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The Cutting Edge

A Voice for Ontario's General Surgeons

ONTARIO ASSOCIATION OF GENERAL SURGEONS
(OMA Section on General Surgery)

OAGS
Ontario Association of General Surgeons
Association des Chirurgiens Généraux de l'Ontario

Participate in your local governance

OAGS warns General Surgery risks losing out to other specialties

By Dr. Chris Vinden

In the good old days, not very long ago, there wasn't much separation between the Ministry of Health and the patient. It was fairly simple…the Ministry funded the hospitals and doctors looked after the patients.

However, things have become a whole lot more complicated in the last 8 years. For some services, the Ministry now funds Cancer Care Ontario (CCO), which then funds the Local Health Integration Networks (LHINs), which then fund either the hospital, a Community Care Access Centre (CCAC) or an Independent Health Facility (IHF). Eventually, after several layers of bureaucracy, the care is delivered.

In the old model, if things didn't go well, there was at least a reasonably clear line back to the minister for some accountability, and the public could exercise its democratic rights and turf the minister at the next election. In the new model, things get a whole lot more complicated. Instead, non-elected officials selected by other non-elected officials with minimal direct accountability can be responsible for major policy changes.

While the minister may still be ultimately responsible, there is now an awful lot of insulation between the patient and the elected officials. While many of us have measured views of politicians, at least they are accountable; their job is on the line and the public expects some results. I don't ever recall voting for anybody at CCO nor for anybody in my LHIN.

So, what does all this have to do with General Surgery and the OAGS? Quite a lot, actually.

If we are to effect change for General Surgery, we need to know which levers to pull and push. Frankly, that is becoming a lot more complicated. Do we lobby CCO, the LHINS, the Ministry or the opposition? Do we go through the OMA with its complex governance and conflicted subspecialty lobbies? Do we try to go directly to CCO? Or, do we try to go above their heads and back to the Ministry? Where do the hospitals fit in all of this? These are the issues with which the OAGS is grappling.

Our current approach has been to try to get some strong General Surgery voices on major committees at the CCO or LHIN level. This usually entails a lot of frustrating meetings held at inconvenient times in inconvenient places and tend to be completely devoid of the efficiencies and succinctness that surgeons value. These meetings (except for OMA business) are not remunerated and usually require sacrifice of time and potential income.

This might not sound like an advertisement for participation, but we need General Surgeons to step up and get involved. If you can't get involved, at least be vocal about issues that affect you.

The alternative is a system moulded by other subspecialty groups who took the time to participate. I am reminded of the old joke that plays on European national stereotypes. Heaven is where the French are the chefs, the Germans are the mechanics, etc. (Google it). Hell is a subtle rearrangement of these tasks.

While we still have a cordial relationship with our gastroenterology colleagues, they clearly see the role of surgeons in endoscopy quite differently than we do. If all the prominent committee jobs at CCO or the LHINs went to gastroenterologists, we could have our own bad version of that joke.

We are living in changing times, and we need to embrace that change and be part of it - rather than just reacting to it. Other subspecialists will almost certainly be vying to be on those same committees. And, you can be assured that they are unlikely to have the best interests of General Surgeons at heart.

Please make yourself aware of what is going on in your local LHIN and get involved.

- Dr. Chris Vinden, OAGS President, is a General Surgeon on staff at London Health Sciences Centre - Victoria Hospital.

INSIDE

NOTICE: OAGS 2014 MEMBERSHIP DRIVE (Jan-Dec, 2014)

Please be reminded that the OAGS is still collecting annual dues for the current calendar fiscal of 2014. The 2nd Notice Invoices will be enclosed with this issue. For more details or to pay online, please visit our website: www.oags.org/join.htm . For any queries, please feel free to call our office: 1-877-717-7765.

20TH OAGS ANNUAL MEETING: Saturday, November 1, 2014

OAGS Board of Directors, President Dr. Chris Vinden, AGM Committee Chair Dr. Angus Maciver and Section Chair Dr. Jeff Kolbasnik would like to invite all General Surgeons to this fall's 20th OAGS Annual Meeting on Saturday, November 1, 2014 at the Sheraton Toronto Airport Hotel, 801 Dixon Rd., Toronto, ON. For more details: www.oags.org. RSVP Deadline: Oct. 1st.
(Note: Free annual meeting admission for OAGS members.)

Editorial...

By Dr. Timothy Jackson

It's a true honour to serve as the new editor of *The Cutting Edge*. I definitely have big shoes to fill by taking over this role from Dr. Ciaran Kealy who has been with OAGS since the beginning.

This is an especially important year, as we will be celebrating 20 years of working together as General Surgeons, to advance our professional interests in Ontario. Over this time, OAGS has tackled many issues and has made our voices heard.

The Cutting Edge gives us a unique opportunity to connect with each other. In fact, this is what drove me to get involved and participate in OAGS. While many of us belong to other professional organizations and surgical societies, it is OAGS that has our interests rooted at the provincial level. And as we all know, provincial level policies have the potential to impact us the most!

When I look ahead at the future of General Surgery in Ontario, I see "quality" as an area of increasing focus. It's now been over 100 years since Ernest Codman pioneered outcomes reporting in surgery. For decades, data-driven quality improvement has reduced complications and saved money in various health systems around the world. The process of collecting and analyzing high quality data gives surgeons the opportunity to identify areas where they need to improve. This cycle of continuous quality improvement has consistently demonstrated to result in fewer complications and better care for patients.

In Ontario, we lack many of the mechanisms that are necessary to accurately collect and act on quality data. While some hospitals participate in comprehensive data driven quality programs, the majority do not. We have the opportunity and the obligation to be a part of developing and implementing these policies and processes. Not only is this the right thing to do for our patients, but it would also help us to demonstrate the value of the care that we provide. We already have strategies in place that measure costs. So, now it's time to measure quality. Once cost and quality are considered together, we can determine value.

The issue of surgical quality is now at the forefront, with the introduction of new funding models (such as pay for performance and quality based purchasing). These are policies that will affect all of us. In these paradigms, data will inform payment. We need to ensure the right quality metrics are used and the information that is being collected is accurate. Administrative claims data typically used to assess hospital performance are simply not reliable enough for this purpose. We need clinical data that takes into account the health status of the patients we operate on and the complexity of cases we perform. If we don't take the lead and get involved in the process of data collection, benchmarking and reporting, it will almost certainly happen without us (and to us).

I believe General Surgeons already provide excellent care to patients in Ontario. By collecting high quality data and analyzing it in the right way, we will be able to prove it. Now is the time to get ahead of the curve by taking ownership of our outcomes and demonstrating our worth. By being active players in the quality agenda, it will not only empower us to set the standards and create policy, but it will also help us to move away from constantly reacting.

One of the key lessons learned is that collaboration accelerates the quality improvement process. When surgeons work together - sharing quality wins and losses, care improves much faster than if we go at it alone. I believe OAGS can help support this collaborative approach to quality improvement, which has been a winning formula in many other states and provinces. Our challenges will lie in funding and linking our many hospitals across the province. However, high quality care costs less, and there is a real return on investment tied to these activities.

Dr. Tim Jackson

Hopefully, this will be a big part of the next 20 years of OAGS - continuing to connect us as a profession. These are very exciting times for General Surgeons in Ontario. Change is coming, and we can lead it!

Thanks again for the opportunity to serve as the editor of *The Cutting Edge* and to Dr. Kealy for his many years of service, thoughtful contribution and leadership. I'm looking forward to the Annual Meeting and connecting with all of you there. As always, we welcome any comments or feedback on *The Cutting Edge* or OAGS. Have a great summer. - Tim

- Dr. Tim Jackson, OAGS Secretary and Newsletter Managing Editor, is on staff at UHN - Toronto Western Hospital.

Upcoming CPD Events

DATE	EVENT
Aug. 26-30, 2014	IFSO 2014 / XIX World Congress The Fairmont Royal York, Mississauga, ON http://www.ifso2014.com
Sept.10-13, 2014	MIS Week Annual Mtg and Endo Expo Caesar's Palace, Las Vegas, Nevada, US www.sls.org
Sept. 17-21, 2014	Canadian Surgery Forum 2014 Vancouver, BC http://www.canadiansurgeryforum.com/
Sept. 26-27, 2014	Canadian Society for Vascular Surgery - 36th Annual Hyatt Regency Hotel, Toronto ON http://www.canadianvascular.ca
Oct. 1-3, 2014	27th International Course on Therapeutic Endoscopy The Fairmont Royal York Hotel, Toronto, ON http://www.thera-endo-toronto.com/
Oct. 9-10, 2014	Multidisciplinary International Rectal Cancer Society (MIRCS) Annual Scientific Meeting Hilton Philadelphia City, Philadelphia, PA http://www.mircs-cme.org/site/Default.aspx
Oct. 16-18, 2014	Symposium on Advanced Wound Care Caesars Palace, Las Vegas, Nevada http://www.sawc.net/fall/
Oct. 18, 2014	1st. Annual Hernia Surgery Conference Park Hyatt Toronto, Toronto, ON http://www.canadianherniasociety.ca
Oct. 26-30, 2014	American College of Surgeons/2014 Clinical Congress San Francisco, CA http://www.facs.org/clincon2014/index.html
Oct. 30-Nov.2, 2014	Action 2014: Skin Health For Canada Westin Harbour Castle Hotel, Toronto,ON http://cawc.net/index.php/conference/
Saturday, Nov.1, 2014	**20th OAGS Annual Meeting** **Sheraton Toronto Airport Hotel & Conf. Ctr., Toronto** **http://www.oags.org**
Nov. 7-8, 2014	UofT Update in Minimally Invasive Surgery Shangri-La Hotel, Toronto, ON http://www.cpd.utoronto.ca/minimallyinvasive/
Nov.12-15, 2014	Multidisciplinary Update in Breast Disease 2014 One Ocean Resort & Spa, Atlantic Beach Florida www.mayo.edu/cme/surgical-specialties-2014s306
Dec.1-4, 2014	European Colorectal Congress 2014 Munich, Germany http://www.colorectalsurgery.eu/
Dec.9-13, 2014	2014 San Antonio Texas Breast Surgery Symposium San Antonio, Texas http://www.sabcs.org/
Feb. 17-18, 2015	Definitive Surgical Trauma Care (DSTC) Course Vancouver General Hospital, Vancouver, BC https://events.ubccpd.ca/website/index/110044

For the complete listing of CME events, check our website:
http://www.oags.org/events.htm
For a listing of national and international CME courses:
http://www.doctorsreview.com/meetings/

Resident Rostrum

By Dr. Kellen Kieffer
O.A.G.S. Resident Representative

Why Residents Need To Spend A Few Extra Days in the Endoscopy Suite

There has been a lot of talk lately about the role of endoscopy in the future of General Surgery. There is no question that it has become a highly politicized subject, and we are at risk of being edged out by the gastroenterologists.

In my training so far, I have witnessed collegial and productive relationships between our two specialties. There are problems of a medical nature, such as chronic diarrhea and IBD, which require endoscopy for diagnosis and management – well suited to gastroenterology. There are also surgical problems, such as colon cancer, best handled by General Surgeons…. We've all been there - hours into a laparoscopic sigmoid colectomy converting to a low anterior because the cancer that was measured at 25cm is actually in the mid-rectum. In practice, however, there is no distinct line between the diseases managed by GI and by General Surgery. The "scope" of practice (pun intended) between the two specialties has considerable overlap, and that leaves room for some jockeying for work.

"A number like 300 clearly favours GI trainees...."

There are two factors pushing us toward a turf war. The first and most important is that colonoscopy is paid very well. We wouldn't even be having this discussion if not for the seemingly arbitrary way that colonoscopy is one of the most lucrative parts of medicine. Secondly, both General Surgery and GI are training way too many residents, and we're all going to want an income after graduation.

Back in the 70's, colonoscopy was pioneered by surgeons and then fell quickly out of favour because, as is the case with most new technology, it was felt to be cumbersome and dangerous. The specialty of gastroenterology originated and prospered because as endoscopic technology improved, General Surgeons were slow to become interested again.

I would argue that endoscopy is an essential part of General Surgery, and much of endoscopy, especially interventional endoscopy, belongs in the surgical realm.

1. Endoscopic interventions are used for surgical diseases. These are diseases that have traditionally been treated by major surgery (e.g. GI bleeds, bile duct stones, large colon polyps) and are now treated using endoscopy, because it is better for patients. General Surgeons understand the full course of the disease: we admit the patients to hospital, follow them, perform the endoscopic intervention and then perform the surgery - should endoscopy fail. I would argue that our judgment for each individual part of the patient's care is better, because we have a better understanding of the whole picture.

2. Often, endoscopic interventions are surgery. An ERCP is endoscopy up until the sphincterotomy. That is surgery. You are cutting human tissue and you are assuming the inherent risks such as perforation and massive bleeding. Management of surgical complications is a cornerstone of surgical training and practice, something to which medical specialists are not exposed. The same can be said for mucosal resection of colonic polyps and dilatation of strictures.

I have just mentioned two reasons why General Surgeons are important in endoscopy, but we also have to consider why endoscopy is important for Surgeons:

1. Endoscopy makes up about 30-40% of the work of your average community General Surgeon. It contributes to 50% of our income. If we were to lose endoscopy, there would be room for far fewer General Surgeons.

2. Endoscopic surgical techniques could very well become much more important in the future. Interest in NOTES has declined because in its current form, it is too expensive and too complicated to provide any advantage over laparoscopic or open surgery. However, the potential advantages of endoluminal surgery are significant, and we would be remiss not to be involved as the technology improves. PCI was a "disruptive" technology that revolutionized the treatment of cardiac disease, and cardiac surgeons have largely been replaced as a result. If an endoluminal technique revolutionizes GI surgery, then those who already possess advanced endoscopic skills will be in the best position to move forward. Those individuals should be us. Realistically, we should be the ones developing the advancements in the first place, because if we don't, then someone else will. We need to take a page from the vascular surgeons rather than cardiac surgeons, to secure the future of the specialty.

So, if you will agree with me that endoscopy is important, how, as residents, do we put ourselves in the best position to make endoscopy a big part of our future careers? I have been given some advice in this regard that I agree we all need to hear.

1. Log as many scopes as you can. It has been recommended that we perform 300 colonoscopies during our training to be considered "competent" to perform this procedure after graduation. This number seems ridiculous to many, considering how many active surgeons do very well with colonoscopy, having only completed a handful in their training. And why should we spend so much time on one procedure when we are responsible for learning so many more, of much greater complexity? The answer is that we need to do this for political reasons. A number like 300 clearly favours GI trainees, who will easily be able to achieve it, and it likely originates from GI academics whose careers have been made by endoscopy "quality assurance." And although this is probably at odds with what's best for the health care system, it's the way it is, and if we don't keep up, then we will be edged out. So, pick up community rotations or do extra scope days - whatever it takes to get to 300 (or as close as you can realistically get.)

2. Try to develop a breadth of endoscopic skills. Good examples include variceal banding and esophageal dilatation. Banding is a potentially life-saving skill that many surgeons are happy to defer to gastroenterology. That being said, how many places outside of major academic centres have a full complement of on-call gastroenterologists providing 24/7 coverage? Often the buck stops with the General Surgeon.

3. When you are out in practice, do endoscopy! This includes procedures like the ones mentioned above, with which many General Surgeons don't feel comfortable and don't perform in their practices. The more endoscopic procedures we stop doing because of "comfort levels," the more endoscopy we will lose to GI.

4. We need new graduates with skills in ERCP and perhaps also endoscopic ultrasound. There are many surgeons across the province who do ERCP, and their training for this procedure varies from some extra time after residency to something they learned in residency to something they learned on the job. Now, it is expected that we learn this as residents or fellows, and it seems that only GI fellows are learning it. All HPB fellows should be training in ERCP (which is not currently the case) and some General Surgery residents should learn it as well, to provide coverage across the province.

5. We need General Surgery graduates to subspecialize in advanced endoscopy and take on this role in academic centres. This will allow us to be active participants at the cutting edge of technology, and it will ensure that we have an equal share in resources at the hospital level (a problem in Ottawa, for example). I feel that an advanced endoscopy fellowship would be an excellent way to market yourself to an academic centre, either by itself or in addition to colorectal or HPB.

See "Residents" on page 10...

CAIR: HHR crisis not being addressed by OAGS

To: OAGS & Resident Representative
Re: Membership Eblast - June Update
Date: May 22, 2014

Dear OAGS /Resident Leadership,

I see on the (May) OAGS Update that there is a section for lobbying outreach titled PROVINCIAL ELECTION.

As someone who is very involved with the Canadian physician health human resource (HHR) crisis (as I know OAGS Resident Representative Kellen Kieffer is as well and had recently attended the HHR Summit at the Royal College), I was surprised that this issue was not one of the main topics in either the letter to government or in any of the resources. While there are other issues highlighted, the renewal of the specialty of General Surgery in the context of the Ontario Health Care system and its implications for training were sadly missed in the message.

I was wondering if there was an HHR strategy with regards to General Surgery both at the supply side (residency position allocation plan) as well as a demand side (resource allocation/hospital infrastructure plan) to champion this issue at the OAGS level.

As the voice of General Surgery at the provincial level, I'm sure the resident body as well as the membership at large would hope that OAGS had a strong plan forward with regards to a General Surgery human resource strategy.

I look forward to any feedback and would be happy to provide national/other provincial leader contacts for any coordination or information you would need.

Thank you for considering,
Jesse Pasternak
PGY 5, McMaster University, General Surgery
Chair, Health Human Resource Committee, Canadian Association of Interns and Residents **(CAIR)**

To: Jesse Pasternak, PGY 5, McMaster University, General Surgery
Chair, Health Human Resource Committee, CAIR
Date: May 22, 2014

Hi Jesse.

I want to assure you that the resident employment situation is being taken very seriously by the OAGS, however there are some blunt political realities. To be seen during an election as worrying about doctors' job prospects is simply not political hay for any party. No politician is going to discuss this issue during the election. It would be seen as catering to the 1%. We presented the parties with a document that just focused on issues that impact on the public and their issues with access/quality; we deliberately avoided issues that impact directly on doctors. The vast majority of the public still think there is a doctor shortage and explaining the true reality is not sound byte material and would distract from a political party's message. Basically, physician employment issues are NOT election material and we would be foolish to try and make it one.

This issue takes up a significant proportion of the OAGS agenda. We have already played a significant role in increasing awareness of underemployment through a dedicated session on the issue at the Canadian Surgery Forum and have been lobbying within CAGS. However, we do not have any of the levers that actually control things in our hands. We are still faced with organizations and models that do not believe there is a surplus of surgeons. I understand (through the grapevine) that at a recent meeting for program directors, there was no consensus on the numbers that should be trained or even a consensus that there is an oversupply happening. For example, check the BC website: http://www.generalsurgeons.ca/wp-content/uploads/2013/04/GS_Brochure_Pages_sm_2013.pdf

Some of the initiatives that are under discussion at the OAGS are:

- Setting up a database about the current status of recent grads as to whether they have achieved full employment or are underemployed. This is very important, as we need actual data to present to the Ministry rather than just rumours. This will be difficult to do and almost certainly will have to be done through program directors' offices.
- We are having a session at our AGM this year about various options for transitioning out of practice, job sharing, etc
- We are actively lobbying for fee schedule changes that will achieve better intra-sectional relativity. This will likely be the most important issue that will encourage surgeons to retire - freeing up space for your generation.
- We have become aware that for some people, an acute care only practice without longitudinal care obligations is actually an attractive option for the same set of reasons that emergency medicine is an attractive and competitive specialty. (e.g. the ability to travel, take long breaks, etc.)
- We have had extensive discussions about professionalism issues associated with having locums doing the majority of call without any elective resources.
- We have had extensive discussions on whether it is appropriate to charge a levy on locums.

The other blunt reality is that our letter just resulted in a big shrug from all the politicians to whom we have sent it. They are basically not focussed on any of these issues. All three parties responded with irritating form letters advising us of how great they are.

I hope this explains our position. Your issues are important and are not ignored. With regards to the database of the employment status of recent grads, this will be a significant challenge for us. OAGS has historically been oriented fairly strongly towards the needs of community surgeons and does not have a strong network with the program directors. This might be a project for PAIRO or CAIR to take on and which we could perhaps facilitate maintaining. Certainly, we would require strong contacts at each academic institution, as the status of recent grads is really only known by local knowledge at each institution. I would ask that you interact with your peers at all Ontario medical schools and brainstorm about how such a database could be populated.

Sincerely,
Chris Vinden, OAGS President

Date: June 10, 2014
Dear OAGS:

Thanks so much for the email. I would be delighted for this issue to be highlighted in the next *Cutting Edge* newsletter.

I think one of the main problems with Health Human Resource planning in the context of surgery is that there is a void of information on this problem in Canada today. If our correspondence is published, I would hope some of the current information we know about the situation today will be shared with Ontario's surgeons.

Some of the issues: ♦Due to the gravity of the issue, the program directors across the country have decided to decrease residency positions in Canadian General Surgery programs; ♦surgical specialties at the accreditation body in Canada continue to become more sub-specialized; ♦earlier direct-entry decisions for trainees, yet increasing post-specialty fellowship requirements remain a basic dilemma – this is within the context that trainees do not have access to information on where and in what specialty Canadians need actual care; ♦many hospitals continue to have surgeons with long wait lists but no infrastructure to hire new surgeons to meet patients' needs. This last point is beginning to permeate within the public as the idea that there is an "effective" doctor shortage where qualified practitioners cannot meet the health needs of Canadians due to system infrastructure restraints.

I think all new surgeons and trainees share the appreciation that this is an important part of the OAGS representation strategy including its great work on locums and transitions. Certainly, we would support them in any way we can to push for a National Strategy outlining a situation where our system graduates the right amount of surgeons who can access the right amount of infrastructure to ultimately provide care to Canadians who need it.
Sincerely,
Jesse

Guest Speakers AGM2014

Welcome to this fall's roster of topics and guest speakers:

♦ Billing Corner Round-Up

Dr. Alan Lozon, GBHS, Owen Sound

Dr. Lozon will lead the usual Billing Corner interstitials which will be complemented at the end of the program with special guests from the Ministry of Health and Long Term Care who will participate in a Q&A session:

- **Dr. Jude Coutinho – Medical Advisor, Health Services Branch**
- **Bev Lyman – Senior Manager, Health Services Branch**
- **Vanessa Zanette – Program Manager, Claims Services Branch**

♦ Breast Surgery: Management of the Axilla

Dr. Ralph George, SMH, Toronto

Dr. George (MD, FRCSC) is an Associate Professor of General Surgery at UofT and Med. Dir. of the CIBC Breast Centre at St. Michael's Hospital. He is the Founder of General Surgical Oncology; he is also Chair of the Royal College Specialty Committee for Surgical Oncology. Dr. George Chairs the CBCF Scientific Advisory Committee and is a past President of CAGS.

♦ Surgery for Diverticulitis: When/How in 2014

Dr. Nancy Baxter, SMH, Toronto

Dr. Baxter (MD,PhD,FRCSC,FACRS) is a practicing colorectal surgeon and the acting head of the Division of General Surgery at St. Michael's Hospital. She is an Associate Professor in the Dept. of Surgery and Inst. of Health Policy, Mgmt. and Evaluation at UofT and an Adjunct Scientist at ICES. Clinical interests include rectal cancer, colon MIS, and complex benign colorectal disorders.

♦ DEBATE: Surgical Safety Checklist

Dr. Chris Hayes, SMH, Toronto

Dr. Hayes (MD,MSc,MEd) is the Critical Care Response Team Site Director and the Medical Director of Quality and Performance at St. Michael's Hospital. A UofT Assistant Professor in the Dept. of Medicine and Inst. for Health Policy, Mgmt. and Evaluation, he is also the Medical Officer for the Canadian Patient Safety Institute. Dr. Hayes is a recognized leader in patient safety and quality improvement.

Dr. David Urbach, TGH-UHN, Toronto

Dr. Urbach (MD, FRCSC) is an Associate Professor in the Departments of Surgery and Health Administration at UofT. His clinical practice is devoted to gastrointestinal and endocrine surgical oncology and minimally invasive surgery at TGH-UHN. Dr. Urbach co-authored a study "Introduction of Surgical Safety Checklists in Ontario", which appeared in the NEJM, March, 2014.

♦ Management Strategies with Complex Wounds

Dr. Sam Fratesi, SAH, Sault Ste. Marie

Dr. Fratesi (MD, FRCSC, FACS, MEd) is a General and Vascular Surgeon in Sault Ste. Marie, ON. Medical interests include carotid artery disease, distal bypass, and wound care. Dr. Fratesi established a multidisciplinary wound care clinic at Sault Area Hospital back in 1995, which focuses on diabetic foot care, leg ulcers, lymphedema, pressure sores and non-healing infected wounds.

OAGS International Key Speaker

Dr. Kenji Inaba, MD, FRCSC, FACS

A native of Canada, Dr. Kenji Inaba completed his undergraduate studies at McGill University, med school at Queen's University, his Masters at UofT and his General Surgery training at UWO. Dr. Inaba is currently an attending Trauma Surgeon at the LAC+USC Medical Center and an Associate Professor, Clinical Scholar of Surgery and Emergency Medicine at the University of Southern California. He is the Medical Director of the Surgical Intensive Care Unit and the Associate Trauma Medical Director. A recipient of 21 teaching awards, he is the Program Director for both the General Surgery Residency and the Surgical Critical Care Fellowship. In addition to his teaching at USC, he is both widely published and has lectured extensively, having given more than 150 invited lectures around the world.

♦ Talk #1: "Preventable Deaths in Trauma - Quality improvement and medical errors in trauma patients"

♦ Talk #2: "What's New in Trauma in 2014" / ♦ Banquet Talk: TBA

♦ Panel Discussion: 7 Pearls of Perioperative Optimization

Dr. John Bohnen, SMH, Toronto

♦ Pearl #1: SSI Prevention...Besides Antibiotics

Dr. Bohnen (MD, FRCSC, FACS) is Professor of Surgery and Vice-Dean, Clinical Affairs, UofT - Div. of General Surgery, St. Michael's Hospital, Toronto, ON. He is a General Surgeon with clinical and scholarly interests in surgical infections, abdominal wall hernias, quality improvement, surgical education and practice standards.

Dr. Anna Day, SWHSC, Toronto

♦ Pearl #2: Smoking Cessation

Dr. Anna Day (MD, FRCPC) is a Respirologist and Professor in the Departments of Medicine and Health Policy, Mgmt. and Evaluation at UofT. She is Chair of Continuing Education for the Division of Respirology and Director of the Gender and Airways Program at Women's College Hospital. Clinical interest is in gender and pulmonary health - psychosocial/biological.

Dr. Stephen Kelly, JHCC, Hamilton

♦ Pearl #3: Bowel Preparation

Dr. Kelly (DM, MA, MB Chir, FRCS) is currently the Associate Chair of Education and Associate Professor, Div. of General Surgery, McMaster University HSC. His research interests include surgical education and colorectal disease. He is also the former Program Director of the General Surgery Residency Program.

Dr. Hugh MacDonald, KGH, Kingston

♦ Pearl #4: Fluid Restrictions

Dr. MacDonald (MD, FRCSC) is an Assistant Professor and Division Chair at Queen's University, Kingston, ON. He practises General and Colorectal Surgery at Kingston General and Hotel Dieu hospitals. Dr. MacDonald has clinical interestes in colon cancer, colorectal surgery and inflammatory bowel surgery.

Dr. Allan Okrainec, TWH-UHN, Toronto

♦ Pearl #5: Anastomoses With/Without NSAIDs

Dr. Okrainec (MDCM, MHPE, FACS, FRCSC) is Deputy Head of the UHN Div. of General Surgery and an Assistant Professor in the Dept. of Surgery at UofT. His clinical practice specializes in MIS (abdominal and gastrointestinal). His research interest is in the use of simulation for the teaching and assessment of laparoscopic skills.

20TH OAGS Annual Meeting

Ontario association of General Surgeons

(OMA Section on General Surgery)

Sheraton Toronto Airport Hotel
801 Dixon Rd., Toronto, ON
Saturday, November 1

AGM2014

ACCOMMODATION

A limited block of rooms is being held at the **Sheraton Toronto Airport Hotel, 801 Dixon Rd., Toronto** at a group rate of **$119 CDN** plus taxes per single/double room. The block deadline is **Oct. 1st** or until the block fills. **REBATE:** Those reservations under the **"OAGS Annual Meeting"** block will also be given an OAGS post-meeting rebate of $30/rm/night - a great deal at $89/night! (Note: Rebates will be mailed out AFTER the meeting by the OAGS - not the hotel.)

To Make Your Own Reservations: *(OAGS is not responsible for your hotel reservation/cancellation.)*

- Call the Sheraton Toronto Airport Hotel directly at 1-866-932-7058 / 416-675-6100.
- Online: Visit www.oags.org/agm.htm to be linked directly to the hotel.

PARKING

Parking will be free for those attending the meeting, courtesy of the OAGS. Members should provide necessary vehicle details in advance or upon arrival at the OAGS registration desk before 10am. DO NOT pay the parking meter. *(Be sure to arrive early to avoid delays.)*

MEMBERSHIP DUES

OAGS 2014 annual membership dues (Jan-Dec) include benefits such as free admission to the upcoming 20th OAGS Annual Meeting. For more details/benefits, visit: www.oags.org/join.htm .

RSVP & PAYMENT

How to RSVP to the OAGS Office:

- **Phone:** 1-877-717-7765 / 705-745-5621 **Email:** info@oags.org
- **Online: https://www.surveymonkey.com/s/HJ3JQT9**

How to Pay: (2 methods)

- **Cheque** - Make payable to "OAGS" and send via post...or
- **PayPal** - Major credit cards accepted online only: www.oags.org/join.htm .

Dr. Tim Jackson, TWH-UHN, Toronto

♦ Pearl #6: Pre-Operative Weight Loss

Dr. Jackson (BSc, MD, MPH, FRCSC) is an Assistant Professor of Surgery, UofT and practises General Surgery at the TWH-UHN. His clinical focus is in bariatric and gastrointestinal tract surgery. Currently, his research interests are in surgical quality improvement and surgical outcomes. (OAGS Board Member)

Dr. Collan Simmons, SGH, Stratford

♦ Pearl #7: NPO & Carb Loading

Dr. Simmons (BSc, MD, FRCPC) is currently Chief of Anesthesia at Stratford General Hospital, Huron Perth Healthcare Alliance. His clinical interests are in Regional Anesthesia. Originally from B.C., he completed his residency at UofT and subsequently did research in Yokohama, Japan and San Diego, California.

♦ Cost Containment in OR: Can we justify all the toys?

Dr. Tim Jackson, Toronto & Dr. Chris Vinden, London

Dr. Jackson, OAGS Secretary, has research interests in surgical quality improvement and surgical outcomes. Dr. Vinden (MD,FRCSC) is a UWO Associate Professor, Division of General Surgery and practises General and Laparoscopic Surgery at Victoria Hospital, LHSC. (OAGS President)

♦ Transitions: Easing Into Retirement, Job Sharing, etc.

Dr. Frank Baillie, HGH, Hamilton

Dr. Baillie (MD, FRCSC) is an Associate Professor for the Dept. of General Surgery and Director, Distributed Education, McMaster University. He practices emergency, trauma and general surgery at Hamilton General Hospital. (OAGS Board Member)

Registration Deadline:

Oct. 1st, 2014

Target Audience:

Active & Inactive General Surgeons
General Surgery Fellows,
Residents, Med Students

CME Accreditation:

This event is seeking accreditation by the Canadian Association of General Surgeons as a group learning activity as defined by the Maintenance of Certification Program of the Royal College of Physicians and Surgeons of Canada.
(1 credit/ 1 hr attended)

Admission Fees (day only):

- **FREE** - Current OAGS Member
- **$450** - Non-OAGS Member

Gen Surgeon (active/inactive/O-P)

- **$ 30** - Non-OAGS Member

Gen Surgery Resident/Fellow

- **FREE** - Medical Student

Wine/Banquet Fee:

- **$50** - Member & Non-Member

NOTE: Refunds will not be issued for cancellations after the deadline.

Toll Free: 1-877-717-7765
Phone: 705-745-5621
Fax: 705-745-0478
Email: info@oags.org
Web: www.oags.org

~ Celebrating ~ 20 Years
OAGS
Ontario Association of General Surgeons
Association des Chirurgiens Généraux de l'Ontario

IN MEMORIAM

Dr. Richard H. Railton
November 8, 1931 - July 16, 2013
Primary: Welland General Hospital, Welland, ON
(OAGS Member: 1996-2011)

Dr. Alan D. C. Ryley
August 23, 1955 - June 20, 2014
Primary: Joseph Brant Hospital, Burlington, ON
(OAGS Member: 1996-2014)
(OAGS Board Member: 1998-2002)
(OMA Section Executive: 1998-2003)

Dr. Alan Ryley

Note: Let us know of any other colleagues who should be remembered.
Contact OAGS: info@oags.org

Locum & Job Listings

The OAGS does not offer a job placement program. We provide space in our newsletter/website for both those who are seeking and/or institutions/communities that are offering a General Surgery position in the province of Ontario. Rates can be found on our website: **www.oags.org**

All candidates should be eligible for licensure in Ontario and have obtained or be eligible to obtain RCPSC specialty qualifications. Surgical credentials can be confirmed by calling the Royal College directly: 1-800-461-9598 ext.478.

ONLINE VACANCIES & LOCUMS:

- Advanced Multi-Specialty Walk-In Clinic (Mississauga)
- London Endoscopy Clinic (London)
- McMaster University - St. Joseph's Healthcare (Hamilton)
- The Reimer Clinic (Kitchener/Ottawa)
- Rouge Valley Health System - Centenary (Toronto)
- Thornhill Endoscopy Centre (Toronto)
- Weeneebayko General Hospital (Moose Factory)
- West Parry Sound Health Centre (Parry Sound)

For more details on the above, please visit our website at:
www.oags.org/joblisting.htm

OAGS MEMBERS:
OAGS members can post an online ad for **FREE** - whether you are posting a vacancy or seeking a position.

To Place a Job Ad: info@oags.org
Download a form: www.oags.org/joblisting.htm
Other websites with job placement programs: www.hfojobs.ca

OAGS1

www.twitter.com/oags1

We're now on Twitter, so be sure to follow us. If you have any notices or research you'd like to bring to our attention that might interest your colleagues, let us know and we might tweet them!

Advanced Multi-Specialty Walk-in Clinic

Full-Time General Surgeon
Mississauga - Immediately

The Advanced Multi-Specialty Walk-in Clinic is in search of a general surgeon or other surgical sub-specialists for a full-time permanent position in a clinic environment. On-site existing staff includes Family Physicians, Pediatricians, Ob-Gyn, General Surgery, ENT, General Internists, and Ophthalmology.

This clinic is located in the urban centre of Mississauga, Ontario - minutes from the convenience and entertainment district of downtown Toronto. Without the obligation of taking call, this position might be ideal for a surgeon looking to change from the rigours of a hospital practice. Candidates will perform general surgical procedures and must be flexible with hours.

Contact:
Dr. C. Meola
Phone: 416-464-0238
Email: 21northwest@gmail.com