other Council meetings not held at the time of the Annual Meeting, they shall receive a per diem allowance, as determined by Council (from time to time) and recorded in the Minutes. A per diem allowance shall also be paid for those extra days required for Council meetings before and after the actual dates of the Annual Meeting.

8 *Term of Members*
The year of tenure of members of Council shall run from the beginning of the first regular meeting of the Council (following the close of the Annual Meeting) to the day prior to the first regular meeting of Council in the following year.
(Reference: Executive meeting, 12 November, 1977)

A5 – Executive Committee

1 *Meetings*
The Executive Committee of Council, *hereafter designated as the Executive*, shall meet as often as necessary and at the call of the President, to further the affairs of the Society.

2 *Minutes*
The Honorary Secretary shall be responsible for taking the Minutes of meetings of the Executive and for their distribution to members of Council within 60 days of the meeting.

3 *Expenses*
Members of the Executive will be reimbursed for travel expenses and will receive a per diem allowance when Executive meetings are held separately from the Annual or Council meetings, as determined by Council from time to time. They will also receive a per diem allowance for extra days required before or after the actual dates of an Annual or Council meeting.

A6 – Officers of the Society

1 *General*
The elected Officers of the Society shall be deemed to be the President, First Vice-President, Second Vice-President, Honorary Secretary, and the Honorary Treasurer. The Immediate Past President shall, by virtue of his/her previous office, be deemed an Officer.

2 *Nominations for Officers*
A list of nominations, as approved by Council, and preferably with short resumés, shall be mailed to all Active members of the Society. An invitation for further nominations for any elected Office shall also be enclosed.

Such additional nominations must contain the name of the nominee, the Office for which he/she is nominated, the signatures of five Active members and a written statement by the nominee, indicating his/her understanding of the responsibilities involved and his/her willingness to allow his/her name to stand.

3 *Election of Officers*
A closed ballot vote shall be conducted where necessary. Otherwise, the nominations proposed

by Council shall be deemed elected by acclamation. The election results shall be announced at the Annual General Meeting and shall be circulated to the membership through the Minutes. The results shall also be published in the Newsletter and other appropriate medical publications.

4 *President*
The duties of the President shall be those as defined in the Constitution. The President shall preside at meetings of the Executive.

5 *First Vice-President*
The First Vice-President, in addition to his/her Constitutional duties, shall be an ex-officio member of, and report to the Executive regarding the activities of, the Committees on Standards of Practice, Public Relations, Organizational Affairs, and Continuing Education.

6 *Second Vice-President*
The Second Vice-President, in addition to his/her Constitutional duties, shall be an ex-officio member of, and report to the Executive regarding the activities of, the Committees on Allied Health Professions, Medical Economics, Scientific Affairs, Archives, Manpower, Membership and Awards and the Advisory Committee on Research Awards.

7 *Honorary Secretary*
The Honorary Secretary, in addition to his/her Constitutional duties, shall be an ex-officio member of, and report to the Executive regarding the activities of, the Committee on Local Arrangements of the Annual Meeting. He shall also report to the Executive regarding the management and operation of the Society office and all arrangements for future Annual Meetings.

8 *Honorary Treasurer*
The Honorary Treasurer, in addition to his/her Constitutional duties, shall be Chair of, and report to the Executive on behalf of the Committee on Finance. He/she shall receive proposed budgets from all Committees within 90 days of the Annual Meeting and shall present these budgets, with his/her recommendations, to Council at its first regular meeting.

9 *Signing Officers*
The Signing Officers of the Society shall be any two of the President, the Honorary Secretary, the Honorary Treasurer, the Editor of the Journal, the Executive Director, the Associate Director, or under exceptional circumstances, other persons as may be specifically authorized by Council for limited periods of time.

10 *Expenditure Authority of Officers*
Unbudgeted expenditures, without prior Council approval, may be made by the Honorary Treasurer, the President, or the Executive within the limits established by Council. No other person may authorize the expenditure of unbudgeted funds of the Society.

11 *Expenses*
Elected Officers shall be reimbursed for travel expenses and shall receive a per diem allowance when attending meetings on behalf of the Society, not covered by the Council and Executive allowances. *Prior approval for such expenses shall be obtained from another member of the Executive.*

12 *Appointment of the Editor*

The Editor of the Canadian Journal of Anaesthesia shall be appointed at the Annual General Meeting by the President, on behalf of the Executive, for a specified period to commence on 1 January of the following year.

The terms of appointment or reappointment of the Editor shall be recorded in writing, and approved by the Executive on the advice of the Honorary Treasurer.

The search for an Editor shall be conducted through a Search Committee appointed for that purpose by the President.

13 *Honoraria*

The Honorary Secretary, the Honorary Treasurer, and the Editor of the Journal may be paid honoraria as determined by Council from time to time.

A7 – Meetings

GENERAL

The Society shall hold an Annual Meeting, together with required Council and Executive meetings, at a time and place to coincide with a Scientific meeting and such Scientific exhibits, Commercial exhibits and Symposia as are approved by the Council

A ANNUAL MEETINGS

1 *Location*

The Council shall be responsible for the selection of the date and site of the Annual Meeting and shall assign, through the Society office and with local advice, the hiring of such facilities as are required for the Annual Meeting and the associated meetings and exhibits.

2 *Planning*

The Honorary Secretary and the Executive Director shall be responsible to the Executive for the co-ordination of all planning and preparations for the Annual Meeting.

3 *Scientific Meeting*

The Committee on Scientific Affairs shall be responsible to the Executive for the organization of the Scientific meetings, Symposia and Scientific exhibits and shall properly plan and budget for these events. Council, on the recommendation of the Executive, shall approve honoraria and expenses for speakers involved as may be determined from time to time.

4 *Local Arrangements*

A Committee on Local Arrangements shall be formed annually to represent either a host city or Division of the Society or other appropriate group. This Committee, with the approval of the Executive, shall be responsible for the physical arrangements and promotion of the non-scientific functions conducted in conjunction with the Annual Meeting. The Chair shall communicate regularly and often to the Executive Director as planning proceeds.

The Committee shall appoint a local Press Officer.

This Committee shall also have its plans and budget approved by the Executive and shall report to Council after each meeting.

Members of the Committee on Local Arrangements (maximum 5) and spouses will be granted full free registration. (Reference: Executive meeting, February 1979)

5 *Publicity*
The Executive Director shall be responsible for advance notice of the Annual Meeting and its Scientific Programme in Society and other medical publications. The Committee on Public Relations in conjunction with the local Press Officer will establish local and national media coverage of these Annual Meetings.

6 *Guest Speakers*
Guest lecturers and invited members of structured panels are required to submit a manuscript of their presentation for consideration of publication in the Canadian Journal of Anaesthesia. (Reference: Council meeting, 4 February 1979)

B OTHER MEETINGS
In addition to the Annual Meeting, the Society may participate in sponsored, co-sponsored or supported meetings. A sponsored meeting shall be conducted under the auspices of the Society, a co-sponsored meeting shall be conducted with moral and/or partial financial support of the Society, and a supported meeting shall financial support from the Society but the Society shall not assume responsibility for the organization or content of the meeting.

Any Division or group of Divisions requiring sponsorship or support of meetings must apply to Council with a budget, before the Annual General Meeting of the year preceding the proposed meeting.

C CONDUCT OF BUSINESS MEETINGS
Every meeting of the Society shall be conducted according to Roberts' Rules of Order, except where otherwise specified in advance. All voting for any election of Officers (if required) shall be by closed ballot.

A8 – Policies Concerning Donations and Outside Sponsorship of Society Activities

1 The Society may accept financial contributions from commercial enterprises towards the cost of CME Society-promoted activities, which shall be subject to the following guidelines:
(a) The organization, content and choice of speakers shall be determined by the appropriate members of the Society.
(b) The contributions shall be made as a donation to the Society, and placed in a separate bookkeeping account. Disposal of the funds shall be the Society's responsibility.
(c) The Society shall acknowledge such donations in the following manner:
The Canadian Anaesthetists' Society gratefully acknowledges the assistance of:
A.....Company
B.....Company
C.....Company
to the Scientific/Education programme.
(d) Scientific and educational activities undertaken by commercial enterprises at the Society's Annual and Divisional meetings shall only be permitted if they do not conflict with the Society's programme, and after discussion with, and approval by, the appropriate members of the Society.

2 With respect to commercial exhibits at the Society's Annual or Divisional meetings, negotiations for space or display should be conducted separately from discussions for CME sponsorship.

3 (a) The Society recognizes the value of social functions at its Annual or Divisional meetings. If commercial enterprises sponsor or contribute to such functions, these functions shall take place at a time agreeable to the Society and shall neither compete with nor take precedence over central events.
(b) The Society shall acknowledge the contribution or sponsorship in the following manner:

The Canadian Anaesthetists' Society gratefully acknowledges the assistance of:
A.....Company
B.....Company
C.....Company
to this .....(event).

4 The above policies shall apply to Divisions as well as the Society.

5 Any acceptance of commercial sponsorship shall not constitute endorsement of any product or service.

A9 – Fees and expenses

1 *General*
Membership fees and matters relating to allowed expenses shall be determined by Council from time to time and recorded in the minutes of Council meetings.

[Paras 2, 3, and 4 specify monies that increase periodically with time and the cost living. These concern: Presidential Expenses, Expenses of the Editorial Board and Guest Lecturers. They are omitted here because they are changed periodically.]

A10 – Canadian Anaesthetists' Society Medal

1 *Purpose*
This is a personal award consisting of an inscribed gold medal, given in recognition of excellence in matters related to Anaesthesia.

2 *Eligibility*
The Medal may be awarded to any individual, not necessarily an anaesthetist or other physician, but ordinarily a Canadian who:
(a) has made a significant and substantial contribution to Anaesthesia in Canada through teaching, research, professional practice, or related administration and personal leadership.
(b) is not a member of the current Council of the Society;
(c) may be active or retired from his/her field of interest.

3 *Nomination and Selection*
Any Active member of the Society may submit a nomination.

Nominations shall be made in the form of a written, confidential submission to the President of the Society. A curriculum vitae of the nominee may be one of the supporting documents.

Nominations shall be referred to the Committee on Membership and Awards for consideration.

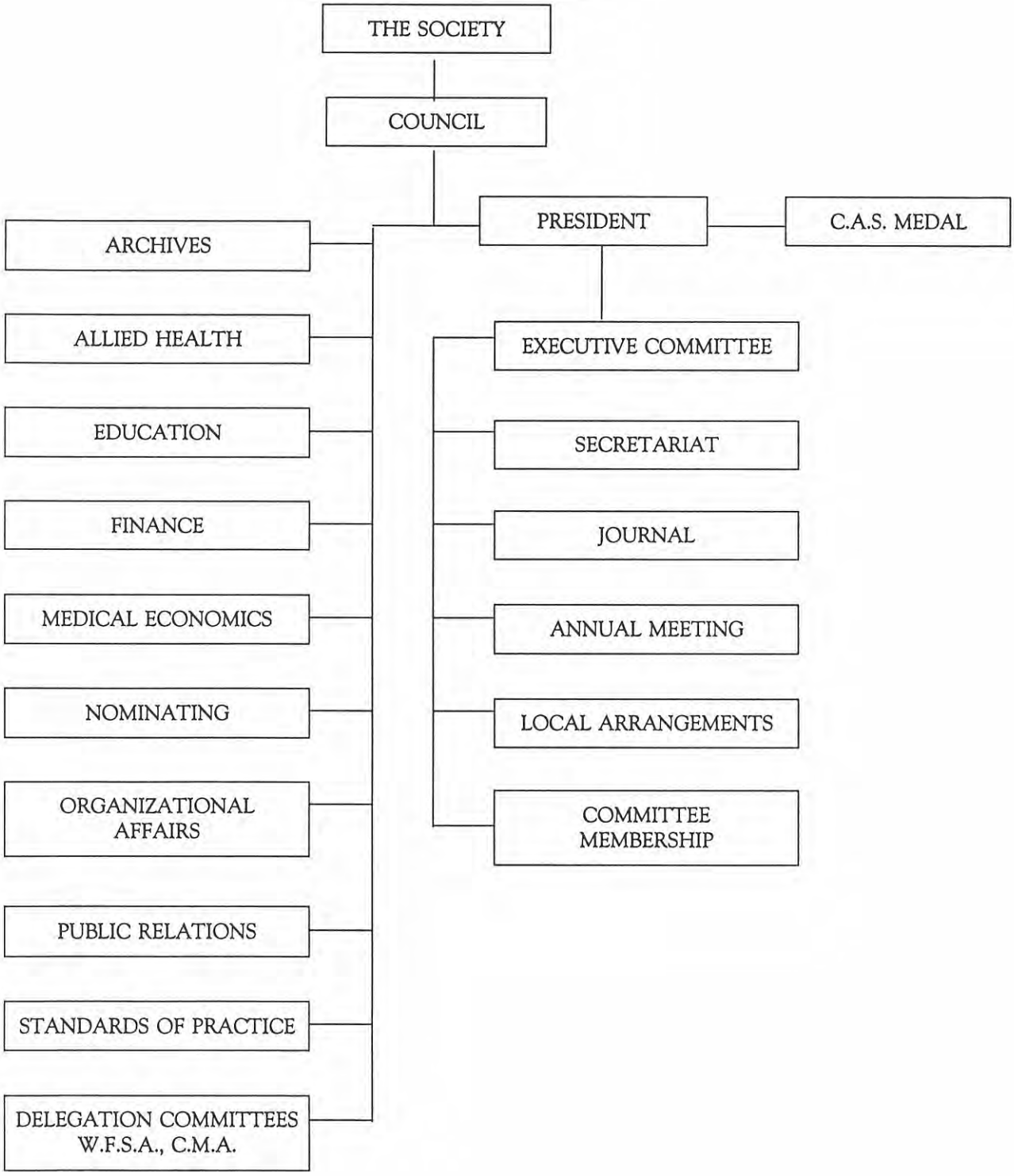
All nominations should be received by January 1.

Each nomination shall be held for not less than five years, and shall be reviewed each year. Any individual may be nominated again.

Recommendations from the Committee on Membership and Awards shall be presented by the President to Council at its Mid-Winter meeting. Council, acting as a Committee of the Whole, shall require a two-thirds majority vote for approval.

The Medal need not be awarded yearly.

A11 - Organizational Chart



Section B – Standing Committees

[The material in Section B, relating to Committees, was extensively revised by the Committee on Organizational Affairs and ratified by Council in February 1991.]

1 *General Guidelines*
All Committee members and Chairs shall be appointed by the Executive on behalf of the Council, after consultation with the respective Committee Chairs.

Appointments shall normally be for a 3-year term, subject to annual review. Members may be asked to serve additional 1-year terms, to a maximum of 6 years. The bilingual and regional nature of the Society should be reflected in Committee membership.

The Chair and Committee members may be requested to attend Committee, Executive, or Council meetings. Allowances for such attendance shall be paid as outlined for Council members.

The Chair of each Committee must submit a budget to the Honorary Treasurer, for Council approval, before any expenditure may be authorized.

It is recognized that the functions of the Standing Committees will change from time to time. These guidelines indicate the basic Committee duties. Committees, except where restricted by the Constitution, are encouraged, with prior Council approval, to expand their activities and to accept new responsibilities.

B1 – Committee on Allied Health Professions

1 The Committee is responsible for observing the developments within the allied health fields and for informing and advising Council regarding developments pertaining to Anaesthesia.

2 The Committee may be required to provide representation to the coordinating or development bodies within specific allied health professions.

3 The Committee may form permanent sub-committees for continuing liaison with specific allied health professions.

4 The Committee shall consist of a Chair and at least four members who have had experience in, contact with, or continuing interest in specific allied health professions.

5 The Second Vice-President shall be an ex-officio member of this Committee and shall report its activities to the Executive.

6 Members of the Committee may represent the CAS on the following committees:
- 6.1 Advisory Committee to the Canadian Society of Respiratory Therapists. (This is a joint committee with representatives from at least the CAS, the Canadian Thoracic Society and the Canadian Paediatric Society, advising the Canadian Society of Respiratory Therapists on the content of its training programme and providing liaison between the Canadian Medical Association and the Canadian Society of Respiratory Therapists.)
- 6.2 Conjoint Committee for the Accreditation of Educational Programmes in Respiratory Therapy.

6.3 Conjoint Committee for the Accreditation of Educational Programmes in Emergency Medical Technology.

Members of the above committees will report to Council through the Committee on Allied Health Professions.

B2 – Committee on Archives

1 The Committee is responsible for the review, cataloguing and maintenance of such records, documents, articles, and equipment that are of historical significance to the Society and to Anaesthesia in Canada.

2 The Committee is responsible for exhibits of material as may be determined by Council.

3 The Committee shall encourage the publication of papers related to the history of Anaesthesia in Canada.

4 The Committee shall consist of a Chair and at least two other members of the Society who have an interest in the objectives of the Committee.

5 The Second Vice-President shall be an ex-officio member of this Committee and shall report its activities to the Executive.

B3 – Committee on Continuing Education

1 The Committee is responsible for providing Council and the Society with information and advice concerning the continuing education of Society members in Anaesthesia and in related fields. This shall include providing recommendations to the Committee on Scientific Affairs on the continuing medical education programme offered in conjunction with the Annual Meeting.

2 The Committee shall consider and may advise Council regarding both specialty training and general practice training in Anaesthesia.

3 The Committee may advise Council and, with approval, may conduct programmes of self-education and self-assessment.

4 The Committee shall consist of:
- Chair
- Four regional members (Western, Ontario, Quebec, Atlantic)
- A member of the ACUDA Education Committee
- The Chair (or delegate) of the Specialty Committee in Anaesthesia of the Royal College of Physicians and Surgeons of Canada
- One General Practitioner anaesthetist (Associate CAS member)

5 The First Vice-President shall be an ex-officio member of the Committee and shall report its activities to the Executive.

B4 – Committee on Finance

1 The Committee is responsible for providing assistance to the Honorary Treasurer in the preparation of budgets, projections and audits.

2 The Committee may make recommendations to Council regarding annual dues, extraordinary expenditures and investments of Society funds.

3 The Committee shall consist of:
- Honorary Treasurer, Chair
- Honorary Secretary
- President
- First Vice-President
- Executive Director (non-voting)

4 The Editor of the CJA shall be invited to attend all meetings.

5 The Committee is also responsible for annual review of the senior administrative staff of the Society. (Reference: Executive meeting, June 15, 1990)

6 The Honorary Treasurer will report the activities of this Committee to the Executive.

B5 – Committee on Local Arrangements

1 A Local Arrangements Committee shall be formed for each Annual Meeting.

2 A Chair should be appointed at least two years before the date of the meeting.

3 The Chair should choose the other members of the Committee. Close liaison must be maintained with the CAS central office so that the various functions and activities are organized, including:
(a) Social Tour Programme
(b) Hospitality Suite
(c) Art Exhibit
(d) Fun Run
(e) Entertainment
(f) Transportation
(g) Promotion/Press Officer/Photographer
(h) Council Dinner location
(i) Workshops
(j) On-site liaison

4 The Committee shall communicate regularly and frequently with the Committee on Scientific Affairs. The Chair shall attend the meeting of the Committee on Scientific Affairs at the time of the June Council meeting one year preceding and at Mid-Winter Council four months prior to the Annual Meeting.

5 The Chair shall report to Council in the year preceding the meeting to obtain approval of plans and meeting expenses.

See "Guidelines for Local Arrangements" (Appendix 1, Section D)

B6 – Committee on Manpower

1 The Committee is responsible for advising the Society on issues of anaesthesia manpower.

2 The Committee shall consist of:
- Chair

- One representative from each of the four Divisions (Western, Ontario, Quebec, Atlantic)
- Corresponding members may be recruited as necessary

3 The Second Vice-President shall be an ex-officio member of the Committee and shall report its activities to the Executive.

B7 – Committee on Medical Economics

1 The Committee is responsible for providing Council with information and advice regarding provincial health care plans, Divisional negotiations, fee and payment schedules and other considerations which influence the economics of anaesthetic practice.

2 The Committee shall consider and advise Council regarding changes in regulations and interpretation of the Federal Income Tax Act as they refer to the anaesthetists.

3 The Committee shall consider task force and other reports that relate to Anaesthesia, which are submitted to government or to professional bodies and shall advise Council of anticipated economic implications.

4 The Committee shall consist of at least three members who can provide a varied geographic representation.

5 The Second Vice-President shall be an ex-officio member of this Committee and shall report its activities to the Executive.

B8 – Committee on Membership and Awards

1 The Committee shall advise Council on matters related to membership in the Canadian Anaesthetists' Society.

2 The Committee shall have the responsibility of reviewing membership data and of planning strategy for promoting membership in the Society.

3 The Committee is responsible for advising Council on the awarding of the Canadian Anaesthetists' Society Medal.

4 The Committee shall oversee the mechanism for initiating and receiving nominations for Senior and Honorary membership in the Society, shall annually consider these nominations and, when appropriate, recommend nominees for Senior and Honorary membership.

5 As directed by Council, the Committee shall accept such additional responsibility for matters relating to membership and awards.

6 The Committee shall consist of:
- Chair
- At least one representative from each of the four Divisions (Western, Ontario, Quebec, Atlantic)

7 The Second Vice-President and the Executive Director shall be ex-officio members of the Committee and shall report its activities to Executive.

8 The term of membership on this Committee shall be from three to five years.

B9 – Committee on Nominations

The terms of reference and membership of this Committee are as described in the Constitution, Chapter 13:

13.1.1 The Nominations Committee shall be appointed by the President and shall consist of the Immediate Past President and two Active members of Council, not Officers.

13.1.2 The Nominations Committee shall prepare a list of nominations for the offices of President, First Vice-President, and Second Vice-President, Honorary Secretary, and Honorary Treasurer, and shall transmit this through the Honorary Secretary to Council for consideration.

13.1.3 The Honorary Secretary shall submit the final list of proposed Officers to the Active members of the Society at least sixty (60) days prior to the Annual General Meeting of the Society, and shall invite further nominations for these offices in a manner to be prescribed, to be returned to the Honorary Secretary within ten (10) days.

The Committee shall submit to the Mid-Winter Council meeting a recommendation for Chair of Council for the succeeding Council.

B10 – Committee on Organizational Affairs

1 The Committee is responsible for providing a continuing review of the By-laws and the Rules and Regulations of the Society, and for advising Council on the need for revisions consistent with the changing standards of practice, membership, or other circumstances.

2 The Committee shall review the Minutes of Council and Executive meetings and the Minutes of the General Meetings, and shall advise Council regarding required amendments to the By-laws.

3 The Committee shall review, clarify and present to Council any Constitutional changes proposed by Active members of the Society.

4 The Committee shall assist Divisions on Constitutional matters.

5 The Committee shall consist of at least three members.

6 The First Vice-President shall be an ex-officio member of this Committee and shall report its activities to the Executive.

B11 – Committee on Public Relations

1 The Committee is responsible for studying the relationship of the Canadian Anaesthetists' Society with the general public, the media and with other members of the medical profession, and for advising Council on methods of improving this relationship.

2 The Committee shall reconsider and recommend means of increasing interest and recruitment in the specialty of Anaesthesia.

3 The Committee shall be responsible for arranging media coverage of the Annual Meeting of the Society.

4 The Committee shall assist Divisions in public relations activities and shall report to Council, from time to time, on these activities.

5 The Committee shall consist of at least three members, one of whom shall be the Press Officer responsible for the current Annual Meeting.

6 The First Vice-President shall be an ex-officio member of this Committee and shall report its activities to the Executive.

B12 – Research Advisory Committee

General Purpose
The Research Advisory Committee is a standing committee responsible for:

(1) advising the Society on the promotion of Anaesthesia research in Canada;
(2) adjudicating such competitions and administering such research programmes as are established by the Society.

Membership
The Research Advisory Committee shall consist of:
- Chair
- CAS Member-at-large
- Editor, *Canadian Journal of Anaesthesia*
- Chair, CAS Committee on Scientific Affairs, or delegate
- Chair, CAS Committee on Continuing Education, or delegate
- CAS Member representing the ACUDA Research Committee
- Second Vice-President, CAS, (ex-officio)

Scientific Objectives
The Research Advisory Committee shall:

(A) Advise the Society concerning research activities, and assist in promotion of Canadian Anaesthesia research by:

(i) Counselling the Society on policy and procedure to be followed most effectively to support research activity;
(ii) Interaction with external sponsors of research to ensure promotion of both the Society's objectives and the sponsor's interests;
(iii) Interacting as necessary with other groups with a similar function (i.e. Research Committee of ACUDA) to ensure optimal promotion of research activities;
(iv) Maintaining a watching brief on medical research in Canada to ensure that the Society remains responsive to trends and initiatives as they develop.

(B) Adjudicate the awarding of fellowships and grants including:
(i) Review of applications received as to eligibility, appropriateness and scientific content;
(ii) Recommendation to the Society of the order of merit of applications for each award.

(C) Oversee the administration of all awards, fellowships and grants offered by the Society for research activities. Such shall include:
(i) Developing procedures for application by prospective candidates for such awards;
(ii) Soliciting applications for these awards from Society members;
(iii) Developing and monitoring procedures for handling award and fellowship payments;
(iv) Developing procedures for reviewing the progress reports from award and fellowship recipients;

(v) Maintaining awareness of the efficacy of the Society's research awards programme in promoting Canadian Anaesthesia research.

B13 – Committee on Scientific Affairs

1 The Committee is responsible for advising Council regarding the scientific affairs of the Society.

2 The Committee shall consist of:
- Chair
- Editor, *Canadian Journal of Anaesthesia*
- Four representatives appointed from each of the four Regions (Western, Ontario, Quebec, Atlantic)
- A representative from ACUDA, nominated by ACUDA
- One member of the Board of Trustees of the IARS, nominated by the IARS
- A representative from the host Division my be appointed for a one-year term prior to the meeting.

3 The Second Vice-President shall be an ex-officio member of the Committee and shall report its activities to Executive.

4 The Committee shall:
(i) Be responsible to Council for the preparation, arrangement and execution of the scientific programme associated with the Annual Meeting of the Society; Consultation from the Committees on Continuing Education and Local Arrangements shall be sought in this regard;
(ii) Obtain Council's endorsement of the proposed papers, panels, symposia, scientific exhibits, etc., together with budget and time requirements before its programme is finalized;
(iii) Provide Council with a report and recommendations after each Annual Meeting;
(iv) Provide scientific programmes for other Annual Meetings as required.

B14 – Committee on Standards of Practice

1 The Committee shall advise Council on matters related to the improvement of the standards of Anaesthetic practice in Canada.

2 The Committee shall advise Council on matters related to Anaesthetic safety with respect to the patient, the anaesthetist and the health care system.

3 The Committee shall encourage improvements in organization, equipment and facilities whenever possible.

4 Representatives of the Society to other national or international standards organizations, whether requested by the Society or by other organizations, shall be considered Subcommittees of this Committee.

5 The Committee shall consist of a Chair and at least three members, including delegates as necessary.

6 The First Vice-President shall be an ex-officio member of this Committee and shall report its activities to the Executive.

7 Sub-committees and delegates may include:

(1) Sub-committee on Hospital Accreditation; (This Sub-Committee will provide liaison with the Canadian Council on Health Care Facility Accreditation);
(2) Delegate to Canadian Standards Association Committee on Health Care Facilities;
(3) Delegate to Canadian Standards Association Committee on Anaesthetic Equipment;
(4) Delegate to Canadian Standards Association Committee on Gas Pipelines;
(5) Delegate to International Standards Organization – Technical Committee 121.

Delegates may report directly to CAS Council if deemed desirable.

B15 – Delegation Committees

1 *General*
The Society shall promote liaison with other national or international professional Societies. Where this is to be on a continuing basis, the representative(s) shall be appointed by Council on an annual basis or as required. The appointees ordinarily shall be current or past members of Council, and thus be familiar with the affairs of the Society. The appointees, for the purpose of official representation, shall be considered to be members of Committees of Council, and shall report to Council from time to time.

2 *Delegation to the World Federation of Societies of Anaesthesiologists (WFSA)*
(a) Members of the Society (and alternates) to the number prescribed by the WFSA Constitution and By-laws shall be appointed preferably one year in advance of the quadrennial Congress of the WFSA;
(b) The senior delegate (usually an Officer of the Society) shall submit a written report on the quadrennial meeting of the WFSA at the next meeting of Council;
(c) Council *may* provide financial support for travel expenses of the official delegates of the Society to the Congress.

3 *Delegation to the Council of the Canadian Medical Association (CMA)*
(a) Council may appoint a representative of the Society to attend the Annual Meeting of the CMA Council;
(b) The delegate attending the CMA Council shall submit a written report to the Council of the Society at its next meeting;
(c) Council *may* provide financial support for travel expenses of the delegate to attend the Annual Meeting of the CMA.

Section C – Guidelines for Sections

1 Special interest groups shall be referred to as Sections of the Canadian Anaesthetists' Society (CAS).

2 The Society shall encourage the formation of such Sections where sufficient interest exists. CAS members requesting permission to form a Section shall make a written submission to the Honorary Secretary who shall refer the application to the Executive.

3 Sections shall be established only after approval by Council.

4 The purpose of Sections shall be to foster the education and interest of members. Sections may be asked to give an opinion on matters related to their special interest.

5 Activities of Sections shall be approved by the Society.

6 Sections shall be encouraged to meet at the time of the Annual Meeting of the Society.

7 The content of Sectional meetings shall be primarily of clinical interest. Research papers shall remain on the scientific agenda of the CAS meeting. Liaison with the Committee on Scientific Affairs must take place to ensure that conflicts do not occur and that maximum use is made of invited guest speakers. Honoraria and expense payments for guest speakers shall conform to the Society's current policies.

8 Members of Sections shall be members of the Society and each Section shall be governed by the Society's Constitution and By-laws and by its Rules and Regulations.

9 Each Section shall have an Executive consisting of:
- Chair
- Vice-Chair
- Secretary

Each shall be elected annually by the voting members attending the Annual Meeting of the Section. Sections shall be encouraged to rotate their Executive on a regular basis.

10 Each Section shall submit an annual written report, including a financial statement, to the Council of the Society at its Mid-Winter meeting.

11 Each Section shall produce an annual budget which will be submitted for approval to the Honorary Treasurer. All Sections should be self-financing.

Section D – Appendices

Appendix 1
Guidelines for Local Arrangements
Canadian Anaesthetists' Society Annual Meetings

The Chair of the Committee on Local Arrangements shall be chosen well in advance of the event year. Sub-committee, if desired, or "responsible" persons may be appointed by the Local Arrangements Chair for the following:

1 Social Tour Programme (spouses and/or children)
2 Hospitality Suite
3 Art Exhibit
4 Fun Run
5 Entertainment
6 Transportation
7 Promotion/Press Officer/Photographer
8 Council Dinner location
9 Organization of workshop(s) as part of the scientific programme
10 On-site liaison

It may be that individual events need not be the responsibility of any one person; rather, the Local Arrangements Chair may decide the delegation of action and participation.

1 *Society Tour Programme*
This should be self-supporting; profit is not the aim. The format for tours is somewhat "historical": a city tour on Saturday, a specialty tour on Sunday, an all day tour on Monday, and no tour on the final morning. Any of this may be changed should the need to reflect local highlights arise. Information on local restaurants should be provided.

2 *Hospitality Suite*
This should be centrally located to encourage maximum attendance by spouses and/or delegates who wish to view the Art Exhibit. Refreshments should be available in the mornings, and the room should be staffed for three full and one half days.

3 *Art Exhibit*
This event should be encouraged. However, should participation and interest decline, it could be either cancelled or re-vamped.

4 *Fun Run*
The emphasis is on "fun." This event has always been sponsored and should continue this way. From the selection of the site to the awarding of prizes, this event is organized locally. Any printing can be handled through the central office.

5 *Entertainment*
This category covers all events that require entertainment. The flavour should be "local" if possible, and should, of course, be within a specific budget. If necessary, an entertainment coordinator may be used to avoid a committee member having to deal directly with entertainers.

6 *Transportation*
Should this be required for a social or scientific event, it should be organized and coordinated by a local person. Prices should be known prior to the setting of the Annual Meeting budget.

7 *Promo/Press Officer/Photographer*
This should be a local person who can contact all television and radio stations and newspapers to promote the Society and some of its speakers. This promotion will involve sending out press kits (prepared by the central office). Interviews may be given on-site, and this should be coordinated with the programme in order to avoid conflict. The photographer should be a different person, who is competent and who enjoys taking photographs, but is willing to work for expenses paid.

8 *Council Dinner Location*
This should be in an off-site, local spot. The selection of a menu for the dinner should be a local responsibility. Budget shall be mutually agreed according to Council policy.

9 *Workshop(s)*
Traditionally, this is one portion of the scientific programme which involves the Local Arrangements Chair. The topic(s) should have the approval of the Committee on Scientific Affairs.

10 *On-site Liaison*
This covers the volunteer help, preparing work schedules, bus departures, local information and some assistance with registration. The requirements would be known well in advance in order to allow maximum time to recruit people.

Central Office

The coordination of most aspects of the meeting now takes place from the central office. The budget is set in the fall months, following the itemized accounting of the previous year's meeting. A draft of this budget is approved at the Executive meeting in November of the year preceding the meeting, and the final version is approved at Mid-Winter Council four months prior to the Annual Meeting.

The physical aspects of set-up in the facility, together with all hotel arrangements, are the concern of the central office. So also are audio-visual requirements, translation, catering and staffing needs. The needs of the volunteers are the responsibility of the Committee.

The Chair of the Committee on Scientific Affairs communicates through the central office, which permits a much broader sense of how events and plans are proceeding.

The central office communicates with all speakers and VIPs, advising them of expense policies where applicable. Registration information and systems are put together as soon as the content of the meeting is known. A great deal of printing and assembly of material is involved in registration mailings.

The Exhibit is organized from the central office.

Sponsorship is handled through the central office.

Printed material originates from the central office and strict deadlines are in place. Promotional pieces are prepared by graphic artists selected by the Society. The purchase of any gifts, plaques and the Medal is also handled through the central office.

The central office coordinating person(s) will make a minimum of two trips to the site in the year preceding the meeting. These will be budgeted.

APPENDIX 5

Officers of the Society, 1943–1993

President

1943–44	H.R. Griffith
1944–45	H.R. Griffith
1945–46	H.R. Griffith
1946–47	K.M. Heard
1947–48	H.J. Shields
1948–49	B.C. Leech
1949–50	F. Hudon
1950–51	S.M. Campbell
1951–52	E.A. Watts
1952–53	G. Cousineau
1953–54	R. Fraser
1954–55	J.P. O'Donnell
1955–56	A.B. Noble
1956–57	M.W. Bowering
1957–58	E.W. Lunney
1958–59	E. Allard
1959–60	E.A. Gain
1960–61	R. Meredith
1961–62	R.G.B. Gilbert
1962–63	H.B. Graves
1963–64	R.A. Gordon
1964–65	L. Longtin
1965–66	D.F. McAlpine
1966–67	I.E. Purkis
1967–68	S.L. Vandewater
1968–69	M. Minuck
1969–70	A. Jacques
1970–71	N. McMillen
1971–72	G.M. Wyant
1972–73	J-P Dechêne
1973–74	I. MacKay
1974–75	J.E. Wynands
1975–76	J.H.A. Lawrence
1976–77	J.E. Feindel
1977–78	D.E. Crowell
1978–79	G. Houle
1979–80	W.J. Farley
1980–81	J.B.R. Parker
1981–82	J.C. Pouliot
1982–83	E. Michel
1983–84	J. Price
1984–85	T. Queree
1985–86	J. Taillefer
1986–87	R. Gregg
1987–88	D.S. Skene
1988–89	P.G. Duncan
1989–90	W.D.R. Writer
1990–91	J. Samson
1991–92	R. Baxter
1992–93	A.O. Davies

Secretary–Treasurer

1943–46	M. D. Leigh
1946–61	R. A. Gordon
1961–68	S. M. Campbell

Secretary		Treasurer	
1969–71	A.B. Noble	1969–71	J.H.S. Mahood
1971–77	S.L. Vandewater	1971–77	D.W. Aitken
1977–80	A.J. Dunn	1977–82	G.R. Sellery
1980–84	D.V. Catton	1982–87	J.E. Beckstead
1984–89	G. Houle	1987–93	L.W. Hersey
1989–93	D. Fear		

Editor

1954–82	R.A. Gordon
1983–87	D.B. Craig
1988–	D.R. Bevan

Chairman of Council

1972–75	A.J. Dunn
1975–78	G. Houle
1978–80	L. Perrault
1980–82	D.S. Skene
1982–84	W.B. MacDonald
1984–87	L.W. Hersey
1987–90	J. Cowan
1990–93	S. Lenis

APPENDIX 6

Divisional Representatives to Council, 1943–1992

Year	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario
1943–45	WESTERN PROVINCES – E.H. Watts, B.C. Leech, D. Aikenhead				K. Heard H.J. Shields
1945–46	D.D. Freeze	W.S. Johns E.H. Watts	B.C. Leech	D. Aikenhead	J.A. Blezard K.M. Heard H.J. Shields R.A. Gordon
1946–47	D.D. Freeze B. MacEwen	E.H. Watts	J. McCutcheon	D. Aikenhead	J.A. Blezard S. Campbell H. Shields
1948–49	W.M. Hall	E.H. Watts	M. Nicholson	R. Letienne	R. Meredith A.B. Noble R.J. Fraser W.E. Brown
1949–50	K. Langston	J. Anderson	M. Nicholson	D. Barnhouse	R. Meredith R.J. Fraser W.E. Brown C. Wainwright
1950–51	W.M. Hall	A.S. Hall	D. Daymond	M. Bennett	A.B. Noble R.J. Fraser W.E. Brown K. Richardson
1951–52	J.P. O'Donnell	R. Douglas	R. Daymond	D. Huggins	H. Robinson W.E. Brown A.M. Noble J.M. Wishart

Year	Quebec	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland
1943–45	G. Cousineau F. Hudon	MARITIME PROVINCES – E. Lunney, C. Stoddard			
1945–46	G. Cousineau F. Hudon	E. Lunney	C. Stoddard	J.C. Houston	
1946–47	W. Bourne G. Cousineau H.R. Griffith	E. Lunney	C. Stoddard	J.C. Houston	
1948–49	A. Wilkinson H.R. Griffith M. Legare	F.R. Connell	C.H.L. Baker	C.W. Tanton	
1949–50	M. Clermont H.R. Griffith G. Cousineau	G.V. Parsons	C.H.L. Baker	C.W. Tanton	
1950–51	M. Clermont H.R. Griffith G. Cousineau	G.V. Parsons	C.H.L. Baker	L.E. Prowse	C.D. Kean
1951–52	W. Bourne H.R. Griffith F. Hudon	E.R. Davis	C.H.L. Baker	L.E. Prowse	C.D. Kean

Year	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario
1952–53	M. McMillan	N.W. Nix	M. Bowering	D. Huggins	R. Stringer R. Orange A.B. Noble H. Robinson
1953–54	G.W. Barnes	F. Fish	M. Bowering	H. Eshoo	R. Stringer R. Orange A.B. Noble H. Robinson
1954–55	H.V. Hughs	C. Fletcher	T.V. Darke	H. Hutchison	D. Probert S. Campbell J.M. Wishart J.E. Condon
1955–56	J.J. Carroll	F.E. Lundy	M.V. Morton	D. Tass	R.A. Chaplin R. Probert J. Gorman J.M. Wishart
1956–57	H.S. Randall	F.E. Lundy	M.V. Morton	A.W. Natsuk	J. Gorman J.M. Wishart R.A. Chaplin G.F. Smith
1957–58	P.B. Percheson	D.F. Cameron	M.V. Morton	M. Minuck	G.F. Smith J. Gorman J. Wishart E.S. Russell
1958–59	H.B. Graves R.E. Simpson	D.F. Cameron	M.V. Morton	L. Cruickshank	G.F. Smith J.M. Wishart E.S. Russell D.W. Best
1959–60	J.B. Fulton R.G. Simpson	E.H. Dobbs	D. Ewart	S.L. Drulak	J.M. Wishart E.S. Russell D.W. Best J.M. Shapley
1960–61	J.B. Fulton W.L. Esdale	E.H. Dobbs	D. Ewart	M. Minuck	J.M. Wishart E.S. Russell D.W. Best J.M. Shapley
1961–62	W.L. Esdale G.E. Sleath	C. Learmonth	D. McAlpine	J. McCammon	D.W. Best E.S. Russell J.M. Shapley D.T. Law

Year	Quebec	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland
1952–53	E. Allard H. Griffith F. Hudon	J. MacDougall	C. Stoddard	L.E. Prowse	C.D. Kean
1953–54	L. Lamoureux H.R. Griffith E. Allard	J. MacDougall	R.W. Ballem	L.E. Prowse	C.D. Kean
1954–55	R.G.B. Gilbert H.R. Griffith E. Allard	J. MacDougall	G. Donaldson	L.E. Prowse	C.D. Kean
1955–56	M. Dubeau H.R. Griffith L. Lamoureux	A.M.R. Brown	R.A.P. Fleming	L.E. Prowse	C.D. Kean
1956–57	H.M. Slater H.R. Griffith G. Cousineau	J.A. Dobson	A.S. Wenning	L.E. Prowse	C.D. Kean
1957–58	H.M. Slater H.R. Griffith G. Cousineau	J.A. Dobson	A. MacIntosh	L.E. Prowse	C.D. Kean
1958–59	H.R. Griffith G. Cousineau J-P. Dechêne	W. Oatway	A.F. Pasquet	L.E. Prowse	C.D. Kean
1959–60	H.R. Griffith G. Cousineau D. Power	G. Parsons	A.S. Wenning	L.E. Prowse	T. Stentaford
1960–61	H.R. Griffith G. Cousineau D. Power	E. Daigle	C.H.L. Baker	L.E. Prowse	T. Stentaford
1961–62	H.R. Griffith G. Cousineau L. Longtin	J. Caron	I.E. Purkis	L.E. Prowse	T. Stentaford

Year	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario
1962–63	W.L. Esdale G.E. Sleath	C. Learmonth	D. McAlpine	M. Minuck	J.M. Shapley D.W. Best S. Vandewater H. Edwards
1963–64	H.H. McCartney G.E. Sleath	N.E. Foster	M.W. Bowering	M. Minuck	J.M. Shapley D.W. Best P. Clancy S. Vandewater
1964–65	H.H. McCartney J.L. Oulton	N.E. Foster	M.W. Bowering	M. Minuck	S. Vandewater J.M. Shapley P.R. Clancy L. Simonsen
1965–66	H.H. McCartney J.L. Oulton	N.E. Foster	G.M. Wyant	M. Minuck	P.R. Clancy L. Simonsen J. Mahood M. Tousignant
1966–67	J.L. Oulton N. McMillen	N.E. Foster	G.M. Wyant	P. McGarry	P.R. Clancy L. Simonsen J. Mahood M. Tousignant
1967–68	N. McMillen I. Paterson	J.D. St. Clair	G.M. Wyant	P. McGarry	L. Simonsen J. Mahood M. Tousignant I.M. Mackay
1968–69	I. Paterson A.K. Gibbon	J.D. St. Clair	G.M. Wyant	P. McGarry	J. Mahood M. Tousignant I.M. Mackay D.W. Aitken
1969–70	I. Paterson A.K. Gibbons	J.D. St. Clair	D. McAlpine	P. McGarry	M. Tousignant I.M. Mackay D.W. Aitken A.J. Dunn
1970–71	A.K. Gibbons G.W. Sleath	J. Lawrence	D. McAlpine	S. Kantor	D.W. Aitken I.M. Mackay A.J. Dunn K. Goodwin
1971–72	G.W. Sleath J. McConnell	J. Lawrence	D. McAlpine	S. Kantor	A.J. Dunn K. Goodwin H. Grennell D. Crowell

Year	Quebec	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland
1962–63	H.R. Griffith G. Cousineau A. Jacques	J. Caron	I.E. Purkis	L.E. Prowse	T. Stentaford
1963–64	H.R. Griffith P. Cousineau P. Galibois	J. Caron	I.E. Purkis	L.E. Prowse	T. Stentaford
1964–65	H.R. Griffith G. Cousineau P. Galibois	H. Richter	A.S. Wenning	L.E. Prowse	T. Stentaford
1965–66	J.B. Sutherland R.G.B. Gilbert J-P. Dechêne	J. Price	A.S. Wenning	L.E. Prowse	T. Stentaford
1966–67	J.B. Sutherland R.G.B. Gilbert J-P. Dechêne	E. Daigle	A.S. Wenning	L.E. Prowse	T. Stentaford
1967–68	R.G.B. Gilbert J-P. Dechêne J.M. Bergeron	E. Daigle	A.A. Drysdale	L.E. Prowse	T. Stentaford
1968–69	J.M. Bergeron J-P. Dechêne G.F. Brindle	E. Daigle	A.A. Drysdale	L.E. Prowse	T. Stentaford
1969–70	J-P. Dechêne J.G. Maille J.E. Wynands	R. Guerrette	A.A. Drysdale	L.E. Prowse	T. Stentaford
1970–71	J.G. Maille J.E. Wynands R. Dery	R. Guerrette	A.A. Drysdale	L.E. Prowse	T. Stentaford
1971–72	J. House J.E. Wynands R. Dery	R. Guerrette	J.H. Feindel	D. MacDonald	T. Stentaford

Year	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario
1972–73	G.W. Sleath J. McConnell	J. Lawrence	D. McAlpine	S. Kantor	K. Goodwin H. Grennell D. Crowell R.L. Matthews
1973–74	J.A. McConnall G.W. Sleath	W.J. Farley C.D. Elton	E. Cockings	W.B. Syslak	K. Goodwin H. Grennell D. Crowell D.V. Catton G.R. Sellery
1974–75	E.J. Treloar L.C. Jenkins	C.D. Elton W.F. Farley	E. Cockings	W.B. Syslak	D. Crowell H. Grennell D.V. Catton G.R. Sellery N. Ironside
1975–76	L.C. Jenkins W.A. Doll	W.J. Farley G. Purdell-Lewis	J. Parker	C.T. Ethans	H. Grennell D.V. Catton G.R. Sellery N. Ironside N.H. Ready
1976–77	W.A. Doll J.H. Hendry	W.J. Farley J. Purdell-Lewis	J. Parker	C.T. Ethans	D.V. Catton G.R. Sellery N. Ironside E. Michel D. Adamson
1977–78	J.H. Hendry R.L.D. Adams	W.H. Hesson J. Purdell-Lewis	J. Parker	C.T. Ethans	N. Ironside E. Michel D. Adamson P. Dwane D. Skene
1978–79	R.L.D. Adams K.W. Turnbull	W.H. Hesson J. Purdell-Lewis	W. MacDonald	J.E. Beckstead	E. Michel D. Adamson P. Dwane D. Skene D. Fear
1979–80	K.W. Turnbull E.C. Queree	W.R. Hesson M. Ishii	W. MacDonald	J.E. Beckstead	D. Adamson E. Michel P. Dwane D. Skene D. Fear D. Pelton

Year	Quebec	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland
1972–73	J. House G. Huole J.G. Maille	C. Armstrong	J.H. Feindel	L.W. Prowse	T. Stentaford
1973–74	J. House G. Houle J.G. Maille G.F. Brindle	C. Armstrong	K. Fairhurst	D. MacDonald	R. MacDonald
1974–75	G.F. Brindle L. Perreault J.C. Pouliot D. Trop	C. Armstrong	K. Fairhurst	D. MacDonald	R. MacDonald
1975–76	G.F. Brindle L. Perreault J.C. Pouliot D. Trop	E. Daigle	K. Fairhurst	D. MacDonald	R. MacDonald
1976–77	L. Perreault J.C. Pouliot D. Trop B. Gagnon	E. Daigle	K. Fairhurst	D. MacDonald	R. MacDonald
1977–78	J.C. Pouliot D. Trop B. Gagnon J-G. Patoine	E. Daigle	W. Thompson	D. MacDonald	C. Condon
1978–79	J.C. Pouliot D. Trop B. Gagnon J-G. Patoine	J. Price	W. Thompson	D. MacDonald	C. Condon
1979–80	B. Gagnon C. Briere D. Gagnon L. Marceau	J. Price	D.D. Imrie	D. MacDonald	P. Redfern

Year	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario
1980–81	T.C. Queree R.J.W. Ford	R.C. Gregg W.R. Hesson	W. MacDonald	J.E. Beckstead	P. Dwane D. Fear D. Pelton R. Linton L. Hersey
1981–82	T.C. Queree R.J.W. Ford W.G.B. Phillips	R.C. Gregg M. Ishii	K. Banton	J.E. Beckstead	P. Dwane D. Fear D. Pelton R. Linton L. Hersey
1982–83	W.G.B. Phillips R.J.W. Ford	R.C. Gregg M. Ishii	K. Banton	P.G. Duncan	D. Fear D. Pelton R. Linton L. Hersey D. Skene
1983–84	W.G.B. Phillips W.D. Martin J.J.L. Crosby	R.C. Gregg M. Ishii	K. Banton	P.G. Duncan	D. Pelton R. Linton D. Fear L. Hersey D. Skene J. Cowan
1984–85	W.D. Martin J.J.L. Crosby L. Bowers	M. Ishii R. Reine	K. Banton	P.G. Duncan	D. Pelton R. Linton L. Hersey D. Skene J. Cowan P. Heyland
1985–86	J.J.L. Crosby L. Bowers S. Baker	H. Reine A. Munn	K. Banton	P.G. Duncan	R. Linton L. Hersey D. Skene J. Cowan P. Heyland L.M. Beckham
1986–87	J.J.L. Crosby S. Baker R. Baxter	H. Reine A. Munn	K. Banton	P.G. Duncan	R. Linton L. Hersey D. Skene J. Cowan P. Heyland L.M. Beckham

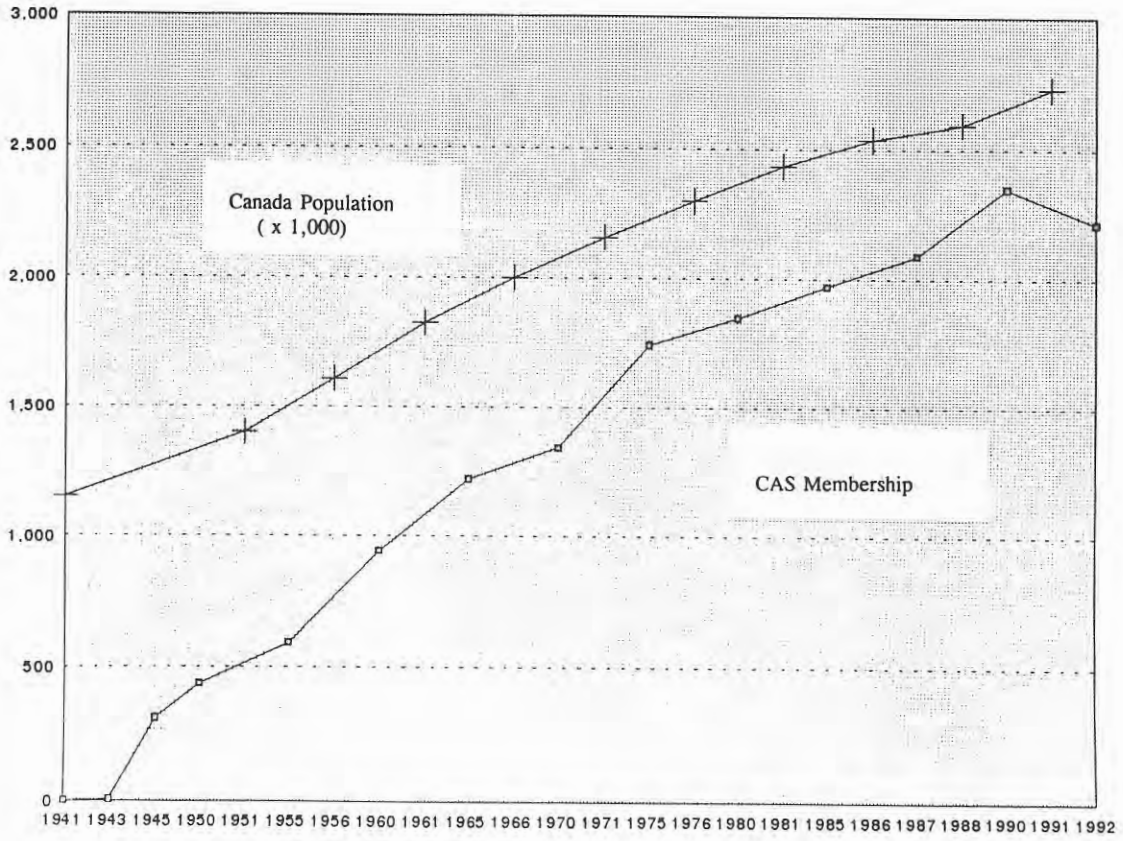
Year	Quebec	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland
1980–81	B. Gagnon C. Briere D. Gagnon L. Marceau	J. Price	D.D. Imrie	D. MacDonald	P. Redfern
1981–82	B. Gagnon D. Gagnon L. Marceau J. Taillefer	J. Price	D.D. Imrie	D. MacDonald	P. Redfern
1982–83	B. Claveau L. Letendre L. Marceau J. Taillefer	C. Armstrong	J.P. Donachie	D. MacDonald	D. Reid
1983–84	B. Claveau L. Letendre L. Marceau J. Taillefer	C. Armstrong	J.P. Donachie	D. MacDonald	F.C. King
1984–85	L. Letendre L. Marceau J. Samson	C. Armstrong	D. Writer	D. MacDonald	F.C. King
1985–86	L. Letendre L. Marceau J. Samson	I. Keith	D. Writer	D. MacDonald	F.C. King
1986–87	J. Letendre L. Marceau J. Samson	I. Keith	D. Writer	D. MacDonald	F.C. King

Year	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario
1987–88	S. Baker R. Baxter W.M. Robinson	A. Munn T. O'Leary	G. Hodgson	S. Ullyot	L. Hersey P. Heyland L.M. Beckham A. Davies E.S. Shelley G.L. Dunn
1988–89	W.M. Robinson B. Saunders	A. Munn D. DuVal	A. Enright	S. Ullyot	L.M. Beckham E.S. Shelley G.L. Dunn W. Lambert
1989–90	W.M. Robinson B. Saunders R.P. Grant	D. DuVal C. Davies	A. Enright	S. Ullyot	L.M. Beckham E.S. Shelley G.L. Dunn W. Lambert S. Jelenich
1990–91	A. Boulton R. Grant D. Wishart	C. Davies D. DuVal	D. Shephard	S. Ullyot	I. Anderson M. Beckham G. Dunn S. Jelenich W. Lambert S. Shelley
1991–92	D. Gambling D. Wishart	C. Davies D. DuVal	D. Shephard	I. White	I. Anderson N. Ashurst J. Cowan G. Doig W. Lambert S. Shelley L.M. Beckham
1992–93	D. Cole D. Gambling D. Wishart	M. Beriault J. Low	J. Stevenson	I. White	I. Anderson N. Ashurst W. Barry J. Cowan G. Doig W. Lambert S. Shelley

Year	Quebec	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland
1987–88	J. Letendre L. Marceau J. Samson	I. Keith	C. Walker	D. MacDonald	B. Hamilton
1988–89	L. Marceau S. Lenis P. Limoges	D.J. Cubitt	C. Walker	D. MacDonald	B. Hamilton
1989–90	L. Marceau L. Lenis P. Limoges	R. McLean	K. Hamilton	D. MacDonald	J. Flynn
1990–91	Dr. J-F. Hardy P. Limoges L. Marceau	R. McLean	K. Hamilton	D. MacDonald	J. Flynn
1991–92	J-F. Hardy L. Marceau	A. Bond	J. Clark	D. Johnson	M. Bautista
1992–93	J. Demers J-F. Hardy S. Michalk J. Poirier	A. Bond	J. Clark	D. Johnson	M. Bautista

APPENDIX 7

Membership Growth, 1943–1993



APPENDIX 8

The Evolution and Role of ACUDA

A 1957 editorial entitled "Of University Departments of Anaesthesia" (*Canad Anaesth Soc J* 1957; 4: 1–2) first expressed concern about the status of academic anaesthesia in Canada. At that time the issue was "the lack of financial support for the professional teacher." Later concerns involved teaching anaesthesia to medical students, attracting more quality Canadian graduates into anaesthesia, and university diploma courses.

In 1961, these concerns led to the formation of an informal group comprising the heads of anaesthesia departments. This group met during the Canadian Anaesthetists' Society annual meeting to discuss matters of mutual interest. Variously referred to as the Conference of Heads of University Departments of Anaesthesia, the Committee of Heads of University Departments of Anaesthesia and the Association of Directors of University Departments of Anaesthesia, the group was mainly interested in training and education, and manpower.

Representation on the Society's Education Committee enabled them to maintained a relationship with the Society that served the interests of both groups. The department heads, however, appear to have favoured an arm's length relationship, as indicated by the statement in the Minutes of a meeting on 25 June 1967 that "we should try to dissociate ourselves officially from the C.A.S."

Because it became apparent that the real responsibility for setting academic standards rested not with the Royal College nor the Canadian Anaesthetists' Society but with the academic departments, the group formalized its activities in 1975. At the suggestion of Dr. Stuart L. Vandewater of Queen's University, a retreat for department heads was held in Kingston on 27–28 February. Formalization enabled the group to express the concerns of academic departments more adequately at the level of the Royal College, the Association of Canadian Medical Colleges and the Canadian Anaesthetists' Society. These concerns included training and education in anaesthesia as well as the operation and function of academic research and the development of research. The outcome of the Kingston Retreat was the establishment of the organization now known as ACUDA, the Association of Canadian University Departments of Anaesthesia.

ACUDA's Constitution and Bylaws were approved in June 1976. The Objectives reflect the formal nature of the Association:

- To affiliate in a single organization representatives of all Canadian University Departments of Anaesthesia.
- To develop and promote undergraduate, postgraduate and continuing education by Canadian University Departments of Anaesthesia.
- To advise on the training of allied health care personnel as it relates to anaesthesia.
- To promote the development of research and scientific progress in anaesthesia.

- To represent academic Departments of Anaesthesia and promote their interests within professional or learned societies, advisory boards, councils to government or public service organizations.
- To promote exemplary patient care and advise responsible bodies on matters concerning the standards of anaesthetic practice.
- To support the interests of the profession through the objectives of the Canadian Anaesthetists' Society.

ACUDA differs from the earlier Conference of Heads of University Departments of Anaesthesia in that it comprises academic *departments* rather than *heads*. Furthermore, ACUDA has three standing committees: Education, Research and Departmental Management. As well, the affairs of ACUDA are overseen by a Chairman, Vice-Chairman, Secretary-Treasurer, Immediate Past-Chairman and the Chairmen of the three standing committees.

ACUDA met as a discrete organization for the first time in January 1977, and held its first regular annual meeting on 18 June 1977, in association with the CAS Annual Meeting. The relationship between ACUDA and the Society is also maintained by ACUDA representation on the CAS Council and by Society representation at ACUDA meetings.

The relationship between ACUDA and the Society is determined by the characteristics of each organization and particularly by their interests and perspectives. The relationship has the hallmarks of a town-gown relationship, which for most of the time is mutually beneficial but at other times generates conflict. Thus ACUDA representation on the Council of the Society gives ACUDA insight into the role and concerns of the Society as a journeyman organization that endeavours to represent all anaesthetists, while Council appreciates more the role and concerns of ACUDA. Conflict arises only when one organization infringes on the other's role and constituency. Two examples: responsibility for recommending individuals for membership on the Royal College's Specialty Committee in Anaesthesia has always been that of the Society (the Society's viewpoint); and, in the words of Dr. Emerson A. Moffitt, "the Society has many aims and functions but responsibility for survival and development of academic anaesthesia ultimately rests with the 16 university departments" [*Canad Anaesth Soc J* 1978; 25: 1–3 ("Academic Anaesthesia Organizes")] – ACUDA's viewpoint. Essentially and ideally, however, each organization enlarges the other.

The following individuals, all members of the Canadian Anaesthetists's Society, have served as Chairmen of ACUDA since 1976:

1976 G.F. Brindle (Sherbrooke)
1977 E.A. Moffitt (Dalhousie)
1978 F.J. Wright (Queen's)
1979 J.G. Wade (Manitoba)
1980 D.V. Catton (McMaster)
1981 L.C. Jenkins (British Columbia)
1982 L.C. Jenkins (British Columbia)
1983 W.B. MacDonald (Saskatchewan)
1984 J. Sandison (McGill)
1985 A.A. Scott (Toronto)
1986 C.E. Hope (Dalhousie)
1987 C.E. Hope (Dalhousie)
1988 L. Perrault (Montréal)
1989 L. Perrault (Montréal)
1990 J.P. Tetrault
1991 J.P. Tetrault
1992 D.B. Craig

APPENDIX 9

*Definition of Anaesthesia and the Role of the Anaesthetist**

Anaesthesia is the specialized branch of medicine primarily concerned with the prevention of pain and the provision of life support during surgery. It is carried out by physicians with specialized training and experience: it is a profession and not a hospital service.

Anaesthetists may be further described by the following patient care activities:

1 Establishing a professional relationship with the patient, offering reassurance and explanation, evaluating the anaesthetic risks and how these may be minimized by proper preparation prior to surgery, weighing the advantages and disadvantages of the available techniques, selecting the least harmful and most suitable to the needs of the patient and surgeon.
2 Protecting the patients from the stress of surgery, rendering them insensible to pain, and providing support of vital functions of respiration, circulation and fluid balance during surgery and in the immediate recovery period.
3 Acting as a consultant to surgeons and other physicians in the management of patients prior to operation, following the immediate recovery period, and in problems of intractable pain.
4 Providing obstetrical analgesia and anaesthesia, and resuscitation of the newborn.
5 Resuscitating patients with acute respiratory and/or circulatory failure, and providing safe management of unconscious patients, whatever the cause. This may include participating as a member or director of a team in acute care visits, with special reference to respiratory and cardiovascular support and management of electrolyte and acid-base disturbances.
6 Teaching the principles of anaesthesia to medical students, respiratory technologists and other allied health students where appropriate, in both community hospitals and teaching hospitals.

These responsibilities in patient care are equally applicable to practitioners, other than specialists in anaesthesia, who choose to administer anaesthetics, or participate in other aspects of anaesthesia, altering the emphasis in the areas defined above, and perhaps embracing new areas.

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*Approved by Executive Committee 7 May 1977 and Council 19 June 1977.

APPENDIX 10

Recipients of the CAS Gold Medal, 1962–1990

1962	W. Bourne
	H.R. Griffith
	H.J. Shields
1963	I.W. Magill
1964	F. Hudon
1967	G. Cousineau
1968	S.M. Campbell
	J.S. Lundy
	R.R. Macintosh
1969	J. Gillies
	R.A. Gordon
1971	A.B. Noble
1979	L. Longtin
1981	A.J. Dunn
	S.L. Vandewater
1982	A. Jacques
1983	R.G.B. Gilbert
1984	G.M. Wyant
1986	W.E. Spoerel
1987	J.G. Wade
1988	J.E. Wynands
1989	D.V. Catton
1990	E.A. Moffitt

The Gold Medal is the highest award of the Canadian Anaesthetists' Society. On one side is represented the emblem of the Society (see Frontispiece); on the other are inscribed the words *Presented for Meritorious Service in Anaesthesia/Offerte pour services éminents pour anesthésie*. It is awarded in recognition of excellence in matters related to Anaesthesia to an individual, "ordinarily a Canadian ... who has made significant or substantial contributions to Anaesthesia in Canada through teaching, research, professional practice, or related administration and personal leadership."

APPENDIX 11

Canadian Anaesthetists' Society Prize, 1961–1988

Year	Awardee	University or Institution
1961	R.A. Millar	McGill
	L.W. Hersey	Western Ontario
1963	L.C. Jenkins	British Columbia
1967	R. Déry	Laval
1968	P.R. Ramachandran	Toronto
1969	B. Britt	Toronto
1970	W.H. Noble	Toronto
1971	D.B. Craig	Manitoba
1972	R.R. Crago	Toronto
	A.C. Bryan	Toronto
	A.K. Laws	Toronto
	A. Winestock	Toronto
1973	T.L. Dobbinson	Toronto
	H.I.A. Nisbet	Toronto
	D.A. Pelton	Toronto
1974	P.R. Bromage	McGill
	P.R. Melzack	McGill
1975	W.H. Noble	Toronto
1976	B. Britt	Toronto
1977	R. Meloche	Nôtre Dame Hospital, Montréal
	T.C. Pottecher	Nôtre Dame Hospital, Montréal
	J. Audet	Nôtre Dame Hospital, Montréal
	O. Defresne	Nôtre Dame Hospital, Montréal
	C. Lepage	Nôtre Dame Hospital, Montréal

Year	Awardee	University or Institution
1978	W. Stoyka	Toronto
	D.Z.N. Frankel	Toronto
	J.C. Kay	Toronto
1979	R.L. Knill	Western Ontario
	P.H. Manninen	Western Ontario
	J.L. Clement	Western Ontario
1980	R.J. Byrick	Toronto
1981	W.H. Nobel	Toronto
	J.C. Kay	Toronto
	J.A. Fisher	Toronto
1982	R.L. Knill	Western Ontario
	J.L. Clement	Western Ontario
1983	R.L. Knill	Western Ontario
	T.H. Kieraszewicz	Western Ontario
	B.C. Dodgson	Western Ontario
	J.L. Clement	Western Ontario
1984	J.F. Nicholas	Western Ontario
	A.M. Lam	Western Ontario
1985	R. Kozody	Manitoba
1987	P.G. Duncan	Manitoba
1988*	R.J. Byrick	Toronto

* The CAS Prize was discontinued after 1988.

APPENDIX 12

Residents' Competition Prize Winners, 1967–1992

Year	Awardee	University
1967	M.G. Viguera	Toronto
	G.R. Sellery	Toronto
	D.L. Zoerb	Saskatchewan
1968*	L.A. Frostad	
	C.H.N. MacDonald	
	G.M. Paprica	
1969*	W.D. Lahay	British Columbia
	W.H. Noble	Toronto
	W. Stoyka	Toronto
1970	W. Stoyka	Toronto
	E. Carden	British Columbia
	D.B. Craig	McGill
1971	R.K. Calverley	British Columbia
	H. Samulska	Toronto
	C. Margaria	McGill
1972	B. Saunders	British Columbia
	J. Obdrzalek	Toronto
	R.R. Crago	Toronto
1973	D.S. Arthur	Toronto
	D.H.W. Wong	British Columbia
	D.H. Rimer	Manitoba
1974	R.L. Knill	Toronto
	J. Boyce	Queen's
	H.R. Wexler	Toronto
	H.M. Chinyanga	Toronto

Year	Awardee	University
1975	P.C. Darimont	British Columbia
	J.E. Beckstead	Manitoba
	C.H. Johns	Manitoba
1976	J. Boyce	Queen's
	R.J. Byrick	Toronto
	B.A. McLeod	British Columbia
1977	A. Gelb	Western Ontario
	G. Johnson	Manitoba
	B.Y. Ong	Manitoba
1978	K. Rose	Toronto
	R.S. Lee	Western Ontario
	S. Bright	Western Ontario
1979	J. Fisher	Toronto
	B.C. Pickering	Manitoba
	S. Baker	British Columbia
1980	R. Forbes	Alberta
	B.J.H. Robertson	Western Ontario
	B. Milne	Queen's
1981	M.J. Mitchell	British Columbia
	H. Kieraszewicz	Western Ontario
	B.G. Dodgson	Western Ontario
1982	C.A. Moote	Western Ontario
	K.H. Rogers	Queen's
	R.M. Friesen	Manitoba
1983	J. Nicholas	Western Ontario
	J. Ramsay	McGill
	L. Veilleux	Sherbrooke
1984	C. Putnius	Manitoba
	C. Dodd	Calgary
	R. Robbins	McGill
1985	B. Newman	Western Ontario
	S.G. Brown	Western Ontario
	S. Tam	Toronto
1986	P. Labrecque	McGill
	T.E. Woodcock	Western Ontario
	F.J. Mensiuk	Manitoba
1987	H. Vaghadia	British Columbia
	G.C. Allen	Ottawa
	K. Ringaert	Manitoba

Year	Awardee	University
1988	S. McKenty	Sherbrooke
	D. Cheng	Toronto
	P.Y.H. Yu	British Columbia
1989	E. Effa	British Columbia
	J. Parlow	Queen's
	P. Patel	Manitoba
1990	R. Segstro	Western Ontario
	J. Leon	Toronto
	L. Murphy	Ottawa
1991	B. Kavanagh	Toronto
	L. Isabel	Laval
	M. Stockwell	Saskatchewan
1992	M. Stockwell	Saskatchewan
	R. Preston	Ottawa
	D. Campbell	British Columbia

*Names in alphabetical order; otherwise, in order of merit.

APPENDIX 13

Research Award Winners, 1985–1992

Year	Award	Awardee
1985	CAS	H. Nathan
1986	CAS	D. Archer
1987	CAS	S. Elia
	Sheridan	D. Mazer
1988	CAS	R. Hall
	Sheridan	G. Plourde
	ICI Pharma	M. Ali
1989	CAS	D. Chartrand
	Sheridan	D. Cheng
	ICI Pharma	D. Johnson
	Janssen	D. Penning
1990	CAS	B. Orser
	Sheridan	G. Allen
	ICI Pharma	P. Labrecque
	Janssen	P. Fiset
1991	CAS	K. Brown
	Sheridan	B. Bissonnette
	ICI Pharma	N. Bodner
	Janssen	J. Parlow
1992	CAS	O. Hung
	Sheridan	P. Sirko
	ICI Pharma	P. Fiset
	Janssen	C. Ries

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