Ten years ago, we had a good department. We delivered a high quality of care, enjoyed an excellent relationship with our surgical and nursing colleagues, and could boast one of the best residency programs in the Faculty of Medicine. Then along came Eric Jacobsohn with a vision of something different. There is no question that Eric is a big personality and had some pretty big ideas. Anyone who has been around for ten years will remember that for a department that already felt pretty good about itself, the suggestion that there might be more to which we could aspire was met with skepticism, to put it charitably. That first year and a half were interesting, although to a large extent more in the sense intended by the curse “may you live in interesting times”. Nevertheless, with patience and some liberal cheerleading, good things started to happen. Quite contrary to the predictions of a small but vocal minority, Eric worked very hard to increase collaboration and consensus.

The first fundamental change was to envision the city as one system instead of seven. This was embodied in the Anesthesia Program Committee, which brought together representation from all sites and sections. The APC worked
A Message from the Chair

This edition of Gasline represents the last edition in my tenure as Professor and Head Department of Anesthesia and Medical Director of the Winnipeg Regional Health Authority. I will use this opportunity to reflect on the status of the Department and also to acknowledge the many faculty, students, staff and other collaborators who have played such an important role in the evolution of our Department.

I will start with our clinical roles. We provide exemplary clinical care for at least 8 sites across the city. Our clinical care model is the most integrated clinical care delivery model of any city in Canada and reflects the reality of delivering clinical care in hospitals that have a limited range of specialties. Faculty have generally adapted well to the model of having more than one clinical site, but clearly the benefit has been mainly to the patients we serve! Patients at all sites are cared for by faculty members who are integrated members of a Department of Anesthesia and are active in the academic life of the Department. Research has expanded to the sites and the ‘division’ between sites has largely disappeared. This has all been made possible by our robust infrastructure, and VENTIS has served us very well in accomplishing this role. However, clinical care remains a challenge in recruiting the appropriate number of specialists. I think anesthesiology remains in a rather enviable position regarding recruitment. Many specialists in Canada have difficulty finding appropriate career opportunities. This does not mean that there needs to be complacency in our position as care givers. Clinical care, one of the pillars of a robust profession, needs to be innovative. Simply delivering care in the long run, albeit at a tremendously high level, will not be enough to secure our positions. Our profession will be required to become more innovative if it is to remain a leader in the delivery of care in the operating room, in perioperative medicine, pain therapy, and other clinical areas. Although we had been leaders in critical care several decades ago, anesthesiology no longer retains a leadership role in North America. We run the same risk in other areas! These seem like philosophical concepts and are for “others to address”, however, I submit that each and every clinician has a responsibility to ensure the evolution of anesthesiology.

The next pillar of a robust profession is our role as educators. Our Department has done a tremendous amount of good work in assuring an excellent residency program. The recent Royal College evaluation attests to this. The adoption of competency-based medical education will create a significant change in the way residency education is done and will tax our evaluation methodologies. We are well placed to take on this challenge and have the appropriate resources to make this happen! However, all faculty will be required to take a role in this significant change. Our fellowship programs continue to attract fellows from around the world. We are currently working with other international sites to increase exchange with our Department and international universities that wish to send their trainees to Winnipeg for further training. Our roles as educators in preclerkship and clerkship are robust and have shown significant growth. Our contribution exceeds our proportional size, a feat shared by only two other departments in Canada. The lack of engagement of Canadian faculty at large is disturbing, especially in light of struggling research agendas.

The third pillar of a robust profession is the research mission. We have been very fortunate to build our research infrastructure in the last 10 years. The research department, with its administrative hub and several research technicians, has made it easier for faculty to engage in research. Our Department, as well as the profession as the whole, is significantly underrepresented in obtaining Tri-Council and other national peer-reviewed research. Our profession, without evidence of competitive national funding, will be faced with serious challenges ahead. A profession without significant knowledge creation runs the risk of becoming a clinical guild and is at risk for being challenged in the clinical domain. Anesthesiology will have to collaborate with other clinical departments and basic science departments to creatively recruit scientists that can ‘live’ in both departments and further the academic goals of both departments. Many of the highly funded departments of anesthesia in the USA have been very successfully integrating PhD scientists into clinical and translational research, in furthering the academic mission of the anesthesia department. We have started along this course and it is imperative that we further develop these relationships.

Now for a few words of thanks. Many faculty, residents, students and colleagues in other departments have played an important role in assisting me over the last 10 years to develop our Department. I am very proud of the Department as it stands and thank you all for your efforts. I thank you all and wish you ongoing success in your careers! Finally, congratulations to the new Department Head. I look forward to contributing as a clinician, educator and scholar.

Dr. Eric Jacobsohn
Editors Message

On behalf of Sean Jardine, Bruce Knoll and the Gasline Team, I would like to introduce our latest summer edition of Gasline.

The current issue of Gasline highlights the tenure of Dr. Eric Jacobsohn as Chair of the Department of Anesthesiology and Perioperative Medicine, University of Manitoba, Faculty of Medicine. Before he arrived our department was quite different than the one it is today. Although it functioned as a good clinical department with a strong pool of attending physicians, there was untapped potential for the department to be greater. More importantly, there was a risk of complacency. If I could characterize the early years of Dr. Jacobsohn’s leadership when he arrived from Washington University, it would be that he had a clear vision and the determination to execute it. This edition of Gasline has content relating to the leadership of Dr. Jacobsohn with contributions from the associate heads, the dean of medicine, and Reid McMurchy.

The Anesthesia department at the University of Manitoba has always had staff with strong humanitarian interests. When there is a global crisis or disaster, our faculty has been there to answer the call. Dr. Kelvin Williamson is an example of such altruistic faculty. He has provided a fascinating article with insight relating to the Fort McMurray disaster and his involvement in providing medical care.

This edition of Gasline also has an important contribution from Dr. Hilary Grocott, the editor in chief of the Canadian Journal of Anesthesiology. He outlines important pearls and a framework for publishing scientific articles.

Gasline is rounded out by content contributed by Dr Marshall Tennenbein, Dr. Jamit Dhaliwal, Dr. Craig Haberman, Dr. Rob Brown, Dr. Darren Holland and Mark Ratz with articles ranging from the Canadian National Anesthesia Simulation Curriculum to current updates of our residency and pain fellowship programs.

The Gasline team hopes you enjoy the latest edition of our department newsletter and would like to extend wishes for a happy and safe summer season.

Dr. Amit Chopra

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GASLINE TEAM | 2016

EDITOR - IN - CHIEF: DR. AMIT CHOPRA
CO-EDITOR/DESIGN: SEAN JARDINE
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I recently became aware of non-anesthesia physicians doing femoral nerve blocks in EM for femoral fractures. Of course my instinctive response was something loosely along the lines of "who do they think they are?", or perhaps something a little less noble. On reflection, however, I had to ask myself, what really defines the skill set of a given group, or conversely, a skill as belonging to that group? Is there anything that we could point to that would justify ownership? We, as do all physicians, have a need to define what it is that we do. This applies to pretty much everything we do. There are new areas of expertise - perioperative medicine - to which we would like to lay claim, and there are others continually looking to lay claim to our traditional areas of expertise.

I have always thought the core of the answer to this conundrum to be knowledge creation. They who make the knowledge are the experts. I still think that is fundamental. However, I don't think it suffices to describe the issue. After all, I didn't personally do any of the studies upon which my practice is based. I am also fairly certain that I have no genetic or spiritual link to those researchers that would make me as an anointed anesthesiologist uniquely capable of interpreting their mysteries.

The solution to my problem was revealed to me by a comment made by Eric Sutherland the other day while we were discussing - brace yourself - Competency-Based Education. Once we describe the competencies that are required to do what we do, and evolve education and assessment tools to show that we actually learn them, we have defined ourselves. There will no doubt be competencies in our list that are in many other lists. We are hardly the only people who know how to start an IV. There will be a few that are unique to us, but what will define us is the framework of interrelated competencies and metacompetencies that describe a Perioperative physician. It doesn't really matter who shares some of the pieces.

Of course, describing ourselves falls into life's endless list of things that are easy to say and hard to do. Anesthesia is ahead of most in evolving our CBE, to the credit of some really hard work by the Specialty Committee. I believe that anesthesiologists do possess a valuable skillset unlike any other practitioner. If we do this properly, it will clearly set that out. Of course, if the resulting framework fails to distinguish us from others, then we either are not unique, or have failed to describe ourselves adequately. Thus, it behooves all of us to think about what makes us important and help build the framework that reflects that.

Dr. Rob Brown

Gasline Quick Shot

Dr. Trevor Lee recently graduated from Carnegie Mellon University with a Masters in Medical Management. Dr. Lee is the first Canadian to ever receive this degree. He has also recently been elected as a Fellow of the American Association of Physician Leaders (FAAPL).
very well under Eric’s lead and adopted a model that saw most anesthesiologists moving between sites. Slate cancellation rates due to anesthesia shortages were very high prior to having this flexibility and lead to tremendous frustration with patients having their surgeries cancelled with short notice. Managing the city like one big enterprise has greatly improved our ability to adapt to the constant fluctuation of demand. Cancellation rates due to anesthesia have essentially dropped to zero in spite of our continuing resource shortages. At the same time, our culture shift began. The Balkanization of the departments began to dissolve, to be replaced by a sense of city-wide community. We capitalized on strengths of each other and ultimately have elevated the daily practice across the whole system. Our clinical service model was improving, but that is only part of the mission of a department.

There were still strides to be made in research and teaching, to which end Eric adopted the Associate Head structure, lovingly referred to by some as the “three stooge” model. That allowed us to focus and coordinate our growing efforts. While most other departments in Canada seem to largely be either complacent or impotent, we have completely changed our image. The visiting professors who come to adjudicate our research night consistently marvel at the quality of the work being done. We have added real resources not only to support the research ideas of faculty, but to bring new ideas and creativity to expand our vision. A major part of the expanded research mission is the Anesthesia Oversight Committee (AOC) which, from the departmental tithe, has distributed approximately $1 million in seed monies for research projects form our faculty. At the annual ACUDA meetings, it is constantly admired and envied by other University Departments of Anesthesia.

Prior to Eric, anesthesia was nominally responsible for 4 hours of lectures in the UGME curriculum, only one of which was taught by a practicing anesthesiologist. We are now seen as a stalwart in UGME. Through our robust participation in mentorship, small group teaching and clinical skills, it would now be a rare medical student who did not know at least one anesthesiologist. Our excellence in residency education has extended beyond our department as well, and the expertise of our department is relied upon by FPGME. Our simulation team provides an educational program among the top in the country and is engaged in leading change.

All of this progress notwithstanding, the most profound impact that Eric has had on our department is the culture change that has evolved over the last 10 years. Eric is incredibly passionate about Medicine and Anesthesiology, and it percolates through every interaction, from leading APC, to mentoring undergraduates. He exemplifies not just what we can do, but how rewarding it can be. Between his consistent public and private exhortations to excellence and his own leadership by example, we have come to see ourselves differently, as clinicians, leaders, academics, teachers and most importantly physicians. He truly “walks the walk” in terms of his excellence as a clinician, both in the operating room and ICU, as a teacher, as a researcher and above all, as a leader. I am confident that many years from now we will look back at the last decade as being one of the most transitional and impactful in our history. We wish to thank Eric on behalf of the whole community and wish him the greatest of success in his next endeavor.

**Rob Brown**  
Associate Head Education

**Stephen Kowalski**  
Associate Head Research

**Shawn Young**  
Associate Head Clinical Operations
**A Message from Dr. Brian Postl**

Dr. Eric Jacobsohn is coming to the end of a ten year term as Head, Department of Anesthesia & Perioperative Medicine, Faculty of Health Sciences, University of Manitoba and the Program Director, Anesthesia Program, WRHA. Anesthesia is indeed a very different place today than when he arrived.

The scope and role of the Department has increased across the city and province with a consistent standard of care throughout and an advanced scheduling and management system that has served as a model for the faculty.

Education programs continue to thrive at a PGME level and the contribution at an undergraduate level has been outstanding.

The research effort and productivity has likewise increased with Department members collaborating with other disciplines, specialties and in the broader national research and publication community. As well, residents have also become more engaged with research and the annual Resident Research Day has continued to grow and demonstrate the important contributions residents make to the research enterprise.

The Department has performed well financially and money from member tithes has been well utilized to support academic activities. We have also seen remarkable commitment to service throughout the Department as residents and faculty members/clinicians volunteer their clinical skills to serve those in critical need through humanitarian missions such as the Red Cross emergency response to the Nepal earthquake and the Operation Walk mission to Nicaragua.

Lastly, under Dr. Jacobsohn’s leadership, the Department launched a Brandon stream of the Anesthesia residency program in 2015, the first Royal College program for the Brandon satellite program site.

It is a time of change indeed; an active search is nearing completion. Dr. Jacobsohn’s legacy will be a highly functioning and committed Department to advance the academic mission of the University and patient needs across the province.

**Gasline Quick Shot**

Dr. Raja Rajamohan (middle) at his farewell party. Dr. Rajamohan is heading to Vancouver to continue his Anesthesia career at St. Paul’s Hospital.
“Whats Going on in ACA Land?”

Well Spring is here an it’s a great time for golfing, fishing and bear hunting! It's also a great time to be an Anesthesia Clinical Assistant as we continue to develop our role as essential members of the Anesthesia Team at all sites within the Winnipeg Regional Health Authority (WRHA).

In the last issue of Gasline, then ACAP Director Dr. Young indicated that the Physician and Clinical Assistants of Manitoba (PCAM) were in the midst of contract negotiations with Manitoba Health and the WRHA. I am happy to report a contract has been negotiated and ratified. As you can imagine, there have been challenges during implementation of this contract due its uniqueness that ensures clinical assistance to Attending Physicians of all specialties is available, however, the ACA group is fortunate to have PCAM Executive Members, Victor Duarte as Vice President and Sean Jardine as Director of Communications for contract clarification. Importantly, there should be no recognizable changes to ACA provision of service as a result of this contract.

The Manitoba ACA Program continues to be well recognized as one of the top in the country. Jared Campbell has been on the Anesthesia Assistant Executive Section at the Canadian Anesthesia Society (CAS) for three years as Secretary, and I am currently in my fourth year as Chair, previously held by Jeff Kobe. Some important contributions we have been involved in at CAS are the “National Education Framework for Anesthesia Assistants” document, as well major influence from our Program can be seen in the recently published “Position Paper on Anesthesia Assistants: An Official Position of the Canadian Anesthesiologist’s Society”. In addition to Jared and I, Faylene Funk and Regina Kostetsky are currently involved as working group members in the development of a National Exam for Anesthesia Assistants. I can tell you we are still a long way away from any Nationally consistent curriculum, examination, registration and scope of practice, but I am confident Manitoba’s influence will ultimately be recognized in all categories. Part of my role has been inviting speakers to the CAS conference, and I am fortunate this has been a relatively easy task. At this year’s upcoming conference in Vancouver, Dr. Young has accepted my invitation to present. His topic “Sedation for Trans-catheter Aortic Valve Implant”, moderated by Jared Campbell, is sure to garner significant interest. I hope to see you in Vancouver at this year’s CAS conference.

I would like to take this opportunity to thank Anesthesia Department Leadership for ensuring our continued presence and influence at CAS, as this would be a tremendously difficult endeavour without their support over the years. Notably, on behalf of all ACAs I would especially like to thank Dr. Jacobsohn. From the very beginning Dr. Jacobsohn has been immensely supportive and committed to our programs success. He has always ensured we were valued as we worked towards becoming essential members of the Anesthesia care team. He has been instrumental in finding solutions to the challenges we have encountered over the years and even now, at likely his busiest, he has taken on the role of ACAP Medical Director. Personally, I have sat with Dr. Jacobsohn at CAS meetings and watched with reverential respect and wonder as he relentlessly expressed the importance and significance of the inclusion of multiple medical backgrounds into the Profession of ACAs and that Manitoba’s ACA program will be the one that will guide the Nation in the future. He did this in a room full of National Anesthesia leaders that were not of the same opinion, but by the end of the meeting were clearly convinced otherwise. It was in those few minutes that he selflessly and without concern for his own reputation emphatically declared his support for us on a National platform. I will always carry the memory of the meeting Chair resorting to profanity to terminate Dr. Jacobsohn’s discussion! That truly is character leadership.

I believe that is all the current updates I have. As always, feel free to call on your ACA for both clinical and non-clinical assistance.

Thanks to all Attendings

Mark Ratz, BN, Cl.A-Anesthesia
ACAP-Lead
Chair Anesthesia Assistant Section-CAS
PCAM-Anesthesia Representative
“If I only knew then what I know now” is a frequently paraphrased quotation that I hear from both research novices and seasoned investigators alike as they describe the trials and tribulations of designing, conducting and reporting their research studies. Research is unquestionably one of the most satisfying academic endeavors, but it can also one of the most frustrating. As Editor-in-Chief of the Canadian Journal of Anesthesia, far too often I see the products of research that are in desperate need of considerable remediation before they will “pass the bar”. Very often, there are issues which could quite easily have been addressed in the design stage. However, if only uncovered at the stage of manuscript review and consideration for publication, they are often times impossible to adequately address. This does not always mean a failure of the paper to be published, however, it does frequently limit the full significance and potential for the work to impact practice. At the end of the day, our collective academic pursuit is fundamentally rooted in improving the experience and outcomes of our patients. We do a disservice to this population if we do not make the most of the resources that we have and optimize the potential for our research to influence practice. What follows in this commentary are a series of simple steps that the prospective researcher can undertake in order minimize their frustration and maximize the potential impact of their paper.

One of the fundamentally important aspects of designing a research study is to come up with a research idea that is important. Thus, the first question I ask myself as an editor is, “Is this an important question/issue?” The resources required of research are too valuable and the patients available for clinical studies too few to conduct research of minimal significance. When balanced with a pragmatic approach, it makes for an ideal study.

What follows next is the fleshing out of the detail of the project, including putting it into context of what has preceded it. That is, your research question needs to be framed, the population to study identified, and the endpoints determined. Often not done, the study question should ideally be preceded with a systematic review of the literature to understand what, if any, knowledge gaps exist. After this, the engagement of a statistician is fundamentally important. It is important so that you predefine the endpoints that are of interest and understand whether the study is of sufficient size (i.e. a sample size calculation to inform statistical power) to answer your question. Once you know “what” you are going to study, “who” you are going to study, and “how many” patients to study, understanding “how” you are going to analyze the data once it is gathered is paramount. Indeed, the statistical plan should almost always be defined \textit{a priori}. At this point, you have made significant gains in any given project, even though a single patient has not yet been enrolled. Importantly, all of these issues will be fundamental questions that future reviewers will keep in mind when you submit your paper for publication.

Pre-enrollment registration of the clinical trial has taken a long time to become common place in research. Certainly for randomized controlled trials (RCT), it is now fundamentally important to have this in place before...
the study is begun. Most journals will not even accept an RCT that has not been registered prior to patient enrollment. However, it is also important that trial registration is extended beyond the RCT and observational trials are also eligible for registration at the most commonly used clinicaltrials.gov website. Importantly, even systematic reviews and meta-analyses can be registered the PROSPERO website.

After these fundamental issues are addressed, approval of the institution will be required, including the research ethics board, as well as the necessary in-hospital impact committees. Importantly, there are numerous valuable resources around us, including the resources available through our own research office that should facilitate a lot of this early study development.

It is now time to collect the data. The hard work that has preceded this point will almost certainly be equally matched. Once the data has been gathered, analyzed and prepared to frame within a written submission, a very important part of the research experience is about to begin. Often the question is asked, “I’ve got all the data, but I don’t know what to do with it, and don’t understand all the components that needs to be included in a manuscript.” Once again, thankfully, there are a number of valuable resources available to us to assist in the writing process. One of the most important resources is the various “reporting guidelines” (see www.equator-network.org ) that have been disseminated, both to assist the writer, guide the reviewer and the reader, but also to ensure that research reports tell the whole story – transparency is critical.

Once the research report has been drafted, revised, re-read – with the cycle seemingly endlessly repeated – the study report will be ready for submission. Choosing which journal to submit the study is also important. The guidelines for authors for the journal should be rigorously adhered to out of both respect for journal, but also because they outline some of the fundamental components of the study should be in place. As a result, often missing elements of the guidelines for authors are some of the most important aspects of the manuscript.

The paper is now ready to be submitted. It has already been a very long journey and the next phase is about to begin. The steps that follow with submission, review and revision process can be, itself, an arduous experience. However, by taking into account these fundamental early steps, you have optimized your ability to have your research report favourably considered. You can sit back and relax with the satisfaction that you have done the best that you can do and now it is up to the reviewers, editors and the scientific community to determine how to judge and contextualize your efforts.

Dr. Hilary Grocott
As some of you may or may not know, I am the Medical Director for the province’s Office of the Fire Commissioner. This office is home to the provincial Emergency Services College and is also home to the Heavy Urban Search and Rescue Team (USAR, or HUSAR). There used to be 5 teams in Canada: Vancouver, Calgary, Winnipeg, Toronto, and Halifax (Halifax no longer has a team); leaving 4 active teams in the country.

Traditionally, this team is designed to be able to access, manage, and rescue victims in the setting of structural collapse. Areas of expertise include: trench and confined space rescue, high and low angle rope rescue, shoring and structure stabilization, demolition, rapid water, cold water rescue, CBRNE (Chemical, Biological, Radiological, Nuclear Defence) management, and expertise in establishing and maintaining an ICS (Incident Command System) and Unified Command.

There are not a lot of structures collapsing in this day and age, so the trend has been to broaden the team’s capabilities to an all hazards approach. Recent activations of the country’s USAR teams include: Elliot Lake, Calgary floods, Manitoba floods, forest fires, fire suppression and property protection, missing persons, and rescue missions (lost ice fishers). Many times, an individual team is deployed; but there is the capability to request additional resources from another team. During the Calgary floods, Vancouver assisted the Calgary team. This spring, Manitoba came to the aid of the Calgary team.

Most recently, one of the largest and longest USAR deployments occurred; the Fort McMurray fires. I had the privilege to be part of the 22 members
from Manitoba who joined the aid effort. I will share my experience here. Words, video, or images cannot truly describe the amount of destruction encountered. Some areas of the city were untouched (other than smoke damage), while others were totally decimated. My first thoughts the first time I stood in a destroyed neighbourhood approximately the size of the Osborne Village area was “This is what I imagine Hiroshima looked like after the bomb”.

I was in Alberta from Monday, May 9 until Monday, May 16, 2016. Our role was to integrate with the Calgary team, filling any roles needed. Some of these roles included: Camp management, Emergency Operations Centre (EOC) management, logistics, finance, planning, medical. The week prior, Fort McMurray was mainly populated with active firefighters and disaster response personnel. The week I was there, about 2500-3000 people, from a number of response agencies, were present. One of the main challenges was that of accountability and safety.

My role was as a leader of medical services for the entire area (a job shared with a colleague from Alberta). There were 2 physicians, along with paramedics and a nurse, to service the response. There were also provincial ambulances for medical evacuations, as well as aeromedical capability (if the conditions would allow). However, they were used only if transport was deemed necessary. All “disaster area” management was coordinated through our medical team.

The main areas that we responded to were mental health, public health, primary care, and foot care. The main goal for most therapy was to ensure the patient can safely continue their role as a responder, escalating care if needed. Just a few of the cases I encountered were: foreign body removals, dental abscesses, a hypertensive emergency, PTSD, a GI outbreak (requiring isolation of patients, shutting down a camp kitchen, and taking over operations at staging area), and assessments and treating patients who have been without prescription medications for 2 weeks. Luckily,
Despite days with despicable air quality, there were no serious inhalational or respiratory emergencies. There were days where the air quality was so bad, visibility was impaired and respiratory protection was required.

One of the main objectives identified for safe transition from response to a recovery phase was to ensure appropriate medical services. The hospital, although not structurally affected by fire, had extensive smoke damage (requiring replacement of almost everything in it) and had an undetermined power loss. This meant that pretty much everything had to be restocked. The USAR teams had the assets to construct a field hospital which can run for an extended period of time, if needed. As such, the medical team was given the task to erect the temporary hospital (with insulated walls, HVAC, plumbing, electrical, lighting, a functioning lab, portable X-ray, and a small head CT scanner). The tents were powered with 2 massive diesel generators. We worked with AHS (Alberta Health Service) staff (nurses, and local physicians), to transition medical services from our disaster response team to theirs. The temporary hospital was fully operational the day we returned to Manitoba.

Near the end of my experience, the Prime Minister visited the area and spoke to all the responders and praised their efforts.

Disaster Response and Management is a very unique field and allows participation from a broad range of individuals. Healthcare plays a vital role and Anesthesiologists can have a huge impact in disaster response. Other colleagues who have participated in relief or response missions can attest to the unique challenges encountered, and the value that Anesthesiologists can add to this environment.
## Current AOC Projects

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<td>Mutch, A</td>
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<td>CVR maps and POD in AAA pts</td>
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<td>Sleep apnea associated with shoulder surgeries</td>
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<td>OSA in shoulder surgery patients: A retrospective study</td>
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<td>Management of OSA patients undergoing bariatric surgery</td>
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<td>Retrospective study of OSA patients post-operatively</td>
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<td>Prediction of nocturnal hypoxemia in parturients</td>
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<td>Plavix &amp; hip fracture: delays in surgical repair MCHP</td>
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<td>Sethi, S</td>
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<td>ASO in children: a new management plan</td>
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<td>Ketamine in OSA after tonsillectomy</td>
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<td>Wourms, V</td>
<td>MRI assessment in cerebral aneurysm vasospasm</td>
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We are almost at the end of another academic year and are in full swing with oral exam prep for the fifth years. We wish the PGY 5s all the best and know that they will do well. With the finish of one academic year comes the start of another and we look forward to welcoming the new PGY1s. This year we matched 6 spots including another resident for the Brandon stream. In addition to the 6 FRCPC spots we will also have 3 Family Practice Anesthesia residents joining us in July.

We continue to work towards a new curriculum for Competency by Design both at a national and a local level. Dr. Eric Sutherland who serves on the Royal College Specialty Committee has been extremely busy in this regard. Dr. Jason Frank from the Royal College gave a talk on May 16. It was great to see a good turn out so that we all have a better understanding of where we are heading in PGME and the reasons and logic behind it. At a local level we will begin to roll out and try some new evaluations and we will be asking for both faculty and resident feedback on these new initiatives. The goal date for full roll out still remains July 2017 for all anesthesia programs across the country. The time in training will not be reduced from the current five year program. Ottawa and Dalhousie are currently piloting programs with the potential to reduce training time, however the intent here and at all other programs is not reduced training time.

We will again be running the boot camp rotation in period three for all of the first years. During this time they will complete a number of mandatory PGME courses, ATLS, an online ultrasound course, begin training on trans-thoracic echocardiography, a number of lectures and hands on sessions on anesthesia basics as well as professionalism and physician wellness talks. Thanks to all of those who have agreed to participate and a huge thanks to Erika Blouw for doing the lion's share of organizing this rotation.

We also have a very well developed Physician Wellness curriculum now thanks to the efforts of a number of people, but most notably Daniela Goldie. This has been developing and evolving in conjunction and consultation with Dr. Anita Chakrivarti from the University of Saskatchewan. I believe that this will serve the residents very well and definitely has the potential to evolve into staff sessions. Certainly there is much more of a recognition now that this is an important part of medical education curricula and as ongoing professional development for physicians in practice.

We have recently developed a much more defined and formal relationship with the Department of Family Medicine as it pertains to the training of the Family Practice anesthesia residents. Dr. Kevin Convery is the Family Practice Anesthesia Program Director and has been working closely with us and will continue to play a prominent role in the administration of the program. It has been a pleasure getting to know Kevin and working with him, I know that the FPA program will be well served with him as the Program Director.

I would like to acknowledge and thank Dr. Strumper who has jumped in with both feet as associate program director and is doing a great job. Likewise a huge thanks the members of the education committee that includes Dr. Steve Booth, Dr. Jennifer Ballen, Dr. Ainsley Espenell and Dr. Eric Sutherland as well as Chief resident Dr. Darren Holland, Co-chief Dr. Ravi Jayas and Central Committee Chair Dr. Brian Csupsak for their tireless efforts and huge contributions to the residency program.

If I could make one plea it would be that faculty continue to fill out daily evaluations, especially the comments, as this helps a tremendous amount with helping the residents develop and improve their skills. Without this information providing constructive feedback on monthly and 6 month evaluations becomes difficult if not impossible. Have a great summer everyone.

Dr. Craig Haberman
Greetings. Another spring is upon us and the residents have survived another winter. We've spent many hours laboring in the dark ICUs and many more navigating the labyrinth of VENTIS, but we've still found a lot to celebrate. First of all, it's great to hear the infectious laugh of Tara DeCastro back in the department as she resumes her role as residency program administrator after her maternity leave. She hasn't missed a beat and is already keeping us all in line (Note to Tara: Yes, I finally submitted my Royal College Intent to Graduate form). The return of Tara means that Penny Godawatte is moving out of the program administrator office, but fortunately she doesn't have to move far as she has accepted the position of FPA program administrator. Penny has done a marvelous job under difficult circumstances and we appreciate all the hard work she has done for the residents in the past year.

This winter we have also had another successful recruiting year. First, Jennifer Dundas has transferred into Anesthesia from Neurosurgery and will join the R2 cohort. Second, we matched 6 residents to the RCPSC program through the CaRMS match. Five residents matched to the Winnipeg stream and one to the Brandon stream. Duncan Maguire, Kristin McPhail, Samuel Neily, Quyen Nguyen, Scott Richardson and Mohit Sharma will all be joining us in July. Third, 3 residents in the FPA program will be joining us in July: Tyler Bullen, Jarrod Nickel and Mike Nichol. We look forward to working with all of these recruits in the near future.

In April, many of us were able to attend the Department of Anesthesia Annual Gala. It was a great night of celebration with some memorable speeches, fine dining and even finer dancing. Congratulations to Craig Haberman who received the YK Poon Teacher of the Year award. Craig has been Program Director for almost 7 years now and has spent countless hours in the OR and in his office ensuring that we receive an exceptional education. Peter Inglis also deserves congratulations as he was awarded the Douglas B. Craig Resident of the Year award. Peter has led the resident group through his calm and unassuming demeanor. His impact on the resident group was recently summarized, “Peter doesn't talk a lot, but when he does you'd better listen”. Lastly, congratulations to Tom Mutter who received the inaugural Beckstead Family -HSC Anesthesiology Research award. I think that this means that there will be many more excellent resident research projects under his tutelage.

It's also important to mention that Anesthesia has further solidified it's dominance over the Orthopods in the first Anesthesia vs Ortho hockey game (If you aren't familiar with the Anesthesia vs Ortho feud it's worth watching a few YouTube clips on this). It was a hard-fought battle but Anesthesia prevailed with a 4-2 win and most importantly nobody sustained any fractures.

On a final note, there are no babies to introduce to the department (this is the first Gasline in years without a newborn to introduce) and the R5s still appear to be mentating after their written exam. Congratulations R5s and good luck with the oral exam.

Take care and see you in the OR.

Dr. Darren Holland
Department of Anesthesia Annual Gala 2016
Qualico Family Center

1. Dr. Brian Gregson, Residency Completion
2. Dr. Cameron Goldie, Residency Completion
3. Dr. Caleb Zelenietz, Residency Completion
4. 5th Year Residents
5. Dr. Andrew Reda, Residency Completion
6. Dr. Andrew Weiss, Residency Completion
7. Dr. Miranda Charette, FP Anesthesia Completion
8. Dr. Peter Inglis, Douglas B. Craig Resident of the Year
9. Dr. Craig Haberman, YK Poon Award Winner
10. Dr. Michael Leonhart, FP Anesthesia Completion
11. Dr. Sethu Madhavan, Cardiac Fellowship Completion
12. Dr. Yaryna Bychkivska, Simulation Fellowship Completion
13. Dr. Russell Price, FP Anesthesia Completion
14. Dr. Gordon Li, Cardiac Anesthesia Fellowship Completion
As someone new to Anesthesia in 2008, I had lots to learn about the Program. I knew few of the Faculty and none of the staff, but Brock (Dr. Brock Wright, Senior VP, Clinical Services & CMO) assured me that this would be a great opportunity to work with a strong medical leader that was making change. I assumed that the pace of change would be slow, as is often the case in institutions such as the hospitals, the region and the University. I quickly realized that while true at times, it is not always the case … especially when working with someone like Eric. Change can come as fast as he can reach his phone.

The last 8+ years for me has seen the establishment of the Academic Oversight Committee (AOC), the introduction and role expansion of alternate service providers, introduction of new clinical services (e.g. perioperative medicine) and new Fellowships, Professorships and research awards, VENTIS, growing Faculty recruitment from around the world, expansion of the Department's role in the medical school and a number of other changes of similar magnitude. Eric has been the driving force behind all of these in some way … often leading the way and sometimes, although admittedly less often, quietly behind the scenes having delegated the responsibility to other leaders in our Program.

I look forward to working with our next Head as we continue to move our Department and Program forward, but I will miss working with Eric (most of the time). He's been a visionary leader, a fierce advocate for patients and all who work in the Department/Program, a promoter of citizenship, contribution and professionalism … and always a Professor.

Reid McMurchy
Administrative Director
Anesthesia Programs

Gasline Quick Shot

Dr. Craig Haberman is awarded the YK Poon Award for Clinical Teacher of the Year. Dr. Haberman is finishing his term as the Anesthesia Residency Program Director.
The Pain Fellowship, what’s it all about?

The prevalence of people living with chronic pain in Canada is reported to be nearly 20% with a lifetime incidence of about 80%. A multitude of diseases, traumas and surgeries have the possibility of chronic pain syndromes associated with them. It is because of this common problem that, at the University of Manitoba, that we are proud to offer a fellowship in Interventional Chronic Pain Medicine.

The Interventional Chronic Pain Medicine Fellowship at the University of Manitoba is a one-year program that is available to Anesthesiology and Physical Medicine doctors.

The fellowship is a mixture of clinic time, interventional time and operating room time that is designed to give the physician the skills and knowledge base necessary to have a future practice in interventional pain medicine.

Our fellows train in a truly multidisciplinary clinic setting between Health Sciences Centre and Pan Am Pain Clinics. They train alongside attending pain specialists with backgrounds in Anesthesiology and Physical Medicine and Rehabilitation. They also work closely with psychologists specializing in pain management, nurse specialists and physiotherapists on a daily basis.

Our clinics at HSC and Pan Am are focused on this multidisciplinary approach to pain management involving medical management, psychological and physical rehabilitation treatments and interventional approaches which include everything from fluoroscopic and ultrasound guided nerve blocks and ablations to spinal cord stimulator implantations and everything in between. The clinic continues to evolve and diversify and most recently the group has been partnering with orthopedic surgeons in the city in an attempt to provide relief through medical and interventional approaches for patients with chronic knee pain either before or after total knee arthroplasties.

We currently have two outstanding fellows in our program. Dr. Maxime Fortin-Verreault and Dr. Jeetinder Makkar. Please welcome these hard-working trainees to our Department next time you see them!

The U of M is also currently in the application process with the Royal College of Physicians and Surgeons of Canada to run a 2-year FRCPC fellowship training program in Chronic Pain Medicine. We will consider beginning this program after the completion of our current two fellows. The decision whether we will run the current one-year Interventional Chronic Pain Fellowship concurrently with the 2-year Royal College Fellowship (which is not interventionally based and may require extra training to become proficient in interventional procedures) has not been made. This new fellowship will involve a wide variety of mandatory rotations including the likes of Addiction Medicine, Psychiatry, Neurology, Physical Medicine and Rehabilitation among others and will reflect the diverse knowledge base that is utilized in pain medicine.

Dr. Jamit Dhaliwal
Pain Fellowship Director

Gasline Quick Shot

Dr. and Mrs. Jim Beckstead present the Inaugural Beckstead Family - HSC Anesthesiology Research Award. The award was given to Dr. Tom Mutter.
Canadian National Anesthesia Simulation Curriculum

The Canadian National Anesthesia Simulation Curriculum (CanNASC) Task Force was established in 2013 by the Royal College of Physicians and Surgeons of Canada Anesthesiology Specialty Committee. The committee make-up includes representatives from all 17 Canadian Anesthesia Residency programs, the RCPSC Specialty Committee Chair, a Royal College member-at-large, and an appointed CanNASC Chair. I was fortunate to be asked to be the University of Manitoba representative on the task force.

The overall goals of the task force are to develop national consensus on, implement, and continually evaluate a set of standardized high-fidelity simulation scenarios that must be satisfactorily completed by every anesthesia trainee prior to completion of his/her residency and certification.

In order to reach these goals, the task force engaged in monthly teleconferences and twice a year in person meetings at the CAS and Simulation Summit conferences. The first step was conducting among task force members a national simulation resource survey aimed at assessing implementation feasibility across the country. This was followed by a second survey to determine scenario topics that are considered to be rare and/or clinically important events and essential to competency as an anesthesiologist. This survey was distributed to every Canadian Anesthesia resident, program director, simulation instructor, and residency program committee member. Consensus on curriculum was achieved by the task force focusing on 2 criteria: 1) the topic addressed a gap in the anesthesia training program (defined as a subject that is considered important, but is sub-optimally taught and/or assessed in the program, and 2) teaching and/or assessing this subject is best done with the use of a highly resource intensive full body mannequin.

Scenario development, assessment strategy, implementation, and data collection and analysis will be covered in a manuscript currently being penned by the task force.

CanNASC scenarios have now been run in 2 consecutive years. At the University of Manitoba, our residents have completed the scenarios in the winter/spring months of their final year of training. This was a significant change in philosophy for the use of simulation in our residency program. Prior to CanNASC, simulation has been used locally since 2008 for formative assessment. This type of evaluation is used to help students identify their strengths and weaknesses and is generally low stakes. With CanNASC, simulation has now been used at the U of M for summative assessment. The goal of summative assessment is to evaluate student learning against a standard, and is often high stakes.

Many simulation experts have argued that simulation should not be used for summative assessment. They consider the simulation lab a place where trainees should feel comfortable making mistakes, because by making mistakes is how we learn. By its nature, the simulation lab can be a very intimidating place where you know you are being observed by both your superiors and co-trainees (both senior and junior). You are very well aware that some medical emergency is about to take place, but not sure of when or how it will present. Imagine coming to work to the OR, knowing that your patient is about to crash.

Although the sim lab cannot fully recreate the OR, at times it can feel very real when the familiar tone of the pulse oximeter is starting to get deeper and deeper, or the binging of the anesthesia monitor will not stop. At the beginning of each simulation session, we ask participants to “buy in” to the experience, meaning we want them to actively trick their minds into thinking they are actually in the real clinical setting. By doing this, they get maximal learning from their educational experience and will most likely respond to emergencies the same way in which they would in the OR. Also, by totally “buying in”, stress and anxiety are maximized.

So, is it fair to use simulation for formative assessment? Should we be assessing people in such a highly charged environment? I think the answer is yes. But…

The first thing that needs to be made clear is the type of simulation session which the trainee is to experience. At our university, we will continue to use simulation for both formative and summative assessment. The trainee needs to be made aware in advance what form of assessment will be taking place.

Second, the simulation assessment must take place in an environment that is familiar to the trainee. Unless of course one of the objectives of the scenario is clinical management in an unfamiliar location. But in a standard OR or PACU scenario, the candidate must have equipment which they are familiar with either it being the anesthesia machine or difficult airway cart, etc. As well, the trainee must also be familiar and experienced with dealing with simulated anesthesia emergencies.

Third, is the scenario testing a subject that is best assessed by simulation? Simulation is a very resource heavy educational and assessment tool. In a scenario which deals with malignant hyperthermia, the scenario specific checklist should not include knowledge of the ryanodine receptor gene mutation, as that can and should be assessed in a written examination. On the other hand, the scenario should be able to evaluate how the candidate organized resources and directed their team to manage the crisis.
Fourth, the summative assessment must be valid. In other words, is it measuring what it is intended to measure. I’m not a statistician, but generally speaking there are different types of validity. Face validity: does it seem like a reasonable test. Construct related validity: whether the test is a legitimate indicator of performance. Criterion related validity: compares the test results to other measures of performance. In order for any high stakes assessment to succeed, all these criteria need to be met.

Fifth, is the assessment reliable. That is, the ability of a test to yield reproducible results. Internal consistency measures subject performance on different components of a test and inter-rater reliability determines the extent that the examiner influences the score.

Proving validity and reliability are extremely difficult to do, but many studies have shown simulation’s potential to be a valid and reliable form of assessment. CanNASC can be an invaluable tool for residency program committees considering it is objective and standardized. Results can be used to compare residents in the same program as well as one residency program to another.

Those who object to using simulation for high stakes evaluation often argue the psychometrics just aren’t there yet. However, the same can be said for our current forms of evaluation. Anyone who has challenged the Royal College Exam in the last 10 or so years is well aware of question banks for the MCQ exam which are often memorized by candidates. As well, the oral exam component can be quite subjective as well. It is no secret that the decision between a failing mark versus a pass on an oral question can be debated at length by examiners (confidential personal communication). In 2006, investigators Jacobsohn and Avidan published a study which demonstrated poor inter-rater reliability on American Board of Anesthesia style mock oral examinations1. They concluded, for 48% of candidates examined, the chance of passing or failing was examiner dependent. We all know of very strong candidates who have failed the Royal College exam, and of weaker candidates who have passed.

I’m not saying we should do away with the oral and written exams, but use them in conjunction with other forms of assessment. Different tests assess competency at different levels. Miller’s model of competence can be seen below. Written exams assess trainees at the “know” level, while oral exams assess at the “knows how” stage. It can be argued that simulation based exams assess candidates at the “shows how” level.

However, in order to assess at the highest level (Does), this must be done in the actual clinical environment in which competence is sought. This is probably the single greatest advantage of the so-called competency based curriculum, in that it forces residency programs to better evaluate their residents as they progress through residency. Rather than just permitting residents to progress in a time based model, and relying on the Royal College to determine competence at the end of training, individual residency programs will be held more accountable.

When CanNASC started, the idea was to schedule the assessments near the end of residency. However, with the new curriculum, it will probably be incorporated more regularly throughout training.

Lastly, simulation for assessment will probably not end at residency, but continue with Maintenance of Certification. At least in the early stages, this assessment will likely be formative in nature such as being done by the American Board of Anesthesia which requires delegates to complete a simulation based crisis resource management course in every 10 year cycle. Locally, we have our Anesthesia-Centric ACLS Certification as well as discussions regarding simulation to assess the “aging anesthesiologist”. By the time that is instituted, simulation activities will be a normalized activity which every anesthesia provider will likely be well familiar with. The only question will be, will the resources available to provide quality simulation keep up with the demand?

**Dr. Marshal Tenenbein**

Welcome New Anesthesia Residents

**Duncan Maguire** as of press time was last heard from GPS position 43.0483, 42.8657 in a bid for the peak of Mt. Kazbek. Ambition: to make the other D Maguire look like a rookie, stay at home Anesthetist. Undergraduate degree in Economics, U of M Med 2016

**Kristin McPhail** was born and raised in Winnipeg, completing her undergraduate science degree and medical school at the University of Manitoba. She is looking forward to continuing her training in Winnipeg in anesthesia residency. When she is not studying medicine, she enjoys live music, exploring new restaurants, and experimenting with cooking. She also enjoys being active, hiking, and playing the occasional game of soccer. Travelling is one of her biggest passions, and she takes every opportunity she can to explore the world further.

**Scott Richardson** recently graduated from medical school here at the University of Manitoba in 2016 and will be our second resident accepted in the Brandon Anesthesia stream. Scott was born and raised in Manitoba having grown up in Oak Bluff, a small town just outside of Winnipeg. He completed both his undergraduate science degree and medical degree at the University of Manitoba. Scott enjoys spending his spare time at their family cottage on the Winnipeg River. He loves everything outdoors from fishing to off road hiking. He recently returned from a trek in the Himalayas and is already planning his next hike abroad. He is also quite passionate about woodworking and always love a good conversation about tools and carpentry.

**Mohit Sharma** recently graduated from medical school at the University of Toronto in 2016. He moved to Canada from the Middle East when he was 13 years old. Since then, he has lived in Toronto, where he also did his undergraduate in B.Sc. then pursued a M.Sc. from McMaster University with a focus on bone metastasis and possible mechanisms of pain. His primary interests include anything to do with sports. He absolutely loves them. He has always been involved in competitive sports. His favorite is squash and has played it at the varsity level during his master’s. Otherwise, He likes to travel, and learning about different cultures, traditions, and trying different cuisines. Having learned about the abundance of restaurants in Winnipeg, he is looking forward to trying all kinds of food in the next few years.

**Quyen Nguyen** graduated from the Faculty of Medicine at the University of Manitoba in 2016. He and his girlfriend love animals and also love to travel and discover the world through food.

**Sam Neilly** was born and raised in Winnipeg, Manitoba. He received his undergraduate science degree and medical degree from the University of Manitoba. Outside of medicine he loves to spend as much time as possible outside and being active. During the summer he is happiest paddling Manitoba’s lakes and rivers, fishing, or hiking through the woods. When Sam is not outside, he can usually be found at the Winnipeg Squash Racquet Club playing squash or pretending to get in shape. He is beyond excited to be a part of the Department of Anesthesia, and looking forward to the years to come.
Welcome New Family Practice Residents

Tyler Bullen: I graduated from the University Of Manitoba Faculty Of Medicine in 2014. Shortly thereafter, I was accepted into the Annapolis Valley Family Medicine program which is a longitudinal program based in rural Nova Scotia. Prior to entering medicine I worked as a paramedic in the former Interlake Regional Health Authority. I am married to my wife Jessica and together we have two wonderful daughters, Emma and Addison. Outside of medicine I enjoy spending time with my family whether it is hiking, biking or enjoying other outdoor activities. Personally, I enjoy many sports from snow to water to ice and courts. Also, I have recently taken up wood carving and consequently, the art of self-suturing. I look forward to returning to Manitoba and beginning my career in anesthesia.

Jarrod Nickel: I am 27 years old and was born and raised in small town rural Manitoba in the town of Deloraine. I completed an undergraduate Bachelor of Sciences in 2010 at Brandon University before moving to Winnipeg to start medical school. Outside of medicine I am a big baseball fan. I grew up playing fastball until the end of high school and now try to find time to play recreational slow pitch when not on call. I also like to travel around to watch the Toronto Blue Jays a few times each year. Additionally I enjoy golfing and water sports at the lake during the summer, and curling and outdoor skating during the winters.

Another interest of mine is travelling the world with my friends. Although only going on my first out-of-Canada trip 5 years ago, I have managed to travel to various places in North and South America, Europe, and Africa since then, with plans to go to Asia this winter and many more places in the future.

I am excited to be joining the anesthesia team, even if only for a year, but I also look forward to returning to rural Manitoba afterwards and being able to provide comprehensive care to the population that includes.

Michael Paul Nichol: I graduated from University of Manitoba in 2014. I am originally from Brandon and did undergrad at BU. I have now completed my family medicine residency in Dauphin and will return there to work after my anesthesia year. I love the outdoors and do a lot of running and cycling as well as other sports. I’m excited to return to Winnipeg for a challenging and fun year!
Department Announcements

New Faculty:

January 2016:
Jennifer Plester  
St. Boniface Hospital and HSC

March 2016:
Mullein Thorleifson  
Cardiac St. Boniface Hospital and HSC

July 2016:
Camila deSouza  
HSC and St. Boniface Hospital

August 2016:
Andrea Petropolis  
HSC and Grace Hospital

Retirements:

Beatrice Kallue  
June 2016 after 27 years of service

Dr. Laurence Brownell  
June 2016 after 35 years of service

Dr. Ian Thompson  
Aug 2016 after 38 years of service

Baby Announcements:

Dr. Ravi Jayas  
baby girl Isabelle

Dr. Kelvin Williamson  
baby girl Skyler Lynn

Dr. Gordon Li  
baby girl Hannah

General Announcements:

Welcome back Tara DeCastro. Tara is returning to her position as Program Administrator of the Anesthesia Residency Program.

Dr. Johann Strumphier  
asumes the position of Program Director of the Anesthesia Residency Program as of July 1.

Dr. Mullein Thorleifson  
asumes the position of Cardiac Anesthesia Fellowship Director as of July 2016

Dr. Alex Grunfeld was awarded the Donalda Huggins Scholarship in Anesthesia. Dr. Grunfeld is completing a Masters in Science in Clinical Epidemiology at Harvard School of Public Health.

Dr. Duane Funk was awarded the Manitoba Public Insurance Professorship in Neuroscience award. Dr. Funk will receive salary support for 3 years to aid his research in neurological outcomes after surgery as well as traumatic brain injury.

Dr. Tom Mutter was awarded the inaugural Beckstead Family - HSC Anesthesiologists' Research Award.

Dr. Peter Inglis was awarded the 2015 Douglas B. Craig Resident of the Year Award.

Dr. Craig Haberman was awarded the 2015 YK Poon Teacher of the Year Award.

Dr. Linda Nugent was awarded the 2015 Undergraduate Clinical Teacher of the Year Award.

The Dr. William Webster Award for Anesthesia Undergraduate Achievement was awarded to our future R1 Dr. Samuel Neily.
CAS Department Presentations

Poster Presentations by Faculty:

Dr. Hilary Grocott: “Writing and Reviewing for the Canadian Journal of Anesthesia: What does the editor want to see”. Sunday, June 26, 2016 at 1600.


Dr. Sethu Madhavan: Case report in cardiac anesthesia. Time/Date TBA

Dr. Peter Inglis: “Anxiety Triggers Within the Operating Room - A Pilot Study”. Sunday, June 26, 2016, 1200-1300.


Poster Presentations by Students/Staff:

Kanwar Bhangu: “Participation of Canadian Anesthesiology Departments in Undergraduate Medical Education”. Saturday, June 25, 2016, 1200-1300.


Colin Hamelin “Health Habits of Medical Clerks During Operating Room Rotations”. Saturday, June 25, 2016, 1200-1300.

Colin Hamelin “Learning Behaviors of Medical Clerks during Operating Room Rotations”. Saturday, June 25, 2016, 1300-1445.


Other Involvement:

Dr. Eric Jacobsohn: ACUDA Plenary Talk: “Undergraduate Medical Education and the Anesthesiologist: What is the current status in Canada”. Friday, June 24, 2016, 1015-1035.

Dr. Duane Funk: Moderator and presenter: Critical Care Update for Anesthesiologists. Saturday, June 25, 2015, 1015-1200.


Jared Campbell: Moderator

Mark Ratz: Moderator