CAEP Review

Fall 1980
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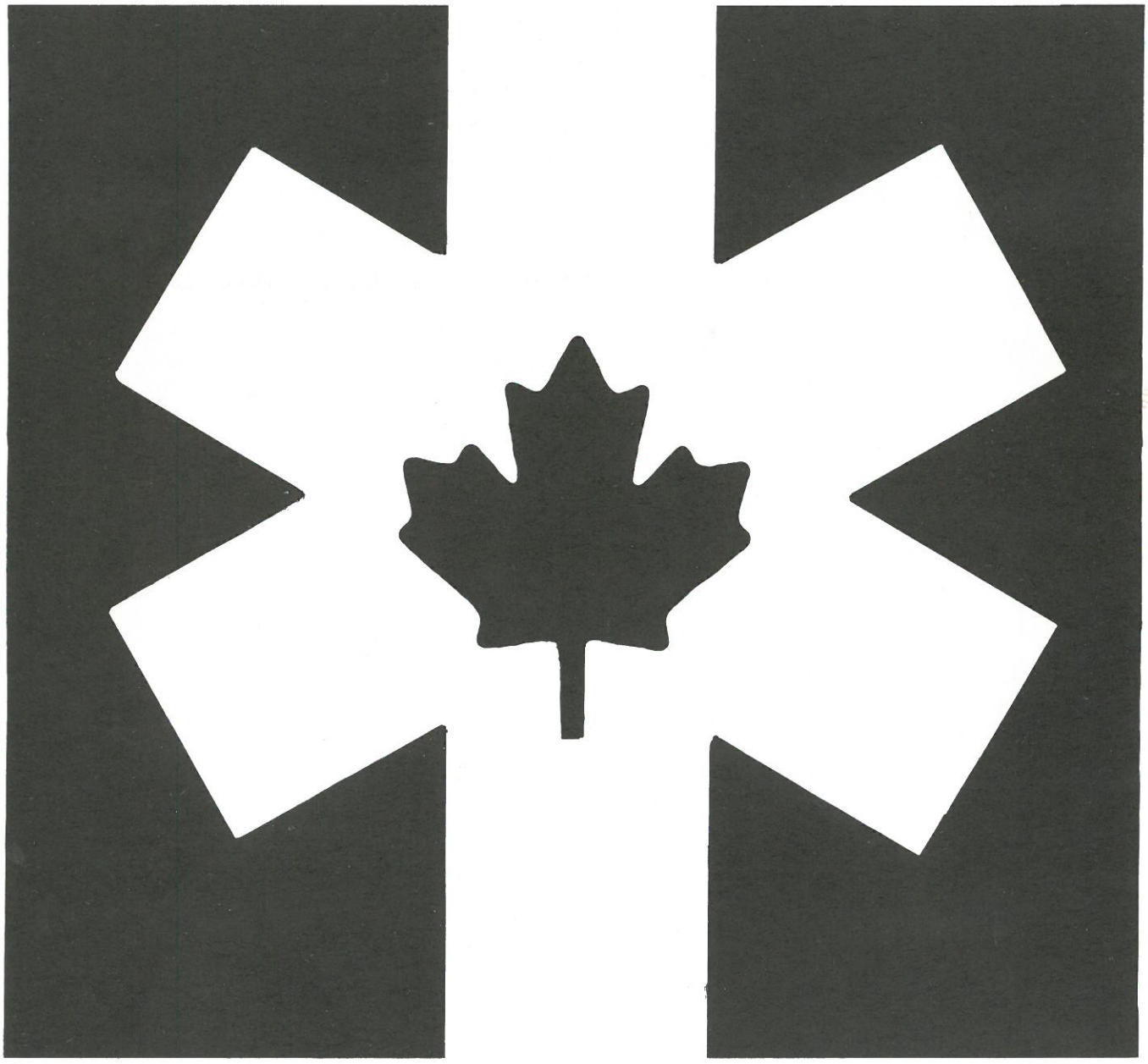
A Canadian Association of Emergency Physicians Publication



CAEP Review

Vol. 1 No. 1 Fall 1980

Editor — Peter L. Lane

Contributors this issue:
Rocco Gerace, Angela Pitchford, David Walker, Paul Assad, Peter Lane.

Layout & Design: Graphic Impression

The *CAEP Review* is published quarterly by the Canadian Association of Emergency Physicians. Opinions expressed are those of the authors and do not necessarily reflect those of the Association.

Subscription is free to CAEP members, $15.00 per yr. to libraries and non-members. All correspondence including unsolicited manuscripts should be forwarded to:

THE EDITOR
CAEP REVIEW
c/o Dept. Emergency Services,
Sunnybrook Medical Centre,
2075 Bayview Ave.,
Toronto, Ontario,
M4N 3M5.

CAEP has a new logo ... Finally!

CAEP's new logo, featured on the cover of this edition of the *Review*, has been the subject of much debate. for over a year now, the executive has scribbled various things on restaurant napkins. Indeed, some versions came close to incorporating those "golden arches" themselves.

Finally, at a recent executive meeting in Regina, the version you see was chosen. Simple in concept, yet clear in intent, it is comprised of the six-armed cross, approved by WHO as the international symbol of Emergency Services, and in the centre, the maple leaf, signifying our national scope.

It is hoped the logo meets with the approval of CAEP members. Comments are invited.

Contents

From the Editor

By Peter Lane M.D., Editor

This is the first issue of the **Review**. As with any first issue, there are still a good many bugs to iron out of the system. The hope is that in this new format, we can create a forum for Canadian Emergency Physicians to exchange ideas and opinions, and to keep in touch with their Association.

Our plan at present, is to publish the **Review** quarterly. I'll outline a few of the regular features you can expect:

President's Notebook: this will be the major opportunity for our President to communicate with the members between annual meetings. If nothing else, *all* CAEP members should read this each issue.

Resident's Corner: the Resident Committee of CAEP will have a page each issue to use as they see fit to communicate with their members across the country.

Across Canada: A series of articles will deal with the evolution of Emergency Medicine in different parts of Canada, written by local Emergency Physicians.

CME Calendar: A calendar of upcoming courses, approved for CME credits by CAEP, will be in each issue.

Emergency Medical Training in Canada: most issues will contain a list of the current training programmes in Canada.

Noticeboard: There will be limited space in each issue for CAEP members to place small notices for upcoming courses, positions vacant or wanted, etc.

Correspondence: There is space to publish any appropriate letters that the **Review** receives. Members are encouraged to use this section to respond to recent articles in the **Review**, to recent events or articles published elsewhere, or to communicate clinical information to your colleagues.

Feature Articles: Each issue, the **Review** will contain one or more feature articles on issues of import or interest to CAEP members. Readers should feel free to write letters commenting on recent articles, submit articles of interest, or suggest topics.

Academic Articles/Research Papers: at this point, there are no plans to solicit or include articles of this nature. However, it is anticipated that as the **Review** becomes established, it may be feasible to expand into this area.

So, that's what you can expect from **CAEP Review** over the next year or more. The editor and the CAEP executive are eager to know how you feel about our new format, and what we might do to improve it. We are almost as new at this as all of you, so your input would be valued. Also, any letters or articles are welcome.

Please address all correspondence to:

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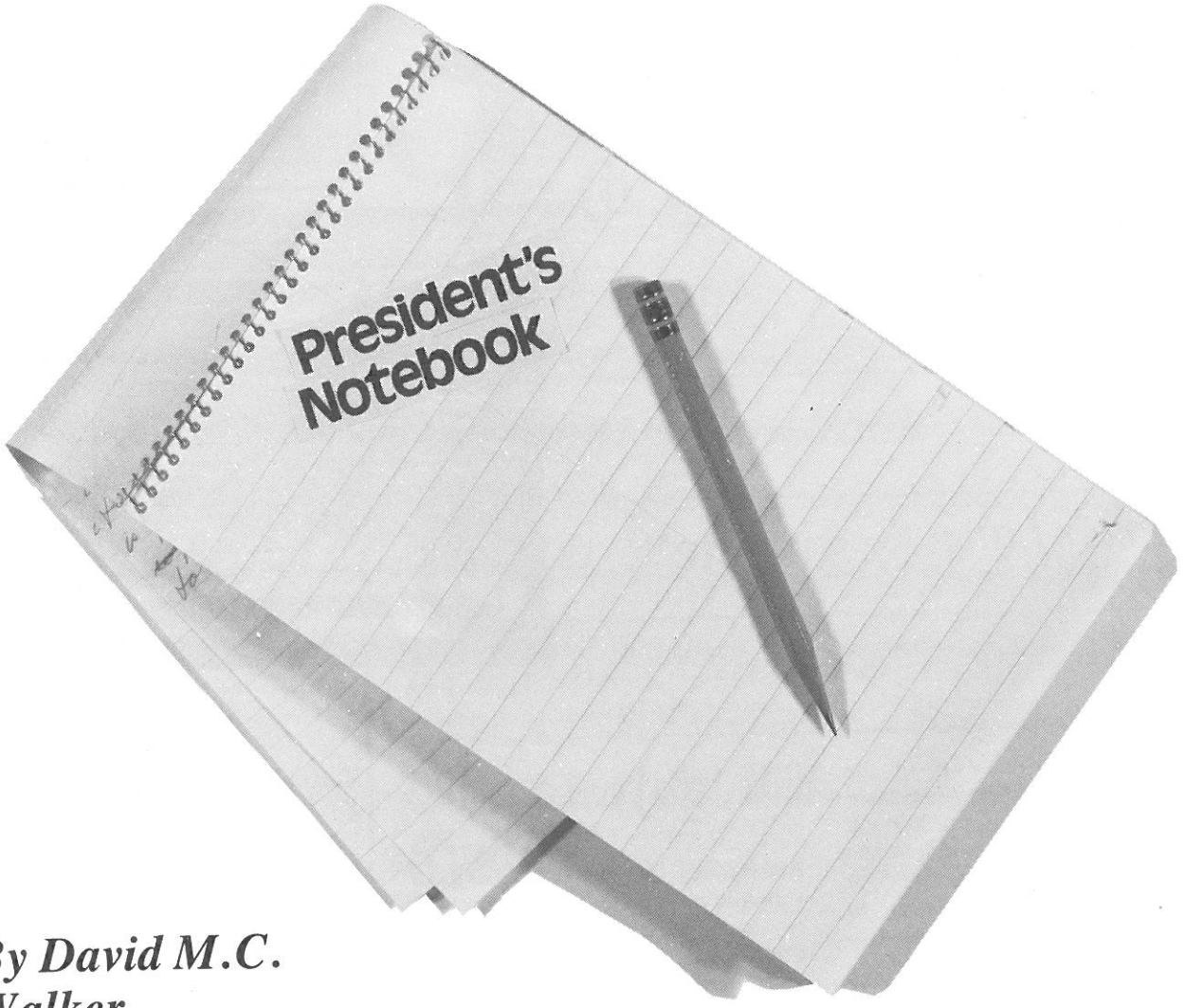

By David M.C. Walker M.D., F.R.C.P.(C)

In 1978 the Canadian Association of Emergency Physicians was born in a small hotel room in Toronto. The purposes and objectives of this organization were intended to satisfy many of the concerns and interests of Emergency Physicians across Canada.

They were enunciated thus:

This Association has been founded to promote emergency health services in Canada. The objectives of the Association are:

1) To study and recommend standards of emergency medical care in Canada

2) To develop and insure the maintenance of reasonable and effective standards for both postgraduate training programs and continuing education for emergency physicians

3) To foster research in the field of Emergency Medicine

4) To promote coordination of community, provincial and national emergency care facilities and personnel

5) To provide representation for physicians who are engaged in the practice of Emergency Medicine in Canada

In the ensuing two years of the life of the Association many changes have occurred and Emergency Medicine is developing at a rapid pace. The Association completed a manpower study recently which revealed that there were four hundred career oriented emergency physicians in Canada and that there was a shortfall in the next four years of about

one hundred emergency physicians. This shortfall exists because of the increased demand for appropriately trained physicians to man Emergency Departments across Canada and the small numbers of physicians who are being graduated from the five post-graduate training programs.

In the past two years, in great part because of the activities of the Association, the Royal College of Physicians and Surgeons of Canada has resolved that Emergency Medicine should become a specialty within the division of Medicine of the Royal College and that accreditation processes should be set into motion to accredit programs in Emergency Medicine which will lead to a certification examination. At the same time, the College of Family Physicians of Canada have recognized the importance of Emergency Medicine within the framework of training in Family Practice and also to assist those who wish to pursue an integrated program in Family Medicine and Emergency Medicine. They are proposing that such steps be undertaken and that there be a certification process in Emergency Medicine within the framework of the College of Family Physicians and that this would also allow a practice eligible route for those not previously certified but who meet certain qualifications of full time practice and experience.

The Association is continuing to provide valuable input to this process and I think it can be said that these developments will go a long way in furthering the aims and objectives of Emergency Medicine in Canada.

The Association has had input into a federal study on emergency health services being performed by David Martin at Health and Welfare Canada and is participating in a similar study on prehospital care. We feel that these involvements can provide the emergency physicians insight and point of view to those in decision making capacities, both provincially and federally.

The Association in the past two years has promoted position papers or patient transfer guidelines, physicians staffing an Emergency Department, and on the needs for certification in Emergency Medicine.

The Canadian Association of Emergency Physicians has also promoted continuing medical education programs in Emergency Medicine and has provided its first most successful annual meeting with a high calibre of scientific content in Vancouver in April, 1980. Plans are well along for the 1981 meeting to be held in Montreal in September. Allied with this, the Association will be finalizing continuing medical education categorization processes that may in large part be used for practice eligibility purposes. On other fronts, we have created a Residents Committee to provide a forum for discussion for residents in Emergency Medicine and to provide information for those who are considering a residency training program in Emergency Medicine; we are undertaking negotiations with the American College of Emergency Physicians to attempt to ensure both reciprocity of continuing medical education credits and also, hopefully, a new deal so that membership in the American College of Emergency Physicians might be modified and become more financially appealing.

Our membership at the present time exceeds four hundred active members and has been computerized so that access to members in various parts of the country can be obtained simply. In this vein, the executive have attempted to maintain close contact with the membership of the Association by holding its executive meetings in a different province on each occasion and we have to date in the past two years met in British Columbia, Alberta, Saskatchewan, Manitoba and Ontario. We are planning to meet in the Maritimes and Quebec within the next year. Since the executive represents all parts of Canada and have to travel to meet in any case, we found that this has proved to be a most beneficial experience, both for the executive and, we trust, for those that we meet in the various centres on those occasions.

One area that the executive of the Association is going to be paying some attention to in the next year is the economics of Emergency Medicine since we feel that there are as varying standards in this area as there are in the general practice of Emergency Medicine and that by collecting information and providing some expertise in this area, that we may assist emergency physicians in Canada in obtaining the best possible economic deal that is available.

There are many challenges on the horizon and with a strong Association and hard work, we feel that the Canadian Association of Emergency Physicians can continue in providing a leadership role in satisfying the objectives that were laid out in that small hotel room two years ago.

Taking an active role in disaster planning

By Rocco Gerace, M.D.

A disaster, medically speaking, may be defined as an episode resulting in a critical number of sick or injured people who cannot be readily absorbed into the Health Care System, without altering the administration of available resources. It is imperative that emergency physicians take an active role in the co-ordination and organization of disaster plans at all levels.

Medical Teams

In the past, physicians have been reluctant to commit themselves to proceed to the site of a disaster feeling that their expertise would be better utilized in the hospital setting. However, in the event of a mass casualty incident, numerous lives can be saved by the presence of a physician. By performing simple resuscitative maneuvers such as opening an airway or initiating an intravenous infusion, patients who may otherwise have died can be stabilized until definitive treatment is available. Because emergency physicians are experienced in the triage and resuscitation of critically ill patients, they are ideal candidates to take part in composition and co-ordination of medical disaster teams.

In the organization of such teams, clear-cut guidelines pertaining to the activation of these teams are necessary as well as on-going education of the disaster teams of their role in the community plan. The composition of the medical teams will vary depending on the size of the community and the availability of medical resources. Several reviews are available outlining medical teams of varying composition to suit the local needs.

Communications

The single most discussed topic in disaster planning as well as the most problematic is that of communications. Frequently, in a true disaster, there is a breakdown in communications. However, one must not adopt a defeatist attitude in early planning. Optimal function of medical teams depends on their ability to communicate readily amongst themselves, with other services, and with their base hospital.

In the planning of a communication system, personnel experienced in communications provide a valuable input. This expertise is readily available in most communities in amateur radio groups. Members of these associations are often knowledgeable in communication technique and equipment, and willing to share this expertise to provide a community service. However, it has been our experience that sole reliance on amateur radio groups is at best optimistic. Every effort should be made to secure two-way radio equipment dedicated solely to be used in the event of a disaster. The expense entailed by purchasing such equipment would be more than justified in even the most minor disaster situation.

Medical Supplies

In order to be effective at the disaster scene, a physician must have sufficient medical supplies to initiate

and maintain resuscitative measures. Contents of disaster trunks will vary with the size and ability of the medical teams. Responsibility for maintenance of disaster trunks must be placed with a reliable person in the hospital setting. This individual checks the trunk on a periodic basis, replacing dated supplies and IV solutions. a representative from the Pharmacy Department should ensure that the drugs are continually rotated to maintain a fresh stock.

The responsibility for transporting supplies to the disaster scene must be clearly assigned. Generally, ambulances are in constant transit between the hospital and disaster site. As such, they are a valuable mechanism for transporting both the medical teams and their supplies.

Ancillary Agencies

Although there is little doubt that community agencies such as police, fire and ambulance services play an important role in disaster planning, there are many more services that may contribute. For example, representation from the transportation industry (ie. air, rail) will not only provide insight into the potential of a disaster situation but will also provide their capabilities in the management of such an episode.

Meeting with representatives from various agencies is an excellent way to provide physicians with insight into capabilities of these agencies as well as personal familiarization, a potential benefit at the scene of a disaster.

Disaster Exercises

Having spent a great deal of time and effort in the formulation of a disaster plan, it is important to test this plan on a periodic basis.There are two types of disaster exercises which may be utilized, both of which have advantages and disadvantages.

The first type is a major mock disaster exercise. This provides site testing of the disaster teams as well as testing of all components of the plan. Unfortunately, the magnitude of such an exercise eliminates the surprise component in conducting the exercise thereby making it somewhat less realistic. Moreover, they are time consuming and expensive, and so, cannot be conducted too frequently.

The second type is the communication exercise in which the fan-out procedure is carried out by telephone. This not only provides a good indication of preparedness and availability of disaster personnel but can be conducted without pre-warning. Communication exercises are inexpensive and do not require a great deal of planning.

Neither of the above types of exercises alone are adequate to properly test a disaster plan. However, by conducting major mock disaster exercises at 3-4 year intervals with communication exercises in the interim, reasonable on-going testing of the plan may be insured.

Discussion

Disaster planning is an essential component of the emergency medical care system. As such, emergency physicians are encouraged to take a very active role in disaster planning and to lend their expertise to the community and hospital in this endeavour.

SELECTED READING

Bouzarth WF, Mariano JP: Disaster Preparedness in Shwartz GR (Ed): Principles and Practice of Emergency Medicine, 1st Ed. Philadelphia, W.B. Saunders Company, 1978 p. 1422-27, Chapter 67

Disaster Planning in Tintinalli J. (Ed): A Study Guide in Emergency Medicine, CH 21:2

Wilkins EW: Disaster Planning in Wilkins EW (Ed): MGH Textbook on Emerg Med 1st Ed. Baltimore, The Williams & Wilkins Co., 1978 p. 743-749

The Role of the Emergency Physician in Mass Casualty/Disaster Management ACEP Position Paper, JACEP 5:11, p. 901-902, 1976

Clark RB: Disaster Drills, JACEP 7:416, 1978

Fairley: Mass Disaster Schemes, BMJ, 4:551-553, 1969

Fisher CJ: Mobile Triage Team in a Community Disaster Plan, JACEP 6:21, 1977

Gerace RV: Role of Medical Teams in a Community Disaster Plan, CMAJ 120:923-928, 1979

Gierson ED, Richman LS: Valley Triage: An Approach to Mass Casualty Care, Journal of Trauma 15:193-196, 1975

Dr. Gerace is an Emergency Physician at Victoria Hospital in London, Ontario.

Residents' Corner

by Paul Assad, M.D.
and Michael O'Connor, M.D.

As the number of Emergency Medicine residency programs grows in Canada, we thought it would be interesting in this issue and in future ones to outline the different programs and to bring out the resident's point of view with regard to these. Two of the most active programs are the ones at Queen's University in Kingston and McGill University in Montreal.

The Queen's program is directed by the Division of Emergency Medicine of the Department of Surgery under director Dr. L.E. Dagnone. The Emergency Departments of the Kingston General and Hotel Dieu Hospitals provide eight full time university faculty members for teaching in Emergency Medicine. The composite annual Emergency Department visits census for both hospitals is 85,000 visits. The first two years of the program include rotations in the Emergency Room, The Coronary Care Unit, General Surgery, Cardiovascular, Thoracic and Neurosurgery, Orthopaedic-Plastic Surgery, Surgical Intensive Care Unit and two other medical specialties. The third year is spent as the senior resident in Emergency in the Emergency Department and is split between the two teaching hospitals. As well, a minimum of one month is spent in the Emergency Department of the Children's Hospital in Eastern Ontario in Ottawa.

As far as the teaching curriculum, there are two weekly teaching rounds and a weekly core curriculum seminar with a journal club being held monthly. Senior residents are involved in teaching sessions for health related professionals and participate in regular, basic and advanced cardiac life support courses.

The McGill program, directed by its new director Dr. Wayne Smith, is under both the Surgery and Family Medicine Departments. It operates out of the Royal Victoria Hospital and has six full time faculty members. The annual visits census for the Royal Victoria Hospital is approximately 50,000. The entire two year program is spent rotating through the adult Emergency Room at the Royal Victoria Hospital, the Pediatric Emergency at the Montreal Children's Hospital including Pediatric Anesthesia, Coronary Care Unit, Neurosurgery, Plastics, Accident Service, Internal Medicine, Surgical Intensive Care Unit, and a series of electives in Radiology, Dermatology, Ophthalmology and Anesthesia. During the senior year a month is spent in Jacksonville, Florida with special exposure and instruction in EMS. Each year the McGill program graduates six fully trained Emergency Physicians, many of whom are presently practicing in the United States and in Canada.

The residents in Montreal feel that certain aspects of their training could be improved such as greater exposure to trauma and neurology. They are presently investigating the possibility of a one month rotation in a trauma centre either in Canada or the United States. In the near future, two faculty members will be visiting several programs in California in order to study possible improvements to their program.

These two programs are certainly well on their way to becoming excellent institutions in the training of Emergency Physicians and the future can only bring improvement. In future issues of the *Review* we will be comparing the other programs presently available.

Dr. Paul Assad of the Royal Victoria Hospital is Chairperson of the CAEP Resident Committee. Dr. Michael O'Connor is Senior Resident at Queen's University.

NOTE: Any residents or medical students wishing to become more involved in the activities of CAEP and it's Resident Committee should contact Paul Assad — your help would be more than welcomed. In particular, representatives from the other three Canadian programmes are needed for the Steering Committee.

Constitution Of The Canadian Association Of Emergency Physicians

This is a most recent draft of revisions to the CAEP Constitution and Bylaws. Members will recognize that it has gone through quite a number of changes since its first incarnation two years ago.
This version is hereby presented to the membership for review and comment. All comments should be directed to:
Dr. V. Wood,
Chairman, Constitution & Bylaws Ctte.,
3580 Puget Dr.,
Vancouver, B.C., V6L 2T7.
before Jan. 1, 1981.
Then, in the summer '81 edition of the ***Review****, a final version of the constitution will be published, as notice of motion for the Annual Meeting in October '81, where it will be voted upon.*
So please, review it, and send your comments in before the New Year.

ARTICLE I

This organization shall be known as the Canadian Association of Emergency Physicians (hereinafter sometimes referred to as the "Association").

ARTICLE II
PURPOSES AND FUNCTIONS OF ASSOCIATION

Section I — Purposes and Objectives

This Association has been founded to promote emergency health services in Canada. The objectives of the Association are:

1. To study and recommend standards of Emergency Medical Care in Canada.
2. To encourage and participate in the development and maintenance of reasonable and effective standards for both post-graduate training programs and continuing education for Emergency Physicians.
3. To foster research in the field of Emergency Medicine.
4. To promote coordination of community, provincial, and national emergency care facilities and personnel.
5. To provide representation for physicians who are engaged in the practice of Emergency Medicine in Canada.

Section 2 — Legal Identity

This Association shall be affiliated with a management company known as the Canadian Emergency Physicians Management Ltd. (the "Company"). The Company is and remains a separate legal entity from the Association. The Company will carry out a management function for the Association. Effective control of the Company shall be by the officers of the Association.

ARTICLE III
MEMBERSHIP

Section 1 — Personal Qualifications

Membership in the Association is a privilege, not a right, and is contingent upon continuing compliance with the Constitution and Bylaws of the Association. No person shall remain a member of the Association unless he is of good moral character and agrees to abide by the Principles of Medical Ethics of The Canadian Medical Association.

Section 2 — Classes of Membership

Membership in the Association shall be classified as follows: (1) Active; (2) Affiliate; (3) Honorary; (4) Resident; and (5) Student.

The qualifications required of the respective classes, their rights and obligations and the methods of their election shall be set forth in the Bylaws. No person shall be denied membership because of sex, race, age, or political or religious beliefs.

ARTICLE IV
OFFICERS, EXECUTIVE AND COMMITTEES

Section 1 — Officers & Executive

The officers shall be President, President-Elect, Secretary, Treasurer, and Past-President. The Executive shall consist of these five officers and one Member-at-Large. Members of the Executive shall be elected by the Association members at the Annual Meeting.

Wherever the term "Annual Meeting" is used in this document it shall mean the annual general meeting of the Association members.

Section 2 — Executive Meetings

The Executive shall meet at least twice annually in addition to the Annual Meeting. Additional meetings of the Executive may be called by the President. The Executive shall receive notification of any and all meetings at least thirty days prior to the meeting. Members of the Executive present at any meeting shall constitute a quorum. Action shall be initiated by a majority vote of Executive members present at a meeting. All meetings shall be open to

members of the Association. A closed meeting may be called for just cause but all voting must be in open session.

Section 3 — Standing Committees

Standing Committees are:
1) Membership; 2) Continuing Medical Education; 3) Annual Scientific Program; 4) Policy and Standards; 5) Constitution and Bylaws; 6) Nominating; 7) Resident; 8) Pre-hospital care.

All the members of Standing Committees must be members of the Association. The Chairmen of Standing Committees will report regularly to the Executive.

Section 4 — Other Committees

The Executive may appoint other committees and respective chairmen as it deems advisable from time to time. All the members of such committees must be members of the Association.

ARTICLE V
ADOPTION AND AMENDMENT OF CONSTITUTION AND BYLAWS

Any member may propose amendments to this Constitution and Bylaws by submitting the same to the Secretary at least sixty days prior to any Annual Meeting. Notice of such proposed amendments shall be given by the Secretary to all members of the Association at least thirty days before the meeting at which the proposed amendments are to be considered for action. The Constitution and Bylaws shall be adopted and amended by an affirmative vote of at least two-thirds of the members present and voting at the Annual Meeting. Amendments to the Constitution and Bylaws shall take effect immediately upon adoption.

BYLAWS OF THE CANADIAN ASSOCIATION OF EMERGENCY PHYSICIANS

CHAPTER I
CLASSES OF MEMBERSHIP AND ELECTION

Section 1 — Eligibility

To be eligible for membership in this Association, the applicant must show a significant interest in Emergency Medicine. He must be of high moral and professional character.

Section 2 — Applications for Membership

All applications for membership shall be in writing on an application form approved by the Executive. Election to membership shall be by Executive action based on but not necessarily in accordance with the recommendation of the Membership Committee Chairman.

Section 3 — Dues

Dues for the various membership categories shall be determined annually by the Executive for the ensuing year. Such dues shall be payable on September 1st of each year.

Section 4 — Termination of Membership

Resignation of membership may be made in writing to the Chairman of the Membership Committee of the Association. Non-payment of dues within one month of notification of delinquency shall be presumptive of resignation.

Section 5 — Active Members

The active members of this Association shall be physicians who are engaged in the practice, teaching, or administration of Emergency Medicine for greater than 80% of their professional time. They must be licensed in the jurisdiction in which they practice. The active members will enjoy the privileges of membership including the right to vote at the Annual Meeting and the right to hold appointed or elected office, as defined in Article IV, Section 1. They shall fulfill such continuing medical education requirements as may be prescribed by the Executive.

Section 6 — Affiliate Members

The affiliate members of this Association shall be physicians who are interested and/or involved in Emergency Medicine. The affiliate members shall enjoy the privileges of membership excluding the right to vote at the Annual Meeting and to hold elected office, as defined in Article IV, Section 1. They may sit on standing and other committees of this Association. They shall fulfill such continuing medical education requirements as may be prescribed by the Executive.

Section 7 — Honorary Members

The honorary members of this Association shall be those who have rendered outstanding service in the field of Emergency Medicine. Candidates for this form of membership shall be proposed in writing to the Chairman of The Membership Committee for subsequent approval by the Executive. The Executive shall decide by a two-thirds majority if such an honor is warranted. Honorary members shall not be entitled to vote at the Annual Meeting nor to hold elected office, as defined in Article IV, Section 1. They may sit on standing and other committees of The Association. They shall not have to fulfill continuing medical education requirements. If the honor is bestowed upon a current member of the Association, he may continue to enjoy the privileges of his membership category.

Section 8 — Resident Members

The resident members of this Association shall be physicians engaged in post-graduate training in Emergency Medicine. The resident members shall enjoy the privileges of membership including the right to vote at the Annual Meeting and to hold appointed office. They shall not be entitled to hold elected office, as defined in Article IV, Section 1. They shall not have to fulfill continuing medical education requirements.

Section 9 — Student Members

The student members of this Association shall be medical students who are interested in Emergency Medicine. The student members shall enjoy the privileges of membership but they shall not be able to vote at The Annual Meeting or to hold elected office, as defined in Article IV, Section 1. They shall be eligible to sit as non-voting members of the Resident Committee and shall be

eligible for appointment to sit on but not chair other appropriate committees. They shall not have to fulfill continuing medical education requirements.

Section 10 — Membership Revoked

Any member who changes his occupation or status in such a manner as to render him ineligible for membership in this Association shall be stricken from the roll of members by Executive action. The Executive may revoke membership for good cause, provided that the members shall be given a fair and impartial hearing to determine the appropriateness of the revocation.

Section 11 — Agreement

Acceptance of membership in this Association shall constitute an agreement by such members to comply with the Constitution and Bylaws thereof and to recognize the Executive as the sole and only judge of his right to be or remain a member, subject to the hearing prescribed above in Section 10.

All right, title, and interest both legal and equitable, of a member in and to the property of this organization shall cease in the event of any of the following: a) the expulsion of such member; b) the striking of his name from the roll of members; c) his death or resignation.

CHAPTER II
MEETINGS OF THE ASSOCIATION

Section 1 — Annual Meeting

There shall be an Annual Meeting of the Association members at such place and time as may be determined by the Executive provided that the time and place of such meeting shall be announced at least three (3) months prior to the meeting.

Section 2 — Nominations and Elections

It shall be the duty of the Nominating Committee to select one nomination for each of the six Executive positions. At least thirty days prior to the Annual Meeting the Chairman of the Nominating Committee shall mail this list of nominations to all of the Association Members. At the Annual Meeting the Chairman of the Nominating Committee shall present this list of nominations to the members, provided that nothing herein shall be construed as preventing nominations from the floor at the time of the Annual Meeting. The election of the Executive shall be by a majority vote of the members present and voting.

Section 3 — General Meetings

The Executive may, from time to time, deem it necessary to call a General Meeting of the membership, to deal with pressing business on which the membership ought to be consulted. Notice for such General Meetings shall be mailed at least thirty (30) days prior to the meeting, along with the proposed agenda.

Section 4 — Procedure at Meetings

Quorum at both Annual and General Meetings of The Association shall consist of fifty (50) voting members. Meetings shall be chaired by The President or his designate. Where procedural disputes arise not dealt with in the context of this Constitution and Bylaws, "Robert's Rules of Order" shall prevail.

Section 5 — Recall Procedure

Any member of the Executive may be removed from office by a three-quarters vote of the members present and voting at any Annual or General Meeting of the Association. If a General Meeting is called for this purpose, notice of the vote to remove shall be given along with notice of the meeting thirty (30) days prior to that meeting.

Any vacancy created by a recall shall be filled by a majority vote of the members present and voting at the meeting at which the recall occurs. Nominations for any vacancy shall be accepted from the floor of the meeting.

CHAPTER III
DUTIES AND TERMS OF OFFICE

Section 1 — President

The President shall be an Active Member of the Association, ex officio a member of all standing committees. He shall be a voting member of the Executive. His term of office shall begin at the conclusion of the Annual Meeting at which his election occurs and shall end at the conclusion of the next Annual Meeting when his successor is elected. In the event of death or resignation of the President during the term of office or if he shall for any reason be unable or unqualified to serve, the President-Elect shall succeed to the office of President for the unexpired portion of the President's term. In the event of death, resignation, or incapacity of both the President and President-Elect, The Secretary shall assume the President's duties for the unexpired term. The President shall serve as Chairman at Executive Meetings and at the Annual and General Meetings.

Section 2 — President-Elect

The President-Elect shall be an Active Member of the Association. He shall be a voting member of the Executive and shall preside at Meetings in the absence of the President. His term of office shall begin at the conclusion of the Annual Meeting at which his election occurs and shall end at the conclusion of the next Annual Meeting when his successor is elected at which time he will normally become the President of The Association.

Section 3 — Secretary

The Secretary shall be an Active Member of the Association. He shall be a voting member of The Executive. His term of office shall begin at the conclusion of the Annual Meeting at which his election occurs and shall end at the conclusion of the next Annual Meeting, when his successor is elected. He shall cause to be kept accurate accounts of the affairs of the Association, including minutes of the Executive, Annual, and General Meetings. The Secretary shall be responsible for communicating to the Association members affairs of The Association.

Section 4 — Treasurer

The Treasurer shall be an Active Member of the Association. He shall be a voting member of the Executive. His term of office shall begin at the conclusion of the Annual Meeting at which his election occurs and shall end at the conclusion of the next Annual Meeting, when his successor is elected. He shall keep financial records of the Association and he shall submit a financial report for each Executive Meeting. At the Annual Meeting, the Treasurer shall present a financial statement to the membership, and recommend a budget for the upcoming year.

Section 5 — Past-President

The Past-President shall be a voting member of the Executive. His term of office shall begin at the conclusion of his term as President and shall end at the conclusion of the next Annual Meeting when his successor's term has ended. Normally he shall be appointed Chairman of the Nominating Committee during his term of office.

Section 6 — Member-at-Large

An Active Member of The Association, other than an Officer as defined in Article IV, Section 1 shall be elected to the Executive annually. He shall be a voting member of the Executive. His term of office shall begin at the conclusion of the Annual Meeting at which his election occurs and shall end at the conclusion of the next Annual Meeting, when his successor is elected.

CHAPTER IV
STANDING COMMITTEES

Section 1 — Appointments

As described in the Constitution, The Executive may appoint standing or other committees to assist the Executive in its work, including the Committees hereinafter specified.

Section 2 — Membership Committee

The Membership Committee shall be chaired by an Active Member who is nominated by the Executive and ratified by the membership at the Annual Meeting. The Chairman shall appoint other members of the Committee. The functions of the Committee shall be: 1) To consider and recommend to the Executive applications for membership; 2) To recommend changes in categories of membership and dues to the Executive; 3) To encourage the enrollment of all qualified physicians into the Association.

Section 3 — Continuing Medical Education Committee

This committee shall be chaired by an Active Member who is nominated by the Executive and ratified by the membership at the Annual Meeting. Members of this committee shall be appointed by the Chairman. The functions of the Committee shall be: 1) To recommend to the Executive minimum standards of continuing medical education for each category of membership; 2) To establish a system approved by the Executive to award Association approval of continuing medical education courses.

Section 4 — Annual Scientific Program Committee

This committee shall be chaired by an Active Member who is nominated by the Executive and ratified by the membership at the Annual Meeting. Members of this committee shall be appointed by the Chairman. The function of this committee shall be to prepare the Annual Scientific Program for the Association.

Section 5 — Policy and Standards Committee

This committee shall be chaired by an Active Member who is nominated by the Executive and ratified by the membership at the Annual Meeting. Other members of this committee shall be appointed by the Chairman. The functions of this committee shall be to consider matters relating to standard of training, certification, and practice of Emergency Medicine and to make recommendations to the Executive regarding policies in these areas, and positions to be adopted by the Association.

Section 6 — Constitution and Bylaws Committee

This committee shall be chaired by an Active Member who is nominated by the Executive and ratified by the membership at the Annual Meeting. Other members of this committee shall be appointed by the Chairman. This committee shall make a study of the Constitution and Bylaws and make recommendations to the Executive for changes, deletions, modifications and interpretations after having given due consideration to submitted proposals.

Section 7 — Nomination Committee

This committee shall be chaired by an Active Member who is nominated by the Executive and ratified by the membership at the Annual Meeting. This will normally be the Past-President. Other members of this committee shall be appointed by the Chairman. This committee shall prepare a list of candidates as outlined in Chapter II, Section 2 of The Bylaws.

Section 8 — Resident Committee

This committee shall be chaired by a Resident Member who is nominated by the Executive, after consultation with the Resident Committee, and ratified by the membership at the Annual Meeting. All Resident and Student Members of the Association shall be considered to be members of this committee. The function of this Committee shall be to consider all matters of interest and relevance to trainees in Emergency Medicine programs, and to make suitable recommendations to the Executive. This committee shall also solicit Resident memberships.

Section 9 — Pre-Hospital Care Committee

This committee shall be chaired by an Active Member who is nominated by the Executive and ratified by the membership at the Annual Meeting. The Chairman shall appoint other members of the Committee. The functions of this Committee shall be to make recommendations to the Executive with regard to: 1) Disaster planning; 2) Community Basic and Advanced Cardiac Life Support programs; 3) Training programs for first-aid attendants, lifeguards, and ambulance and fire department personnel.

Across Canada:

THE EVOLUTION OF EMERGENCY MEDICINE IN WINNIPEG

by Angela Pitchford, M.D.

Emergency Medicine, and in particular, the Emergency Physician have only recently been introduced into the medical scene in Winnipeg. In 1973 the Health Sciences Centre, a University hospital, hired its first fulltime Emergency Physicians. At St. Boniface, the other teaching hospital, Family Practioners staffed the Emergency Department. These physicians worked fee-for-service as opposed to their salaried counterpart at the Health Sciences Centre.

In the early 70's Emergency Departments showed increases in patient volume.

A further change in the staffing of the City's Emergency Departments occurred in 1974, when the government, anxious to have salaried physicians at each of the four peripheral hospitals, instituted a program of hospital medical officers. Until that time, the peripheral hospitals had relied heavily upon the foreign medical graduates to staff both their Emergency Departments and the wards. These physicians would spend a year or two at the peripheral hospitals in preparation for their exams and then would move on to recognized internship programs. This system was far from satisfactory as the standards varied greatly. In the early 1970's, the Emergency Departments in all city hospitals showed marked increases in their patient volume and it became apparent that there was a need to hire physicians whose main interest and training was in Emergency Medicine.

The bulk of the first hospital medical officers in 1974 were drawn from the graduating classes of the University of Manitoba. They worked shifts and put in approximately 40 hours a week. When assigned to the wards they answered acute calls, managed cardiac arrest resuscitations, and assisted their colleagues in Emergency when they were not busy. The routine management of patients was left to the private physician. The physician assigned to the Emergency Department of a peripheral hospital usually worked solo and was responsible for everything that came in the door of the Emergency Department. As shifts became heavier and problems more

complex, the Emergency Physician depended greatly on the help that his ward colleague supplied. In some hospitals the ward physician was also responsible for the running of the Intensive Care Unit.

Since 1974, the Health Sciences Centre has augmented its number of Emergency Physicians so that they are now responsible for providing all the care in the Emergency Department. The interns and residents who rotate through the Emergency Department function under the direction of the Emergency Physicians. At the St. Boniface General Hospital the group of Family Practioners has been replaced by a fulltime staff of Emergency Physicians and a Director.

At the present time four of the six hospitals in the City have staff in excess of eight physicians and have fulltime directors. Initially, young physicians were attracted because of fixed hours and adequate salaries. It became the perfect job for those physicians with interests outside of medicine who did not want to commit themselves to anything beyond the contract year. As the years passed it became evident that a small group of these doctors regarded themselves as career Emergency Physicians. Those in peripheral hospitals often began to resent their shifts on the wards and preferred to spend the bulk of their time in the Emergency Department. Some transferred to the teaching institutions where they were assigned to the Emergency Department. Others were able to change the job description in their own institutions enabling them to spend a greater percentage of their time in the area in which they were most interested.

Part of the improvement is the consistency of care patients receive.

The image of the Emergency Physician has been greatly improved over the last few years, due in part to the numerous television shows glamourizing our profession. Part of this improvement however, is also due to the consistency of care which patients receive when they come to the Emergency Departments. The public no longer assumes that they will be seen by an Intern and because of this, the profiles of many Emergency Departments within the City have changed. At my own hospital, the number of patient visits has not increased drastically over the last few years but the types of patients seen has changed, with the urgent and emergent categories doubling in relation to the non-urgent cases. Outpatient medicine is being directed to the offices of the Family Practioner and patients perceive that minor injuries and illnesses will be treated as the lowest priority in the Emergency Dept. I don't believe that the evolution of Emergency Departments and in particular Emergency Physicians, would have occurred as quickly if it had not been for the institution of Hospital Medical Officers at all the peripheral hospitals.

It is gratifying to see the evolution of the Emergency Physician in Winnipeg. With the passage of time, perhaps the image held by other members of the medical profession regarding this neophyte group will parallel that adopted by the general public.

Dr. Pitchford is Director of the Emergency Department at the Grace General Hospital, in Winnipeg.

CAEP Leadership —

How To Find Us

President	Dr. David Walker, Div. Emergency Medicine, Dept. of Surgery, Hotel Dieu Hospital, Kingston, Ontario, K7L 3H6 613-546-1227
Past- President	Dr. Al Schultz, 5726 Angus Dr., Vancouver, B.C., V6M 3N8 604-266-4403
President Elect	Dr. Greg Powell, Chief, Div of Emergency Services, Foothills Hospital, Calgary, Alta., T2N 2T9 403-270-1635
Secretary	Dr. Peter Lane, Trauma Unit, Dept. Emergency Services, Sunnybrook Medical Centre, 2075 Bayview Avenue, Toronto, Ontario, M4N 3M5 416-486-3290
Treasurer & Chairman, Membership Committee	Dr. Rocco Gerace, Dept. Emergency Medicine, Victoria Hospital, 391 South Street, London, Ontario, N6A 4G5 519-432-2352
Chairman Programme Ctte 1981 Annual Mtg	Dr. Wayne Smith, Clinical Director, Emergency Dept., Royal Victoria Hosp., Montreal, P.Q., H3A 1A1 514-842-1231
Chairman Constitution & Bylaws Ctte	Dr. Vic Wood, 3580 Puget Dr., Vancouver, B.C., V6L 2T7 604-734-1963
Chairman Resident Ctte	Dr. Paul Assad, 355 Jeanne Mance, Apt. 1112E, Montreal, P.Q., H2X 3P7 514-842-1231
Chair CME Ctte	Dr. Carolyn Neal, Emergency Dept., U of A Hospital, Edmonton, Alberta, T6G 2B7 403-432-8822
Chairman Pre-Hospital Care Ctte	Dr. Les Vertesi, 1437 Minto Cres., Vancouver, B.C., V6H 2J6

EMERGENCY MEDICINE TRAINING COURSES

Emergency Medicine Training Programmes in Canada:

Calgary, Alta

— Hospitals	— Holy Cross Hospital, Foothills Hospital, Calgary General Hospital.
— University	— U of 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	— U of 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.

London, Ontario

— Hospitals	— Victoria Hospital St. Joseph's Hospital University Hospital.
— University	— U of 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.

Kingston, Ontario

— Hospitals	— Kingston General Hospital Hotel Dieu Hospital.
— University	— Queen's University.
— 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.

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´

Ottawa ACLS Provider Course — the University of Ottawa/Ottawa General Hospital Emergency Physicians and Algonquin College jointly present this popular ACLS Course. *Dates* — October 24 - 26th. *Course Director* — Dr. Anna Malawski; Register soon as Registration is limited. Contact: Wayne Lewrey,
Continuing Education,
Health Sciences Division,
Algonquin College,
2135 Knightsbridge Rd.,
Ottawa, Ontario,
K2A 0R3.

Emergency Medicine Residency Training Programme:
positions available, University of Calgary, Pre-requisite 2 yrs broad based clinical training. For further information please contact Dr. G. Powell, Chief, Division of Emergency Services, Foothills Hospital, 1403-29th St., N.W., Calgary, Alta., T2N 2T9.

Membership Renewal Time:
CAEP's membership year runs Oct. 1 - Sept. 30. Members can therefore expect a renewal notice in the mail over the next few months. Please, return them quickly, so we can get on with the business of the organization.

Full time Emergency Physicians wanted:
New full-time group forming, opportunity for involvement with pilot pre-hospital care programme; contact:
Dr. J.C. Patterson,
Dept. of Emergency Services,
Plummer Memorial Public Hospital,
Sault Ste. Marie, Ontario,
P6A 2C4.

SPECIAL INVITATION TO CANADIAN EMERGENCY PHYSICIANS

5th INTERNATIONAL CONGRESS ON EMERGENCY SURGERY BRIGHTON, ENGLAND JUNE 7th - 10th, 1981

THE CONGRESS: An annual event attracting Emergency Physicians from throughout Europe, including the U.K.

THE PROGRAMME: An extensive series of lectures, symposia, practical workshops, and plenary sessions has been arranged. Emminent speakers from both sides of the Atlantic will be present. Topics include clinical, administrative, educational and research oriented aspects of Emergency Medicine.

THE LOCATION: Brighton and its beaches are reknowned as among the U.K.'s most popular vacation attractions. A promising series of extra-curricular activities are being arranged.

CONFERENCE CO-ORDINATORS:
Millstream Conferences Ltd.,
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CANADIAN CONTACT:
Dr. Carolyn Neal,
Emergency Dept.,
U of A Hospital,
Edmonton, Alta.,
T6G 2B7.

WANTED

Suggestions about how to use this space

Should we advertise? A major dilemma facing the executive and the *Review* at the moment is whether or not to allow advertising in the *CAEP REVIEW*.

Publishing a newsletter, let alone a full journal, costs a lot of money. This issue costs each CAEP member about $4.00. That's a lot of money.

Drug companies, medical equipment and supply companies are more than willing to spend a lot of money advertising in journals such as ours. The expenses of the *Review* are recoverable through advertising. But at what cost?

The *Review* is the organ of the Association — the communication pipeline to our membership. Should that be the medium for the pharmaceutical industry. Some also argue that the industry has a less than glowing record in the corporate world on many fronts, and we ought not give them space.

The debate is a thorny one, with a number of conflicting principles coming into play. The executive will be considering it over the next few months so let them know your thoughts.