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CAEP REVIEW

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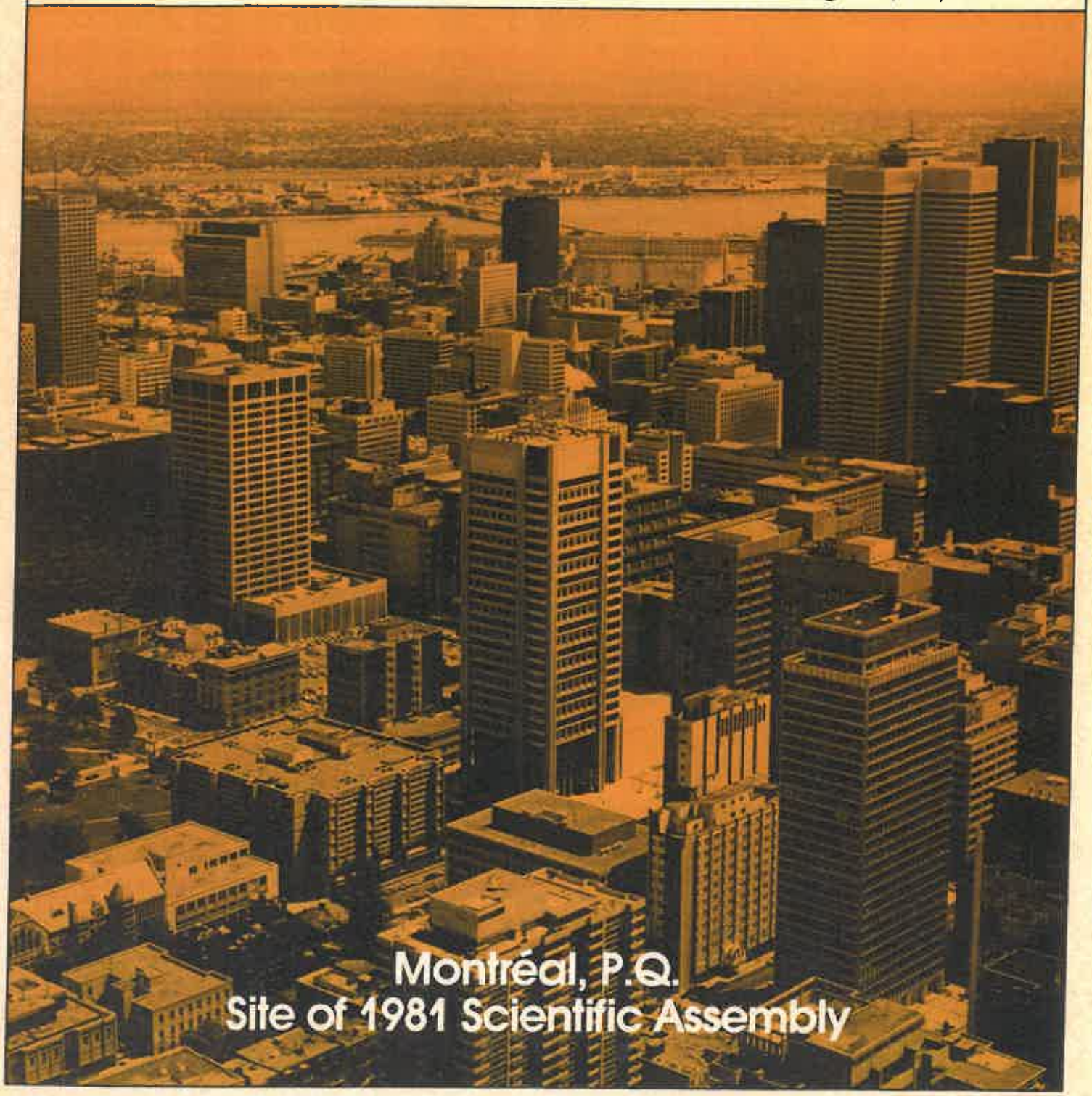

Montréal, P.Q.
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CAEP REVIEW

Vol. 2, No. 2 April 1981

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30

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President's Notebook

Since the publication of the last CAEP Review the Royal College Specialty Committee on Emergency Medicine has met once and had a very successful exchange of ideas. Dr. Greg Powell, Vice-President of CAEP and our representative on that committee, will report on developments to date elsewhere in the Review. Suffice to say that we are very encouraged with what has happened so far.

The issue of certification is, of course, of paramount importance not only to those of us whose career is Emergency Medicine, but also to those dozens of medical students and residents that wish to pursue such a career.

Those of us who work in teaching centres are often asked for advice regarding "How do I become an emergency physician?". And the answer is difficult. For some, who envisage a combination of Family Practice and community hospital emergency coverage, I would suggest an accredited Family Practice programme in a centre that is planning an integrated second year and emergency third year type of programme.

However, the majority of students are interested in full time Emergency Medicine and wonder whether they should:

1. Train in an LREC approved programme in the United States.
2. Train at one of the five unaccredited Canadian programmes.
3. Try to arrange their own programme with eg. a rotating internship.
4. Do a rotating internship and try to get a job in Emergency Medicine as quickly as possible.

It is hard to advise such students. There is no doubt that most major centres in Canada are interested in hiring graduates from one of the yet unaccredited Canadian programmes. And this is the advice I usually give.

We are hopeful that the Royal College will approve a practice eligible route to certification based on training and experience and that training in one of the Canadian programmes will be viewed as highly applicable to practice eligibility. Similarly the College of Family Physicians of Canada has suggested a generous practice eligible route to their form of certification in Emergency Medicine and some candidates will find this the most appropriate route.

The Canadian Medical Association is also interested in a truly conjoint two part national certification accreditation system for emergency physicians consisting of a written exam approved and sponsored by all appropriate and concerned organizations (CMA, CFPC, ACEP, etc) and a training programme accreditation system to be added to an existing mechanism such as the National Conjoint Committee on Accreditation of Preregistration Physician Training Programs.

This plethora of suggestions and routes is confusing and potentially fragmentary to the student and physician interested in seeing the discipline of Emergency Medicine achieve its rightful place in the overall structure of organized medicine. The executive of CAEP is well aware that our leadership role in these ongoing negotiations must be played out with common sense and careful planning. It takes much time and effort. It is, however, gratifying that Emergency Medicine is recognized as a critically important aspect of medical care by all concerned, and that recognition matched with our enthusiasm and expertise should shortly result in a clarified and appropriate route for students and emergency physicians to be trained and/or certified as the specialists that they are.

Further developments will be reported to you promptly.

David M.C. Walker, M.D., F.R.C.P.(C)
President
The Canadian Association of Emergency Physicians

From the Editor

Slow but Sure

With this issue of the *Review*, some of the changes have been made that we've spoken of over the past few months. We're eager to hear how you feel about these. Is the publication a useful addition to the literature of Emergency Medicine? Do you feel its a cost-effective means of communicating with other CAEP members? Let us know

The Scientific Section Drs. Johnston and Doris of Detroit have provided the *Review* with its first "original article". Their study of the cervical spine curvature with and without different types of rigid collars represents just the sort of practical information that Emergency Physicians find helpful. We hope that more such reports of studies will be forthcoming in the future.

Dr. William Ghent has long been considered a "founding father" of both Emergency Medicine and the care of the trauma victim in Canada. Over the years he has sown many a seed in the minds of physicians, politicians and the public regarding the two topics. And, he has nursed a number of the seeds to fruition, contributing to the rapid pace of development in both fields that we see today. "Time and Trauma", the First Annual Roads Lecture given at the CMA meeting in Vancouver in September, is another example of the Ghent tradition of seed sowing. It represents one of the most comprehensive and engaging accounts of the historical development of the care of the trauma victim ever written.

Advertising As you can see, this issue represents the first time the CAEP *Review* has included full-page colour advertisements for commercial products. As yet, however, we are a long way from our goal of making the *Review* self-supporting from revenues. This will come with time, once advertisers recognize that the *Review* is the only sure way to get a message to Canadian Emergency Physicians.

The other rather remarkable change in advertising that readers will note is the phenomenal increase in the number of positions available. Its plain to see that with CAEP assuming a higher profile, and with specialty status having been granted, the demand for trained and/or experienced Emergency Physicians is exploding. Whether this rapid expansion on the demand side for E.P.'s is healthy or not remains to be seen. I suspect it just might be the topic for a future editorial.

Format Finally, a few minor changes have been made in the format of this month's *Review*. The heavier, glossier paper should both improve colour reproduction and the publication's "durability" in Canada's postal service.

The *Review* will also be going to a more standard cover format. This will afford improved recognition and be easier to produce each time.

Reader's comments from the last issue have led to most of these changes. This is CAEP's publication, so your views on the *Review* are welcomed and heeded. Should you consider them appropriate for publication in the "Letters" section simply indicate so.

Contents

News & Views

Scientific Section

Information

Resident's Corner

Choosing an Emergency Residency Program

In this issue's "Resident's Corner", I would like to touch upon the subject of choosing a residency program and what one should be aware of when looking into an emergency medicine residency. The number of applicants to these programs is steadily increasing. Medical students, interns, and practicing emergency physicians are now becoming increasingly interested in a specialty certification. Having gone through such a program in the last two years, I feel that I am capable of commenting on several important points.

An emergency medicine program should first of all have a strong administrative basis. Its faculty should be composed of full time emergency physicians, from the director down. A large contingent of residency trained physicians is usually preferable because of their academic interest. An academic departmental status is not essential, but desirable for autonomy, usually makes changes easier.

The institution offering training, must be able to have an exposure to all facets of emergency medicine. It must have sufficient volume, and offer all essential specialty and subspecialty services. Also, the resident should be recognized as a future specialist in the field with special qualifications in resuscitation, treatment of the injured patient, and knowledge of the common adult and pediatric emergencies.

A written detailed outline of the program content should be available to the candidate, as well as an outline of the evaluation mechanism including periodic written, oral and on-ward evaluation.

The interview is an excellent opportunity to evaluate the candidate, as well as the program. During this interview, it is important for the candidate to meet as many of the faculty as possible, and not just the director or chief training officer. He should be able to meet one or two senior residents, preferably the chief resident for a candid discussion on the strengths and weaknesses of the program. All too often, perspective resident gets only one point of view. Also, specific points should be discussed with the faculty including:

A. Specific emergency medicine teaching including regular seminars, presentations, national and international meetings.

B. Capabilities of certification in B.C.L.S., A.C.L.S., A.T.L.S.

C. As previously mentioned, a good program should have a detailed training evaluation mechanism.

D. Opportunities for senior residents to get experience in research, manage multiple critical patients, handle major emergencies, teach junior house staff and students.

One should be certain that procedural skills will truly be taught and mastered, and not simply be learned on paper.

Therefore, all these facets should be considered and examined for each of the programs applied for. Probably, the most important part of the interview is the discussion with the senior residents. They will be able to give a resident's point of view and answer most of the specific details, as to the every-day activities. They will also be able to tell the candidate if they feel confident to leave the residency and go into practice as an emergency physician.

What can Canadian Residents learn from E.M.R.A. and U.A.-E.M.

Recently, I had a conversation with Dr. Sheldon Glazer, who is representative on the executive of E.M.R.A. and U.A.-E.M. Dr. Glazer is a senior resident at McGill, in Montreal. Together, we discussed activities of these associations with special emphasis on what Canadian residents can learn from them. There is no doubt that we must start to become more involved in our own specialty. As we all know, we will soon be attaining college certification, either under the Royal College of Physicians and Surgeons or the College of Family Physicians of Canada, through a separate or a joint mechanism. Presently, Residents have no strong representation on any of these committees, of either college. No one has been appointed and our only official representation is through CAEP. Therefore, we will eventually have to form a residents' association, which will be able to sit on different governing bodies.

E.M.R.A., which stands for Emergency Medicine Resident Association, is especially interested in the study of factors affecting residency training, program endorsement, and board certification. Is also active in the review of the circulum core content. E.M.R.A. has a member on different committees and associations such as ACEP and its graduate, undergraduate residency training committee. This committee is mainly interested in developing performance and assessment protocols, skill logs, trauma centre designation, and the definition of emergency medicine and an emergency physician.

An ACEP committee on residency programs is presently being set up to include an E.M.R.A. representative.

They are also looking into including emergency medicine into the intern residency matching plan, which is an American mechanism to match interns and residents with their desired training programs. This has a significant implication for Canadian residents who are recognized by ACEP but have a separate matching program. This point of view as presently being put forward by Dr. Glazer, has our representative.

As one can see, E.M.R.A. is very active in decision making and future of emergency medicine in the United States, and we should be doing the same in the near future. A resident representative on committees presently setting up standards and training criterias for Canadian residency, is essential.

Feedback

I would appreciate your opinions on these points of view, and I am especially interested in any special problems, research projects, in your areas.

I am interested in knowing how the job hunt is going on for senior residents and if any of you have already gotten positions, please write to me, for I would like to publish them in our next newsletter.

As always, I strongly urge all residents who are not members of CAEP, to join, so we can put forth our views and problems.

Dr. Paul Assad,
Chairman, Resident Committee

Prehospital Care and You

Prehospital Care and You

Which branch of medicine is responsible for prehospital care? "Emergency Medicine of course," you say. "There should be no doubt about that in the minds of anyone!" That message may be clear enough to us, who are primarily concerned with emergency practice, but is it really that clear to the rest of the medical profession, or to the general public? The answer is that it may not be anywhere near as clear as we think it is.

Last April CAEP demonstrated its interest in this field by establishing a Prehospital Care Committee. In effect, CAEP was laying its claim to this relatively uncharted piece of medical territory.

There have been other developments on the national scene as well.

Approximately a year and a half ago, the Canadian Medical Association under its Allied Medical Education Branch, established an ad hoc committee to review and set standards for prehospital care on a national level. Attending the first meeting were an assortment of emergency physicians, other medical practitioners, ambulance workers and educators.

The first job of the committee was to survey the existing situation, which was in quite a mess. Standards varied from minimal or no first aid training at all in the Maritimes, to sophisticated advanced life support services in British Columbia, and anything and everything in between in other parts of the country. What kind of care one gets before arriving in the hospital is still a "Rushing Roulette" as ably described by Scanlan (Canadian Family Physician, February 1976).

Next, the committee had to define its own objective. There is lots of precedent here for the CMA already maintains conjoint accreditation with several other allied medical disciplines. The intent is to standardize the schools that actually do the training by establishing an accreditation process, in the same way that the quality of medical schools is standardized by a similar accreditation process.

The next step was to establish the three levels of training that would be accepted by the accreditation committee. Level I is a basic 150 hour standard advanced first aid course. Level II is an intermediate "paramedic" course allowing the use of a few invasive procedures such as IV therapy and MAST trousers. Level III is a full advanced life support course, leading to endotracheal intubation, advanced drug therapy, and other procedures similar to programs already in place in B.C. and in some regions of Alberta.

But how will accreditation actually improve prehospital care? To begin with it must be recognized that the committee has no legal clout. We cannot hammer people's heads and demand that they clean-up their act. But we do carry the prestige of the CMA. Accreditation must by its nature be a voluntary process, but it will be a safe bet to expect a large bandwagon effect.

There are two essential target groups. The first are areas such as Quebec and the Maritimes that have next to no training standards at the present time. Without something concrete and credible to point to, these areas don't stand a chance to convince politicians to open up their wallets. Nationally accepted standards with CMA approval will give them something very concrete and, I hope very credible to argue with. The second target groups are large urban centres with lots of resources and good basic services who are unable to convince legislators to make the necessary step into advanced life support. Again, a nationally accepted standard, especially one approved by CMA, can make the difference in these situations between a yes and a no.

But what does this all have to do with CAEP? Now that the CMA Committee has been formally accepted by the CMA General Assembly, we are in the process of formalizing our relationships. At issue are the questions "What medical body will control the functions of the committee?" and "To what branch of the CMA will the committee be required to relate?" The answer "to Emergency Medicine and to CAEP" does not automatically spring to the lips of most of the people who will actually be making these decisions. And yet, to my own mind, any other answer would be unthinkable.

So how do we ensure that CAEP will continue to play a leading role in prehospital care in the future? First, on a national level, CAEP must lobby and work to keep control of the body for national accreditation. Secondly, it remains the responsibility of individual emergency physicians to establish a higher profile in prehospital care by:

a) teaching EMS workers
b) involvement in community and public awareness programs.
c) using the influence of local organizations to lobby governments, medical associations and public service groups about the need to act together to improve prehospital care.

I don't think I need to talk here about statistics, about the number of lives that could be saved by an effective EMS. There is no need to tell the gruesome stories about needless deaths caused by lack of public and EMS worker education. These are already part of our daily work and part of our professional consciousness.

This is a time when our executive is putting a lot of effort and care into fostering our proper growth into a recognized specialty. We need to solidify our credibility with the rest of the medical profession if we are to avoid becoming a second rate specialty. Prehospital care is a new field with increasing future importance. It needs to be recognized as the exclusive domain of the emergency physicians. Unless this occurs, prehospital care will clearly suffer, because no other medical group is as close to it as we are, and no other medical group is likely to maintain the kind of interest in it that comes naturally to us.

The truth is that prehospital care needs Emergency Medicine to prosper and to grow, and just as much in its own way, Emergency Medicine needs prehospital care.

Les Vertesi, M.D.
Chairman, Prehospital Care Committee

The effect of neck immobilizers on the cervical spine curve

By Charles C. Johnston, M.D.* and Peter E. Doris, M.D.†

Abstract

The effect of neck immobilizers on cervical spine curve was evaluated in this study. Cross table lateral radiographs were obtained of ten normal subjects in the neutral position and while wearing three commonly used immobilizers. In five of the ten subjects, immobilizers altered the cervical spine curve.

Introduction

Emergency medicine physicians and radiologists routinely scrutinize lateral cervical spine radiographs for the "normal lordotic curve."[1-4] The presence of a smooth convex curve is generally considered an indirect sign that there is no unstable boney nor ligamentous injury. Straightening of the lordotic curve is often interpreted as abnormal, indicating muscle spasm or even critical boney and ligamentous injury.[2,5,6] It is well established, however, that a significant percentage of normal subjects have a straightened cervical spine on the standard upright lateral radiograph.[1,3,5]

Acutely traumatized patients are usually first evaluated with a cross-table lateral radiograph while wearing a neck immobilizer. To our knowledge, there are no studies of the incidence of cervical spine straightening in normal subjects under these conditions. The purpose of this study is to investigate the effect of three commonly used neck immobilizers on the cervical spine curve of normal subjects as demonstrated by cross-table lateral radiographs.

Materials and Methods

Ten male hospital personnel, including the authors, were used as subjects. Their ages ranged from nineteen to thirty-six, and none had a history of cervical spine injury nor symptoms. The subjects were shielded with a lead apron and the x-ray beam was closely collimated. Cross-table lateral films of the cervical spine were then taken. The film-beam distance was fifty-two centimeters. Four radiographs were taken of each subject: neutral positions without collar, wearing a plastic reinforced collar, wearing a four poster brace, and wearing a SOMI* brace *(Figures 1 and 2)*. The subjects were fitted carefully with each of the neck immobilizers by a trained emergency medicine physician. Care was taken to provide optimal immobilization without abnormal stress.

Results

Two subjects had straightening of the cervical spine in the neutral position *(Table 1, Subjects 9 and 10)*.

Five subjects had normal lordosis in the neutral position and while wearing each of the immobilizers.

The cervical curve of the other five subjects was altered by the immobilizers *(Table 1, Figure 3-5)*. Three subjects had straightening of the cervical spine while wearing the SOMI brace or the four poster brace. Two subjects, who had straightening of the cervical spine in the neutral position, had a normal lordosis while wearing the SOMI brace and the four poster brace.

True subluxation of the vertebrae was not demonstrated in this study.

Discussion

Several studies report ten to twenty percent of the subjects with no history of cervical spine disorder have straightening of the cervical spine on standard upright lateral radiographs.[2,8] Our series indicates subjects in the supine position for cross-table lateral radiographs have a similar incidence of straightening.

Neck immobilizers may alter the cervical spine curve by tilting the head. Previous studies indicate slight lowering of the chin will cause straightening of the cervical spine in many normal subjects.[2,3,8] Elevation of the chin and slight extension of the neck produce a normal cervical lordosis in most subjects who have a straightened cervical spine in the neutral position.[3]

Summary

The effects of the immobilizers on the cervical spine curve are variable. Immobilizers may cause: 1.) no change 2.) straightening of a normally curved cervical spine. 3.) "correction" of the curve of an initially straight cervical spine. Subluxation was not observed.

Acknowledgements

We wish to express our appreciation to Good Samaritan Hospital and Martin Hochhauser, M.D. for support of this study. We thank Sandra Gladd, R.T.; Paul Gaebel, B.S.; and Barbara Weitzer for technical assistance.

Radiologic Changes in the lordotic curve

Subject	Neutral	Hard Plastic	Four Poster Brace	SOMI Brace
3	NL*	NL	NL	Straightening C_1-C_5*
5	NL*	NL	Slight Straightening C_3-C_5*	Slight Straightening C_3-C_5
6	NL	NL	NL	Slight Straightening C_1-C_4
9	Straightening C_1-C_5*	Straightening C_1-C_5	NL*	NL
10	Straightening C_1-C_3	NL	NL	NL

Table 1: Five subjects had normal cervical lordotic curves in the neutral position and while wearing each of the neck immobilizers. The cervical spine curve of the other five subjects was altered by use of an immobilizer. (*) signify films shown in Figures 3-5.

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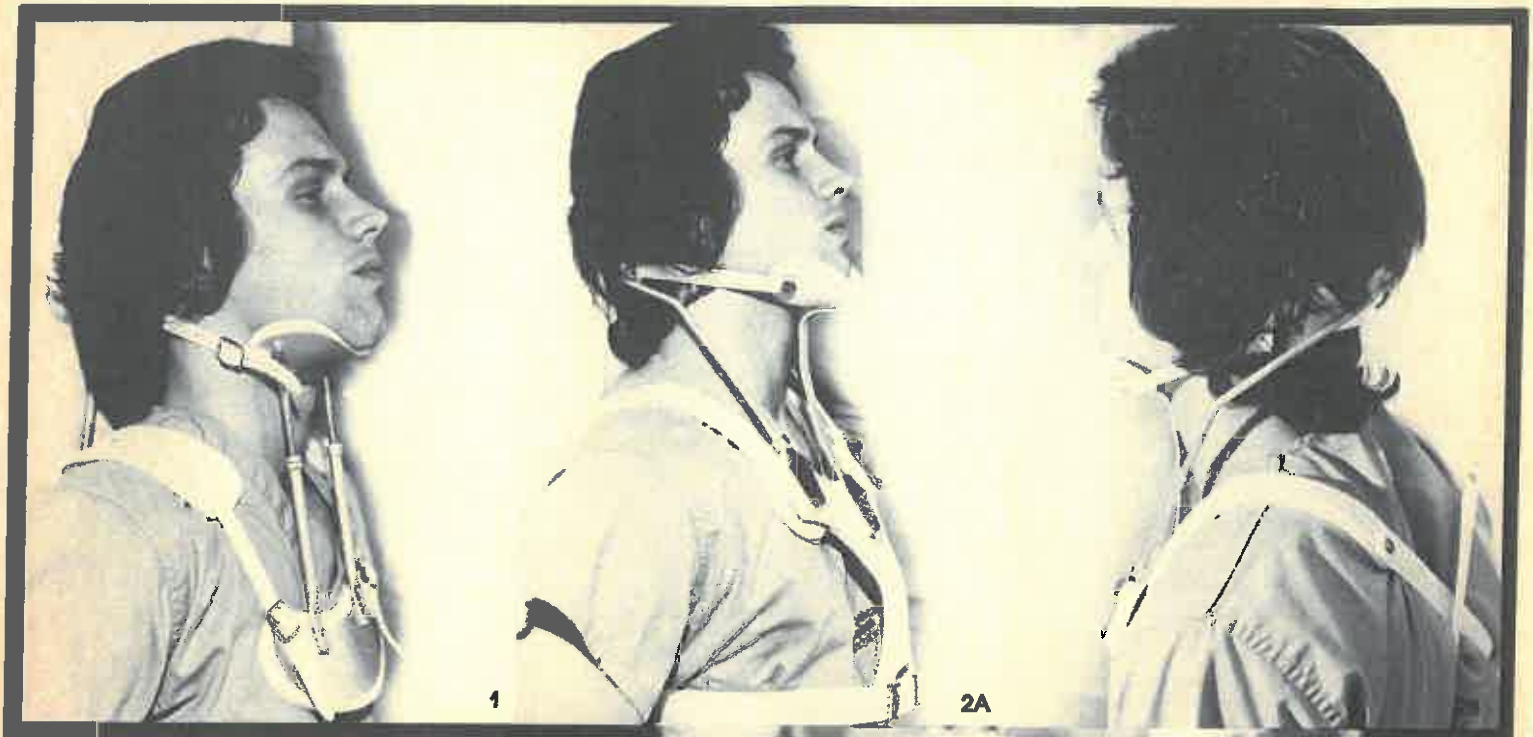
*sternal occipital mandibular immobilization

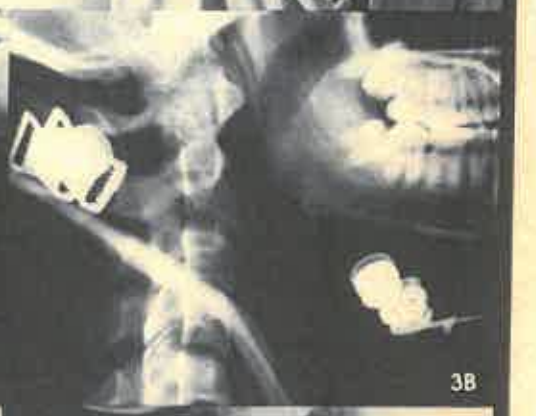


1

2A

Fig. 1 Four poster brace.
Fig. 2A & 2B SOMI brace.
Fig. 3A Subject 3, neutral position. The lordotic curve is normal.
Fig. 3B Subject 3, SOMI brace. Following the application of a SOMI brace there is straightening of the C-1 through C-5 portion of the spine.
Fig. 4A Subject 5, neutral position. The lordotic curve is normal.
Fig. 4B Subject 5, four poster brace. Following the application of a four poster brace, there is straightening of the C-3 through C-5 portion of the spine.
Fig. 5A Subject 9, neutral position. There is straightening of the C-1 through C-5 portion of the spine.
Fig. 5B Subject 9, four poster brace. Following the application of a four poster brace the lordotic curve is normal.

3A



3B

4A

4B

5A

5B

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Towards Certification

Towards Certification

There have been some recent further developments to the evolution of Emergency Medicine towards a recognized specialty with which I believe the CAEP membership should be familiarized. As many of you remember, a major portion of the development took place through meetings of the Conjoint Committee, which was composed of members from the College of Family Physicians and the Royal College of Physicians and Surgeons. The members tried to achieve the common goal of the establishment of a specialty in Emergency Medicine, recognized conjointly by both Colleges. For a variety of administrative reasons and differences in final goals, the two Colleges have set up separate routes of recognition. The Specialty Committee on Emergency Medicine of the Royal College of Physicians and Surgeons of Canada met in January in Ottawa. The College of Family Physicians Committee will be meeting at the end of March in Toronto. The direction for both is now more clearly defined. The Royal College will be planning a four-year program to train the recognized expert in Emergency Medicine. The requirements will be something along the lines of one year broadbased training, plus three further years in a recognized program in Emergency Medicine. This will lead to an FRCP(C).

The College of Family Physicians of Canada is proceeding to develop a program to train the Family Physician/Emergency Physician. This program will be designed to meet the requirements of physicians interested in upgrading skills in Emergency Medicine for work in an Emergency Department or in a remote area. It should be noted that the CAEP Executive fully supports the efforts of both Colleges to increase the quality of Emergency care delivered to the Canadian public by striving to establish a recognition process. It would now seem that the time of confusion is over and that we are looking at a reasonably clear direction from both Colleges. The Specialty Committee of the Royal College will be meeting again in the Spring to set down the detailed accreditation requirements and training guidelines for Emergency Medicine Training Programs in Canada.

For some time, the issue of practice eligibility is something that has concerned all of us involved in the Certification process. At the moment, it appears that both Colleges are willing to talk about the possibility of practice eligibility. This means criteria in addition to, or outside of training, which will allow a candidate access to the Certification examination. The College of Family Physicians of Canada has discussed the process in terms of numbers of hours spent in Emergency work, plus any special training done by the candidate. The Royal College has discussed the possibility of a point system, whereby certain number of points would be allotted for training, a certain number for experience, a certain number for research, etc.; the minimal point criteria being met, the candidate is allowed to write the exam. It must be emphasized that these decisions are at the discussion level and I do not foresee anything being finalized until late Spring. At that time, we will be in further communication with the CAEP Membership regarding the decisions pertinent to all of the above.

Should any members have concerns regarding the direction in which we are proceeding, we would welcome comments, and I would be pleased to carry them forth to the next committee meeting of either College. Please feel free to direct your concerns to any member of the CAEP Executive, who most certainly would be in touch with me prior to the next set of meetings.

I shall look forward to hearing from you.

Thank you.

G. Powell, M.D.
President-Elect
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CME Calendar

1. VIth International Congress of Emergency Surgery, Brighton, England.
June 7th-10th.

Approved for 21 hours Category 1.
Contact:
Millstream Conferences,
213, Piccadilly,
London, W1V 9LD
or
Carolyn Neal,
Emergency Dept.,
U of A Hospital,
Edmonton, Alta.

2. Post-Graduate Conference on Emergency Medicine, Victoria, B.C.
May 25th-29th.

Approved for 30 hrs. Category 1.
Contact:
Dr. J. C. Maccagno,
Parkside Emergency Physicians,
928 Pandora Avenue,
Victoria, B.C. V8V 3P3

3. Fifth Annual Course on Emergency Management.
Presented by Toronto Western Hospital Emergency Associates.

Approved for 14 hours CAEP. Category 1.
May 2nd & 3rd, 1981
Valhalla Inn, Toronto
Contact:
Emergency Associates,
751 Dundas St. W.,
Toronto, Ont. M6J 1T9

4. Interphase '81, Vancouver.
April 13-16, 1981.

Contact:
Interphase
Box 80900
Burnaby, B.C. V5H 3Y1

Across Canada

Les Médecines d'Urgence au Québec/ Emergency Physicians in Quebec

Dans le présent article, je vais essayer de vous définir où en est rendue la médecine d'Urgence au Québec, et pour décrire les médecins qui font de la médecine d'Urgence leur principale occupation, j'emploierai le terme urgentologue, même si ce terme n'est pas encore officiellement accepté.

Historique

Comme partout ailleurs en Amérique du Nord, la médecine d'Urgence au Québec a pris naissance dans un besoin.

Alors que la médecine en général faisait des progrès effarants, les soins de première ligne n'étaient, il y a encore peu de temps de cela, assurés que par des internes ou résidents; ce qui amenait une qualité de soins très inégale vue l'absence totale d'expérience de ces médecins face aux situations à affronter.

Je suis encore très étonné de la longue période de temps que l'on ait pris à réagir. Pour le patient qui présentait un problème urgent, il s'agissait presque pour lui de jouer à la "roulette russe". Sa survie dépendait 1) de l'endroit de la province où son problème survenait, 2) du moment de la journée, 3) du niveau où en était rendu l'étudiant sur lequel il échouait. Si le pauvre bougre par exemple, avait un accident d'auto dans la partie nord de Montréal où les hôpitaux n'avaient souvent pas de résidents, et que son accident survenait durant la nuit, il risquait d'être traité par un interne qui en était à son premier stage de l'année. Alors, imaginez un peu les chances minimes qu'il avait de s'en sortir.

Qu'est-ce qui a amené l'apparition de la médecine d'urgence? Une prise de conscience de certains médecins? Les poursuites légales de plus en plus fréquentes? L'afflux grandissant de patients dans les salles d'urgence causé par l'apparition de l'Assurance-Santé? L'accroissement des connaissances médicales dans la population en général, rendant le client plus exigeant?

Pour nous au Québec, les 4 facteurs mentionnés ci-haut ont eu un rôle à jouer.

Les premiers médecins au Québec à faire de leur principale occupation la médecine d'urgence furent ceux du Centre Hospitalier de l'Université Laval à Québec. Ce Centre Hospitalier qui a pris naissance en 1969 avait des idéaux très élevés. On a confié la salle d'urgence à de jeunes omnipraticiens qui acceptaient d'y travailler à plein temps à salaire, et d'y développer une compétence particulière.

Peu de temps après, en 1970, je formai un groupe semblable à l'Hôpital du Sacre-Cœur de Cartierville. Le mode rémunération était cependant à l'acte et les revenus étaient redistribués selon un système de pool intégral. Ce groupe qui était au début de 6 médecins a eu une croissance constante pour se stabiliser à 12.

Par la suite plusieurs autres groupes se sont formés un peu partout dans la Province. Dans les années 1971, le Dr. Monaghan au nom de l'Université McGill mit en place la première et seule résidence en médecine d'urgence au Québec à l'Hôpital Royal-Victoria.

Clientèle

A cause de l'Assurance-Santé, il y a eu lors des premières années un nombre très important de cas non urgents qui se présentaient dans les salles d'urgence.

Ce nombre de cas non urgents a diminué de façon importante lors des dernières années. Les facteurs responsables sont l'augmentation du rapport médecin/population (ce qui rendait le médecin plus disponible), la formation de nombreuses cliniques privées regroupant plusieurs médecins et offrant des consultations sans rendez-vous, la surcharge importante des salles d'urgence due au manque de disponibilité pour hospitaliser les patients.

Lors des 10 dernières années il y a eu 2 lois qui firent disparaître instantanément 2 catégories de patients plus ou moins désirables. Ces lois furent: la ceinture de sécurité obligatoire et la disparition des dérivés de la dexédrine sur le marché des médicaments. Ces deux catégories de patients à disparaître furent 1) Les patients impliqués dans un accident à vitesse moyenne et présentant d'importantes plaies au visage et au cuir chevelu. 2) Les intoxiqués aux stimulants (speed). Ces deux catégories de patients étaient très accaparants, les premiers pour les médecins, et les derniers pour le personnel médical.

Une nouvelle catégorie de patients a cependant fait son apparition lors des 5 dernières années, et ce sont les cas dits de "dumping", c'est-à-dire, patients âgés que la famille ne veut plus prendre en charge, et que l'on amène à l'urgence vue la non disponibilité immédiate de foyers pour ces vieillards. Comme les médecins spécialistes ne veulent pas prendre en charge ces patients qui ne nécessitent pas de soins spécialisés, ils demeurent souvent à l'urgence pour des périodes prolongées allant jusqu'à 3 mois. C'est présentement la plus important problème des salles d'urgence au Québec, en général.

Genre de pratique

La façon dont s'opère la médecine d'urgence au Québec varie beaucoup. A certains endroits le médecin "urgentologue" donne tous les soins de première ligne et réclame l'aide du médecin consultant lorsqu'une admission est nécessaire pour préciser le diagnostic ou continuer le traitement. Une consultation est aussi demandée pour traiter les problèmes complexes tels que sections tendineuses ou fractures compliquées. Cependent, dans plusieurs hôpitaux, on limite le champ d'activité aux problèmes médicaux, et les chirurgines, c'est-à-dire souvent internes et résidents, donnent les soins de première ligne aux patients présentant un problème de nature chirurgicale. Cette pratique a évidemment pour fondement des considarations d'ordre monétaire, et n'a libre cours qu'à cause du manque d'expérience et de diplômes des urgentologues qui ne peuvent démontrer la supériorité de leur connaissance dans le domaine en cause. C'est une des raisons principales pour laquelle la médecine d'urgence progresse si lentement au Québec, et

qu'un nombre important de médecins se sont laissés décourager après un certain temps. Il est malheureux de constater que le mesquinerie de certains de nos confrères empêchent la progression de ce champ de compétence qui sérait sûrement bénéfique au patient et au renom de la médecine en général.

Enseignement

Seule l'Hôpital Royal-Victoria a une résidence en médecine d'urgence. Cependant plusieurs médecins de salle d'urgence sont chargés d'enseignement et affiliés à une Université.
L'enseignement se donne au niveau de l'externat, de l'internat rotatoire, de la résidence an médecine familiale et de l'enseignement continue aux omnipracticiens.

Certains urgentologues opèrent aussi à d'autres niveaux tels que le BCLS, ACLS, enseignements aux ambulanciers et étudiants en médecine des premières années. Par example, les médecins de notre salle d'urgence (Hôpital du Sacré-Cœur de Cartierville) donnent depuis plus de 5 ans un cours de premiers soins (initiation à la médecine d'urgence) aux étudiants en 2ème année de l'Université de Montréal.

Implication et rapports avec les différents organismes officiels

Il est malheureux de constater qu'au Québec, même si plusieurs urgentologues pratiquent depuis plus de 10 ans, tout effort pour avoir une action concertée a jusqu'à date, échoué.

Un peut probablement invoquer les distances qui séparent les différents groupes, la barrière de langue, les problèmes que chaque groupe doit affronter pour survivre dans son propre hôpital, les horaires très disparates (nuits et fins de semaine) qui rendent les rencontres très difficiles.

Il y a aussi l'opposition recontrée de la part ce certains de nos représentants. Il est à noter par exemple, que notre syndicat (FMOQ) s'est toujours radicalement opposé aux urgentologues sous prétexte que ce rôle revenait aux omnipracticiens en général et qu'il ne devait pas y avoir de domaines particuliers en pratique générale. Ils sont même venus saboter en 1972 par leur intervention une tentative pour former que association des "urgentologues" à Québec. Lors des négociations il y a 4 ans, il nous ont désavantagé au niveau des tarfis de telle sorte que plusieurs médecins se désintéressèrent de la médecine d'urgence pour des raisons monétaires.

En ce qui a trait aux Universités, la réaction est très variés. A McGill et Laval, les urentologues sont bien acceptés. A Montréal c'est différent. On les utiles de façon importante dans l'ensignement mais on refuse de reconnaître officiellement leur existence.

Du côté de la Corporation professionnelle les rapports sont très bons, et c'est de là que nous viennent les plus grandes leurs d'espoir. La Corporation a nommé récemment un comité dont font partie plusieurs urgentologues. Ce comité est chargé d'étudier la distribution des soins d'urgence à tous les niveaux; ambulances, médecins, etc. . . . et il semble inévitable que les conclusions de ce comité vont favoriser notre implantation.

Il y a eu formatin en 1971 d'un chapitre québecois de l'ACEP, mais le manque d'intérêt des membres a forcé l'abolition de ce chapitre qui ne répondait pas aux aspirations de ses membres.

Lorsque l'ACMU s'est formée il y a 2 ans, il y a au méfiance de la part de nos urgentologues québecois vue l'echec des précédentes tenatatives d'association, mais il y a présentement un renouveau d'intérêt et la vigueur de cette nouvelle association pourra possiblement rallier nos suffrages, ce qui permettrait enfin de nous regrouper et d'unir nos actions et efforts.

Conclusion

La Médecine d'Urgence au Québec a passé l'épreuve du temps, (plus de 10 ans) et je crois qu'elle y est pour y demeurer. Le plus dur demeure cependant à faire: implantation de ce système dans tous les hôpitaux importants, diplôme quelquonque assurant un critère de qualité de la part des médecins pratiquant la médecine d'urgence et surtout reconnaissance officielle par nos pairs.

Un des premiers projets à accomplir est à mon point de vue d'implanter une résidence en médecine d'urgence dans une des Universités francophones. Il est aussi urgent à mon point de vue d'obtenir dans le plus bref délai, une forme de certification quelquonque afin d'assurer à la population au moins dans les plus grands hôpitaux une standardisation de la qualité des soins donnés par les médecins.

Robert Fortier, MD
Chef de service,
de Médecine d'Urgence,
Hôpital du Sacré-Cœur de Cartierville

The Book Shelf

Flint's "Emergency Treatment and Management"

— 6th Edition, Editor Harvey D. Kane, 844 pages. W. B. Saunders, Toronto, 1980.

This almost pocket sized (5½" x 8" x 1¾") compendium is an excellent reference volume for all health professionals. Its format is problem oriented and succeeds in touching on (to a greater or lesser extent) almost every situation with which Emergency Department personnel would have to deal. The discussions are practical and clearly laid out without verbosity, and deal with assessment and management in a sensible and realistic order.

Little space is given to aetiologic or physiologic considerations which improves the clarity of the entries but it is unfortunate that no up-to-date bibliography is included for more detailed reference.

The central section of the book comprises a 180 page index of pharmocologic, industrial, botanical, and household toxicology which includes many common compounds which are rarely presented in such an easily accessible manner in other texts.

The treatment of surgical techniques is frequently too brief and includes some methods which would be considered not preferable by many surgeons but does include many helpful "tricks" which many would find welcome.

There are extensive sections on medico-legal matters and pages of samples of official forms which are only applicable to physicians who practice in California and this space may have been better devoted to discussions of more general interest such as disaster management which is given quite short shrift.

This text can be recommended for its portability and ease of use as a reference and would run the risk of being "borrowed indefinitely" as a compliment to its clarity.
K. P. Siren, M.D., CCFP

The CAEP Review will review as many of the books submitted by members or publishers as is possible, provided the subject matter is deemed relevant to Emergency Physicians. Opinions are solely those of the reviewers.

Scientific Assembly '81

Introduction

We are delighted to invite you to the Canadian Association of Emergency Physicians second annual scientific assembly to be held in Montreal, October 12 until the 16, 1981.

The Assembly has been designed to meet the Educational needs of all Physicians practicing Emergency Medicine by offering a wide selection of in-depth workshops, comprehensive plenary sessions and presentation of original research papers.

Current concepts and methods important to Emergency Care shall be presented by a Faculty which has been chosen because of its expertise and sensitivity to the needs of the Emergency Physician and patient.

You shall have the opportunity of choosing between 25 (3 hr.) workshops, 14 (1 hr.) plenary sessions and 3 hours of original scientific presentation. An Advanced Cardiac Life Support Course is also offered prior to the meeting. (12-13th)

All this is in lovely Montreal during the colorful autumn season.

Place

Montreal has its own special character in being the only major cosmopolitan French city on the continent and the second largest French city in the world

The Meridien is an Air France Hotel that has nestled itself in the centre of Montreal life — within walking distance of Old Montreal and the heart of the business and fashionable shopping areas. The hotel itself is part of a unique complex of buildings housing many restaurants and shops.

Come savour the difference

General Information

Registration:
Total registration shall be limited in order not to distract from the meetings (learning) teaching potential. You are encouraged to register early in order to guarantee attendance and first choices of workshops. See Registration form with this Flyer.

All participants are asked to wear the Canadian Association of Emergency Physicians 1981 Meeting Badges during attendance at teaching sessions and meals.

Choice of Workshops:
Each participant is guaranteed attendance at 3 half days of workshops and 3 half days of plenary sessions. The workshop attendance is retricted in number and the choice of workshops will be alloted on a first come first serve basis. Participants who choose to attend all plenary sessions will be able to do so. Pre-registration with the included form is necessary for attendance to all workshops. **NOTE:** The three Infectious Disease workshops should be attended sequentially.

Advanced Cardiac Life Support:
An Advanced Cardiac Life Support Course is offered prior to the conference, October 12 and 13th, 8:00 until 17:00. The course will take place on the hotel premises. REGISTRATION IS LIMITED TO 50. Dr. Michel Tetreault is the course Co-ordinator.

Cancellations:
Cancellations prior to September 15th shall be refunded minus 15% for service fee. Requests for cancellation received after October 5th, will receive **no** refund.

Accreditation:
17 hours Category I Canadian Association of Emergency Physicians credits granted. Application has been made for accreditation by American College of Emergency Physicians, College of Family Physicians of Canada, American Medical Association, and Fédération Médecins Omnipraticiens du Québec.

Accommodations:
A block of rooms has been reserved at the Meridien Hotel where all courses will be. Please register directly with the Meridien Hotel. Special rates are available as Canadian Association of Emergency Physicians participants. Requests for accommodation after September 1st cannot be assured. Montreal has a busy convention year in 1981. Register early! Tel: (514) 285-1450.

Conference Activities:
A Banquet on Thursday, October 15th is included with your registration fee as are all the noon meals and coffee breaks. Registrants shall receive further detail concerning the abundant and varied culinary and socio-cultural activities available in Montreal during the conference.

Spouses-Guest Program
A program tailored to the interest of the spouses and guests of registrants shall be available. Further information will be provided to the registrants prior to the meeting.

Program Chairman:
Dr. Wayne Smith
Royal Victoria Hospital
Montreal, Quebec

CAEP General Meeting will be held Wednesday evening for all members, where discussion of 1981 and 82's activities shall be entertained.

à Bientot

REGISTRATION FORM

Name:

City:

Telephone—Bus: Home:

Address:

Prov./State:

Postal/Zip Code:

Fees:

CAEP Member	$ 225
Non-Member	$ 300
Resident*	$ 150
ACLS	$ 150
Additional Banquet Ticket	$ 30
Total Submitted	$

Workshop Choices:

Please put Workshop Number in Squares

Choice	1st	2nd	3rd	4th	5th
14th AM					
PM					
15th AM					
PM					
16th AM					
PM					

Make cheques payable to CAEP Emergency Care 1981. Registration guaranteed on payment in full.
*Must provide letter from Dean or Residency Director.

ROOM RESERVATION

Meridien Hotel

Name:

Address:

City:

Arrival:

Time:

Departure:

CAEP 2nd Annual Scientific Assembly
October 14 - 16th 1981
Montreal, Quebec

Rates:

Single Occupation	$56
Double Occupancy	$68

Cut off date September 1, 1981
Suites 1 Bedroom and salon/suites 2 Bedrooms and salon/rates on request.
First night deposit required for first night reservation. Make your cheque payable to Hotel Meridien, Montreal.

October 12-13 ACLS Course

Plenary Sessions

October 14th

Chairman — Dr. W. Smith
8:15 Introduction — Dr. D. Walker
8:30 Infectious Diseases in the Emergency Department — Dr. A. Klainer
9:30 Toxicology — Dr. N. Eade
Coffee-Break
10:45 Headache Management in the Emergency Department — Dr. A. Hakim
Lunch
Chairman — Dr. G. Powell
13:30 Management of the "Hot Joint" — Dr. K. Osterland
14:30 New Acute Care Cardiac Drugs — Dr. S. Magder
Coffee-Break
15:45 Pediatric Trauma — Dr. M. Wayne
19:00 CAEP General Meeting
P.M. the 13th No Host Bar

October 15th

Chairman — Dr. D. Walker
8:30-11:30 Scientific Presentations.
Lunch
Chairman — Dr. P. Lane
13:30 Respiratory Failure — Dr. P. Macklem
14:30 Decision Making in Chest Pain — Dr. M. McGregor
Coffee-Break
15:45 Review of Trauma Management — Dr. W. Ghent
19:00 Cocktails
20:00 Banquet

October 16th

Chairman — Dr. R. Gerace
8:30-10:20 The Approach to the "Dizzy" Patient
Presentations and Panel Discussion: Drs. Aube, Katsarkas, Stubington.
Coffee-Break
10:45 The "Occult" Acute Abdomen — Dr. A. Spanier
Lunch
Chairman — Dr. A. Scholtz
13:30 EMS and You — Dr. L. Vertesi
14:30 Medicolegal Aspects of Emergency Care — Maitre Paul Bisaillon

Workshops

October 14th 8:30-11:30 A.M.

Workshop Number
1. Radiology of the Chest for Emergency Physicians — Dr. A. Palayew
2. Occular Emergencies — Dr. Nicolle
3. Care of the Critically Ill — Dr. A. Spanier
4. Seizures: Their Management — Dr. I. Woods
5. Athletic Injuries — Dr. B. Costello — Ms. Dalzell

P.M. 13:30-16:30
6. X-Rays of the Abdomen — Dr. L. Stein
7. Infectious Diseases I — Dr. A. Klainer
8. Neuro-Surgical Emergencies — Dr. J. G. Villemure
9. Environmental Emergencies — Dr. P. Vaktor
10. Endocrine Emergencies — Dr. S. Cruess, Dr. Y. Patel, Dr. D. Goltzman

October 15th 8:30-11:30 A.M.
11. Neuro-Radiology and the Emergency Department — Dr. Ethier
12. Arrhythmia Management — Dr. J. Lemire
13. Toxicology I — Dr. N. Eade
14. Infectious Diseases II — Dr. A. Klainer
15. Stroke: Assessment and Management — Dr. Bass

P.M. 13:30-16:30
16. Pediatric Emergency Radiology — Dr. Nogrady
17. Infectious Diseases III — Dr. A. Klainer
18. Coma: Assessment, Treatment and Prognosis — Dr. A. Hakim
19. Trauma Management — Dr. M. Wayne
20. Toxicology II — Dr. N. Eade

October 16th 8:30-11:30 A.M.
21. Facial and Extremity X-Rays — Dr. Dumas
22. Pediatric Emergencies — Dr. N. Steinmetz
23. Clinical Procedures in the Emergency Department — Dr. G. Powell
24. Hand Injuries — Dr. Gaston Schwartz
25. EMS Planning and Management — Dr. L. Vertesi

Faculty

Dr. Michel Aube, Neurologist, Montreal Neurological Institute, Assistant Professor, McGill University

Dr. Bass, Neurologist, Jewish General Hospital; Assistant Professor, McGill University

Dr. B. Costello, Othopedic Surgeon, Co-director Trauma Service, Royal Victoria Hospital; Assistant Professor McGill University

Dr. S. Cruess, Endocrinologist, Director of Professional Services, Royal Victoria Hospital; Associate Professor, McGill University

Ms. M. Dalzell, Physiotherapist, Dept. of Physiotherpay, Royal Vitoria Hospital

Dr. J. M. Dumas, Radiologist, Royal Victoria Hospital, Assistant Professor, McGill University

Dr. N. Eade, Director Poison Control Center, Montreal Children's Hospital; Assistant Professor, Dept of Pharmacology, Assistant Professor Dept. of Pediatrics, McGill University

Dr. E. Ethier, Radiologist-in-Chief, Montreal Neurological Hospital; Professor, McGill University

Dr. D. Goltzman, Endocrinologist, Royal Victoria Hospital, Assistant Physician, Associate Professor, McGill University

Dr. W. Ghent, Surgeon, Hotel Dieu Hospital, Kingston; Professor, Queen's University

Dr. A. Hakim, Neurologist, Montreal Neurological Hospital; Lecturer Neurology, Neurosurgery, McGill University

Dr. A. Katsarkas, Otolaryngologist, Director Dizziness Clinic, Royal Victoria Hospital, Associate Professor, McGill University

Dr. A. Klainer, Chairman Dept of Internal Medicine, Morristown Memorial Hospital; Professor, Columbia University

Dr. J. Lemire, Chairman of Cardiology, Notre Dame Hospital, Assistant Professor McGill University, Associate Professor, University of Montreal

Dr. S. Magder, Cardiologist, Royal Victoria Hospital, McGill University

Dr. P. Macklem, Physician-in-Chief, Royal Victoria Hospital; Chairman & Pofessor, Department of Medicine, McGill University

Dr. M. McGregor, Cardiologist, Royal Victoria Hospital; Professor, McGill University

Dr. A. Nicolle, Ophthalmologist, Royal Victoria Hospital, Assistant Professor, McGill University

Dr. Nogrady, Radiologist-in-Chief, Montreal Children's Hospital, McGill University

Dr. K. Osterland, Director of Immunology and Rheumatology, Royal Victoria Hospital, Professor, McGill University

Dr. J. Palayew, Radiologist-in-Chief, Jewish General Hospital; Professor and Chairman of Radiology, McGill University

Dr. Patel, Endocrinologist, Royal Victoria Hospital, McGill University

Dr. G. Powell, Chief of Emergency, Foothills Hospital, Assistant Professor, Calgary University

Dr. G. Schwartz, Plastic Surgeon, Royal Victoria Hospital, Assistant Professor, McGill University

Dr. A. Spanier, Surgeon, Director of ICU Jewish General Hospital, McGill University

Dr. L. Stein, Director of Diagnostic Radiology, Royal Victoria Hospital, Associate Professor, McGill University

Dr. N. Steinmetz, Assistant Physician-in-Chief, Montreal Children's Hospital; Assistant Professor, McGill University

Dr. D. Stubington, Chairman of Cardiology Royal Victoria Hospital; Professor McGill University

Dr. P. Vaktor, Emergency Physician, Royal Victoria Hospital; Lecturer, McGill University

Dr. L. Vertesi, Emergency Physician, Royal Columbia Hospital; Vancouver, Medical director ALS Program, B.C.

Dr. J. G. Villemure, Neurosurgeon, Montreal Neurological Hospital, Assistant Professor, McGill University

Dr. M. Wayne, Medical Director EMS Bellingham, Washington, U.S., National Faculty, Advanced Trauma Life Support

Dr. I. Woods, Neurologist, Montreal Neurological Hospital, Assistant Professor, McGill University

The First Annual Roads Lecture

Time and Trauma

By: W. R. Ghent, M.D., F.R.C.S.(C), F.A.C.S.

The honour of the first recipient of a lectureship in any field of endeavour is doubly blessed. First that person may bask in the glow untrammeled by the eloquence of lecturers that have preceded him or her to the dais. Secondly, the initial lecturer has the prime opportunity to present an historical review of the subject to set the stage for more learned and scientific endeavours in the future.

I have been unduly honoured and I am grateful to the Roads Club for this opportunity to expound upon my interest of the past quarter century to such a nice audience in such pleasant surroundings in B.C. In spite of these surroundings, I feel that we must presume, all too sadly, that trauma with its attendant injuries and the sudden death syndrome will remain part and parcel of human existence.

The traumatic experience is many things to many people; the appearance of acne on the unblemished face of a teen-ager, the broken bone of an athlete, the sudden crib-death, the everlasting and increasingly numerous acts of violence and mishaps related to every possible activity which all too often ends the life of the victim, and forever alters the lives of the survivors.

The results of the hostile and traumatic environment in which we live our allotted years in this 20th century, are seen daily in our morgues and in our Emergency Departments — the results of automobile accidents, recreational accidents, home accidents, industrial accidents, farm accidents, murder, and suicide. Numbers when attached to these individual tragedies are impressive indeed. The automobile alone, and our passion for travel, drunk or sober, in the past ¾ of a century has killed at least 10 million people and has affected by injury another 500 million people. By these standards, warfare is hard-pressed in competition. Six thousand young men were killed in Viet Nam in one year and this sparked protest marches in Washington. There were no protest marches for the 25 thousand young people of the same age group that died on the highways of the United States in that same year.

Fifty American hostages in Tehran held universal attention and front page headlines at the turn of this decade. *567 Americans* died by motor vehicle violence on Christmas week-end in 1979, and their plight rated only a fourth page column in the newspapers. Is it familiarity or repetition that allows this luxury of indifference that afflicts the western world?

Most of us in Europe and North America grow up to regard health and the three score years and ten as the natural state of man; disease and accident as the unnatural. Theologians, philosophers, and thinking persons past and present, have devoted centuries of anxious thought trying to explain to themselves and to others why their own particular deity or belief at times, seem to have adopted arbitrary, unfair, and cruel forms of retribution to visit individuals, or even whole eras of human existence.

Two of the greatest traumatic *experiences* suffered by man — the Black Death, and the Nazi Holocaust are worthy recall. Survivors of either event could discover no Divine purpose in the pain that had been suffered. Disasters of such magnitude seemed to indicate that the absolutes of a fixed order were loosed from their moorings.

The first even ended the age of submission, a turn to individual conscience, schism for the church, and the unrecognized beginning of modern society. The second event, the Holocaust, sent Jewish scholars scurrying to re-examine their law in order to explain the sudden blindness of their God.

Individual traumas, or traumatic experiences involving millions and altering history — are they accidents of circumstance, or evolutionary expedients which have been exploited by nature to enable the fittest to survive?

I will, in the next few minutes, conduct you on a short pilgrimage through the Great Ages of Man. It will be a pilgrimage in the sense of a journey of devotion by medical science. Long strides were made by a few, but there was also much backsliding. At times, in a perusal of the surgical literature of the past, one must doubt if the human mind could be regarded as our greatest resource.

Ancient Section

So God created man in his own image, male and female created he them — and eventually two sons were born, Cain and Abel, and it came to pass when they were in the field that Cain rose up against Abel his brother and slew him. *Genesis* — the beginning. Man and trauma synonymous — whether premeditated or accidental.

Anthropological evidence shows that hundreds of people survived blows to the skull, thanks to the skill of the Neolithic surgeon and his trusty flint. The operation they practiced became known thousands of years later as Trepanning. The operation itself did not change for centuries, but the indication for it changed profoundly. Trepanning remains the earliest surgical operation of which any evidence remains.

The most striking example of longevity of any medical treatment, in use for over 5000 years and practised by both the Chinese and the Stone Age Man, was acupuncture. The idea probably comes from the same stable as Trepanning, the design simply being to release pent-up forces in the body.

There are few references in the literature to surgical techniques in the Summerian and Babylonian civilizations. The Egyptian civilizations on the other hand, left considerable information of interest. One papyrus roll discovered in Luxor in 1872, describes the work of a surgeon familiar with the concept of "Triage". The same papyrus recognized aneurysms as a result of injury, and goes on to mention 48 other injuries, plus the treatments. Wounds were closed with adhesive plaster, splints were made of wood or linen soaked in glue. There is also very early record of the use of Opium to relieve pain, and red hot cautery to check haemorrhage.

Early Egyptian surgery was of a fairly high order, but later almost was destroyed by mysticism. The Egyptian medical men, in an attempt to make themselves indispensable, ran headlong into the culture of the times — the sorcery of the Pharoahs — and lost. A parallelism is becoming apparent in modern times — as medicine and government do battle for the right to treat the sick.

The Greek cult of Aesculapius probably represented the most successful attempt in history to fuse religion, magic, and nature curing into the service of healing. Aesculapius was deified, and temples sprang up where the sick could come to worship and seek cures. The cult had the great distinction of employing the first and only surgeons to have a death rate which was exactly nil. At the first sign of approaching death, patients were dumped in the woods nearby lest that their deaths in the temple should mar the omnipotent deity of Aesculapius.

First-aid measures were known to primitive man, and were acknowledged as just

that — something to be employed until the magic took over. Pincers of termites to close wounds, poultices, bleeding and herbal remedies were all in use. The Greek medical men set up stalls equipped with advice, sponges, and running water.

It seems heresy to report that the famed Hippocrates had little to offer over the first-aid level. He wrote extensively of treatment for dislocations and broken bones, but knew little anatomy because of laws prohibiting dissection — but in 460 B.C. water and instruments were boiled and the surgeon's hands and nails were to be kept clean. It took a Lister 2000 years to rediscover this most important of surgical skills.

Greek surgeons brought their skills to Rome to administer to the wounds suffered by the gladiators and gymnasts. The famous Galen, A.D. 131, learned much of his craft on the battered bodies of gladiators. This honour was granted to him after he had devised a successful dressing for ruptured tendons, nerves, and gut.

The Romans viewed medicine as the province of slaves — but by the time of Caesar's legions there were *soldier-medici* — skilled wound dressers on the field of battle. Indeed valetudinaria, legionary hospitals, were established to which the wounded could be evacuated — always close, the better to return the body to combat.

Renaissance and Modern History

A thousand years of darkness characterized the history of medicine from the fall of Rome until the Renaissance — the interim being dominated by religion and magic, each to greater or lesser degrees as dominance was fought for and won or lost.

Men such as Paracelsus and Vesalius appeared, the first lead to a shiving off of science from Religion and Philosophy, the second published an anatomy text based on dissection — so that by the early 16th century medical science was almost free of external encumbrances and ready to concentrate on fighting among themselves. Onto such a stage walked Ambrose Pare, a barber apprentice, in the year 1510.

Pare became a military surgeon in the endless wars in which France was involved at this period. He learned the fundamentals of his profession on the battlefield. He was a prolific writer, regarded very highly by his contemporaries and made outstanding contributions to the surgery of trauma. He first argued that *gunshot wounds were not poisoned* and did not require cautery with boiling oil, thus reducing the damage by at least 50%. He reintroduced the use of the ligature for control of bleeding in amputations and thus relieved patients of the horror of red hot cautery or boiling oil. In the process it became a safe operation. He also detailed the scope and responsibility of forward field hospitals and used camp prostitutes to wash bandages, when not otherwise engaged. This degree of cleanliness not only would have pleased Hippocrates, but gained Pare notable success in the treatment of the wounded.

Pare took surgery almost as far as it could go without anaesthetics and asepsis. In 1597, however, his was a lonely voice crying in the midst of battles in which the death toll was appallingly high.

The 17th century, though its reputation stands higher because of the stirrings of scientific curiosity, showed little improvement from the patient's point of view. One valuable innovation during this period was the first use of the tourniquet, by the surgeon Morel.

William Harvey was a contemporary, and his explorations of physiology were set in place to form a platform on which scientific medicine could be built.

The 18th century saw the barber surgeons separate from their more academic medical contemporaries. The stethoscope arrived, thanks to the Frenchman Rene Laennec. One Percival Pott described treatments for ruptures of liver, spleen, ovary and bladder. The same man also published a book on *"Injuries to the Head From External Violence"*. His 1768 publication of *"Fractures and Dislocations"* was adopted all over the world. Indeed he was the foremost bone setter of his time. The fracture of the ankle that bears his name always ended in amputation prior to his manipulative reduction doctrine.

Analgesia/Anaesthesia

Civilized man's prolonged failure to find ways to remove or reduce pain presents what is surely the most baffling problem in medical history. Opium, Indian Hemp, and wine were all ancient remedies, but by the 18th century a patient about to be

W R Ghent

operated upon received nothing but brute strength to hold him in place. Finally William Morton, a dentist, successfully administered Nitrous Oxide at an operation in the Massachusetts General, and the reputation of anaesthetics spread rapidly. The reason dentists were so intimately concerned suggests that surgeons were "oncers", they did not expect to see a patient twice due to death or fear, and were not unduly worried about causing pain, but a dentist, to attract and keep patients, had a strong inducement to make his work as painless as possible. Chloroform, through the work of Simpson, an Edinburgh Obstetrician, next gained acceptance. Surgeons were soon using anaesthetics, with spectacular advances in all of the cutting specialties.

The Beginnings of Asepsis

One of the greatest tragedies that a quixotic fate could have devised thus was perpetrated — anaesthesia before asepsis — and it is gloomy to reflect that anaesthesia was accepted more rapidly than asepsis and the shocking rate of death due to sepsis continued and mounted as further inroads into the body were made.

Joseph Lister was born in 1827. He was appointed Regius Professor of Surgery in Edinburgh in 1861. The story of his appointment to this high office deserves some mention. At that time this appointment, of necessity, required not only the approval of the Medical Faculty and the University, but also the approbation of the Council and Mayor of the City of Edinburgh. Lay participation in medical matters is not a new phenomenon by any stretch of the imagination. Lister observed and duly reported that before the discovery of anaesthesia, two out of three patients subjected to operation died of shock or sepsis. After the advent of anaesthesia,

one out of every three died, invariably from infection. The nature of the problem had *almost* been suggested before Lister — as early as the 14th century when Henri de Mondeville insisted that "laudable pus" need not be generated in wounds. Obstetricians had *'noticed'* that clean hands and instruments prevented lying-in fever which was *'probably'* infectious. A measure of proof of this theory was added when a professor in Vienna pricked his finger during a post-mortem on a dead mother and died of blood poisoning. The immediate and simple action of washing one's hands in a solution of Chloride of Lime, as had been suggested by several before, dropped the incidence of death at delivery from 1:6 to 1:100. Thus surgeons slowly relearned the lesson of Hippocrates. It is unfortunate that his oath received more attention than his teachings.

Lister knew of this work and was experiencing similar results with hospital wounds. Louis Pasteur showed this generation that infection was the result of airborne organisms gaining access to wounds. After much experimentation, Lister developed a carbolized-oil for his instruments, and proved Pasteur's principles to be correct.

Asepsis was never defined more succinctly than by an old and very successful Yorkshire veterinary surgeon. Before every operation he performed, he insisted on being left alone in the farm kitchen for half an hour. On his death bed his son begged him to tell the secret of his success. The old man made sure no one else was within earshot, and then whispered to his son, "I boils me tools".

Lister turned his attention to ligatures that were free of organisms. Waxed silk left hanging from the wound until it sloughed out was the order of the day — as was the subsequent infection. After much work, Lister came up with a carbolized catgut ligature which could be knotted, absorbed, and the wound closed. His original shellac dressings were replaced with improved gauze dressings impregnated with an ever-growing series of antiseptics.

Most surgery was still performed for the results of injury, and was always traumatic to all concerned. Lister's laborious but certain proof of the correctness of Pasteur's germ theory and his slow evolution of a preventative antisepsis based on that theory formed a key which would unlock *all* of the body cavities with safety for traumatic and non-traumatic situations. The names of the men credited with these advances and the institutions they made famous are legion. The Austrian, British, French, and American surgeons vied for fame with various technical advances bent on the destruction of diseased tissue with the prevention of a reasonable number of hosts. However, there was still a background cacophony of sound from the mouths of those injured both in peace and war.

The "Medical" Outcome of War

Wars and, to a lesser extent, accidents have at once been a great cause of physical trauma, but also have acted as a potent incentive to ameliorate the terrible injuries resultant. Necessity has been the mother of invention, but it is a sad tale to unfold.

The word casualty is often tossed about with reference to mayhem. I suggest there is no such thing as a "casualty", a cold impersonal non-involving noun. Instead substitute, "the victim was a 20 year old only son", or the victim was "the mother of two young children." These are individual traumas, horrible experiences to individual lives suddenly mutilated or ended, and reflected in the survivors forever.

There is no such thing as *"our glorious dead"*, our *"gallant wounded"*, or our *brave warriors*, three of the great platitudes of war literature. The political end-product of battle is victory or defeat. The surgical outcome is always blood.

The chances of a man surviving his wounds in battle have improved with each war, but the Second World War, 1939 to 1945, was the first war in recorded history in which more men died from enemy action than by disease, or lack of medical attention. Even then, the strategic apects of healing took precedence over the humanitarian aspects — neither side could afford such fearful losses — a higher percentage of the wounded *had to be* returned to the wars.

Transportation of the wounded has been a problem, or no problem, in every war. Hannibal had litters to carry the wounded, Attila the Hun left his wounded to be destroyed by the camp women. The Byzantines in the 9th century had men known as Deputati, whose duty it was to carry wounded from the battle in leather straps on the left side of a horse. By the 10th century they had an ambulance corps that had no equivalent for 500 years.

In England during the wars of the Middle Ages, the wounded were billeted in monasteries, sent home, or killed by their comrades. Although vicariously trained medical persons had accompanied military expeditions from the Crusades through the Middle Ages, the first distinct army medical department was not established until 1756, with sanitation, diet, and transportation still the main interest. The wounded were generally regarded by military commanders as encumbrances.

During the American War of Independence, there were no first-aid posts, no one trained to clean a wound, apply a bandage, or make a stretcher. It was so dreadful that it marked a turning point in the U.S. army tactics. In the future, the army would not embark on any military operation until a chain of evacuation and treatment centres had been established. British and French doctors were also agitating to have conveyances to move the wounded away from the battle.

Two great French surgeons, Percy and Larrey, are considered conspicuous as the real originators of the modern plan of removing soldiers from the field by trained attendants in specially designed conveyances.

The word "ambulance" is derived from the Latin, ambulare — to walk. Until the end of the 19th century, the word had a different meaning on the continent from that in England. On the continent an ambulance meant a "field hospital" attached to an army and moving with it — "Hospital ambulant". In England the ambulance was the conveyance itself. The Germans with Teutonic directness, have always called their ambulances "Kronkenwagen". During the Napoleonic Wars, the French further instituted an *'ambulance volante'* to come to the wounded on the field with first-aid and, in conjunction *'voitures d'ambulance'*, light carriages suspended on springs, were employed to remove the men back to the field hospitals. Napoleon considered the arrangement 'one of the happiest conceptions of the age'. The French also instituted a vehicle called the Wurtz, a carriage designed to carry surgeons, dressings, hand-litters, and attendants

nto the battle, an arrangement intended o console the soldier, by sight if not by deed. Lest one feel the French soldiers were babied, Napoleon took 400,000 oldiers on his 1812 march to Moscow — and 100 surgeons. He did not expect arge sick parades. Over 300,000 died of yphus on the way to Moscow and the roops left to storm the bastion were rozen of their will to fight.

As a sidelight to battle surgery, military trategists have argued for years about Napoleon's second great defeat — at Waterloo. It has been conceded that he had superior forces and was a master trategist, — and he lost. The reason for his oss lacks nobility. He had been in the addle for three days reaching the battleground. On day one, his haemorrhoids thrombosed and, if you consider the agony produced by an unsympathetic saddle, one can understand why he spent a sleepless night before the battle. He fell into an exhausted sleep at 5 a.m. only to awake at 7.30, one hour too late to deploy his roops properly and thus was defeated by Wellington.

Florence Nightingale acted as a catalyst or public resentment during the Crimean War, 1854-55, as she reported on the appalling medical conditions that allowed 10,000 of the 23,000 British dead o die from lack of proper care.

The terrible numbers of deaths resulting rom lack of transportation to treatment centers of some kind led *Henry Donant*, a Swiss, to be the founding spirit for the development of the Red Cross. The military hierarchy no longer could merely olerate doctors at war, but must ecognize them as indispensable for their own political survival at home.

Progress was slow; more money always could be found to invent instruments of death than those of humanity — grenades, land-mines, torpedoes, machine guns, all almost as lethal as the automobile, made their appearances in quick succession.

There were small steady improvements of acilities during the American War of ndependence, and the Franco-Prussian Wars of the same period, 1860. Hand-held tters, railway cars, and anything that could roll was pressed into service for evacuation of the wounded.

t was, sadly enough, of dubious survival benefit to the badly wounded soldier to each the hospitals of the time as asepsis ad still not reached the operating room — and anaesthesia had not long reached it. There was still great danger of gangrene, wounds left unstitched to prevent suppuration and were stuffed with sponges — nothing sterilized.

Lister's work was known at this time, but considered a nuisance by most except perhaps the Germans. It is of interest to note that blood transfusion was used on the field for the first time, again by the Germans, in the late 19th century.

Queen Victoria became a champion of sick and wounded soldiers and was instrumental in the opening of the Army Medical School and the Royal Victoria Hospital in the 1860's. Bearer companies were established and became responsible for collecting the wounded and getting them to field hospitals and, generally, sanitation and hygiene were much improved as part of the parcel.

In the Boer War of 1900, the first field dressing kit was available to the soldier for self-application — 2 sterile dressings stitched to a bandage, plus a safety pin.

W.W. I burst upon an unsuspecting militia and surgeons suddenly were confronted with multiple wounds in the same patient for the first time. This change in multiplicity, plus the vast numbers wounded, necessitated a whole new chapter in military surgery.

The war was being fought largely over farm land, so contamination of wounds was probable and common, and the wounded arrived at base hospitals with sepsis well established. It was finally realized that full operative treatment, in well-equipped casualty clearing hospitals, within 12 to 24 hours of wounding was of primary importance. This statement was recognized as the greatest contribution to military surgery made during the war, and essentially consisted of wound debridement. The introduction of the Thomas splint for fractured legs, the opening of the pleural cavity under anaesthetic, and the recognition of shellshock, both physical and mental, were additional advances of this era.

The Austrian, Zinsser, wrote that nobody won the war but the medical services. Their increase in knowledge of treatment of the wounded was the sole gain in the devastating catastrophe.

Medical services had continued to be organized between wars. As early as 1919, a De Havilland aircraft was used as an ambulance transport. In Iraq in 1923, 200 cases of dysentery among a column of British troops were flown 9,000 miles to Bagdad for treatment — flying time 129 hours — and I suppose the press at the time reported it as "diarrhoea with a difference".

Blood transfusion units were organized before 1939, and sulphonamides were introduced in Germany in 1935, these plus the use of closed plaster treatment of compound fractures pioneered by Truetta in the Spanish War was a boon to the soldier, and allowed many desperate cases to reach the operating table and to survive.

The war in North Africa introduced the first parachute surgical units who were dropped where needed. It is interesting to note that the personnel concerned provided the blood for transfusion. One's stint of duty with such units was measured in pints, not in months. Penicillin was used extensively in North Africa with great benefit, and the modern era of treating infection, not preventing it, was inaugurated and another backward step was made.

Transfusion supplies saved many men on the Normandy beaches. Strapped into the equipment of all assault units were transfusion sets and, of more importance, paramedics trained to use the system. Thirty-five years later, we are still fighting to allow paramedics to administer Ringer's Lactate by intravenous in a civilian setting.

Air evacuation in W.W. II was as important as Penicillin and blood supply, and carried huge numbers of men to definitive therapy following initial battle treatment.

The greatest single factor in survival for the allied soldier in W.W. II was the prophylaxis against Tetanus. This horrible death was removed forever from the battle casualties by active immunization of all military personnel.

The "Horsepower Race"

The war to end all wars was at best a short-lived truce and the gaiety of the 20's was repeated in a more restrained fashion. This restraint was not practiced in Detroit and the horsepower race was on. Suddenly civilian surgeons unaccustomed to the total body crush, were seeing and feeling the effects of rapid deceleration. Just as the military surgeons of W.W. I were at first appalled

by the numerous wounds inflicted by shell and mortar fragments, the civilian surgeons of the 40's and 50's were overcome by the multiplicity of body systems that were torn asunder in motor vehicle crashes at ever increasing speeds.

Notable by its isolation in this period, the Cornell Aeronautical Laboratory must receive mention. Tired of aircraft accident investigation, they turned to the motor car and found that ejection at the time of impact accounted for 70% of the fatalities. Of direct importance in the prevention of motor vehicle fatalities was the outcome in legislation re. impact safety door latches. Implicit in their recommendations, almost 30 years ago, was the life-saving benefit of restraint systems for automotive passengers.

If we add the engineering advances in the 60's and 70's with safety glass in the windshield, energy-absorbing steering columns, energy-absorbing interiors, and the provision of seat belts, we cannot expect much more from our vehicles except precise driving capabilities.

This period also focussed attention on the highway itself, and highway design began to reflect the modern trend of run off space, breakaway light standards, and energy absorbing roadside barriers. This too was a bitter fight waged by a few of the medical profession to persuade highway engineers that it was better to damage a light pole than kill a driver.

Still the toll of dead and injured mounted. The first motor vehicle fatality in North America occurred on the streets of New York City in 1908, when a male chauvinist, alighting from a streetcar, stopped to hand down a lady passenger. For his chivalry, he was struck dead by a horseless carriage and thereby contributed the first of 1,000,000 U.S. traffic deaths by 1976. These deaths have been attended by a horrendous flood of injured, some 50,000,000 in the past 60 years in the same country.

Transportation of the Injured Patient

The hapless victim of roadway violence has not fared too well over the past half century. We as civilians were slow to learn the military lessons first applauded by Napoleon as "one of the happiest conceptions of the age". We were content to welcome traffic casualties at the emergency department, no matter how they were transported from the scene. In Canada, as in many other jurisdictions, the regulation of ambulances was non-existent until the early 1970's and this led to the public statement by Maj. General Worthington in Maclean's Magazine in 1967 that "the ambulance situation in Canada could be compared to that received by wounded military personnel in the First World War" 50 years previous.

Things have begun to change for victims of sudden illness and injury. Here in B.C., we have the best province-wide ambulance system in Canada with personnel trained and allowed to resuscitate as well as transport. The tale of two pities — medical indifference and public apathy — finally has been rewritten west of the Rockies and, to a lesser extent, in the sister province of Alberta. In the rest of Canada, the acutely ill and injured are definitely second rate citizens in the emergency care and transportation that is available.

We cannot leave the field of transport for the acutely injured without remembering a medical man, an anaesthetist and a humanitarian, the late Dr. Norman McNally. He started it all in Canada in Ontario when he, as Director of Emergency Health Services of the old Department of Health, persuaded our legislature to remove the hypothetical jurisdiction of ambulance regulation from the Department of Highways in 1965. In 1967 it was changed to the jurisdiction of the Minister of Health, and the first Ambulance Act which defined an ambulance and set basic criteria for its operation was enacted. It was one of my privileges in this field to accompany Norm to B.C. in 1974 to espouse our philosophy in this field. B.C. was fortunate in two ways — a receptive government and a man named Dr. Peter Ransford who has been responsible for the development of B.C.'s emergency care and transport system. The philosophy we enunciated years ago with a definition of an ambulance as "a mobile extension of the emergency department" has been realized here at least."

We must turn to the military even in modern times to learn forward steps in humanity for the injured patient. Two limited wars in all of our memories have set the stage for civilians to follow if they will. In Korea there were two notable occurrences. The advent of the helicopter allowed for quick rescue and deployment to treatment areas for the injured. This allowed many survivors to reach surgical areas for resuscitation a definitive care. The efficiency of swift transport after minimal first aid stabilization was proven beyond the shadow of a doubt.

The Development of Trauma Units

The second innovation in Korea was no as successful. This was the developmen of Organ Trauma Units, i.e. if the head v most seriously injured, the patient went the head unit. This was less than successful and in Viet Nam, the Traumc Unit came to fruition in which total bod care was the order of the day.

In this war, the helicopters used for evacuation were staffed with paramedics who were trained in the ar and science of initial treatment before evacuation began in a vehicle of such size and with such equipment that treatment could be continued until letdown at a "M.A.S.H." unit.

This combined expertise and speed delivered many severely injured patien to the surgeons for final resuscitation measures and treatment that, under normal or civilian circumstances, would have died.

For every action there is a reaction. The reaction in this case was the recognitic of a brand new entity in severely shock patients that survived to reach medicc attention. This entity was first called Vie Nam Lung, then Shock Lung, and finall today is the adult respiratory distress syndrome.

This body reaction to severe trauma in itself I suppose was to be expected. The unexpected was the rekindling of physiological interest in surgeons generally. This, with the aid of the sophisticated monitoring systems, is no called critical care unit. The same expertise aids not only the surgically ill, but also the medically ill to a greater survival rate.

At this point in time, I should introduce modern Harvey, Tom Shires, a military surgeon who, in civilian life, worked at Parkland Hospital in Dallas. He, as Chie the busiest Trauma Hospital in North America, coined the philosophy that a compared to wartime, civilian surgical practice indicated that we live in "a m hostile environment".

This environment *is* hostile in many form of physical violence.

There is another violence that rears its head in the traumatized victim, and th is in the form of bacteria that Lister and

Pasteur had sought to defeat.

The modern trauma victim is more susceptible to bacterial infection than any other patient undergoing surgery. First of all, 50% of all road traffic victims have alcohol on board at the time of injury. This not only makes diagnosis more difficult, but alcohol has a selective action on the polymorphs, our first line of defence, and renders them less than active at a time when they are needed most.

Of course, surgically we do all we can to help these little microbes travel. Our critical care areas are complete with thousands of dollars of individual patient monitoring equipment — and only one sink to wash one's hands between patients for the whole unit. Lister would re-introduce his carbolized spray if he had a chance circa 1980.

The magnitude of this unseen hostility was documented about 5 years ago by Lester Dragstedt, and he estimated that surgically induced infections cost the United States about $5,000,000,000.00 per year.

The Emergency Department

Let us, for a moment in time, retrace our steps to a second vital link in the care of the traumatized patient — the emergency department. This area of a hospital was always considered as an add-on loss leader until after the Second World War. At this point in time, a strange combination of circumstances combined to play the devil's advocate to hospital planning. First, there was an acute shortage of Family Practitioners, secondly there was a large body of young Canadians who had returned from the services and who were accustomed to receiving their medical care upon demand at the military establishments. The final truism in this triad was the sudden realization that if they went to an emergency department, help would be found for them by the nursing staff. Into this melee was thrown the ever-increasing results of sudden stops on the highway and overnight, the emergency department became the busiest place in the hospital.

It was soon evident that this was a specialty area in breadth medically, and a limited area temporally. No longer was it safe or sensible to staff this area with the lowest member of the medical hierarchy — the junior interne. A new specialty has been born and, although emergency departments were once a surgical area, the expertise in the emergency physician's training benefits the M. I. patient as much as the traffic accident victim.

By and large, however, circa 1980 the architectural planning of a majority of our emergency departments in Canada leaves much to be desired. The basic space formula of 6 square feet for each 100 visits per year has not received widespread acceptance by hospital architects, governmental granting agencies, or by hospital Boards of Directors.

The final stage in medical organization is showing signs of vitalization in Canada. I refer to trauma units staffed with surgical and nursing personnel dedicated to the rescue of young lives. The worth of these units has been proven militarily in Viet Nam and also in many areas south of the border.

The development and deployment of these specialized units dictates a regionalization of surgical planning that seems to have escaped our medical politicians thus far in time. The necessary transfer system including paramedic attention for land, water, or air transport must be part and parcel of this regional organization.

Conclusion

Throughout this discourse, I have intimated that trauma is the poor country cousin socially, medically, and politically. The N. R. C. of United States, following the Airlie Conference in 1974, concluded that trauma was "the neglected disease of modern society". As a measure of this neglect, some comparisons are pertinent. If we assume 3 score and 10 as a natural life span, in 1976 in Canada, by premature death, cancer in all of its forms wasted 135,000 person years, cardiovascular disease 192,000 person years, and trauma, with its younger patrons, a staggering 234,000 person years. How did Canadians react? They spent $7,000,000.00 on research for heart disease, $4,500,000.00 on cancer research, and a paltry $220,000.00 on trauma with all of its ramifications. Neglected to the point of ignored.

My greatest wish is that the resolution passed by General Council on 15 September, 1980, will reach fruition in my lifetime. Briefly the Emergency Medical Services Committee of the C. M. A. put forward a resolution to General Council that the C. M. A. assume responsibility for the formation of a Trauma Foundation for Canada. This I hope will be as successful as the Heart Foundation and the Cancer Society in the field of education for the public, and in the process of education, for the solicitation of funds to be applied to research in all aspects of prevention and treatment for the greatest continuing epidemic organized medicine and society has ever faced.

In conclusion, it is with sincere humbleness that I have appeared before you today. I am merely the spokesman for the dedicated people in the "Roads Club". It has been their enthusiasm and work that has for the first time cracked the shell of medical indifference in Canada by the establishment of an Annual Lectureship on Trauma. In the sands of time their achievement will loom large in the lives and the living of future generations in Canada.

Roads Club, Kingston, Ontario, Canada

This club was founded in 1974 by a group of public minded citizens who had become interested in the devastating effects of trauma. The name is derived from the initials of the founding members.

Mrs. Doreen Adams, Dr. Kenneth Adams, Miss Marion Dealy, Miss Theresa Rodgers, and Mrs. Joyce Slomer.

The club has enlarged to a membership of fifty and funds have been collected to over $10,000.00. The club is registered as a charitable organization and a sizable bequest has been donated to the Canadian Medical Association. These funds are used to finance the Roads Lectureship at the Annual Meeting of the C. M. A. This lectureship is dedicated to subjects related to trauma.

The first lectureship was held at the Annual Meeting of the C. M. A. in Vancouver, and I was honoured to present "Time and Trauma" to this audience.

The Roads Club is unique. It is the first of its kind in Canada, and it has established the first and only lectureship on an annual basis dedicated to the education of physicians in the art and science of treatment and prevention of the disease called "Trauma".

Editorial

The Future of Emergency Medicine ... Again!

Editorial pages of late have been replete with musings on the future of Emergency Medicine in both Canada and the United States. "Sounding Boards" in the February 19, 1981 issue of the *New England Journal of Medicine* contained two articles of widely contrasting views. J. D. Leitzell sketched the history of the development of full-time Emergeny Physicians in the United States, and concluded that there are now "tight constraints on the growth of Emergency Medicine". The rise of more primary care physicians was cited as likely leading to an "inevitable" decline in patient volumes. The present "glut of applicants for good positions" will lead to "greater competition" in the years ahead and, presumably, downward pressure on salaries.

Leitzell predicted a rather gloomy and uncertain future for Emergency Medicine in that country.

Another full-time Emergency Physician, and the current president of ACEP, Leonard M. Riggs drew just the opposite conclusion. In his discussion, in the same issue of NEJM, he outlined the history of the "decade of development" which, in September 1979 culminated in the recognition of Emergency Medicine as a specialty by the American Board of Specialties. Riggs also traced the rapid development of residency programmes in the U.S.A., from 1972 when one programme graduated two Emergency Physicians, to 1980 when 53 approved programmes graduated 225 E.P.s. By 1990 it is anticipated that there will be 6500 board-certified E.P.'s in the U.S.A.

Riggs concludes:

"The role of emergency medicine in the continuum of health care has evolved relatively quickly although the field is not without a strong foundation. It is a specialty, like others, that requires energy, commitment and a singular personality".

Closer to Home

A third example of self-avowed "crystal-ball gazing" was in the February 1981 Canadian Family Physician. Dr. Donald Rice, Executive Director of the College of Family Physicians of Canada, posed the question "Certification in Emergency Medicine: A Threat or a Promise for Family Physicians?" Dr. Rice sketched a somewhat editorialized version of the events leading to the current situation regarding certification in Emergency Medicine in Canada. He then attempted to outline the philosophy of the College of Family Physicians of Canada (CFPC) regarding certification

> "given that the problems encountered in most emergency departments are multidisciplinary and first contact (primary care), and given that the vast majority of such problems are non-life threatening (estimated at 85%) and episodic in nature, the CFPC believes that society will be best served by physicians who are trained as family physicians with the additional knowledge and skills appropriate to the management of the true life-threatening emergency".

Dr. Rice has clearly identified the keystone of the CFPC position, and it must be recognized for what it is. The logic here is dangerous indeed, and, if applied to any other specialty, would lead to most peculiar conclusions. Surely, the vast majority of obstetrical cases are simple and non-life threatening. Therefore, we need only provide the family physician with the "appropriate additional knowledge and skills". Surely, the vast majority of anaesthetic, neurologic, dermatologic, surgical and other problems are similarly non-life threatening. Family physicians should therefore be able to competently manage all of these patients!

Emergency Medicine *is* significantly different from all other specialties. This has been recognized by the American Board of Specialties and the Royal College of Physicians and Surgeons of Canada. It is time the College of Family Physicians of Canada recognized this. Henry Graves put it nicely in JACEP in 1976:

> "Family practice is a true specialty and the first recognized specialty in breadth.
>
> It has as one of its criteria that of continuing care of the patient and his family. Its core is heavy in the behavioral sciences as well it should be.
>
> Emergency Medicine is also a specialty of breadth, but, with depth in those areas in which it is particularly involved. Continuing care is not part of our profile and the behavioral sciences enter our training only as they apply to a particular patient in a relatively short time.
>
> Now that I am an emergency physician, the majority of my practice involves the immediate correction of an individual problem and the referral back to the patient's physician. The focus is different, the skills are different, and the content is different. Although much of the content listed in the domain of family practice is also listed for emergency medicine, the emphasis, approach and method of handling are so completely different that they could not be taught correctly side by side."

Rice concludes by raising a few red flags to his readers. He claims that certification will lead to emergency physicians setting up follow-up and ambulatory clinics, leading to increased competition for patients. Where follow-up clinics currently exist, it is to relieve the load in the Emergency Department. Many departments are indeed overrun with ambulatory patients with non-emergent problems. But, they come to the emergency department for a reason. For

some reason, these patients feel they can get better, faster, more accessible care in the country's emergency departments. If the CFPC goal is to discourage this pattern of health consumption, then it must address the question by making the family physician's office more attractive, not by decrying the certification of emergency physicians.

Similarly, Rice warns that certification of emergency physicians will mean that unqualified physicians may not get privileges to practice in the emergency department. Surely, the CFPC is not objecting to defining and recognizing standards of practice by certification. After all, the CFPC has worked long and hard toward the certification of family physicians. This has lead many hospitals to restrict privileges to those family physicians with the CCFP. Indeed, in Ontario, the Chairmen of the Family Medicine training programmes have even said that a CCFP should be a pre-requisite to acquiring a licence to practice in the province! Yet, Dr. Rice urges that the CFPC "discourage hospitals from limiting emergency department privileges to physicians with certification in emergency medicine . . ." This does not appear consistent with the CFPC stand on family physician certification.

The time has come for family physicians and emergency physicians in Canada to recognize that they each have important and evolving roles to play in the health delivery system. The constant bickerings over the "territorial imperative" of each detract from the high quality of care each is capable of providing. In the end, only our patients stand to suffer or gain.

Peter L. Lane

E.M. Training Programmes

Calgary, Alta.

Hospitals Holy Cross Hospital, Foothills Hospital, Calgary General Hospital.
University Calgary.
Programme Director Dr. G. Powell, Chief, Division of Emergency Services, Foothills Hospital, Calgary, Alta., T2N 2T9.
Type of Programme Pre-requisite 2 yrs broadly based clinical exposure, (not necessarily Family Medicine) with a minimum of one further year of Emergency Medicine.
Size 3 residents per year.
Accreditation none.
Certificate hope to be able soon to give a U of C diploma.

Ottawa, Ontario

Hospitals Ottawa General Hospital, Ottawa Civic Hospital, Children's Hospital of Eastern Ontario.
University Ottawa.
Programme Director Dr. A. F. Henry, Chief, Emergency Dept., Ottawa Civic Hospital, Ottawa, Ontario, K1Y 4E9.
Type of Programme three (3) yr post-M.D. programme, two (2) yr of which meet the requirements of the Dept. of Family Medicine Programme.
Size four residents per year.
Accreditation none per se, although it is hoped that residents will be eligible to sit the exams of the CFPC.
Certificate none.

Kingston, Ontario

Hospitals Kingston General Hospital, Hotel Dieu Hospital.
University Queen's.
Programme Director Dr. L. E. Dagnone, Emergency Dept., Hotel Dieu Hospital, Kingston, Ontario, K7L 3H6.
Type of Programme 3 yr post-M.D. or 2 yr post internship, broadly based training, research exposure in final year.
Size maximum of four (4) residents per year.
Accreditation none.
Certification none at present.

London, Ontario

Hospitals Victoria Hospital, St. Joseph's Hospital, University Hospital.
University Western Ontario.
Programme Director Dr. K. Ferguson, Director, Dept. Emergency Medicine, Victoria Hospital, 391 South St., London, Ontario, N6A 4G5.
Type of Programme two (2) yr programme after internship, broadly based training with emphasis on internal medicine.
Accreditation accepted by RCPS(C) as two yrs of internal medicine training.
Certification none.

Montreal, P.Q.

Hospitals Royal Victoria Hospital, Montreal Neurological Institute, Montreal Children's Hospital, Queen Elizabeth Hospital, St. Mary's Hospital, Jacksonville Memorial Hospital.
University McGill.
Programme Director Dr. Wayne Smith, Royal Victoria Hospital, Emergency Dept., 687 Pine Ave., W., Montreal, P.Q., H3A 1A1.
Type of Programme two yr post-internship, broad based training, elective in Jacksonville, Fla.
Size six (6) residents per year.
Accreditation LREC/ABEM (nothing Canadian as yet).
Certificate eligible to write ABEM exams in U.S.A., certifiable from McGill and Royal Victoria Hospital.

Noticeboard

Positions Available

Mid-Atlantic Opportunities
(Partial Listing)

Eastern Pa.
ASSOC. DIRECTOR — Major teaching hospital with active ED, future plans for EM. Residency and trauma centre designation (60K).

Central Pa.
DIRECTOR — Community hospital in semi-rural location, ED volume approximate 23,000 (minimal trauma) — compensation to 80K.

Western Pa.
DIRECTOR — Major teaching hospital in excellent location; prefer specialty board certification and administrative experience. Compensation 90 K.

Western Pa.
ASSOC. DIRECTOR — Community teaching hospital in western area with new emergency and critical care facilities, E.M. residency to begin July, 1981. Compensation 75K.

Western Pa.
Staff physician for new medical center in semi-rural location — active volume of 50,000 with high trauma — compensation 75K.

West Va.
Staff physicians for new community hospital located within 30 minutes of metro area — volume of 26,000. Compensation package exceeds 80K for 40 hr week.

New York
DIRECTOR and staff for community hospital in Upstate New York, compensation to 70K.

For additional information please contact
Daniel Stern and Associates
211 N. Whitefield Street, Suite 240
Pittsburgh, PA 15206
412-363-9700

Emergency Room Physician

Opening for full time or part time physician. Remuneration by the shift at $28/hr. on weekends and $24/hr. on weekdays. Very comfortable pace. Must have ACLS and Ontario license.

For information contact Dr. C. Winegard, Director of Emergency Department, Sarnia General Hospital, Sarnia, Ontario.

Replies to CAEP Review Boxes should be addressed:
c/o The Editor
CAEP Review
Dept. Emergency Services
Sunnybrook Medical Centre
Toronto, Ont. M4N 3M5

Emergency Physicians Wanted

2 full time positions available to expand well established emergency group in Waterloo Region. Approximately 40 hours per week. Income $50,000 minimum in 1st year. Applicants must have Ontario license, CMPA, ACLS, BCLS. Preference given to those with 2 years emergency service experience or more and to those with career orientation.

3 summer locum tenens positions available with well established emergency group in Waterloo Region. Positions to run from approximately mid-June to mid-September/1981. Excellent pay schedule available. Reasonable working hours and conditions. Applicants must have Ontario license, CMPA, ACLS, BCLS. Preference will be given to those with 2 years emergency experience or more.

To apply for the above positions, apply in writing with curriculum vitae and 3 references to:
Dr. James H. Swann
105 Thorndale Place
Waterloo, Ontario N2L 5Y8
For further information call 1-519-886-8686.

Emergency Physician for Teaching Hospital

Qualifications & Requirements:
1. License to practice medicine in Canada
2. Canadian Medical Protective Association insurance
3. Either formal training in, or a practice focusing upon Emergency Medicine
4. At least 3 recommendations from other emergency physicians which comment upon ability to carry out responsibilities mentioned below
5. Submission of a current Curriculum Vitae
6. ACLS training.

Responsibilities:
1. 30-35 hours per week of emergency shifts rotating with seven other emergency physicians
2. On call one night in four to six for trauma patient
3. Teaching— paramedics
   — medical students
   — residents
4. Research into Emergency Medicine related projects

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1. University of Toronto Appointment
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3. Full health, group life and disability insurance
4. Excellent retirement benefits

Reply
CAEP Review, Box 100

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University of Alberta Hospital.

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At the present time remuneration is by salary, at a rate of $53,000 per annum, but this will change to fee-per-item of service on a group basis in the next month or so.
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Please forward applications with curriculum vitae and names of three referees to:
Dr. J. M. Davidson,
Division of Emergency Services,
University of Alberta Hospital,
112 Street & 84 Avenue,
Edmonton, Alberta T6G 2B7

Emergency Physicians

Career oriented Emergency Physicians wanted to establish a full time group in a major teaching hospital in downtown Toronto.

For information call or write:
Dr. T. N. Estall
Director of Emergency Services
St. Michael's Hospital
30 Bond Street
Toronto, Ontario M5B 1W8
1-416-360-4069

Emergency Department Physician

Full time position in Emergency Department of 450 bed general hospital. Fee for service. Rotating shifts. Physician interested in Emergency Department medicine as career preferred.

Please include curriculum vitae and references with application to:
Executive Director
Belleville General Hospital
265 Dundas Street East
Belleville, Ontario K8N 5A9

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or
To Inquire About Available Positions
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Secretary, CAEP
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Sunnybrook Medical Centre
2075 Bayview Avenue
Toronto, Ontario M4N 3M5

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