Canadian Association
of General Surgeons

The First 25 Years

By Dr. Henry Thomas Gee Williams
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FORWARD
Continual change, at varying rates, is a characteristic of the provision of surgical services. In the 1920s and 1930s and much more rapidly in the 30 years after the end of World War II, important changes were taking place. This was the emergence of recognized, defined surgical specialties, with their own professional associations, which developed for a number of reasons.

Some were based on regions of the body, others on organs systems and they were often aided by advances in knowledge, instruments and anesthesia. There were also the added attractions of operating in a normally sterile field, working with tissues that had an excellent blood supply and in a discipline with few emergencies. General Surgery became what was left of the broad surgical spectrum. Indeed, as John Hinchey, Montreal, remarked, “residual surgery” might be a more appropriate term. In the 1960s and early ‘70s the Annual Scientific meeting of the Canadian Royal College, held in January, was a treasured forum in which all medical disciplines took part. But as the surgical specialties and their associations matured, most of them elected to hold their Annual Scientific meetings apart from the Royal College. General surgeons, mistakenly, were content to sit back and let the Royal College look after their interests. In the end they realized that, for their own good, they should have their own association. The considered voice of an association undoubtedly carried more weight in the Council and Committees of the Royal College than that of individuals. Doing something about it however, is always easier said than done.
In 1976, John Hinchey, Montreal, and Marcel Rheault, Montreal, together with their wives, invited Don Wilson, Toronto, to dinner in Sherbrooke, Quebec. This was at the time of a meeting of the Canadian Association of Clinical Surgeons, Eastern Division. The two hosts emphasized to Don Wilson the urgent need for general surgeons to organize and form their own association. The three of them had discussed the matter on a number of occasions in previous years and they all agreed that the time for action had now arrived. For a number of reasons, getting things started from Toronto seemed easier than from Montreal. The Quebec Association of General Surgeons was already established, popular, well organized and well financed. Don Wilson’s parting comment was “Gentlemen you shall have a Canadian Association of General Surgeons sometime next year”.

Don Wilson was the Professor and Chairman of the Department of Surgery at the University of Toronto. He was a well known cardiovascular surgeon although he had initially completed a full training in General Surgery.

He called a meeting of three leading Toronto general surgeons — Neil Watters, the Chief of Surgery at the Wellesley Hospital, Irv Koven, from the Mt. Sinai Hospital and Bernie Langer, who was Head of General Surgery at the Toronto General Hospital and suggested that they work together to establish a Canadian Association of General Surgeons in the following Spring. He generously offered the secretarial facilities of the Department of Surgery in Toronto to help with the organization and also said that the Department of Surgery would cover the costs of organizing an inaugural meeting and give any profit to the new Association.

Neil Watters was also the Chair of the Royal College Committee for General Surgery, on which all the 16 General Surgery Program Directors sat and was therefore very much aware of the views and aspirations of general surgeons from coast to coast. He and his two colleagues were strong advocates of a new organization and, after careful preparation, all general surgeons in Canada were invited to the inaugural meeting on the 11th of May 1977 at the Royal York Hotel, Toronto. The business meeting was followed by an interesting Scientific meeting arranged by Bernie Langer with Professor John
Goligher, Leeds, England, a well known colorectal expert as the guest speaker.

The first business meeting was chaired by Neil Watters. He thanked Don Wilson for his invaluable help and stimulation over the previous 12 months, Irv Koven for the first-class local arrangements and Bernie Langer for the Scientific program. He pointed out that the only body representing approximately 2000 general surgeons in Canada was the Royal College, an appointed body. Both the Royal College and the Professional Corporation in Quebec appreciated the importance of continuing education and consultation with National Specialties Societies and both had given their support to the establishment of the Canadian Association of General Surgeons.

There were three items on the agenda.

1. **The Founding Resolution**
   “Resolved that an application be made to the Minister of Consumer and Corporate Affairs for incorporation under the name of Canadian Association of General Surgeons by the Executive to be elected at this meeting and be it further resolved that said Executive Committee is hereby authorized to execute all documents required in order to complete the application for incorporation”.

   The motion was moved and carried unanimously by the nucleus and corresponding members of the Royal College Committee for General Surgery thereby became the founding members of the Association. (appendix 1)

2. **The Resolution for the Adoption of the General Bylaws**
   The proposed bylaws had been drafted by a subcommittee working from similar documents supplied by the Canadian Orthopedic Association and the Canadian Urological Association. A French translation had been prepared by Jacques Turcotte, Quebec, two weeks before the untimely death of this eminent Canadian surgeon. With a few minor alterations the bylaws were agreed to.

3. **The Election of the New Executive**
   The Royal College Committee for General Surgery had accepted the responsibility to act as a Nominating Committee.
The choice of Bernard Perey as the first President was a good one. Born in France, fluently bilingual, he received his surgical training at McGill and was the first Professor and Chairman of the Department of Surgery in the new Medical School in Sherbrooke, Quebec. He had been on the Council of the Royal College for many years and was the Royal College President Elect. He was an excellent and experienced committee chairman and was to preside over CAGS with vision and enthusiasm. E. Bruce Tovee, who was senior surgeon at the Toronto General Hospital, was recognized, appreciated and much loved as the finest teacher of clinical surgery in Toronto. Dr. Tom Williams, who had been appointed to the Chair of Surgery at the University of Alberta in 1975, provided some geographical balance and was essentially an enthusiastic neophyte in national organizations. Dick Railton was the outstanding general surgeon in Welland and had long been involved in the committee structure of the CMA. He provided the careful financial analysis and sound common sense that is so essential to the success of a new society. Neil Watters then handed over the Chair to the new President, Bernard Perey, who expressed his deep appreciation to the Association for his appointment. He emphasized that the new Executive Committee had much work to do and would meet without delay. The Executive of CAGS met at the Royal York Hotel on the
following day with Neil Watters and Irv Koven together with Mr. Alexander Ramsay, the CAGS solicitor.

The first motion passed by the Executive reads as follows:

“That the annual meeting of CAGS be held in conjunction with the Royal College meeting in 1978 and 1979 and also in 1980 and onward provided the Royal College moved its Annual Scientific Meeting from January to May or June.”

Thus the second Annual Meeting of CAGS would be held in conjunction with the Royal College in Vancouver in January 1978. The question of moving the time of the Royal College meeting had been discussed by College Council for many years but no decision had been reached. There was a possibility that the CAGS resolution would help the Council to resolve the issue in view of the fact that General Surgery formed a significant portion of the Royal College Scientific Program. In the 1940s and ‘50s air travel in winter was unreliable and train travel for surgeons and their wives for one or two nights, especially when groups or friends got together, could be an enjoyable and restful interlude before and after the meeting. Furthermore the railroad station was usually immediately adjacent to the Convention hotel. By the 1970s train travel had lost much of its charm to be replaced by the modern jet aircraft. Any travel in May or June would be easier than in January.

After this political foray, the Executive got down to business. 283 general surgeons had registered for the inaugural meeting which was now called the first annual meeting of CAGS. 181 attended the dinner in the evening. After all expenses had been paid the Association ended up with a balance of $4,500. A special vote of thanks was extended to Ms. Linda Welsh, senior secretary in Don Wilson’s office at the University of Toronto. The President was asked to send her a letter together with a suitable token of appreciation.

It was agreed that the annual dues for the year ending June 30, 1978 would be $50. Membership would be open to all those holding Certificates in General Surgery from the Royal College or the Quebec Corporation or holders of “equivalent qualifications” to be defined later by the Bylaws Committee. A quorum for the business
meeting was set at 50 with a two-thirds majority being required to change any of the bylaws.

The next meeting of the Executive was held on the 22nd of October 1977 at the Park Plaza Hotel, Toronto, which was the favorite hotel of the University of Toronto for its guests and CAGS were offered similar privileges. It was agreed that the 1978 Annual Scientific meeting would be held on Wednesday, the 25th of January with the business meeting starting at 1630 hours on the same day. This would precede the main Royal College meeting on the following three days.

The details of the CAGS Scientific Program were almost complete and Dr. Francis Moore, Boston, was to be the first Annual CAGS Lecturer.

The Secretary had received a letter from the Director of Professional Affairs at the CMA suggesting that CAGS apply for affiliation with the CMA in accordance with Chapter 16 of their Bylaws. This was agreed to and a formal application was made.

An application form for CAGS membership was to be drawn up based on that used by the Royal College; it did not require much detailed information. It was generally felt that the more comprehensive application form with requests for signatures of sponsors was not needed as the Association did not have a limited membership. This form, accompanied by a letter from the President, was sent to all registered general surgeons in Canada. Most of the time of the meeting was spent going over the CAGS bylaws proposed by John Gutelius and his committee. They had worked long and hard at this tedious but very necessary project. Each of the bylaws was carefully considered and approved.

The problem of “equivalent qualifications” for membership was avoided by stating the following prerequisites:
1. A Certificate in General Surgery from the Royal College of Physicians and Surgeons of Canada or the Corporation Professionelle des Medicins du Quebec.

As the last item on the agenda it was agreed that Don Wilson be asked to accept the first Honorary Membership of the Association at the Annual Meeting in January 1978.

The meeting in Vancouver on the 25th of January 1978 was memorable. The 98 members of CAGS who attended were treated to blue skies, sunshine and warm temperatures which helped to give the whole meeting an upbeat mood.

The Scientific Program organized by Lloyd MacLean was much appreciated. Max Cohen had arranged the dinner in the evening at the Ballroom in the Hotel Vancouver. Tickets were $30. each which included two cocktails, a fine menu with wine, a classical trio playing during the reception and dinner, followed by an eight piece combo for dancing. The members of the top table including Dr. Francis Moore, Boston, were piped in and during the evening Don Wilson graciously accepted the first Honorary Membership of the Canadian Association of General Surgeons.

The biggest concern of the Executive at the time was how to encourage more members from Quebec. The Quebec Association of General Surgeons was formed in 1965 and because the Rand Formula applied, all registered general surgeons automatically became members. The QAGS had developed into a first rate organization with a permanent secretariat. It looked after the affairs of Quebec general surgeons well and furthermore was responsible for negotiating with the Federation of Medical Specialists for the General Surgery Fee Schedule. For CAGS to be a truly national organization, more members from Quebec were essential.

Members of the Executive had an informal discussion with two of Quebec’s leading surgeons - Jean Fauteux, Montreal, who chaired the Department of Surgery at the University of Montreal and had a special interest in thoracic surgery and Louis Levasseur, Quebec, a pediatric general surgeon. They pointed out that the key figure in Quebec General Surgery was Jacques Cote, Quebec, who was the then President of the Quebec Association of General Surgeons. With
his support, there would be a good chance of getting additional members from Quebec.

Consequently, the Secretary was asked to fly to Quebec, meet with Jacques Cote and persuade him to accept the position of the CAGS President Elect in 1979. This mission was accomplished over a fine dinner in Jacques Cote’s favorite restaurant in Quebec. Furthermore he agreed to write to all the members of QAGS urging them to consider joining CAGS as well. The application form was bilingual and members could elect to have future communications, such as the Newsletter, in French or English. The response from Quebec general surgeons could best be described as modest; they were already well served.

At the business meeting, President Perey, the Secretary and the Treasurer, gave a full account of how things had developed since May 1977. President Perey had much pleasure in announcing that the Royal College had decided to hold its 1980 and subsequent meetings in the month of June. This was to be a trial arrangement and if successful, would become permanent. How much the CAGS resolution influenced this decision is hard to say but Bernard Perey, with a foot in both camps, had much to do with the final decision. Therefore the ’79 CAGS meeting would be held with the Royal College in January or February in Montreal and the 1980 meeting would be in June either in Ottawa or Toronto. The Association had now 594 members including 282 from Ontario and 91 from Quebec. The Treasurer announced a bank balance of $22,500. He agreed that the Association should avoid accumulating too much money and that every consideration should be given to ways of spending the money wisely. President Perey handed over to Bruce Tovee and Tait McPhedran, Calgary, became the President Elect.

The 1979 meeting of the Royal College in Montreal was listed to start on Wednesday, February 7. The 1978 meeting in Vancouver had begun on the Thursday and so it was now impossible for CAGS to follow the same scheduling in Montreal. The Royal College Convocation was on the Wednesday evening and so it was agreed that CAGS would forego the banquet and dance and simply hold a reception on the Wednesday evening.
The Executive met twice in 1978 on May 20th and on October 28th. This was essential to maintain the momentum that had been built up. Towards the end of 1977, Mr. Alex Ramsay, the Association’s lawyer, had applied to the Minister of Consumer and Corporate Affairs for incorporation. But there was one slight problem in that the Association of General Surgeons of Quebec, who incorporated in 1965, had a prior right to the name and their written consent to the name Canadian Association of General Surgeons was required. Bernard Perey had already made some inquiries and was assured that there would be no difficulty. Consequently the Secretary received a letter of consent from the President of the Association of General Surgeons of Quebec in January 1978 allowing the Association’s lawyer to complete the formalities. Later an affiliation with the Canadian Medical Association would be sought.

The membership had now risen to 712 and the bank balance showed a healthy $27,000. CAGS followed the Royal College standard for the reimbursement of expenses which at the time amounted to the economy return airfare, $65. per night, $15. ground transportation.

At both these Executive meetings, President Tovee made a special plea to ensure appropriate regional representation on the Executive and the standing committees, and that every effort be made to encourage community general surgeons and those in smaller centres to take an active role in the affairs of their Association. He pointed out that whenever Nominating Committees relax and fail to do their homework, University surgeons end up with too much influence. It would be very unfortunate if CAGS came to be considered a cozy club for University surgeons. Nevertheless University surgeons, with their experience, facilities and possibly time, would inevitably carry much of the burden.

The various standing committees set up in January 1978 according to the new Bylaws were beginning to do their work. The Education Committee chaired by Bernard Perey was considered to be the main driving force of the Association. The Research Committee initially chaired by Bruce Allardyce, Vancouver, taken over a year later by John Duff, London, was busily establishing the guidelines for the Resident Research Prize and working to complete a registry of active research projects in Canadian Departments of Surgery.
John Gutelius, Kingston, chaired the Manpower Practice and Economics Committee which, many years later, was renamed the Clinical Practice Committee. Initially it concentrated on three important matters - general surgical manpower, recognition of special skills and economic rewards for surgeons.

The CAGS Board, in the first year, struck a subcommittee on trauma with Charles Burns, Winnipeg, as the Chair. This was a very active committee which eventually led to the establishment of the Trauma Association of Canada. In the same vein, a turf war with the Canadian Association of Gastroenterology led to the formation of the CAGS Endoscopy Committee chaired by Roger Keith, Saskatoon.

In 1978 Neil Watters, as the Chair of the Royal College Committee for General Surgery, announced that the American Board of Surgery had reversed its previous decision on the recognition of Canadian training. They were now prepared to accept the training of a resident carried out entirely in a Canadian Training Program but they pointed out that this recognition was the result of a loophole in the regulations of the American Board rather than a formal recognition according to its by-laws.

Once the consent of the Quebec Association of General Surgeons to the use of the name Canadian Association of General Surgeons had been received, a charter by Letters Patent was granted and this completed the incorporation of the Canadian Association of General Surgeons.

The weather in Montreal for the February 1979 annual meeting presided over by Bruce Tovee, was cold, wet and overcast but all members were enthusiastic and the well organized Scientific Program was appreciated. At the annual business meeting, Bruce Tovee handed over the Presidency to Tait McPhedran, Calgary, who presided over the 1980 meeting in Ottawa in June. The weather was perfect, Ottawa looked its best and the Association had a total membership of 800 Active members and 90 Senior members. The finances were in good order with $58,000. in the bank.

In 1980 Neil Watters stepped down as the Chair of the Royal College Committee for General Surgery to be succeeded by Louis Levasseur,
Quebec. CAGS was invited by the Royal College to forward a list of names from which the nucleus members of the committee would be selected. As Neil Watters emphasized, this was a historic first as never before had the Royal College consulted General Surgery as to the membership of this committee. The close relationship between the Royal College Committee for General Surgery and the Education Committee of CAGS was now well established and the cooperation between the two would endure.

The Association received a thoughtful letter in 1979 from three members of the English Examining Board in General Surgery of the Royal College. They were John Hinchey, Montreal, Roger Keith, Toronto — later Saskatoon, and Frank Turner, Edmonton — later Kelowna, BC. They advocated that CAGS should break away from the Royal College and run a totally independent Annual Scientific Program. On the other hand the Executive strongly favored remaining aligned with the Royal College. The help of the Royal College in the overall organization of the Annual Meeting and that section allotted to CAGS, together with some direct financial aid, more than outweighed any possible advantage of an independent meeting. Furthermore many had a sense of loyalty to the Royal College. The membership was polled by mail and the result showed an overwhelming majority in favor of remaining with the Royal College. It is of interest that all three signatories of the letter eventually became Presidents of CAGS. To some extent, their view was later vindicated by the formation of the Canadian Surgery Forum even though that move was largely imposed on CAGS by decisions of the Royal College.

Keeping up-to-date in one’s own particular discipline is relatively easy but keeping up-to-date with other disciplines requires a special effort and multidisciplinary meetings such as that of the Royal College were very valuable.

It is interesting to see how isolated specialists can become. A prime source of general information used to be the Doctor’s Room of the hospital. This was usually close to outdoor parking and a place where physicians of all stripes gathered on their way in or way out. There were the talkers, the good listeners and the surreptitious listeners behind their newspapers. A few hints here and there would
lead to further enquiries and valuable lessons. But the modern hospital with underground parking, in-hospital offices, and a choice of elevators has destroyed the Doctor’s Room. Furthermore referring family practitioners no longer find it worthwhile to hold hospital appointments.

An attempt to relate the history of the first 25 years of CAGS in one sequential narrative makes very difficult reading. Instead the history of each of the CAGS committees and certain other initiatives of the Board have been covered in separate sections. In spite of some inevitable repetition, this makes it much easier to review areas that may be of special interest to the reader.
By the summer of 1979, CAGS was well established and the Board wanted a distinctive logo. Over the next three years seven designs were presented to the Board and all, after due consideration, were discarded. Some had been drawn by Board members themselves or their ideas had been professionally interpreted. They were turned down for various reasons. Some were not bilingual, others were artistically poor and several represented only part of what was recognized as General Surgery.

A few of the suggestions were quite amusing. One Board member discussed the problem with a hospital artist, who, using an insulin syringe filled with blood and a small needle, produced an artistic collection of spread blood droplets in the top right hand corner of the page. It did not convey the right message. The same artist had prepared a logo for the Canadian Association of Laundry Managers. He placed a sagging line across the top of the page from which hung articles of clothing swinging merrily in a light breeze. The laundry managers were not amused.

By 1982 the Board agreed that, in view of the tight position of the CAGS finances and the perfectly adequate letterhead, no further steps be taken for the time being although any suggestions would still be considered. Finally in 1983 the logo was dropped from the agenda.

The desire for a logo cropped up again in 1987. All the previous suggestions were gathered and sent to Marvin Wexler, Montreal, who was secretary at the time. They were all copied and sent to Board members for their opinion. There was little enthusiasm. Early in 1988 Marvin Wexler suggested exploring the field of heraldry to come up with an appropriate coat of arms for CAGS.
coat of arms has one great advantage in that the wording of a motto must be in Latin, eliminating any attempt at bilingualism. Two surgeons, experts in heraldry, were consulted - Bob Thorlakson, a Winnipeg general and colorectal surgeon and Bob Salter, a Toronto orthopedic surgeon who was also a Past President of both the Royal College of Physicians and Surgeons of Canada and the Canadian Orthopaedic Association. Both were strongly in favor of the idea and subsequently, Bob Thorlakson made a special presentation to the Board of his suggestion for a CAGS coat of arms. His plans were eagerly agreed to by the Board and were duly fashioned by the noted heraldic artist, Gordon MacPherson of Burlington, Ontario.

The ancient art of heraldry dates from the 12th century. Knights in full battle or jousting armor look very similar and chivalry dictated that each knight must be display distinctive symbols over the armor. A personal crest of boiled leather or light wood was attached to the top of the helmet. Hanging down below the crest was a silk mantle of distinctive color and design which also helped to keep the heat of the sun off the back of the armor. The mantle indicated the army or group to which the knight belonged and similar designs were displayed on banners, shields and horse cloths.

When the knights were not fighting or jousting these distinctive emblems would line the walls of the Great Halls of the kings and lords. Each knight had his own motto on the wall above which he would hang his mantle surrounding his crest, helmet and shield. The phrase “Coat of Arms” describes the sum total of these unique objects. In the decorative representation of a coat of arms the mantle is slashed and swirled to hang artificially around the helmet and shield.

The features of the CAGS coat of arms are as follows:

**The shield:**
This has a red and white border recalling the barber surgeon origins. The main charge on the shield is an eagle on a golden field. The eagle is taken from the crest of the Royal College of Surgeons of England and modified. The eagle is red to represent surgery and the imperial crown has been removed and the head turned to face forward. A lance held in the eagle’s right claw represents a surgical
instrument and the addition of a serpent around the lance forms a modified caducis, a symbol of the medical profession from antiquity. The red and metallic gold on the shield are borrowed from the coat of arms of the Royal College of Physicians and Surgeons of Canada.

**The crest:**
On top of the helmet is a coronet of red maple leaves, emblematic of Canada. From this arises the right hand of a surgeon grasping a dagger on which is impaled the head of a dragon connoting the eradication of disease.

**The mantle:**
This is colored a surgical red and lined with gold.

**The motto:**
Sapientia Manuque Apta — (“wisdom and a skillful hand”) is a modification of a motto of the Canadian Royal College which reads “With a keen mind and skillful hand”. Sapientia embodies the concepts of knowledge and judgment, both essential to a surgeon no matter how dextrous.

The CAGS Coat of Arms was presented to and accepted officially by the Chief Herald of Canada, Robert D. Watt in 1992. The formal letters patent were issued to CAGS and the Arms were registered in the Public Register of Arms, Flags and Badges of Canada. A notice of grant was published in the *Canadian Gazette*.

A copy of the Canadian Association of General Surgeons Coat of Arms mounted on red velvet in a gold box frame was presented to the Royal College of Physicians and Surgeons of Canada by Marvin Wexler and a proud Bob Thorlakson; a very fitting finale for an endeavor that they were primarily responsible for initiating and completing.

In the meantime, with the help of Eddie Monaghan, Montreal, and Mr. Dawkins, Toronto, the CAGS coat of arms was made available on ties, blazer badges and brooches. These articles were ordered in quantity and paid for by CAGS. They were held on behalf of CAGS in Mr. Dawkins’ store. They were sold to the membership through the Secretariat at $24, $22 and $10 for the ties, badges and brooches, respectively. Ten years later, much of the order is still in the Dawkins’
store. Despite being displayed at annual meetings, advertised in the Newsletter, the turnover was very slow. Most of the Board members bought ties, a number were given away as gifts by CAGS Presidents but there are still many left. Very few badges or brooches were ever sold. Timing is everything and it so happened that CAGS was marketing its ties at a time when fewer and fewer men were wearing them. They do make unique and handsome gifts and CAGS members can be proud of their Coat of Arms.
EDUCATION COMMITTEE

The first annual business meeting of CAGS was held in Vancouver in January 1978. Bruce Tovee, Toronto, was installed as the second President and Bernard Perey remained on the Board as the Immediate Past President and the Chair of the Education Committee. Addressing the Board, Dr. Perey said that he felt very strongly that the Education Committee, with all its ramifications, should be the main driving force of the Association. He proposed and the Board agreed that the Education Committee be split into three subcommittees:

A) The Undergraduate Education Committee — this would be a relatively minor role as CAGS had little influence on bodies that controlled undergraduate education. Even in 1978 curriculum committees in medical schools were already eagerly chipping away at time spent on undergraduate surgical teaching.

B) Postgraduate Education Committee — Residency Education. CAGS had a significant influence on the decisions of the Royal College through the Royal College Committee on General Surgery, many of whose members had held important positions in the Royal College Committee structure and all were members of CAGS. There were also international legal complications as the American Board of Surgery had announced that, starting in July 1980 they would no longer grant automatic recognition to training in Canadian General Surgery programs. The CAGS Education Committee had given serious thought to establishing a CAGS Intraining Examination along the lines of the very popular examination of the American Board of Surgery.

C) Continuing Medical Education — This would be a major effort of CAGS primarily through its Annual Scientific Program soon to be
enhanced with Postgraduate Courses. A National Committee had recently been struck with representatives of the CMA, the Royal College, the ACMC and the CFPC to develop national standards for Continuing Medical Education. Furthermore the Royal College had been seriously considering setting up a mechanism for recertification at some future date.

On the 17th of October 1978 the Education Committee met with the Program Directors of General Surgery Programs in Canada, the Chairmen of the Royal College Committee on General Surgery and the two chairs of the Examining Boards. It was at this meeting Dr. Neil Watters announced that the American Board of Surgery had reversed its previous decision on the recognition of Canadian training. It was now prepared to recognize training of a resident carried out entirely in an accredited Canadian training program.
Neil Watters was the first chairman of this committee. He had many years of experience of both undergraduate and residency teaching. He said that while surgical clerkships seem to be working well, he deplored the fact that surgeons played a shrinking role in the earlier medical school years. His committee recognized that it was more difficult for surgeons to find time for bedside teaching as compared to internists. Nevertheless he insisted that the committee should continue its existence in order to try and establish national objectives and to emphasize the importance of involving surgeons in undergraduate teaching. Special electives in surgery in second and third years in the medical school should be considered and even undergraduate scholarships in surgery offered.

By the end of 1980 Neil Watters, as the immediate past chair of the General Surgery Committee of the Royal College, circulated a paper on the objectives, contents and methods in the teaching of undergraduates in General Surgery. This was the outcome of deliberations of his Royal College Committee and the CAGS Undergraduate Education Committee. It emphasized that undergraduate surgery teaching is the study of all aspects of those diseases which may sometimes be treated by an operation. Copies were circulated to the Deans and Surgical Chairmen in the 16 medical schools.

In 1981 Rudy Danzinger, Winnipeg, succeeded Neil Watters as the chair of the Undergraduate Education Committee. He was well known from coast to coast as a general surgeon who dedicated his time and energy to improving undergraduate surgical education.

Sadly, the position paper on “Place of Surgery in Undergraduate Education” which had been circulated to the Deans and Department...
Chairmen did not evoke a single reply or comment. Rudy Danzinger and the members of his committee all belonged to the American Association for Surgical Education in the United States and CAGS members with similar interests were encouraged to apply for membership. Meanwhile the committee continued its efforts to define the content of General Surgery.

A Symposium on “Surgical Education in the Undergraduate Medical Curriculum” formed a part of the Royal College program in 1983. This was a lunchtime seminar which was chaired by John Provan, Toronto, and it attracted a small but thoughtful audience. Much of the discussion hinged on the lack of uniformity about internships ranging from straight internships to mixed and rotating internships. Quebec was starting a one year integrated internship under the supervision of the Residency Training Committee in Surgery. Such an integrated internship would become part of a five year training program in surgery and would then meet the requirements of the American Board. Conversely Alberta required a two year internship program for a full license. Another Symposium on “The Role of Departments of Surgery in Undergraduate Education” formed part of the 1984 Royal College Program. Meanwhile the Subcommittee on Undergraduate Education discussed many problems — program objectives, basic knowledge, clinical skills, self directed learning, personal qualities and problems in systems teaching.

In 1986, the Undergraduate Committee produced a draft document outlining the requirements for surgical teaching in undergraduate No programs. This was revised and perfected and circulated to all Surgery Departments under the name of “Surgical Component of the Undergraduate MD Program”. A year later about one third of the Surgical Departments appeared to be using this position paper as a guide and another third were using it on a trial basis.

Peter Knight, Kingston, took over the chair of the Undergraduate Education Committee from Rudy Danzinger in 1987. He was happy that the position paper had been so well received and announced that over 50% of the Surgical Departments were following the suggested guidelines.
A Canadian Association for Surgical Education was formed in 1987 and was recognized by the Royal College. It provided a forum for presentations on Surgical Education. In November 1987 the University of Toronto organized a two-day Symposium on “Undergraduate Surgical Education; the Surgical Continuum”.

In 1989 Daniel Tasse, Montreal, became the Chair of the Undergraduate Education Committee. They proceeded to publish a shorter Canadian version of “Objectives in Surgical Training” produced by the American Association for Surgical Education. The US organization had devised a comprehensive program which included an excellent textbook, “Essentials of Surgery”, complimentary slides, computer instruction disks and videos on surgical technique. Canadian Surgical Departments were encouraged to take advantage of this. The Committee of Canadian Surgical Chairmen had produced a Canadian version.

It was evident that most of the work of the Undergraduate Education Committee was being channeled through the Association for Surgical Education in the United States. The 1992 meeting of the Association for Surgical Education was held in Quebec and this marked the demise of the Undergraduate Subcommittee of the CAGS Education Committee. Daniel Tasse continued as the CAGS representative to CUSEC (Canadian Undergraduate Surgical Education Committee). Unlike the Committee on Postgraduate Education and the Continuing Medical Education Committee, both of which had close contacts with the Royal College, the Undergraduate Committee was never blessed with any significant influence over those who controlled the Undergraduate Curriculum and its surgical components.
At the first meeting of the Education Committee it was agreed that steps should be taken to establish an annual LAGS intraining examination for general surgery residents. Don Willoughby, Halifax, chaired the first Postgraduate Education Subcommittee and he explained that the American Board of Surgery has consistently refused to allow Canadian Surgical Departments to use their intraining examination. He said he would consult Sam Kling, Edmonton, the Director of the McLaughlin Examination Centre at the Royal College as to the cost of producing, distributing and marking of a Canadian intraining examination. Dalhousie University already had an intraining examination for its own general surgery residents and, in the interim, it would be made available to all Canadian general surgery residents. Not unexpectedly, the option of working through the McLaughlin Centre proved to be far too expensive; their fixed costs were high and their primary function was to serve the Royal College.

In February 1980 361 modified Dalhousie examinations were sent to General Surgery residents with the promise that the results would be available before the end of June. The CAGS Board agreed to provide $2,000. towards a similar examination in 1981, with the approval of Gordon Bethune, Chairman of the Dalhousie Department of Surgery. The first Test Committee consisted of Don Willoughby, Halifax, Chairman, Fred Inglis, Saskatoon, Don Currie, Toronto, Maurice Falardeau, Montreal, and Barb Mueller, Hamilton, as a consultant. It was proposed that the examination would henceforth be self financing through charges to Departments of Surgery for each candidate rather than relying on CAGS financing.

It is very much to the credit of Don Willoughby and his associate in Halifax, Step Norvell, that the intraining examination got off to such a good start. Each year since 1980 the examination, both in English
and French, has been held in February. The results have provided Program Directors an excellent measure of a resident’s progress and, over the years, the results in the fifth year provide an accurate prediction for success in the Royal College Fellowship Examination. The examination has not required any outside funding other than the fees charged to Departments of Surgery. The Examination office remained in Dalhousie for many years; members of the Test Committee came and went, but all were experienced Royal College examiners and so the business of the intraining examination was carried on year after year with quiet efficiency. By 1982 the CAGS Intraining Examination had its own question bank with the questions sorted into 60 categories, one-third basic and two-thirds clinical. Each year 20% of the questions would be taken from the previous year, 60% would be previously tested questions and 20% would be new. Cost of the examination was fixed at $50. per resident paid by individual departments; this was half the price quoted by the McLaughlin Centre.

Meanwhile the Postgraduate Education Subcommittee worked hard on other matters of concern. In the late 1970’s some of the medical specialties had moved their final examination for Certification to May or June so that Chief Residents could begin practice on the first of July. This was viewed as a real threat to the hallowed final year of training in General Surgery during which the Chief Residents could concentrate on getting as much clinical experience as possible, knowing that, after the completion of their training, they had ten weeks to prepare for the written examination and about another ten weeks for the oral.

During this time a little discrete moonlighting would keep the home fires burning. Moving the Surgical examination to the end of June would mean that either clinical experience or examination preparation would suffer. The Subcommittee unanimously condemned any move to change the timing of the Surgery examination. A formal letter was written to the Chairman of the Royal College Committee on General Surgery.

John Hinchey, Montreal, the anglophone chairman of the Royal College Examination Board in General Surgery produced a detailed report in 1980 which stressed the value of the intraining evaluation
report, the ITER. There was an excellent correlation between the ITER and the final result. Members of the Examining Board had a number of other observations:

A) The examiners wished to dispense with the part of the examination that involved history and physical examination, because of their experience with poor selection of patients by those in charge of Local Arrangements, the poor facilities that were offered and the significant logistical problems involved in moving from one hospital to another in large cities.

B) The Examining Board suggested that the chairman and the vice chairman be members of the CAGS Test Committee so as to give continuity.

C) The numbers of candidates in the Western examination were so few that it was possible that they did not get as fair an examination as those in the East. They recommended that the Western examination should end.

D) The Board had concerns about the stipulation that knowledge of Head and Neck Surgery and in particular cancer surgery of the oral pharynx was a requirement for General Surgery Certification. The inroads of the Otolaryngologists into head and neck surgery was well established in some of the old schools in the East and their candidates for Certification in General Surgery did poorly on head and neck questions.

E) The Principles of Surgery Examination by the year 1980 was a well established Royal College function that worked very well.

John Hinchey’s report was duly considered by the Royal College Committee on Examinations. They agreed that history and physical examination of patients could be dispensed with but added a useful rider that selected candidates, who were on the borderline after completing the oral examination, could be invited to examine a patient with an examiner present before a final decision was made. The Royal College refused to end the examination in the West but did say that if there were less than 24 candidates its elimination should be seriously considered. Many felt that this was virtually the
death blow to the Western examination. If it were eliminated then the examination would be held in rotation between Montreal, Toronto and Winnipeg.

The Royal College Certificate of Special Competence in Oncology was designed for physicians. Surgeons were specifically excluded. Furthermore this Certificate had been introduced without any discussion with the surgical disciplines. Henry Shibata, Montreal, wrote to the CAGS Board strongly advocating the development of a Certificate of Special Competence in Surgical Oncology. The Canadian Oncological Society was most anxious to have CAGS support for this proposal. Reporting back to the Board, the Postgraduate Subcommittee said that while they endorsed all efforts to promote training in Oncology, a Certificate of Special Competence in Surgical Oncology should not be offered. This did now go down well with some members of the Board. Allan MacDonald, Halifax, protested that the Board members were burying their heads in the sand and that medical and radiation oncologists would inevitably take over the management of cancer patients as time went on. He said that the Royal College manual defines the need for general surgeons to become versed in the treatment of malignant disease and some improvement in the wording might be considered.

The CAGS Board supported a proposal, outlined by Bernie Langer, Toronto, to establish a two year training program in colorectal surgery at the U of T consisting of one year of research and one of clinical work. This would enable candidates to take their American Boards in Colorectal Surgery. This led to the Board establishing a CAGS Committee on Colorectal Surgery. By 1984 the Royal College was beginning to rethink its policy on Certificates of Special Competence, which involve the accreditation of training programs and an examination. Examinations were expensive to organize and run. A Royal College Committee, chaired by John Duff, London, advocated a change from a Certificate of Special Competence to Accreditation of Specific Training Programs without a Certification Examination. Another reason for the lack of enthusiasm for Special Certificates was the veiled implication that those without a Certificate were not competent in that particular field.
In 1984 John Hinchey, Montreal, stepped down as the chair of the English Examining Board of the Royal College to be succeeded by Don Willoughby, Halifax, and Roger Keith, Toronto, as the vice chair. Also Denis Bourbeau, Montreal, succeeded Jean Couture, Quebec, as the chair of the CAGS Education Committee.

Denis Bourbeau’s committee met for a full day in September 1985 and presented a number of recommendations to the Board.

1) A move to an earlier Royal College examination should not be supported by CAGS. It would seriously disrupt the vital last year of training.

2) Training Program Directors and residents should be aware of their legal responsibilities and that all residents should belong to the CMPA.

3) External rotation of residents outside a University or University affiliated hospital should be increased from three to six months.

4) Several short presentations in a CAGS Postgraduate Course should replace the longer more comprehensive talks and the location of the meeting be taken into account in choosing topics.

5) The CAGS Intraining Examination should be included in future CAGS annual meetings and be available to the membership.

Ed Monaghan, Montreal, became chairman of the Postgraduate Education subcommittee in 1986. He outlined the RI (PGY2) matching program for General Surgery Residency Positions. This project was strongly supported by the Royal College in an attempt to reduce the spiraling costs to applicants of traveling to many interviews. There was also some concern that further cutbacks on entries into General Surgery were in the offing. Major changes in internships were to take effect in Quebec in July 1988. There would be two streams towards a license to practice.

1) A Family Medicine Stream — There would be 300 positions in the four medical schools and the RI and RII years would be devoted to general practice.
2) The Specialty Stream — There were 37 recognized programs in Quebec and the entry would be the RI year. There would be a total of 310 positions for all specialties in Quebec. Applicants who were uncertain whether or not to specialize would probably opt for the “safer” family medicine program. There was a possibility that residents could change specialties part way through their program but the fundamental choice of the two streams must be made at the outset. It was evident that health planners were out to reduce costs and make cutbacks without any appropriate consultation.

Media interest in the working hours of surgical residents followed the findings of the New York State enquiry into a surgical misadventure that was being attributed in part to residents working long hours without rest. The Commission’s findings in 1985 suggested that performance in a fatigued state did not suffer when compared with that of a well rested resident. However the residents’ mood was very different if they had less than two hours of sleep. The working hours of residents were curtailed in New York State and it seemed likely that, eventually, similar restrictions would occur throughout North America and Europe. There was strong support for this from the Professional Association of Interns and Residents but residents in the surgical disciplines were much less enthusiastic.

Bryce Taylor, Toronto, succeeded Ed Monaghan as the Postgraduate Subcommittee Chairman in 1988. He said that 1988 was the third year for the Canadian Intern Matching Service (CIMS) match for general surgery. Quebec was no longer in the match and although Calgary joined for the first year, it had dropped out. Matching was occurring at the PGY2 level and the eleven General Surgery programs provided 44 positions for the 89 applicants (down from 120 on the previous year). Many felt that the match should be delayed for 2-3 months from October to December or January in order to give more time for referees to make an informed assessment. However the decision on this matter rested with the Association of Canadian Medical Colleges who began and were responsible for the match.

Steve Norvell, Halifax, was designated as the Executive Director of the CAGS Intraining Examination in 1981. He retired as a member of the staff of the Department of Surgery in Dalhousie in 1987 but
agreed to stay on as the Executive Director and a member of the Test Committee for a few years. This required that he receive an honorarium and the Board agreed to this. In order to cover the additional expense the examination fee was increased to $60. for the year ’87/’88.

The report of the Education Committee to the Board in February 1989 covered a number of important points.

1) In September 1988 the Royal College approved a five year training program in General Surgery - that is five years after internship. In Quebec it would be five years post NO. Only Toronto and Hamilton had straight internships so that most programs would require five whole years following a rotating internship.

2) The Cardiovascular and Thoracic Specialty Committee of the Royal Committee recommended a full five year training in General Surgery followed by three further years in Cardiovascular and Thoracic Surgery for a CVT Fellowship. However this was not accepted by the Royal College Committee on Specialties who recommended a return to a free standing CVT program. There was need for further deliberation.

The Royal College had approved a pilot project for Critical Care Training. Certificates of Special Training Without Certification would be awarded in the primary specialties of Anesthesia, Internal Medicine, Pediatrics and General Surgery. The two year training program consisted of one year of specialized Critical Care Medicine and credit could be given for up to 12 months of the other year for time spent in Critical Care during primary specialty training, which must be identified prospectively and must be taken in the last two years of training and must be in an ICU with an approved program. The implications for General Surgery were very clear.

3) The Postgraduate Subcommittee continued to attempt to define the objectives for residents in General Surgery including when they are seconded to other surgical specialties.

In the 1989/90 year the fee for the Intraining Examination was increased to $75. The increase was for additional expenses to speed
up the conversion of the examination in Halifax to a version that would be compatible with computers in all Canadian Universities and make it possible to move the examination anywhere in Canada. In that year 450 residents took the examination.

For those interested in postgraduate surgical education, the years 1988 to 1993 were very confusing. When Quebec abolished the internship in 1988 there was a strong suspicion elsewhere in Canada that sooner or later the two stream idea would be adopted from coast to coast. The Quebec changes were instigated by the Quebec Ministry of Health as it appeared to give them greater influence over the employment of doctors and there was always a hope that it might save money. New initiatives in Quebec in various fields have often been quietly adopted later in the rest of Canada. Furthermore the Federal and other Provincial Health Ministries were kept well informed. At about the same time the Royal College was considering the adoption of two years of “core training” followed by three years of more specialized training for all its medical and surgical specialties. This was to lead to several years of negotiations through a host of committees before there was any consensus.

Meanwhile the Federation of Medical Licensing Authorities of Canada (FMLAC) in 1991 were proposing 24 months of prelicensure training, the minimum of eight months devoted to core education involving Family Medicine, Surgery, Medicine, Psychiatry, Pediatrics and O&G. All of the medical schools and Deans and Associate Deans were very much involved especially as controlling provincial funds for resident training was one of their responsibilities. The Canadian College of Family Physicians were quietly in favor of the system in Quebec, possibly because it appeared to increase the status of Family Practice. Behind the scenes, the wishes of the Federal and Provincial Governments were made known discretely.

To the casual observer, how all this was resolved is still something of a mystery. A “concensus group” met in August 1991 and strongly supported two routes to licensure - the “Q5” examination at 17 months after MD followed by certification, either within the Royal College or the College of Family Practitioners, and Licensure. These recommendations were accepted by the Medical Council of Canada in December 1991. However there still remained the question of how
to handle the PGYI year as there needed to be enough experience in the various disciplines to prepare for the Q5 examination. To make all this more difficult, Ministers of Health, encouraged and supported by the Barer-Stoddart Report, were introducing a 10% cut in the intake of first year medical students which would eventually effect Postgraduate Programs. This was in spite of the fact that many parts of the country were already experiencing a shortage of doctors.

By the end of 1992, core training in General Surgery was in various stages of development across the country. The CAGS Postgraduate Education Subcommittee recommended that:

1) Core training should focus on the principles of surgery.

2) Specialty rotations should be flexible and consider subsequent training.

3) No seconding to surgical services simply for service.

4) Program Directors should have power to withdraw residents from poor services.

5) Core training was not expected to provide a broad medical education which should have been completed in undergraduate years.

6) PGYI core surgery should count as a basic clinical training year described by the Royal College.

Training in General Surgery would require two years of core training, one year of options and two years of further training in General Surgery. There should be at least 30 months of training in General Surgery and 12 of these should be completed as a senior resident. The loss of the rotating internship was deplored by many; it had allowed the intern to make an informed choice as to a future career and at the same time allowed hospital staff members to assess an intern’s potential as a future member of the staff, significantly enhancing the value of letters of recommendation.

Since the early 1980s the Royal College had been pushing for all specialties to complete the Certification examination within the last
year of training. Now that the young MD could not get a license to practice until specialty training had been completed, the timing of the examination had become critical. Ed Monaghan held a meeting in September 1991 of the Royal College Specialty Committee, and despite all the statements that the CAGS Education Committee and the Board had made over the previous 15 years deploping the change in the examination timing, 15 of the 21 members were in favor of completing the examination process within the a year of training; four voted against and two abstained. This placed the onus for making such arrangements on the Royal College but their staff said they required at least six weeks between the written and the oral examination to ensure a proper assessment.

Six months later in February 1993 the Board heard from the CAGS Secretary, Roger Keith, Saskatoon, that a National Coordinating Committee for Postgraduate Training had been formed. This committee has representatives from the Royal College, Canadian Medical Association, the Canadian College of Family Practitioners, Canadian Association of Interns and Residents, the Association of Canadian Medical Colleges and the Federation of Medical Licensing Authorities of Canada. It reported directly to a Committee of the Deputy Ministers of Health and was the only effective line of communication to them. The first chairman of the Committee was Dr. Allan Cox, retired Dean of Medicine from the University of Western Ontario together with a non-medical co-chairman. The mandate was to oversee postgraduate training with a view to reducing costs and placing emphasis on the basic specialties.

Bryce Taylor, Toronto, the Chair of the Education Committee, presented an important report to the Board in February 1993.

1) Core Training — the concept was accepted by the Royal College in September 1992. The Council moved “that core training in Surgery be accredited in conjunction with the surgical program of which it forms part. Program Directors will be considered to be responsible for the full training in their specialty”. There were no specific rotations mandated so that all training could be arranged to meet the published core educational objectives. The core program would be directed by a representative committee. Core training must begin in July 1994 although most programs had started in July 1993.
2) “Basic Clinical Training”. This term replaces “internship” in all Royal College requirements. The PGYI year in core will be acceptable for “basic clinical training” and Program Directors will have some flexibility.

3) The Education Committee had worked for some years to produce specialty specific Final ITER’s. The General Surgery FITER was first used in the 1993 examination process primarily to consider borderline cases. It is interesting that within a year the Examining Board had evolved a system of weighting to assess properly the FITER’s from the various programs. The Education Committee also helped to produce the revised Certificate of Completion of Training (CCT) which is to be completed early in the calendar year stating that the candidate is recommended for the examination and is completely trained and eligible as of the date stated for the end of training. Should problems arise in the meantime there should be immediate communication with the Royal College.

4) The Royal College now advocated an option for training in community hospitals in the General Surgery Program.

The CIMS match now called the PGY1 match seemed to be making good progress. In 1993 276 Canadian graduates applied for positions. There were 48 in General Surgery in ten schools (excluding three French schools, Dalhousie, Manitoba and UBC). Seventy five of the 76 applicants ranked General Surgery first and 35% of them received their “first choice”. In 1993 General Surgery, Orthopedics, Anesthesia, Diagnostic Radiology and Internal Medicine and O & G took part in the match. UBC was a special case; at the time they only accepted candidates for General Surgery training who had already completed two years post MD training in Family Medicine.

Bryce Taylor’s committee also produced a report entitled “The Optimal Community Experience in Canadian General Surgery Programs” which listed the general objectives and recommended details regarding the community setting, range of experience and the responsibilities of both the resident and the supervisor. This report was accepted by the Royal College Specialty Committee for General Surgery and after ratification higher up the Royal College ladder were incorporated into the training requirements.
The Match continued to improve. The coordination of out of town interviews was better although the number of candidates in each centre created some strain. In 1994 there were only 1,255 positions for 1,608 total applicants which included 1,301 Canadian graduates. The Government felt that the situation was no concern of theirs. Quebec had introduced another change. Each RI was supplied with a training card which allowed rotation to various hospitals as directed by Program Directors. The contract was between the resident and the hospital and the cards must indicate that malpractice insurance has been purchased by the hospital. The Provincial Government had control of the cards in order to determine when to issue a license and influence where the resident might practice. The Government could decide on the basis of manpower studies the number of cards that are issued; furthermore they could determine the levels of “desirability” of certain specialties, e.g., General Surgery, General Medicine and Anesthesia were classified at Level A (very desirable) while Plastic Surgery was given a Level D (not desirable). Meanwhile the National Coordinating Committee was pushing for the concept of resident cards to be used throughout the country.

At the same time core training seemed to be developing in 16 different ways and core directors received little guidance. The tussle between the authority of core directors and that of specialty training directors essentially determined the the content of “core”. Specialty Program Directors try to devote more and more of core time to their particular specialty. At the University of Montreal residents in “Core training” remain undifferentiated and would be matched to a specialty only at the end of the two years. Bryce Taylor received many complaints from Program Directors that they were overwhelmed by requests from the Royal College adding details to their training requirements including general, sociological and ethical considerations.

After several years of deliberation the Royal College in 1995 finally recognized Cardiac Surgery and Thoracic Surgery as a primary surgical specialties and the training would include two years of core training followed by up to six years of. specialty training. This made it very difficult for a person who had completed a General Surgery training to acquire further training in either Thoracic or Cardiac Surgery. Peripheral Vascular Surgery retained a Certificate of Special
Competence following Certification in General, Cardiac or Thoracic Surgery. These new arrangements would not take place until July 1996 at the earliest.

Dr. Ken Harris took over the Education Committee in 1995 and the committee dealt with new twists to old problems. The Royal College insisted that Examining Board provide eligible candidates with the opportunity to complete their entire process of examination leading to Certification within the six weeks prior to the completion of residency training. The new licensing regulations made this imperative. The exact details of the examining process remained in the hands of the McLaughlin Centre at the Royal College. Most Program Directors proceeded to juggle rotations as best they could so as to accommodate the residents.

The 16th Intraining Examination was held in February 1995. 453 took the examination and because a number of core residents took the examination, this was the highest number so far. The examination had been made available to CAGS members provided they took the examination in a teaching centre along with the residents; only 23 general surgeons took up the challenge.

Starting in September 1996 the Education Committee and the CAGS Board had an additional member representing residents in General Surgery training. To reduce costs, the residents were selected from Teaching Programs close to the site of the annual meeting.

One thing was becoming evident. With bed closures, day surgery, and clinical assistants it had become increasingly difficult to give a good clinical training. In later years the situation was to be compounded by mandated reduction in on-call time and working hours. Trying to accommodate a research year within a residency program was becoming increasingly difficult and furthermore the American Board of Surgery requires 54 months of clinical training.

The Royal College Task Force to review fundamental issues in specialty education finally produced its report in 1996. Known as the Maudsley Report many regarded it as a disappointing and blissfully vague publication which emphasized training in communication, medical legal matters and ethics.
Following the 1996 Carms (Canadian Resident Matching Service) Match each student received a questionnaire and there was a 75% response. 63% thought that they were fairly well prepared to make a choice for the future. 75% preferred an interview on site rather than a video conference as it allowed them to view the facilities and talk to the local general surgery residents. In spite of every effort to make the interviews as convenient as possible, students spent an average of $2,000 each on the process with B.C. the highest and U of T the least. In 1997 1,362 students entered the match, 55% were matched to their first choice of University and 88% to their first choice of specialty. There were 55 applicants in General Surgery. In all of Surgery, 76% were matched to the discipline of their first choice and 47% to the program of first choice.

Little mention has been made of the CAGS Merck Frosst Awards made to a General Surgery resident who had made a special effort to teach other residents and students during the previous year. There were 16 $1,000 awards each year, one to each General Surgery Training Program. These were started in 1982 and had continued each year without interruption. It was a well thought out program, a credit to Merck Frosst and the Education Committee; the more the residents teach each other and their juniors, the better the programs become. Only those who have tried to organize similar awards will appreciate that it can be a frustrating task. A year goes by quickly and the organizer, the chair of the Education Committee, has barely finished with one before the next recipients have to be selected. Program Directors are slow in making their choice and even slower in replying to letters and some never do. The names of the winners must be sent to Merck Frosst in good time so that the appropriate cheques can be made out accompanied by letters of congratulations from the President of CAGS and Merck Frosst. Finally some form of presentation ceremony had to be arranged with appropriate recognition to Merck Frosst. Originally the presentations were to be made at the CAGS annual business meeting but when only a few of the recipients were present, the effect was less than desired. This was followed by the plan for a local Merck Frosst representative to make the presentation to the resident at an appropriate Surgical Rounds. This provided good recognition to Merck Frosst and made the other residents sit up and take notice and it also made it imperative that the local choice was well thought out and fair. As the years went by,
pharmaceutical companies employed fewer representatives who had larger areas to cover and so by 1996 the recognition consisted of names read out at the annual business meeting, a vote of thanks to Merck Frosst and the cheques, a certificate and accompanying letters were mailed out. But even this wasn’t the end of the difficulties because some of the successful residents were away on Fellowships and trying to trace them to a current address was difficult. This was eventually dealt with by calling for nominations in January and having the whole process competed well before the end of June.

Noelle Davis, Vancouver, took over as the new chair of the Education Committee in 1997. By now the Royal College Examination Committee had declared that the MCQ could be taken in the penultimate year and the oral exam at the end of the final year. The Committee was pleased to endorse Robin McLeod’s, plan for Evidenced Based Studies in Surgery. Using the best evidence to give the best care involved research to find the facts followed by wide dissemination of information. Evidence Based Care was a big issue in the UK and was becoming more so in the US and Canada. Corporate sponsors were anxious to be associated with the movement and Johnson & Johnson/ Ethicon in the past had provided several Fellowships for surgical trainees to learn the disciplines involved. The McLeod plan was to choose a contentious issue, select a few good current articles on the subject, and combine these with an in-depth critique of the methods used together with a review of the clinical and methodological ramifications. A similar program had been used in the city wide U of T Journal Club for some years. Packages were to be mailed out every two months to Program Directors for distribution to their General Surgery residents. This was a nation-wide project under the auspices of CAGS and under the control of Robin McLeod and her colleagues. Johnson & Johnson had agreed to fund the project entirely for at least three years. Later the program would be made widely available to CAGS members through the CAGS Web page.

In 1997 the CAGS Test Committee office was moved from Halifax to St. John’s. Steve Norvell, Halifax, had stepped down as the Executive Director and this position was assumed by Chris Heughan, St. John’s. Chris Heughan had been a member of the Test Committee for many years as well as a member and chair of the Royal College
English Examining Board in General Surgery. Steve Norvell had been a great help in making the move as smooth as possible and an opportunity was taken to modernize the equipment and introduce optical scanning. These two gentlemen are to be complimented for the fact that the Examination continued smoothly without interruption.

Noelle Davis stepped down as Chair of the Education Committee in 1998. She had been appointed to the Cancer Services in British Columbia, and she could no longer devote sufficient time to the Education Committee. Meanwhile the organization of the Merck Frosst awards had been delayed by several months. Walter Yakimets, Edmonton, agreed to become the Chair of the Education Committee. He was an old CAGS war horse who had served the Association in several capacities since 1977 and was a long time member and Chair of the Royal College Examining Board in General Surgery. With a very special effort he rescued the Merck Frosst awards and chaired the Education Committee until 2002 when Helen MacRae, Toronto, took over this position.

For some years the Education Committee had worked hard to try and modify and simplify the Royal College evaluation forms to incorporate the section on ambulatory care and the CanMeds 2000 objectives; these are the seven essential roles of a specialist set out by the Royal College — medical expert, communicator, scholar, collaborator, manager, health advocate and professional. This was a difficult, frustrating and fuzzy task.

The report on the 1999 Fellowship examination emphasized the fact that the management of complex acute problems was poorly handled. This had been foreseen many years earlier to be a likely result from the changes in residency training. It is just impossible to sound convincing at an examination if similar problems have not been wrestled with for many hours at the bedside.

The Royal College proposed that by the year 2001 it would have a single condensed examination with both the written and oral being taken within a few days. Education experts at the Royal College were pushing for standardized questions in the oral examination but this was opposed by the CAGS Education Committee and the Royal
College Committee on General Surgery. Some of the College staff members sat in on the oral examinations to have a better insight as to what actually takes place. In the following year lack of experience and confidence in managing complex problems again was a disappointing finding. The Committee felt that with the examination held in June the training period is effectively now four and three-quarter years. Adding four weeks annual vacation, the Christmas, New Year and Spring breaks, off work at noon following night call, the effect of day surgery, bed closures and strikes the actual period is even less. The matter was referred to the Royal College Specialty Committee on General Surgery chaired by Roger Keith.

In the year 2000 the Education Committee had tried to develop a job matching service for residents. A section in the Newsletter was devoted to this but the process was not a great success. Such an initiative had been tried by CAGS in 1979 and soon floundered. The truth is that such schemes end up trying to match persons that no one is anxious to employ.

The Committee was concerned about the drop off in interest in General Surgery by students. It is possible to graduate with an MD with virtually no experience in surgery of any kind and it is very questionable that the undergraduate curriculum is adequate for a start in residency training in General Surgery. For several years the Committee had mulled over the possibility of increasing training from five to six years but the chance of this taking place is very remote. According to their contracts it would require the unanimous agreement of all General Surgery residents in Canada for such a measure to be adopted.

When Chris Heughan took over the management of the CAGS Intraining Examination he was an active member of the Department of Surgery at Memorial University. He declined to accept an honorarium for his work but when retired from the University in 2002 the Board insisted that he be awarded a yearly honorarium to be paid out of the Examination Fund. The fee for the examination had now risen to $75 and many felt that this was too low. However as the Fund retained a modest surplus there was no move to increase the fee. In 2001 the CAGS Test Committee inaugurated the CAGS /Stevens Norvell prizes to commemorate Steve’s excellent work in getting the
CAGS Intraining Examination underway and guiding it smoothly for so many years. The prizes, valued at $500 each, are awarded to the resident with the highest mark in the CAGS Intraining Examination in his or her year of training to a total annual expenditure of $2,500, taken out of the Examination Fund.

The Education Committee also discussed Transplantation. For many years General Surgery residents had been persuaded to assist in harvesting procedures which usually involved working most of the night. Some residents enjoyed it, others complained. On many occasions Allan Macdonald, Halifax, had emphasized the great value of such procedures in giving the residents confidence in working throughout the body cavities and the retroperitoneum. The Committee worked with the CAGS Transplantation Committee to write objectives for training in Transplantation which, once circulated, usually tend to improve clinical experience. There was a general feeling that any rotations in Transplantation Surgery should be elective.

In November 2002 the Education Committee held a workshop. They were concerned about residents who drop out of General Surgery programs at the RI and RII levels. In some programs 80% of the residents in a particular year dropped out which has serious implications for the programs in subsequent years. Some residents had been deterred from continuing in General Surgery by the grumbling of their teachers as scheduling difficulties on the ward and in the operating rooms increased. Other residents were using General Surgery as a back door into other surgical specialties. These concerns and some suggestions were included in letters circulated to Deans of Medical Schools.

It is difficult to judge the effect that the Postgraduate Education Committee may have had in resident teaching. Many of its actions were reactions to decisions made by other bodies. Nevertheless, it certainly helped to keep all the players well informed and with so many cross memberships to Royal College Committees the work of the Committee was without doubt, far more beneficial than might seem at first sight.
CONTINUING MEDICAL EDUCATION

When Bernard Perey, Sherbrooke, and later Halifax, stepped down as the first President of CAGS in 1978 he remained on the Board as the Chair of the Education Committee. He said that a major effort of his Committee would be to assist the Program Committee in organizing the best possible annual scientific meeting. Each year there would be a gradual improvement, building on the experience of the past and in time, postgraduate courses would be added. In 1978 a national committee had been struck with representatives from the CMA, the Royal College, the ACMC and the CFPC to develop standards for Continuing Medical Education credits and the Royal College was seriously considering recertification at some future date.

Walter Yakimets, Edmonton, was the first Chair of the Continuing Medical Education subcommittee. He and his committee organized a very successful Postgraduate Course on anorectal surgery in 1980. There was some confusion about the registration fees. It seems that both CAGS and the Royal College worked independently with CAGS charging members $30. and the Royal College $75. Eventually those who paid $75. received a rebate.

For some years the Quebec Association of General Surgeons had used a self evaluation MCQ as part of its annual scientific meeting. This was followed immediately by a discussion of each of the questions by acknowledged experts and an opportunity for discussion from the floor. Each member marked his own paper. The whole process was very popular with Quebec surgeons and was an excellent example of an effective CME. The Quebec Association of General Surgeons agreed to the use of the Quebec question bank elsewhere in Canada and the Yakimets Committee thought that it should be possible to
arrange similar examinations in other provinces with the help of Provincial Associations of General Surgeons.

In Quebec, all general surgeons belong to the Quebec Association of General Surgeons and pay annual dues deducted at source. Unfortunately throughout the rest of Canada, general surgeons were very poorly organized. It was suggested that the five regional Advisory Committees of the Royal College might be willing to facilitate one day intensive courses with self assessment examination for CAGS members but Jacques Cote, Quebec, said that such a move would not be viewed favorably by the Quebec Association of General Surgeons even though the Royal College funded half of the cost of the Quebec multiple choice examination. In May 1982 Walter Yakimets arranged for the self assessment examination to be part of the scientific program of the Alberta Association of General Surgeons in Banff. The guest speaker was Denis Bernard, Montreal, who had many years of experience with the examination in Quebec and was always a favorite on any program as he spoke clearly and simply from his wide experience. The original intention was to hold the examination on the main day of the meeting, the Saturday, but it had to be postponed until the Sunday morning and, sadly, only 16 of the 35 members attending stayed on; those that did enjoyed it very much.

Several Board members had suggested that the bank of questions in Halifax for the CAGS Intraining Examination could be used for a CME self assessment examination. However Steve Norvell, Halifax, pointed out that the questions most useful for a CME program are those in which there is considerable doubt as to the best answer and stimulate brisk discussion. The Banff examination was repeated in 1984 and was given a much better slot in the program. Walter Yakimets hoped that the examination could be held in Newfoundland in 1984 and possibly in Southern Ontario and central B.C. in the same year. Arranging for the self assessment examination to be held in other parts of Canada proved difficult even though the examination was available to general surgical societies free of charge. A combination of clashes with other meetings, poor provincial organizations and lack of local initiative was hard to overcome.

The Royal College Postgraduate Courses (on GI Endoscopy and Trauma) in 1984, held in Calgary, were very well presented and
appreciated. 120 attended. 80 of which paid the full fee. In 1986 Walter Yakimets was made a member of the Program Committee in order to simplify the organization of Postgraduate Courses and avoid any duplication. The Education Committee also advised the Board that a number of short presentations in the Postgraduate Course would better serve the purpose than the 30 minute dissertations which sometimes had a soporific effect.

Walter Yakimets stepped down as the Chair of the CME subcommittee in 1987. He had been a valuable and dedicated worker on behalf of CAGS and the Continuing Medical Education Committee for ten years and he received a heartfelt vote of thanks from the Board.

The new Chair of the CME subcommittee was Joel Freeman, Ottawa. The mandate had been expanded to include seeking corporate support for scientific programs and working with interested corporations to prepare CME orientated events. Joel Freeman was succeeded by Grant Stewart, Calgary. He and his committee felt that lectures, seminars and symposia were not the best way to change the attitudes and methods of practising surgeons. This would better be done through the presentation of opportunities for problem solving combined with audience participation and self assessment. All this could be linked to CME credits but should not conflict with programs already organized by Universities or Provincial Surgical Societies. While there was full cooperation between the CME subcommittee and the Program Committee in the organization of Postgraduate Courses, some CAGS Board members were feeling uneasy by what seemed to be the substitution of talk for action. In the early 1990’s the Continuing Education Subcommittee had only an advisory role in arranging the Postgraduate Courses. The process had been taken over by the Program Committee and the Royal College.

The Subcommittee had helped to introduce the Royal College MOCOMP program to general surgeons but, in spite of some initial enthusiasm, in the end, only 30% of all Fellows were registered and, sadly, only 8% of General Surgical Fellows had done so. The Royal College was concerned and in the Spring of 1997 they held a conference on the Assessment of Competence. CAGS was
represented by Chris Heughan, St. John’s, and Ed Monaghan, Montreal. Disappointed by their lack of success with MOCOMP, the College felt that an effort should be made to have Fellows demonstrate continuing clinical competence. Governments and the public wholeheartedly supported the idea. The College had rejected, on several occasions, the approach of many American Boards who have regular Recertification Examinations. It was said to be too difficult and too expensive. Most participants in the conference thought that the College would likely opt for a more forceful participation in a MOCOMP type program with penalties for noncompliance. A year later the Royal College announced that they would outline the new policy and require the National Specialty Societies to do most of the work. The Board knew that CAGS was well placed in this regard with intraining examinations, an annual scientific meeting, postgraduate courses and self assessment tests.

The new name of the program was announced in late 1998 - “Continuing Professional Development” - CPD. All certified specialists were to be enrolled by the end of 2001. There would be mandatory reporting of all forms of CME and an audit beginning in 2006. Fellows who had received their Certificate before 1971 were exempt. The National Specialty Societies were given the task of compiling lists of suitable educational activities and weighting their importance. The responsibility of this fell on the shoulders of Walter Yakimets, Edmonton.

The Royal College was insisting that its initiative was primarily to assess competence which contrasted with the thrust of many Provincial Colleges who have designed programs to assess performances as judged by colleagues and patients. While the difference between these two approaches might be very obvious to a professional educator, it is less so for a practising surgeon. By February 2000, the Royal College asked CAGS to qualify as an accreditor of the CME activities under its control. Before being granted this privilege, the College required a CAGS mission statement, an audited financial statement, an assessment of the educational needs of CAGS members and an insistence that any agreement between CAGS and any corporation giving financial support for educational activities must be in writing, copies of which must be available for inspection by the College. All this was a difficult and frustrating task which Walter Yakimets succeeded in completing to the College’s satisfaction.
The Royal College CPD program was circulated to all Fellows of the College. A first sight it appeared to be too complex. However, like most instruction manuals, once they have been studied carefully, everything falls into place and the whole thing seems ridiculously straight forward. All surgeons could register and enter their points online and should have no difficulty in accumulating the necessary scores each year and the total in five years. Walter Yakimets traveled from coast to coast talking to groups of general surgeons at various meetings outlining the system and how it can be mastered. He regretted a certain lack of enthusiasm by CAGS members. To some COPD would be more appealing.

The penalty for noncompliance was the delisting from the official List of Fellows of the Royal College although the surgeon would retain the Certification. While at first glance, this may not appear to be a serious sanction, it does give Governments, Universities, Hospital Administrations, Surgical Departments and even the public considerable leverage.

The Royal College recognized SESAP for 60 credits. This contrasted with the CAGS examination which only qualified for two. Walter Yakimets explained that this was because SESAP has up-to-date references on each question and provides a detailed critique of the appropriate answer. Nevertheless the CAGS examination can be extended into a number of “Personal Learning Experiences” and an assessment of changes in practice which may be worth many additional credits.

Meanwhile the Evidence Based Surgery Project, initially introduced in 1998 at the U of T as a course for general surgery residents and extended later to all Canadian General Surgery residents, was proving a great success. Each resident receives, over the year, a number of carefully selected papers on a chosen topic together with a critique, both of methodology and the substance of the papers. The program was well established by 2001 and was used by 15 of 16 Canadian Surgical Departments. A randomized study was carried out to assess the value of the system to the practising surgeon. 100 CAGS volunteers were entered into random groups so that 50 received the eight packages over a year and 50 did not. At the end of 12 months they were all asked to take a test to assess their skills of
critical appraisal. The positive result led to the initiative to have the Evidence Based Reviews in Surgery available to all CAGS members by end of 2002 on the CAGS web site with restricted access.

How CPD will work out in the long run remains to be seen when the first review is due in 2006. The Royal College was still unhappy that many surgeons were relatively poorly informed on the whole process and said that experts were available to give talks to local groups but only at local expense.

As a result of Walter Yakimets’ work, CAGS became an accredited accreditor of CPD programs of other National Specialty Societies and many groups were anxious to have the benefit of his experience and advice. This privilege was extended by three years and CAGS has since been asked to review applications for accreditation from other groups including orthopedics, transplantation, provincial societies and regional and hospital groups.

Walter Yakimets handed over his CME responsibilities to Helen MacRae, Toronto, in 2001. He also advised that the Chair of the Continuing Education Committee should always be a member of the Program Committee to make sure that all the Royal College accreditation principles were being met. The Board realized that without his competence and dogged persistence, the introduction of Royal College CPD to general surgeons could well have been a major nightmare.
John Gutelius, Kingston, was the first chair of this committee which had a broad mandate. In 1978 it was recognized that age attrition in general surgery manpower was apparent from coast to coast. The maximum output of general surgeons in Canada at the time was approximately 35 per year, which was not considered enough to make up for retirements by the year 1980 and a serious situation would develop in future years. The Committee was anxious to identify changes in the volume of work performed by general surgeons in recent years and they felt that this information would be readily available on the computers of provincial paying agencies. But all this was much more easily said than done.

The volume of general surgery from 1973 to 1977 had increased by 4% in Ontario and there had been a 9% increase in overall services rendered. Biliary tract surgery had increased by 20%, that of small and large bowel had increased by 10% and groin hernia repair had increased by 10%. 30% of payments were for the non-procedural services. 30% of payments covered common procedures and the remainder covered a wide range of items. At the same time the number of general surgeons in Ontario remained steady despite the increase in population. However 25% of all general surgeons in Ontario were over 60 and 30 of these would leave practice each year. The maximum output of general surgeons from Ontario schools was 20 per year. Responses from other provinces were either inadequate, incomplete or absent. Extrapolating these figures to a national population it seemed that between 80 and .90 general surgeons would need to enter practice each year to maintain general surgical services at the 1980 level.

The Committee recognized that provincial sections in general surgery had not researched or presented their cases well to the tariff
committees of the Provincial Medical Associations. Many of the other surgical specialties had been far more active and effective in this regard. Efforts to improve the total allocation of money to the section of general surgery were encouraged and the committee was also prepared to exchange ideas as to the best way in which these allocations could be distributed on the fee schedule. General surgeons do more than 60% of the night and after hours work and fee negotiators made little or no effort to take this into account. The committee agreed to recruit a consultant to carry out a national study of work loads in general surgery in a clear, professional and unambiguous way. Dr. Tom McKenzie was a family practitioner in Kingston who held a Master’s degree in Economics and would be available for such a study, he estimated $6,000. would cover the cost.

In 1980 Richard Railton, Welland, took over from John Gutelius as the Chair of this Committee. It should be mentioned at this point that, in addition to his work on the Committee, John Gutelius was also largely responsible for putting together the first CAGS bylaws; the President and Board extended him a warm vote of thanks.

Tom McKenzie’s final report was tabled on the 6th of May 1981 in Toronto. It was based on returns from Ontario, Alberta, Newfoundland and British Columbia. General surgery was the least rewarded surgical specialty and it ranked below many of the other disciplines including anesthesiology, pathology, radiology and physical medicine. It was evident that general surgeons were not receiving adequate remuneration for non-operative services. Six common procedures — gallbladder surgery, appendectomy, hernia repairs, hemorrhoidectomy and surgery for cancer of the colon and breast accounted for 70% of all procedures. The CAGS Board agreed that the McKenzie Report was based on solid facts and presented an accurate picture of the economic status of general surgery. The eventual cost to CAGS was $13,000. Several Board members pointed out that the major conflict in the allocation of monies to a general surgery fee schedule has been with other groups of practitioners.

Fred Inglis, Saskatoon, produced a succinct summary of the McKenzie Report which included a definition of general surgery.
Copies were sent to all general surgery Tariff negotiators. He questioned the extrapolated national figures, based on the Ontario findings, that 80 to 90 general surgeons should enter practice each year to maintain the current numbers. He thought that 50 to 60 would be adequate as in many parts of the country there were older general surgeons who spent at least 50% of their time in Family Practice. Be that as it may, in 1981 only 36 Canadian graduates received their Royal College Certification in General Surgery.

Two features of the McKenzie Report were of special interest.

1. The difficulties of dealing with surgical complications were insufficiently rewarded.

2. General surgeons do not carry out a sufficient number of procedures in their offices. The Board suggested to the Program Committee that a seminar on all aspects of office practice would be most appropriate.

The CAGS Board, after a long breakfast meeting, adopted a Definition of General Surgery: “General Surgery is that field of surgical skill that includes the surgery of the head and neck, alimentary tract, chest, breast, the endocrine glands exclusive of the pituitary, the trunk, the soft tissues and limbs, blood vessels exclusive of the heart and the management and direction of the care of multiple trauma. It includes the special designations of general thoracic surgery, vascular surgery and pediatric surgery.”

This definition is based on what general surgeons are actually doing as opposed to the Royal College definition which is primarily designed for Program Directors.

In 1982 Peat Marwick were asked by Ministers of Health from the four Western Provinces to review and report on medical manpower and especially that pertaining to surgical services. Although the document was classified, it was possible for the CAGS Committee to review its recommendations. The report recognized that general surgeons are usually older than other surgical specialists and the governments were advised to increase the number of residents in general surgery except in Manitoba. Although Provincial
Governments funded residency training through the Offices of the Deans of Medicine, no action was taken on the report.

In 1983 the Society of University Surgeons in the United States held a symposium with Francis Moore, Boston, David Skinner, New York, and Robert Zepper, Miami, as the leading speakers. The topic was “Are we, can we and should we be training general surgeons”. The unequivocal answer was yes. Furthermore the American Board of Surgery ruled that any General Surgery program in the US that does not offer all of the following experiences in residency training will have their Accreditation withdrawn - GI surgery, breast, head and neck, endocrine, trauma, sepsis, nutrition, pre and postoperative care, vascular surgery, oncology, bronchoscopy, endoscopy, gastroscopy and colonoscopy.

Allan MacDonald, Halifax, pointed out that looking at surgery as a whole, the fall off in the number of general surgeons over the last 20 years seemed to have been taken up by other specialists and governments, by and large, feel that there is no overall shortage of surgical skills. Nevertheless, the Peat Marwick report predicted that there would be a severe shortage of general surgeons by the year 2000.

CAGS received a letter in 1984 from Allan Lomax, Creston, B.C. He was a solo general surgeon in a small town and he was concerned that such surgeons are expected to be on call and manage all emergency problems whenever they are at home. However when it comes to elective surgery the town’s elite elect to go to larger centres. The Committee decided to prepare a questionnaire to be sent to general surgeons working in centres with a population of less than 15,000 in order to develop sound statistics on this matter. Fred Inglis, Saskatoon, had taken over the Chair of the Committee in 1984. 300 questionnaires were circulated to general surgeons in small communities and 95 had replied. Their concerns are very different from those in larger cities or University centres. 50% of their work consisted of gynecology, cystoscopy and head trauma and on the whole they felt that their basic training in their residency was inadequate.

Frank Turner, Kelowna, B.C., was appointed as the Chair of this Committee in 1985. For some years he was a general surgeon at the
University Hospital, Edmonton, before moving to Kelowna where he had practiced for 10 years. He tackled the work of the Committee as a general surgeon working in a moderate sized city, away from any University department, but as one who is also aware of the views of University surgeons; this was an unusual but welcome combination. In February 1986 his Committee reported on a number of matters:

1) Mandatory retirement — the Committee agreed that it was unacceptable that age be the sole criterion for mandatory retirement; individual assessment was essential. Other factors that should be considered would be the size of the centre, availability of other general surgeons, relative experience and teaching requirements. University competence should not be confused with competence in surgical practice after the age of 65. More detailed guidelines would be worked on subsequently.

2) Guidelines for qualifications of surgeons working in smaller communities — There is a potential hazard in allowing family practitioners, who are not fully qualified, to perform operations in small communities that have no easy access to fully qualified general surgeons. The Committee was asked to investigate the situation through the Provincial Registrars and report later.

3) A Symposium on Surgery in Smaller Communities in the September 1985 annual meeting was planned.

CAGS was now nearly 10 years old and the manpower situation in Canada in general surgery was essentially unchanged. Getting accurate figures was proving difficult and this would remain so for the next 15 years. The Canadian Medical Directory compiled their lists from returns from Provincial Registrars; it always inflated the number of general surgeons. Some were working in other surgical fields such as CVT, Thoracic Surgery and Vascular Surgery. Others were retired or semi-retired while retaining their registration and some only carried out the occasional general surgical procedure. Achieving accurate statistics even in the prairie provinces was to prove a daunting task. The only truly accurate figures were from Quebec. In 1986 the estimated number of new general surgeons entering practice in Canada each year to maintain the overall number of general surgeons varied from a low of 60 per year to a high of 90.
But in 1985 only 61 general surgeons obtained their Certification and at least 15 of these intended to pursue other fields of surgery. Out of the remaining 46 only 37 were Canadian graduates. So the inevitable shortfall was again obvious and would likely be worse in rural areas than in cities.

Frank Turner invited the Provincial Fee Negotiators to meet with his Committee in September 1986. Only those from Alberta, Newfoundland, B.C., Ontario and Quebec attended. They discussed many points including the historic role of general surgeons, whether there should be additional fees for difficult cases and the status of their section in relation to other specialty surgeons especially in Quebec where the average gross income for general surgeons equaled the net income in other provinces. They also discussed how to get fee committees to pay attention to documented evidence that general surgeons were not being paid competitively.

The Board was told that CAGS had been asked to work with the CMA/Royal College Manpower Study that was underway. The target was to estimate the needs as from December 31/86. The CMA Data Bank was initiated in 1982 but by 1986 already had a 40% error rate. Tait McPhedran, Calgary, and Gerry Nason, CAGS Executive Director, attended a meeting of the Royal College and the CMA to consider CAGS’ participation in validating current data. The Chiefs of Surgery in all hospitals would be asked to give exact numbers of general surgeons that were working and to estimate the number that were needed. The hope was to have all this summarized by the end of January 1987.

Reporting in February 1987 Frank Turner said that the CMA Data Bank contained 2,683 certified specialists in General Surgery. Work by provincial validators with further phone calls showed that 1,517 were full time practising general surgeons and of these 204 were not practising in Canada. Governments accepted the CMA Data Bank figures. From 20 - 30% of general surgeons in Canada would retire before 1991. This would create a need for an additional 344 but only 190 new general surgeons are likely to be supplied from Canadian schools during this period, leaving a shortfall of 154 in 1992. There were other factors at work; the increase in the number of women residents who are generally accepted to have 70% of the productivity
of the men and new young surgeons were not willing to put in the long hours of their predecessors. Added to this was the probability of some statutory regulation of resident work hours in the near future.

Frank Turner and his Committee had done much good work in a short time and they looked forward to presenting their findings to a conjoint meeting of the Royal College and the CMA. They surmised that the productivity of all surgeons and general surgeons in particular, could be increased should hospitals make this a priority over just saving money. This would include more surgical beds, more OR staff to ensure quick turn arounds between cases and even the use of twin theatres with the help of nurse anesthetists. All members of the Board agreed that the biggest shortage of general surgeons was in the smaller towns and rural areas and these communities were seeking an “all purpose” surgeon prepared to conduct a less restricted practice with the inclusion of orthopedic surgery and gynecology.

Frank Turner and John Hinchey represented CAGS at a press conference on the surgical manpower crisis. They reiterated many of the factors that had been discussed by the Board for almost ten years. These included the very real shortage in smaller communities, encroachment by other specialists, changes in surgical training - specialty versus extended general surgery training, change in patterns of practice and lifestyle, increased demands by the public, retirement, fee schedules, morbidity patterns, technological changes, the needs of tertiary care centres and the decreased productivity of women surgeons. They also said that, not infrequently, general surgeons are not considered as specialists even by hospital administrators. They advised that the irregular and long hours of general surgeons, the acuity of their patients and their roles in consultation should be emphasized in all public pronouncements.

CAGS received substantial publicity following the 1987 press conference on but as Gerry Nason, CAGS Executive Director, pointed out, general surgeons were not necessarily the best judges of what the public might consider to be dramatic news. It was agreed that CAGS should take full advantage of the extensive press coverage devoted to any Royal College annual meeting.

Frank Turner chaired his last Committee meeting in September 1988. All the Provincial Fee Negotiators had been invited but only two
attended. Each year, under his chairmanship, the Provincial Negotiators had been invited but, at best, the turnout was below 50%. Nevertheless there was sufficient evidence to show that general surgeons in some provinces were doing better than others and that general surgery continued to be the lowest paid of the surgical specialties and was often less well rewarded than non surgical specialties. Coming to grips with these disparities was proving a very difficult job as fee schedule changes were occurring the whole time and fee negotiators themselves were only too happy to emphasize items which they considered to be poorly paid, and very reticent in providing details of the converse. They made three recommendations.

1) There was an urgent need for an active organization of general surgeons in each province. Those that were better organized and provided continuity of leadership seemed to be doing better.

2) Emphasis must be placed on general surgeons being paid for what they actually do rather than pushing for minor adjustments.

3) It is important to educate the public and the government as to the work of a general surgeon.

It is difficult to estimate how much effect all this work had on Provincial Health Ministries. As one Board member pointed out once again, they tend to add up the total number of surgical specialists in their province, use this to work out a population ratio and then assume that, even if some surgical divisions were undermanned, that some form of redistribution of the work would leave the public well served.

Chris Heughan, St. John’s, became the next Chairman of the Manpower Practice and Economics Committee in 1989. He pledged that the Committee would work to promote a good image of general surgery, would strive to achieve some correlation in fee negotiations and consider the special problem of the aging of the population. He said that the CMA was committed to keeping their manpower figures up to date although few had much faith in their accuracy.

After many years of debate, the Royal College finally scrapped any plans for Recertification. Instead they circulated a paper on
Maintenance of Competence”. They favored a “menu approach” with various items of educational value being awarded a number of points and surgeons would be expected to accumulate a certain total over five years. The Royal College was interested in starting five or six pilot projects on MOC and said that they would be happy to receive a proposal from CAGS. Accordingly, Jean Couture, Quebec, and Roger Keith, Saskatoon, were asked to make a presentation to the Royal College Conference on Specialties. Because of bad weather, only three presentations in all were made. CAGS was very supportive of MOC, another was lukewarm and a third positively antagonistic. The program was to be called MOCOMP. The plan was for the College to select two national societies to enter a pilot project and after three years the program would be evaluated prior to its introduction to all the National Specialty Societies on a voluntary basis. Dr. John Parboosingh, Calgary and later Ottawa, was appointed the Director of the MOCOMP Project at the Royal College. There was some delay until a questionnaire circulated to all College Fellows to assess their current practice and desire for Continuing Medical Education had been analyzed and studied.

Several provinces were trying to establish a Relative Value Guide for the fee schedules in order to try and correct some of the imbalances in remuneration between various sections of the profession. While it is one thing to try and improve the average income of a section, it is a very different matter to reduce or even hold back advances in other sections. The Manpower Committee had hoped to act as a clearing house for RVG guides but that proved to be impossible.

MOCOMP moved quite quickly. Response to the questionnaire was just about what the Royal College Committee expected. CAGS was selected as one of the experimental entrants into the scheme and late in 1992 each member received a booklet in which they were expected to enter the time spent and quality of various educational efforts. CAGS members were expected to enroll and cooperate. In all, over 2,000 specialists in the Royal College agreed to enroll of which 250 were CAGS members. Portions of the CAGS Newsletter were used to encourage members to take part in MOCOMP. At no time was there any intention by the Royal College to either police or punish. By the end of 1992 500 general surgeons had enrolled in MOCOMP, 400 of them were CAGS members. Three quarters came
from centres with over 100,000 population. In spite of the significant amount of paper work that MOCOMP entailed, Chris Heughan asked for patience. Surgeons realized that the Royal College had developed this program in response to demands from the public and licensing authorities that specialists are seen to keep up to date.

The problem of training in surgery for family practitioners came to the fore in early 1993. CAGS had received a letter from Allan Trautman, Lethbridge, stating that the University of Calgary, at the urging of the Alberta Government, was preparing a one year training program in general surgery for family practitioners to take on a restricted surgical practice in smaller centres. Wally Temple, Calgary, said that the U of C was under great pressure to comply with the Government’s request but the hospital surgical staff had rejected the initiative. The initial move had come from the College of Family Practitioners. Three years previously a similar move had been advocated in Saskatchewan but the matter was soon dropped and it did not appear to be an issue elsewhere in Canada.

While the CAGS Board understood the plight of the small rural hospital and appreciated the efforts of Government to maintain rural services, Michel Talbot, Coteau du Lac, advocated that CAGS should take a strong position on the matter and follow the example of Quebec that there was no place for a lone general surgeon in a rural community. In Quebec, rural hospitals were closed down and patients referred to regional centres. The CAGS Board stuck to its position that general surgery should only be carried by appropriately certified physicians. It was agreed that the Secretary, Marvin Wexler, would gather information, verify the facts and draft a CAGS policy statement that would be circulated initially to the Executive for their approval and afterwards to the National Coordinating Committee for Postgraduate Training (on which all Deputy Ministers sit with representatives from the Canadian College of Family Practitioners, the Federation of Medical Licensing authorities of Canada, the Royal College and CMA, the CMPA, and to Conrad Pelletier, Chairman of the Canadian Association of Surgical Chairmen. The only access to the National Coordinating Committee is either through the CMA or the Royal College. Stu Hamilton, Edmonton, and the new Chair at the University of Alberta Department of Surgery, said that he inherited the problem when he started his new position in July 1993.
He said that small rural hospitals have considerable political power which was exerted through the Department of Health with some help from the Alberta Medical Association and the Dean’s Office in the Faculty of Medicine. Although several established surgeons had been asked to take part in the program, only Grande Prairie had agreed and only one family practitioner was trained in 1992 and there were no applicants for 1993. The list of procedures suitable for family practitioners with further training included hernia repair, appendectomy and breast biopsy. A letter from the Chair of the Alberta College Committee on Privileges in Hospitals under 100 beds questioned whether general practitioner surgeons had more complications than the specialists. Furthermore two general practitioners in Southern Alberta had been credentialled in 1993 to undertake laparoscopic cholecystectomy — they had received some training by surgeons from the University of Alberta.

Gilles Hurteau, the Executive Director of the Royal College, said he was committed to high standards of surgical care and was not in favor of the Alberta initiative. He arranged a meeting between CAGS and the Canadian College of Family Practitioners which took place in September 1993. The CAGS Executive met with Gilles Hurteau, Reg Perkins from the College of Family Practitioners and Dean Morse, President of CCFP. CAGS was represented by Fred Inglis, Saskatoon, Marvin Wexler, Montreal, and Allan Trautman, Lethbridge. Marvin Wexler asked the family physicians if they viewed the problem as being inadequate acute care, lack of proper facilities in smaller hospitals or simply the inconvenience to the local population of having to move to a regional centre. The answer was that all three were important. Furthermore rural surgical needs included orthopedics, gynecology and operative obstetrics. The anesthetists had worked out an agreement with the family physicians for further training over one year to meet stated objectives.

The CAGS Board insisted that a position paper must emphasize CAGS readiness to support whatever measures are needed to solve the problem. They agreed that further instruction to family practitioners should be limited to the recognition of sepsis and shock, ATLS, the preparation for safe transport and certain simple diagnostic invasive procedures. CAGS must have a cooperative attitude and the paper should be based on the principle of good
patient care and any teaching of family practitioners in surgery must be conducted by surgical specialists.

The Committee on Manpower Practice and Economics was restructured in 1993 and renamed the Clinical Practice Committee. It would have a mandate for MOCOMP, needs assessment, CME and evaluation, quality management, clinical practice guidelines and representation on the National Specialties Society Committees of both the Royal College and the CMA. The mandate excluded fee negotiations and manpower problems which were transferred to the CAGS Provincial Representatives. The Chairman of the Clinical Practice Committee would become the CAGS representative to the CMA. This was an admission that CAGS could only influence fee negotiations in a very general way and that national manpower assessments, predictions and recommendations were both too flawed, too late and of little interest to Governments.

Bill Pollett, St. John’s, became the new Chair of the Clinical Practice Committee in 1993. Guidelines for producing Canadian Clinical Practice Guidelines had been approved by the CMA Board. All realized that producing clinical practice guidelines is not only difficult but costly. If they were too broad they were of no value but if too detailed they would be too restrictive, would hamper innovation and would play into the hands of lawyers. Finding a balance between the two extremes was the challenge. The Committee agreed to select a suitable topic and work towards producing guidelines without delay.

The CMA met with the affiliated National Specialty Societies in February 1994 and CAGS was represented by Bill Pollett. Several important matters were discussed. The CMA had endorsed the fair distribution of resources and the universality of care from coast to coast. Hugh Scully, Toronto, chaired a CMA Committee which was studying the finances of the Canadian Health Care System. His report was awaited with interest. The National Coordinating Committee was involved in the planning of Postgraduate Education and all physician resource issues. The 10% decrease in the number of PGYI positions had given rise to much uncertainty. Specialty Societies have limited access to this committee, either through the Royal College or the CMA.
The draft guidelines for added surgical skills for family physicians produced by the conjoint CAGS/CFPC/RCPSC working group appeared in the summer of 1994. They agreed that there may exist a need in some rural areas for family doctors to acquire added surgical skills but the decision to acquire these skills should be made by University Residency Program Directors. The skills would be specific to individual regions based on appropriate needs and the decision to use these skills would be based on the patient’s consent. Unstable patients should be transported to specialty centres after resuscitation. The needs of a community for general surgical care should be provided by a regional network with cooperation between specialist general surgeons and family physicians with added surgical skills. Only family physicians with these added skills working within these established guidelines would participate in the network except for minor surgical procedures taught within the core Family Medicine Residency. The training and credentialling of these added surgical skills to family physicians should only be undertaken by certified general surgeons. The duration and content of training to become competent would be determined by Program Directors in General Surgery and Family Medicine.

The required skills would include resuscitation of severely ill, septic and traumatized patients, ATLS; surgical procedures involving the skin and subcutaneous tissues; appropriate diagnostic manoeuvres to aid in efficient management and establishing emergency management protocols to achieve accurate triage; the ability to diagnose and stabilize emergency conditions of the GI tract and transfer to a regional centre. The CAGS Board approved the document in principle although there were reservations. Many urged full cooperation with the family physicians rather than confrontation which would only encourage superspecialization within the College of Family Physicians. The document moved the discussion from a provincial to a national level.

Many of the skills that family physicians were anxious to acquire involved other specialties and their national societies were also in discussion with the College of Family Physicians. Caesarean section and the management of ectopic pregnancy were being considered by the Canadian Society of Obstetricians and Gynecologists. The Canadian Orthopedic Association had added the management of
compartment syndromes and aspiration of septic joints as appropriate skills.

The draft document was to have been approved by all concerned in May 1995. However the CSOG were not happy with the wording as it applied to ectopic pregnancy and Caesarean sections. This delayed the final approval and the publishing of the details in the Annals of the College. Also Gilles Hurteau had retired as the College Executive Director; he had been truly interested in the whole process and was largely responsible for getting things moving. There was always the possibility that with the changing of the guard, the whole matter would be quietly forgotten. Sure enough, two years later in February 1996 there was still no general agreement. CFPC had reduced some of their demands but both SCOG and COA were not satisfied. The Executive of the Royal College thought that a cooling off period was in order.

The subspecialization within surgery across the country had led to fewer general surgeons available for hospital emergency call. Hospital administrators in some areas were insisting on unreasonable call schedules in order to meet the demands for care. The committee produced a position statement on on-call time. They said that “general surgeons provide an essential surgical service across the country but this is often time consuming and competes with maintenance of competence, other medical responsibilities, rest, family and other non-medical obligations and interests. CAGS endorsed a maximum of one in five night call system in a well developed service. In some areas this may not always be possible but no surgeon can be expected to provide continuous call or more frequent call than is compatible with the safety of the patient and the well being of the surgeon. It is the responsibility and right of a surgeon to state when he is no longer capable of providing safe on-call coverage. On the other hand it is the responsibility and obligation of the hospital to provide a level of staffing that provides for reasonable on-call time. On-call duties require adequate access to elective OR time”. The Board ratified the statement which was translated and widely distributed.

“Resources for General Surgeons” was another position paper produced by the Clinical Practice Committee, approved by the
CAGS Board and approved by most of the Provincial Representatives. It should help surgeons reach agreements with hospital administration.

Alternative methods of remuneration were being widely discussed in 1995 and in that year the Queen’s University Medical School, Kingston, entered into a faculty wide “alternative funding plan” with the Ontario Government. There was a five year guarantee of the overall annual sum based on the 1991/92 billings to OHIP. This was in addition to the University funding through the Ministry of Education. The total was distributed to departments and then to individuals. The Faculty also received an additional three million dollars as a signing bonus. Two-thirds of the Faculty agreed to sign on right away. Later a secret ballot showed a much higher proportion of physicians were in favor. Initially, surgery, psychiatry and anesthesia held out but after some pressure 90% of the surgeons agreed to sign. Radiology continued to hold out. SEAMO (South East Academic Medical Organization) controls the fund which is in turn controlled by an organization of clinical teachers. Points were awarded for clinical work, teaching and research with $15,000. a year at risk on the point system. After one year each individual has his or her salary discussed and this is combined with the activity based compensation assessed on the points. WCB and Federal Government billings are excluded up to $15,000.

There were problems. Evaluation remained a black hole in spite of the fact that the Ontario Government had given an additional three million dollar grant to a project to study how to evaluate Faculty members. All the money in the envelope was allocated making it difficult to bring in new junior members and fitting in participating members with part-timers was a gray area. Some of the waiting lists increased and there was a big drop in upper GI endoscopy.

In September 1996 Dale Mercer, Kingston, gave a follow-up talk to the CAGS Board on the Queen’s Alternative Method of Remuneration. Flexibility within a department was difficult and between departments was impossible. The basic scientists within the Faculty of Medicine were excluded from the plan and this was now recognized as a mistake. Originally there was to be continuous evaluation of the system but lack of funding and inadequate data
had made this impossible. The total OR hours increased 60% with no increase in the number of cases. Emergency cases would go to the on-call surgeon 95% of the time. The ratio of new patients to repeat outpatient visits increased dramatically. The number of surgeons involved in undergraduate education increased probably because Activity Based Compensation equates teaching with clinical activities. Resident research and funding for such research also increased. The alternative funding plan stabilized funding to a compact medical centre. The educational value seemed questionable and the research aspect suffered because the basic sciences were not included. Referring family practitioners complained that it was much harder to get the specialist to see a patient and generic clinics resulted in lack of choice. The number of visits to internal medicine decreased dramatically, illustrating the subtle distinction between fee for income and fee for service. The plan did not free any worthwhile academic time but it significantly improved the lifestyle of clinicians.

The committee produced guidelines for ambulatory care called “CAGS Position Statement on Ambulatory Care” in 1996. It emphasized the following principles - the quality of care must not suffer; the final decision in the case of a particular patient must rest with the surgeon; the assessment of benefits should be based on outcome rather than utilization of facilities; and it is inappropriate to have a fixed ratio of patients allocated to ambulatory care. The statement was adopted by the Board and appended to the CAGS Newsletter and briefly outlined in CJS. In Quebec there are financial penalties if less than 90% of hernia repairs are performed in an ambulatory setting.

Bill Pollett attended another meeting of the CMA Committee of Affiliates in August 1997. The CMA proposed a 12 month additional training for family practice programs to improve skills to deal with relatively straightforward surgical procedures. Once again appendectomy, hernia and laparoscopic cholecystectomy were specifically mentioned including the management of common fractures and obstetrical and gynecological emergencies. The position of CAGS in all this had been made abundantly clear in 1995 and 1996 but the conjoint committee originally set up by Gilles Hurteau was now dormant and there was still no reply from the Society of Obstetricians and Gynecologists. The majority of the CAGS
Board were in favor of regional centres with improved transportation to better serve rural areas. Nevertheless Bill Fitzgerald, St. Anthony, warned that it would be mistake to be too rigid. Family practitioner surgery takes place in many centres in Canada and Governments see this as being one way of providing service. Furthermore, if necessary, the process could be legitimized through Provincial Colleges without any reference to Surgical Societies. Also Provincial Governments are prepared to pay any necessary increases in CMPA dues that might ensue. In Saskatchewan almost all the small hospitals were being closed elsewhere, except for Quebec, Provincial Governments do not have the political will to follow this course.

The clinical guidelines for breast cancer produced by the Health Canada Breast Initiative had been carefully reviewed by the Clinical Practice Committee and discussed by the CAGS Board. The process had been supported by the Royal College and the CMA and the guidelines had been widely published. Several members of the Board had minor reservations about some of the recommendations and appropriate changes would be included in a future edition.

The credentialling of uncertified surgeons came up for discussion again at the Annual CMA meeting in 1998. It really was just another aspect of added skills for family practitioners. The Government of Alberta had spent forty million dollars in attracting 90 South African trained doctors to smaller communities in the province. Many had come via Saskatchewan. Some had received surgical training and the Alberta College was under increasing pressure by the Government, the local MLA, the local hospital board and administration to grant certain surgical privileges. They were anxious to have a selective examination based on the CAGS Intraining Examination bank and should the candidates pass they would be referred to the Universities for clinical evaluation. The CAGS Board emphasized that the Intraining Exam is designed to test the progress of residents and not to credential physicians and this type of fractional certification presents a major insurance risk to hospitals, the College, the Government and the University, should the plan be adopted. These sentiments were conveyed to the CMA.

Dr. Brazeau, the new Executive Director of the Royal College, took office in 1998 and, stimulated by the Canadian Association of Rural
Physicians and the Canadian College of Family Physicians, said he was anxious to reopen discussions. The Association of Rural Physicians had produced a position paper strongly advocating steps to some form of surgical accreditation for rural physicians. Most of the thrust was coming from Alberta where the government was leaning on Deans of Medicine to persuade their Department of Surgery to cooperate.

The problem no longer existed in Quebec. All Quebec hospitals have at least two general surgeons and family practitioner surgery has been eliminated. All agreed that there is no surgical procedure that is always easy especially so within the body cavities. Bill Pollett remarked it was ironic that in 1992 the certification for family practice was introduced and now efforts were being made to accept a lesser standard of “specialist” care.

The push for accrediting family physicians for added skills in surgery led the Federal Government to ask the Royal College to strike a committee to review the problem, collect data and report. The Minister of Health promised one hundred fifty million dollars ($150,000,000.) to facilitate the process if the need for such accreditation can be clearly shown. As one Board member pointed out, $150,000,000. would fund a number of training positions for full general surgery residency for general practitioners. Experience in British Columbia had shown that such a course rarely works as promises to return to a rural surgical practice after training are easily broken. The CAGS Board agreed that it should be proactive, that more solid information was required and that CAGS should support modifying general surgery training to be more appropriate for rural practice and that the original CAGS statement that surgery in body cavities should only be undertaken by certified surgeons, should stand. The Executive with the Clinical Practice Committee redrafted such a statement for wide distribution.

Early in the year 2000 Bill Pollett said that a meeting of all the interested parties took place and an application was made to Health Canada for a significant grant to define the needs for surgery in small hospitals.
Michel Talbot, Coteau du Lac, succeeded Bill Pollett as the Chair of the Clinical Practice Committee in the year 2000. He attended the CMA Committee of Affiliates in August 2000. The CMA had two important committees covering many areas of health care.

**Task Force 1** — This had made a number of recommendations, including an increase in medical school enrollments from 1,577 to 2,000 without delay; the new positions should be properly funded with no strings attached, and, funded residency positions should be increased from 100 per 100 medical graduates to 120. The CMA should develop a formal and continuing process to monitor and make recommendations on medical schools and postgraduate training regularly every two to three years.

**Task Force 2** — This is jointly chaired by the CMA and the Royal College and has wide ranging terms of reference — to gather in formation on the delivery of physician services, to assess the patient/physician satisfaction, to provide analysis of the gathered information and make recommendations. The reports from these two committees were to be carefully reviewed by CAGS, when they are published.

The final draft of the CMA Committee on “Nurse Assistants in the OR” was to have been ratified but was delayed. There were moves to legislate nurse practitioners as first assistants in the OR and in the pre and postop care but the real need is for quality surgical assistance in the operating room and many believe that this is best provided by OR technicians. OR technicians are not allowed to handle drugs and cannot be used as circulating nurses. Some hospitals in Toronto were striving to become resident independent and in many other cities there are pools of family practitioners and retired specialists that are on call as assistants in the OR.

After a wait of nearly two years the application to Health Canada for funding for an in-depth assessment of the need for surgery in rural hospitals was initially turned down. Bill Pollett agreed to continue to be the CAGS liaison person with the group representing all the interesting parties. The Board agreed that this should not be looked upon as a CAGS victory and unless Canada trained surgeons for rural practice with many added skills in O&G, orthopedics and urology, a
alternative would be found somehow. Allan MacDonald remarked that since the College of Family Practitioners engineered the demise of the internships, young doctors can complete their family practice training with no more than three weeks in their three year training as the only surgical experience. The strong initiative in Alberta remained. The Grande Prairie program closed down because the surgeons did not wish to cooperate but is still active in other centres. Bill Mackie, Edmonton, questioned whether there really was a problem as it seemed that the desire of family physicians is to deal with essentially elective cases rather than difficult urgent problems. He urged that CAGS should stick to its policy outlined in the position paper.

An interesting solution was being tried in Quebec. Groups of surgeons in larger centres are formed into teams to serve a defined rural area. One member moves out for one or two weeks to be succeeded by a colleague. They deal with elective cases and straightforward emergencies while difficult cases are referred to the same group in the city. All expenses are covered, accommodation is provided for the surgeon and the family and remuneration is at $10,000 a week. Manitoba has a somewhat similar but less structured program.

Ciaran Kealy, Sudbury, followed Michel Talbot as the Chair of the Clinical Practice Committee. The Committee was asked to consider the position of a surgeon with an International Fellowship moving to Canada. Prior to 1997 such a person could apply to the Royal College for a review of training and a ruling as to any further training requirements. Then if there was a program with a vacancy at the appropriate level, the surgeon could prepare him or herself for Certification. However since 1997 these reviews were no longer undertaken although this decision is being reconsidered. All members of the Board agreed that International Fellows that were practising in Canada with limited licenses in certain provinces should be welcomed as CAGS members.

In the year 2002 Health Canada finally approved a grant of $83,000 for the CAGS and the Society of Rural Physicians study. Bill Pollett also recommended another study by CAGS and the Canadian Post-MD Education Registry (CaPER) to track students from the R3 level
to Certification together with a study of early drop outs in the R1 and R2 years. He suggested that an application for a $10,000 grant from Health Canada to do this be augmented by a $1,000 grant from CAGS and this was formally approved.

The Clinical Practice Committee held a conference call discussing the resources, OR time, equipment and cutbacks in general surgery. In many cases the resources available did not conform with “the essential resources for the care of patients requiring general surgery” as outlined in that CAGS position paper. The Committee maintained that the one in five on-call rotation has now been generally accepted as not unreasonable. Furthermore an additional on-call stipend of $500 a day and $1,000 per weekend day would be fair and reasonable and the Provincial Representatives were being consulted.

Ciaran Kealy resigned as the Chair of this Committee in 2002. He had been a staunch supporter of CAGS from the beginning and was an active and influential provincial representative for Ontario for many years. His assessments on the state of general surgery in Canada were always concise and correct. He was one of the founding members of the Ontario Association of General Surgeons which had, over the years, developed into a flourishing group that always supported the aims of CAGS.

CAGS and other National Specialty Societies can only communicate with Governments through letters, position papers, the press and very rarely by committee. The provincial specialty societies and their members must deal directly with Departments of Health, Hospital Administrators and Provincial Medical Association committees on fees and both approaches can be very frustrating.

It would be easy to assume that CAGS over the 25 years had relatively little influence on general surgery manpower, conditions of practice and economics. But as anyone who has had experience of administration either in hospitals, Universities or provincial or national committees knows, a well thought out, well written, properly circulated proposal, even when it initially elicits little or no response, often turns up some years later from another source and be adopted — nearly always without attribution.
Quotation:

We trained very hard, but seemed that every time we were beginning to form into teams we would be reorganized. I was to learn later in life that we tend to meet any new situation by reorganizing and a wonderful method it can be for creating the illusion of progress whilst producing confusion, inefficiency and demoralization.

Petronius, AD 66
The inaugural meeting of CAGS was held at the Royal York Hotel, Toronto, on the 12th of May 1977. After a short business meeting in which the CAGS Executive was elected, there was a very well received one-day scientific program. Professor John Golligher, Leeds, England, was the Guest Lecturer.

Lloyd MacLean, Montreal, was elected the Chair of the Program Committee and was responsible for the 1978 Annual Scientific Meeting on Wednesday, the 15th of January in Vancouver immediately preceding the main Royal College meeting on the following three days. Francis Moore, Boston, was the first CAGS Lecturer; he was well looked after with a first class return airfare for Dr. & Mrs. Moore and a suite in the hotel. Perhaps the hospitality was a little excessive but the funds were available and well known surgical personalities often need some persuasion.

Lloyd MacLean was succeeded by Bernie Langer, Toronto, as the Chair of the Program Committee and was responsible for the CAGS Scientific Program at the Royal College meeting in Montreal on Wednesday, the 7th of February 1979. Unfortunately the Royal College had moved its meeting one day earlier to start on the Wednesday instead of the Thursday. Convocation was to be held on Wednesday, February 7th, and so CAGS agreed to forego the CAGS banquet and dance and simply hold a reception, while the CAGS one-day Scientific Program overlapped with the first day of the Royal College meeting. In those days, there was little consultation between the CAGS Program Committee and that of the Royal College.

George Konok, Halifax, took over the Chair of the Program Committee for the June 1980 CAGS meeting in Ottawa. He pointed out that another problem facing his committee was having adequate...
continuity within the committee’s membership. All agreed that the matter could be safely left in the hands of the Nominating Committee.

By the 1980 Program the structure was becoming more clearly defined. There were three Paper Sessions and four structured Symposia on pancreatic cancer, inflammatory bowel disease, intra-abdominal sepsis and major trauma to the limbs and abdomen. The first Postgraduate Course was on anorectal diseases with two eminent visiting speakers, Stanley Goldberg, Minneapolis, and Peter Hawley, St. Mark’s Hospital, London. The CAGS Annual Lecturer was Nels Koch, Goteborg, Sweden; he was totally funded by the Canadian Foundation for Ileitis and Colitis. There was some confusion in the organization of the Postgraduate Course as both CAGS and the Royal College office were working independently. To avoid such problems in the future, it was agreed that the Chair of the Program Committee, reimbursed by the Royal College, and one other member of the Program Committee, reimbursed by CAGS, would attend the Royal College Program Committee meetings. The June meeting in Ottawa was the first change on the part of the Royal College to move the meeting away from January. The weather was excellent but the timing was inconvenient for many of the affiliated National Specialty Societies so the 1981 Royal College meeting in Toronto was moved to September, where it has remained to the present day. The policy on approved expenses for CAGS guest lecturers was changed in 1981. They would receive a first class return airfare and accommodation if they were traveling on their own but should they come with their spouse, they would receive two economy return airfares.

Denis Bourbeau, Montreal, took over from George Konok for the 1982 CAGS program in Quebec. The Royal College had laid down specific conditions; the National Specialty Societies affiliated with the Royal College could have one Symposium and one other joint Symposium. Those societies not affiliated with the Royal College could have only joint Symposia. There could be no conflict with the Royal College lectures. Finally the number of Paper Sessions and Symposia allowed for affiliated societies was based on the membership and attendance at previous meetings. Starting in 1981 the Royal College moved the start of its meeting from Wednesday to
Monday; this clashed with the meeting of the Canadian Society for Clinical Investigation.

The September 1982 CAGS meeting extended over four days.
Monday - Postgraduate Course on Acute GI Bleeding.
Tuesday p.m. - Symposium on Shock with CSCI.
Wednesday a.m. - Paper Session.
Wednesday p.m. - Residents’ Awards and Guest Speakers.
Thursday a.m. - Paper Session.
Thursday p.m. - Symposium on Gastric Carcinoma with CAG.

Because of the difficulties in complying with all the Royal College requirements, a proposed Trauma Symposium was dropped and led indirectly to the establishment of an independent Trauma Association of Canada. The Postgraduate Courses were not well attended and a better effort on the part of the Royal College and CAGS to publicize Postgraduate Courses was essential in the future. A special effort was made to provide a good mix of basic science and clinical papers in order to encourage the maximum attendance.

By September 1983 Denis Bourbeau reported that his committee now had satisfactory control of Postgraduate Courses and many of the 1982 problems had been solved. The September 1983 program in Calgary was well organized, well produced and well received. CAGS had been joined by members of the Association of Surgeons of Great Britain and Ireland and a few of their members took part in Symposia. A few Board members insisted that only original papers should be included in the CAGS program but most were less stringent in that previous presentation at a local or provincial meeting should not necessarily bar presentation at the CAGS annual meeting.

Peter Cruse, Calgary, took over as Chair of the Program Committee to prepare for the September 1984 meeting in Montreal. There were two Postgraduate Courses on Endoscopy and Trauma, a Breast Cancer Symposium with Bernard Fischer, Minneapolis, as the Guest Lecturer. On the Wednesday there was a lunchtime seminar on Obesity Surgery followed by a Symposium on Multi-organ System Failure. Thursday saw a Head and Neck Symposium on Management of Thyroid Disease and another on Peptic Ulceration. This was followed in the afternoon by a Symposium on Controversial Aspects...
of Colon and Rectal Cancer Surgery. Peter Cruse complained that there had been some confusion with various groups organizing their own part of the program. He emphasized that it was essential for the Program Committee to assume full responsibility for all parts of the program. A special effort had been made to increase papers on Critical Care and Trauma now that separate organizations had evolved for these disciplines.

Joel Freeman, Ottawa, assumed the Chair of the Committee to prepare for the September 1985 meeting in Vancouver. The membership received a preliminary printed program in May. This contained the information to register for Postgraduate Courses through the Royal College. There was some disagreement at the Board meeting regarding remuneration for members participating in Symposia and Panels. Some felt that members should be willing to give freely of their time to the Association and participation should be looked upon as a special honor. The American College of Surgeons do not reimburse their speakers. On the other hand, other Board members said that it could cost a significant sum for a speaker to make slides and prepare for Symposia and they would not necessarily be compensated by University departments. In the end it was agreed that reimbursement should be considered when the financial position allowed and at the discretion of the Program Chair and Session organizers. The Program Committee had produced a highly interesting program for 1985 and Joel Freeman and his Committee were warmly congratulated. Once again there had been discussion with the Royal College regarding the abstracts. If the submitter had not listed the abstracts with the Royal College first, it would not be included in the program.

The three Postgraduate Courses in the 1986 meeting in Toronto presented a problem but it was agreed that the Course on Breast Surgery would be held on the Sunday with the Course on Endoscopy being moved to the Monday to run simultaneously with the Course on Head and Neck Surgery. In fact the attendance figures for these courses were most satisfactory. 113 for Breast Surgery, 86 for Endoscopy and 94 for Head and Neck Surgery. All these courses had been widely advertised well ahead of time. Attempts to hold joint Symposia between CAGS and CAG had not been successful.
In 1986 the Roads Foundation in Kingston, Ontario, had promised $1,000 a year to CAGS for a lecture on a trauma related subject in honor of Dr. Bill Ghent, Kingston who had recently died. Bill Ghent had organized a very effective system of trauma care for the Kingston area. It was originally planned to include this lecture in the 1987 program but in fact it was delayed for another year.

Walter Yakimets took over from Joel Freeman as the Chair of the Program Committee in preparation for the 1987 program in Winnipeg. It included three Postgraduate Courses, six Symposia and three Paper Sessions. Of these, one Symposium, one Paper Session and one Lecture were conjoint sessions with CAG; Walter was commended for the collegial gesture. In addition there was the President’s Address, the CSRF Research Prize paper, the Royal College Medallist in Surgery, the Colorectal Guest Lecturer and the SelfAssessment examination. CAGS had collected over $20,000 in corporate support for the 1987 meeting, largely due to the efforts of Zane Cohen, Toronto and Joel Freeman, Ottawa. This illustrates how much easier it is for surgeons close to corporate headquarters to secure corporate funds as compared with those on the East coast, the Prairies or the West coast.

Ottawa hosted the 1988 annual meeting in September. Once again there was good corporate financial support. There were two Postgraduate Courses, one along with CAG and the other with TAC on ATLS. All was not plain sailing with the CAGS/CAG course because CAG had a different format and a corporate sponsor (Glaxo) to cover all costs. In fact few of the CAGS suggestions had been incorporated into the final course content. It made Dr. Yakimets wonder if all his effort was worthwhile. There was also an unfortunate conflict between two surgical lectures, the Malcolm Brown Lecture and the Gallie Lecture. This was eventually solved with some last minute representations to the College by Bernie Langer, Toronto.

Once again the work of the Program Committee was complicated by a change in the timing of the Royal College meeting. They had switched from Monday to Thursday to Thursday to Sunday as this had a significant effect on airfares. CAGS did have the option of including the following Monday as well.
Meanwhile Walter Yakimets had drawn up a standard format for CAGS for the annual meeting. Postgraduate Courses would be held on the Thursday and the following Monday. There was some doubt that the Monday would attract a large enough registration but the Chairman emphasized that the subject matter was much more important than the day. Meanwhile the monies to cover the expenses of the W. R. Ghent Lecture had been received by CAGS and was channeled through the Canadian Surgical Research Fund.

Robin McLeod, Toronto, assumed the Chair of the Program Committee for the 1989 annual meeting. She outlined again the standard format for future CAGS programs which was drawn up by Dr. Yakimets and herself in 1987. There were to be two Postgraduate Courses each year. One at the beginning and one at the end of the annual meeting. Course number one on the Thursday will rotate through four topics - head and neck, “open”, endoscopy and oncology. Course number two on the Monday will rotate through liver, pancreas and biliary tract, colorectal, upper GI and “open”. The “open” slots provided some flexibility. The two courses for 1989 were breast and endocrine neoplasms on the Thursday and upper intestinal surgery on the Monday. The income from the courses was close to the break even point.

The budget for the 1989 meeting projected expenses of $50,000 and a revenue of approximately $51,000. The revenue came from a combination of corporate sponsorship and income from the Royal College. The Royal College retained half of any profits from Postgraduate Courses but refused to be responsible for any losses. They also paid CAGS approximately $3,000 for each Symposium to cover the speakers’ expenses. CAGS members were happy to donate their share to the Association. The value of avoiding non-CAGS visiting speakers who came from afar was very evident.

The 1989 meeting in Edmonton was well received and there were 260 registered CAGS members accounting for over 11% of the total Royal College attendance. The Trauma Symposium turned out to be very popular and the presence of “invited discussers” greatly helped to keep the discussion going. The two Postgraduate Courses were on Oncology and Upper GI Problems and they received good reviews. For a number of years the “touch pad responder” had been a popular
feature of the meeting in spite of the cost of nearly $12,000 per day. This was the older hard wired version which was very expensive to set up. In spite of the cost, the Board agreed that it was well worthwhile to continue using it.

The Royal College was not altogether happy about the weekend scheduling of the annual meeting. It had sent a questionnaire to all affiliated societies to get their opinion. Originally the annual meeting was held during the week but had been moved to the weekend to make it easier and cheaper for those in private practice to attend. There had been some complaints about the weekend meetings on religious and family grounds. Solo practising surgeons had no doubt that the weekend meeting was more convenient. Others with Royal College or CAGS Committee responsibilities pointed out that the week before the meeting was lost regardless. The lower airfares and better hotel rates if members stayed over Saturday night were a very real attraction. In any event the Royal College was committed to the weekend meetings until 1995 and there has been no change since then.

The meeting in Toronto in September 1990 followed the new format for the meeting which everyone agreed was excellent. The registration for the Head and Neck Surgery Postgraduate Course was only fair. However Marvin Wexler’s course on Biliary Tract Surgery was a great success and several members of CAG took part with enthusiasm. In all some $32,000 had been raised in corporate donations and the logo of the company sponsoring the program was projected on the screen as the program started.

John MacFarlane, Vancouver, praised the work of his predecessor, Robin McLeod, as he took over the Chair of the Program Committee for the September 1991 scientific program in Quebec. An Associate Chair Person was appointed by the CAGS Board and would attend the Royal College Annual Scientific Program Committee along with the Chair. The Local Arrangements Chairman was also appointed ex officio to the Program Committee. A specific member of the Program Committee was designated to contact corporate sponsors in a way that Robin McLeod had done so successfully in previous years.

The 1992 program in Ottawa and the 1993 program in Vancouver all followed the now well established format. In 1991 the Postgraduate
Courses were “Management of Surgical Infections” and “Problems in Colorectal Surgery”. In 1992, “Upper GI Tract Surgery” and “Aspects of Trauma Management” and in 1993 “Laparoscopic Surgery” and “Surgical Oncology”. By now there was general agreement by the membership that the CAGS scientific program had become a first rate experience. It was shorter, cheaper and more convenient than the American College meeting and was virtually free of any emphasis on political or economic aspects of practice.

In 1991 a Royal College Task Force advocated a unified theme for the whole of the Royal College meeting and affiliated National Specialty Societies were expected to focus on that issue. The theme for 1992 was “Diseases of Lifestyle” and in 1993 “Quality Assurance”. This was an additional burden on the Program Committee. MOCOMP credits were allotted to the structured portion of the program in 1993 but the Paper Sessions came under “Self Directed Learning”. Lunchtime Symposia were introduced in 1992, a sure sign that time was getting tight. By 1993 the Royal College financial contribution to the CAGS program had increased to $13,000. It was based on the allotted number of Symposia at a rate of $3,500. per Symposium. 1993 saw the coat of arms appear on the front of the program brochure.

Michel Gagner, Montreal, and Dmetrius Litwin, Saskatoon, both of whom were founding members of the Canadian Society for Endoscopic and Laparoscopic Surgery, which had given CAGS some concern in previous years, took a leading part in the 1993 course on Laparoscopic Surgery. Professor A. Cushieri, Dundee, Scotland, gave the Langer Lecture on “The Future of Laparoscopic Surgery and Robotic Developments”; he also took part in the Postgraduate Course. It had originally been intended that the Langer Lecturer should act as a Visiting Professor for a number of days in one or more nearby Departments of Surgery. Professor Cushieri’s commitments made this impossible but it was a good idea that never really caught on.

John MacFarlane stepped down as the Chair in 1993 but remained on the Committee for one more year. He had been a hard working and very effective Chair. He handed over to Gerry Fried, Montreal, for the 1994 program. There was general agreement that the 1994
program in Toronto was the best yet. The two Postgraduate Courses were on Endoscopic and Laparoscopic Surgery and Surgical Nutrition. The attendance at the Monday course on Surgical Nutrition was poor. Looking back over the previous years the Monday attendance was always on the light side regardless of the topic. It was therefore decided that for the 1995 meeting in Montreal there would be two half day courses on the Thursday; one on Trauma and the other on Breast Surgery. The Monday slot would be eliminated. In many ways this was a step forward as it led to concise courses filled to the brim with useful information. But it also led to a complication with the Royal College. The College charged CAGS $4,000. for advertising a course, collecting the fees and paying the expenses. They, quite rightly, considered each course as a separate entity with a separate fee and charged $8,000., a double administration fee. This led to considerable correspondence with the College but eventually the solution was to hold the two half day courses, counted as one course with two subjects, one fee and one administration charge. CAGS understood that the Royal College was struggling to reduce its financial loss at each annual meeting but in the end, common sense prevailed.

Joe Meakins, Montreal, organized a Canadian Surgical Biology Club as part of the Royal College meeting but outside the CAGS scientific program. It conflicted with part of the CAGS program and the CAGS Lecture; a poor attendance for an invited speaker reflected poorly on the Association as a whole. The President was asked to discuss the matter directly with Joe Meakins. A suggestion was made that concurrent sessions might be necessary to accommodate special groups.

In previous years an outline of the scientific program was circulated with the Newsletter in May then, as soon as the final CAGS program was ready it was distributed to the membership as another reminder of the forthcoming meeting. But in 1993 it gave rise to a lot of difficulty. The Royal College, at the last minute, changed several of the venues and rooms resulting in much confusion. Gerry Fried said that the best solution was to have the program distributed at the meeting so that it was printed at the same time as the Royal College program; this has been the practice since.

The next Chair of the Program Committee was Eric Poulin, Quebec. He took over from Gerry Fried to organize the 1996 meeting in
Halifax. The program was held in concurrent rooms so as to provide space better suited to the size and interest of the audience. One of the sessions would be the Surgical Biology Club. Over the years many attempts had been made to interest the membership as a whole in Canadian surgical research. Interspersing research papers with clinical papers had a depressing effect on attendance. For a few years, Garth Warnock organized “Frontiers in Surgery” to include the best of the research papers presented by residents or Fellows. They were introduced by their supervisors who were asked to explain the relevance of the work. It attracted those interested in research but had little appeal to those that were clinically orientated. Joe Meakin’s Surgical Biology Club was another attempt and the Board was pleased to include it as part of the CAGS program. Everybody enjoyed the meeting in Halifax. The weather was good, distances between venues were short and there was a general air of good fellowship. The Ghent Lecture was given by Dr. Irwin Hirsch, Boston University, who was in charge of medical services for Desert Storm.

The makeup of the Program Committee had at last been finalized. Over the years the CAGS Board realized the importance of improving communication between the Program Committee and the other CAGS Committees. In 1997 the Committee was made up of eleven members, the Chair, three representatives of the general surgical community at large and seven members representing the various participating societies and the principle committees of CAGS. Eric Poulin also suggested that a “Surgeon of the Year” in the categories of academic surgery and community surgery be nominated and the awards made at the President’s Dinner. Many felt this to be an excellent idea and Bill Pollett, St. John’s and the Clinical Practice Committee were asked to draw up criteria with the full cooperation of Provincial Representatives. However the idea never really came to fruition.

CAGS were back again in Vancouver for the September 1997 meeting. The two concurrent sessions with one main room and a smaller one had been a great success in 1996 and was to be the arrangement of the future. The two half day Postgraduate Courses were on “The Prevention and Management of Intraoperative Misadventures” and an update on “Critical Care, Surgical Sepsis and
Nutrition”. There was also an interesting Symposium on Medical Ethics with a panel of four general surgeons, two Department Chairs and an ethicist. They discussed a number of cases illustrating ethical dilemmas. Dr. Eric Poulin, Quebec, stepped down as the Chair of the Committee after the Vancouver meeting. The Committee was now a very well oiled machine and cooperation with the Royal College was superb. The flexibility inherent in having two concurrent rooms was much appreciated by all concerned.

Bill Fitzgerald, St. Anthony, became Chair of the Program Committee for the 1999 meeting in Toronto. The established format was followed with two concurrent rooms and two half day Postgraduate Courses on “Care of the Elderly Surgical Patient” and “Benign and Malignant Breast Disease”. The Roads Foundation in Kingston were no longer able to support the Ghent Lecture. They wished to conserve their limited funds to projects in the Kingston area. Miles Irving, Manchester, England, was an official guest of the Royal College and was also asked to give the Langer Lecture. He had a special interest in abdominal wall fistulae and surgical nutrition. A Denver company was prepared to record the proceedings of the scientific program and make it available on tape on the same day. They wanted a $2,000. down payment and the tapes would cost $10. to $12. each. There was a possibility that Pfizer would cover these costs. A new format for the program brochure was introduced; it would be more user friendly with each day starting at the top of a new page. A detailed printout of the program would be distributed with the May Newsletter but without the room numbers.

Montreal was the site of the 1999 program. Sunday afternoon was left free. In past years it was devoted to surgical education but the attendance was very poor. The Committee decided to have the video session by invitation rather than by application. This should give participants more time to prepare. Two Postgraduate Courses were “Trauma” and “The Surgeon in Cyberspace”. The latter course included hands on instruction in the use of computers and ultrasound in general surgery.

A similar program format was organized for the September 2000 meeting in Edmonton. The two half day Postgraduate Courses were on Head and Neck Surgery and Colorectal Surgery. The Royal
College had requested that all National Specialty Societies convening with the Royal College should meet on the Friday morning for a theme symposium. Suggested topics were “Provision of Specialty Care”, “Allocation of Appropriate Resources”.

In 1996, the Royal College was acutely aware that for many years there had been a significant financial loss at the Royal College annual meeting held along with a number of National Specialty Societies. Ernst and Young were asked to undertake a financial review of College affairs. As a result the Royal College in early 1998 said that it proposed to restrict its meetings to matters concerning education, training and accreditation plus general advocacy for Canadian specialists. The National Specialty Societies had a choice of running an autonomous program side by side with the Royal College or having a totally separate meeting. The earliest date that CAGS could arrange for a separate meeting seemed to be September 2001. Roger Keith, Saskatoon, President of CAGS, was asked to strike a committee to explore the matter and report.

Ever since 1978 CAGS had been allotted a complimentary suite for the President and Secretary for the duration of the CAGS scientific meeting and the associated committee meetings. However in early 1998 the Association received a letter from the College saying that this concession would no longer be available. A reply, expressing disappointment, was sent to the College. Meanwhile a survey of the membership showed that most were in favor of a Fall meeting in various centres, separate from the Royal College, and if possible, along with other surgical societies. The Colorectal Society joined up immediately, TAC were interested. Others were thinking it over. Bill Fitzgerald and his Committee came up with the name “Canadian Surgery Forum” which implies a welcome for any other surgical society.

The Board agreed that the first meeting of the Surgery Forum in 2001 in Quebec would be organized using the services of the Royal College Meeting Services Division. The cost of these services would be approximately $40,000. The registration fee would be collected and banked by the College on behalf of the Forum. There would be additional costs of about $80,000 which would be comfortably covered by the registration fee of $300. by 300 members. Without
the help of the Meetings Division, CAGS would not have been able to secure the facilities in the Quebec Hilton.

Because the 2001 meeting in Quebec was the first Canadian Surgery Forum, the Program Committee was faced with more work than in the previous years. Bill Fitzgerald agreed to stay on the Committee as a Co-Chairman along with Ralph George, St. John’s and later Kingston. The Royal College Meetings Service was very efficient and helpful. The Poster Session both in Edmonton and Quebec was given an early evening slot. Senior members were pressed into attending and given special assignments where they were expected to encourage discussion. Finger food was provided and there was a no host bar. Theses measures significantly increased the attendance which had never been good in previous years. The budget for the Quebec meeting stood at $140,000. $40,000 of this was for services supplied by the Royal College. Each of the 35 booths would bring in $2,400 which should be added to $200 per registrant for the Postgraduate Course and $300 per member general registration fee. If there was a profit 10% would be taken off the top for the Quebec Association of General Surgeons who took part in the meeting with CAGS and the Colorectal Society. Half of any remainder would be retained to help with the meeting in 2002 and the other half distributed according to a formula to be agreed upon by the participating societies.

At a Board meeting in September 2000, Allan MacDonald, Halifax, made the excellent suggestion that part of the program, possibly half a day, might be offered to the local Department of Surgery to publicize their work. Brian Taylor, London, Chair of Surgery at the University of Western Ontario, agreed to put on a program for the September 2002 meeting in London, Ontario.

Looking back over the years, CAGS can be very proud of its Program Chairs and Committees. Each year the program always had some new idea or new arrangement culminating in the present meeting which is valued and appreciated by the membership. All the Program Committee Chairs up to 1998 were associated with a University Department of Surgery. They all did their best to make the program relevant, worthwhile and enjoyable to all groups in the membership. Bill Fitzgerald was the only exception. He received his
surgical training in Toronto and soon afterwards took up a position with the Grenfell Mission in St. Anthony, Newfoundland. There he enjoyed a very wide ranging surgical practice and CAGS was very fortunate to have the benefit of his experience, hard work and common sense at such a critical time in its development.
In May 1978, Harry Himal, Montreal, and later Toronto, presented a report from the Research Committee. The Committee proposed and the Board agreed that —

1) The Association should award a annual prize of $500 plus an all expenses paid to the annual meeting for a research paper presented by a resident in General Surgery, while still in training, on research work carried out in Canada or by a Canadian elsewhere.

2) The encouragement of nation-wide clinical trials.

3) Establishing a registry of active general surgery research projects in Canadian surgical departments.

The first chairman of the Research Committee was Bruce Allardycie, Vancouver, with three other members, John Duff, London, Harry Himal, and Allan MacDonald, Halifax. Reporting to the Board in February 1979 he said that the Committee had met in person in October 1978 and had prepared a more detailed report.

1) Resident Research Contest.

The judges had found that basing awards on the short Royal College meeting abstract did not give sufficient information. From 1980 onwards, candidates would be asked to submit a three page abstract of their work.

2) Retrospective Reviews

Two were underway. Harry Himal was collecting the Canadian experience of Zollinger Ellison tumors and Mike Grace was...
reviewing uncommon anal and rectal tumors. The response to the two reviews would determine if this approach might be effective in encouraging the promotion cooperative clinical trials.

3) The Canadian Research Registry

The Committee felt that this should be revised every three years.

Those who have tried to develop nation-wide compilations of any kind soon realize what a disheartening business it can be. At least a quarter of the returns are either late or very late and a few are never completed. The result is that by the time a registry is assembled and published it is already out of date. Despite these reservations, the Board agreed that the effort should continue.

The Research Committee also considered three new initiatives.

a) Prospective Trials - it was recognized that the Medical Research Council has little money to support any study in its initial phase. The Committee set aside the sum of $5,000. to support such trials and would consider submissions.

b) Two thousand dollars was made available to a Canadian researcher to study some special technique at another centre.

c) The Committee proposed to investigate the weaknesses in Canadian Surgical Research, especially during residency training and prepare a position paper.

In 1980 John Duff became the Chair of the Research Committee. He reported in October of that year that the Resident Research Contest had so far been a great success with around ten first class entries each year. The winner in 1980 was P. Soon-Shiong from UBC for his paper “Fundic Inhibition of Acid Secretion and Gastrin Release”. The pharmacological control of acid secretion was just beginning. Disappointingly, the audience for the winning paper was poor. A better and earlier advertising of the competition was essential and simply writing a letter to the Department Chairs was not enough. The response to the multicenter retrospective reviews had been disappointing.
Steve Strasberg, Toronto, had planned to arrange a research workshop on bile as part of the 1982 scientific meeting. Unfortunately the workshop was displaced by a Postgraduate Course on TPN. Soon afterwards Steve Strasberg relocated to the United States. The Research Registry was updated in 1982 but the mail strike significantly hindered the process. The Registry was published with an index and made available to anyone with an interest. Some Board members had questioned if the $5,000. grant to Dalhousie for a chemotherapy trial in breast cancer had any relation to trials in the United States. They were reassured that it did not. Nevertheless it was agreed that before any further grants are made for clinical projects the Dalhousie project would be carefully reviewed. A Research Symposium on Transplantation at a lunchtime meeting was arranged by Allan MacDonald as part of the 1982 scientific program.

In February 1983 Allan MacDonald, the new Chair, said that his Research Committee were concerned that there were no surgeons sitting on any of the MRC granting panels and although surgical research in Canada was active the MRC was not the favored granting agency. Surgeons do have the same rate of approval as other disciplines; they make fewer applications and have even fewer successes. The Committee had prepared a document “Surgical Research in Canada” which strongly advocated the establishment of a separate MRC grant panel for surgical projects. A copy was sent to Pierre Bois, the President of the MRC, but his reply was non-committal and included a request for a slate of surgeons that might be willing to serve on MRC committees. The updated Research Registry had 250 projects listed but only three of these were supported by the MRC and only eleven of them were outside McGill or the University of Toronto.

A report from Dalhousie said that 180 patients had now been entered into the chemotherapy trial organized by Drs. Bethune and Bodurtha. Although the MRC considered this to be an important survey it refused to provide additional funding because it did not think the program could be properly organized and supervised by surgeons.

Allan MacDonald’s term ended in 1984. He had led his Committee with vision, speaking with conviction and authority in a very persuasive way. Before stepping down he established that candidates...
for the Resident Research Prize would henceforth provide the complete paper to ensure that the prize was not awarded for incomplete work. He had also written to Imperial Oil of Canada suggesting that they establish a liver transplantation program in each Canadian Surgery program. The sum of $300,000. over three years providing $50,000. to each institution as surgical departments develop programs was suggested. However all Canadian corporate offices were already well aware that harder times had arrived.

The new Committee Chair, Max Cohen, Vancouver, met with his Committee early in 1985. They were anxious to have closer contact with young surgical investigators in the country and organized a very successful Research Conference at the Chateau Montebello, outside Ottawa, in June 1985 which was attended by 23 surgeons and resident investigators. They identified a number of problems in Canadian Surgical Research — failure to recruit the most scholarly individuals, training programs not geared to train surgeon scientists, surgical investigators not held in high esteem by clinicians, a critical shortage of adequate funding and the demands of research, teaching and practice produced intolerable time constraints. The CAGS Research Conference has been an annual event each summer since 1985 and was supported by the Canadian Surgical Research Fund (CSRF). Travel expenses were paid by the individual surgical departments. When Max Cohen moved to New York in 1986 the Board expressed their appreciation of his initiative. Charles Wright, Saskatoon, and later Vancouver, was appointed as the new Chair. He was anxious for the Research Conference to develop into a study group - an opportunity for young and experienced general surgical researchers to meet and exchange knowledge and ideas. The Program Directors would be asked to choose the best surgical residents to attend and present their work for critical appraisal. Each Conference would also have a keynote address from a senior research colleague.

Slight changes in the requirements for applications for the Resident Research Prize were introduced in 1988. The applicant must be a resident or a Fellow in a Canadian University, list CAGS as its first choice for paper presentation and identify their submission as one to be considered for the prize. A substantial synopsis was required properly to consider their work. Once the first choice was made for the prize, the remaining best papers would be included as part of the
scientific program. There was still some concern that the prize was not adequately advertised and steps were taken to remedy this.

The first half of the 1980s saw increasing concern throughout North America that surgical research was not being properly funded. A Conjoint Council on Surgical research in the United States had representatives from many surgical associations. Dave Mulder, Montreal, chaired the Committee of the Canadian Surgical Chairmen and the matter was a regular agenda item on meetings of its Research Committee. There was little or no liaison between these bodies and little was achieved. There was also the real possibility that surgical applications were poorly presented and perhaps just not good enough. The Medical Research Council announced the scheme whereby grants for research from other agencies could be supplemented 50¢ on the dollar. It would also apply to Research Fellowships funded by Lederle and Merck Frosst. Each of these companies agreed to award two Fellowships worth $15,000 each for two years. The Lederle Fellowships were awarded through open competition through the Canadian Surgical Research Fund but the Merck Frosst Fellowships were specifically designed for the U of T and McGill. The MRC supplements were not automatic and had to be applied for.

In 1990 Charles Wright left Saskatoon for an appointment as the Vice Chair of Research at the Vancouver General Hospital. He was succeeded by Gerry Fried, Montreal. The 1989 Residents Research Prize was funded by Davis & Geck who helped CAGS in this way for many subsequent years. Gerry Fried hoped that in future years CAGS might consider two research prizes - one in clinical and the other in basic science. The Board agreed to this proposal in February 1991 and Davis & Geck generously agreed to fund the two prizes, each of $500. plus a travel allowance. The splitting of the prize into one clinical and one basic science prize was a great help to the selection committee.

Efforts to bring the General Surgery Research Register up to date had once again proved to be difficult partly because of the way in which the information is kept in various surgical departments. The Committee also felt that it would be helpful to combine this with a collation of information on Research Fellowships.
Meanwhile the Residents Research Conference continued from strength to strength. Many residents said that these conferences were an up to date review of research in each department of surgery and any questions regarding a particular project or available Research Fellowships could be answered on the spot and with up to the minute information. The 1993 Resident Research Conference was held in Banff. The weather was perfect and 19 residents attended although unfortunately there were none from the Atlantic provinces.

Garth Warnock, Edmonton, and later Vancouver, succeeded Gerry Fried in September 1993. The 1994 Research Conference was held in Sainte-Adele, Quebec, in June. All members of the Research Committee attended. The keynote address was given by Dr. Jane Fulton, a health care economist. Three research awards of CSRF were made to Drs. Vivian McAllister, Dalhousie, S. E. Karp, Montreal and N. L. Davis, UBC. The Lederle awards were now being administered through the CAGS Research Committee by John Marshall, Toronto. Each was for $15,000., one in surgical infection and the other in surgical oncology.

Garth Warnock also represented CAGS as a member of the Research Committee of the Canadian Association of Surgical Chairmen. This Committee had asked the CAGS Program Committee to consider a Symposium entitled “Frontiers in Canadian Surgical Research” which would occupy one and a half to two hours of the scientific program. This would give an excellent opportunity to recognize both Lederle and Davis & Geck.

In the earlier CAGS scientific programs, research papers were collected into a separate short program held in a small room. This encouraged freer and constructive comment and criticism. Later the Board felt that integrating the research papers into the main program would expose the general membership to new ideas. That did not work well and the advent of a research paper was often a signal for a significant exodus from the room.

Buffalo Mountain Lodge in Banff was the venue for the June 1995 Resident Research Conference; it had become a very successful annual event. All members of the Research Committee attended together with other faculty members and resident representatives of
nearly all the Canadian General Surgery Teaching Programs. Dr. Warnock’s committee published a Research Newsletter entitled “The Cutting Edge” which outlined research activities in surgical departments together with details of the Research Symposium. This was circulated to the membership along with the Newsletter.

There were seven applications in 1995 for the CSRF awards two of which were funded. It was now evident that recently appointed staff in academic departments had come to rely on CSRF for this seed money. Meanwhile it was agreed that these awards should only ordinarily be made to CAGS members. There were 22 applications for the CAGS Resident Research Prizes, one in clinical science and the other in basic science. Two members of the Research Committee were now members of the Canadian Association of Surgical Chairmen Research Committee which was compiling a comprehensive registry of research projects in Canada involving all surgical disciplines. The CASC also arranged a workshop on grant application in the 1985 Royal College program and there were plans to publish it as a booklet.

The advertising for prizes, awards and fellowships that were judged or controlled by the Research Committee had improved greatly. Surgical department notice boards, the Canadian Journal of Surgery and the CAGS Newsletter were all used to good effect. The Research Committee was becoming interested in training requirements for “surgeon scientists”. The Royal College had developed a concept of the FRCS Clinical Investigator which was largely based on the guidelines laid down at the University of Toronto. Many surgical departments were establishing similar programs. Meanwhile obtaining funding for surgical fellowships remained a priority. The Lederle and the Merck Frosst Fellowships had lapsed but in 1996 two new Fellowships - the Bayer Fellowship in surgical infectious diseases and the Wyeth-Ayerst Fellowship in trauma and surgical infections were established, both valued at $15,000. per year. The Wyeth-Ayerst award was for two years only whereas the Bayer Fellowship continued until 1999. Pfizer funded a Fellowship in infectious diseases for two years in 1999 and 2000. The Corporate takeovers within the pharmaceutical and surgical supply industries were a frequent occurrence and the uncertain future made corporate executives wary of any long term commitments.
Garth Warnock was appointed to the American College of Surgeons’ Surgical Research and Education Committee for a three year term in 1996 and informed the Board that, because of his new commitment, he felt that the CAGS Committee might be better served with a new Chair. Garth Warnock and his Committee had continued the good work of their predecessors and had reorganized the work of their Committee in a very commendable way.

John Marshall, Toronto, was appointed Chair of the Research Committee in 1996. By now, dealing with the prizes, awards and fellowships had become a pleasant routine. But there had been further cuts to MRC funding and only 15% of all applicants were successful. Furthermore all grants were subject to an across the board reduction of 30%. Funding through the CAGS Research Committee was appreciated all the more.

The 1998 Residents Research Conference was moved from June to the end of May. This was several weeks earlier than the previous meetings but was necessary to avoid a clash with the new Royal College Fellowship Examination. The following year the Committee agreed a further change for future conferences; individual Departments of Surgery would host the annual Resident Research Conference and the first of these was organized in early June 2000 by Carol Swallow, Toronto. With the advent of the Canadian Surgery Forum the Residents Research Conference was moved again to the Fall so as to coincide with the September meeting of the Forum and the first such retreat was held on the 9th of September 2001 at Laval University, arranged and chaired by Yvan Douville. These new arrangements may not have been as relaxing and festive as the earlier resort meetings but it nicely integrated the Residents Research Conference into the total program on the Canadian Surgery Forum, allowed residents, at the beginning of their final year of training, to attend the Canadian Surgery Forum and also made it easier for research supervisors and other staff members to attend.

Vivian McAllister, London, succeeded John Marshall as Chair of the Research Committee in 2000. Davis & Geck were taken over by Tyco; that ended over 20 years of faithful sponsorship of the CAGS clinical science and basic science prizes. From 2000 these became CAGS awards in the shape of an illuminated certificate and a cash
prize of $500. Perhaps one can discern some of the dismay felt by the Research Committee; the Davis & Geck prizes had evaporated to be replaced by significantly less generous CAGS prizes, the last sponsored Fellowship by Pfizer ended in the year 2000 and there was little prospect of any new corporate support. Being by nature an optimistic fellow, Vivian McAllister looked forward to the future. The new arrangements for the Residents Research Conference were more valuable educationally and were still being conducted with the old convivial spirit. With the advent of the Canadian Surgery Forum and separation from the Royal College annual meeting, there was hope for closer and more fruitful cooperation between CAGS and interested corporations that would benefit funding for research through CAGS. Since the CAGS Research Committee took over the responsibility of choosing the recipients of the CSRF research grants it had at its disposal the voluntary donations of the CAGS membership. The Committee had carefully distributed this sum in two and sometimes three annual awards concentrating on seed money for up and coming surgical investigators. Indeed most of the well known productive surgical researchers in Canada today are grateful for the support that they received earlier in their careers from CAGS.
RECOGNITION OF SPECIAL SKILLS

In the early 1970s, a number of the sections within General Surgery were anxious to have their restricted practice recognized by the Royal College. The College had a well established method for this called “A Certificate of Special Competence”. A number had been granted in other specialties of Medicine and Obstetrics and Gynecology and seemed to be working to everyone’s satisfaction. But there were two problems. Such certificates implied that practitioners without a special certificate lacked the special skills; this was of little concern to the Royal College but the costs involved were a serious worry. The administration of a Certificate of Special Competence with the necessary accreditation of training programs and the certifying examination was becoming increasingly expensive.

The special certificate in Thoracic Surgery was already in place by 1978, controlled by its own Royal College committee. Vascular surgeons, who already had their General Surgery Fellowship, were very anxious to have their own Certificate of Special Competence.

General Surgeons had very little representation on the relevant Royal College Committees but with the support of the CAGS Board and letters from the CAGS President, the College, in the summer of 1980, had agreed to a Certificate of Special Competence in Vascular Surgery. The appropriate committee was struck to administer the Certificate, chaired by Louis Levasseur, Quebec. The requirements included a Certificate in General Surgery from the Royal College and 18 months of training in Vascular Surgery, six months of which could be included within the General Surgery training. There was an oral examination but no written. There was no grandfathering provision. The first examination for Vascular Surgery was held in 1983.
The thoracic surgeons and vascular surgeons were now content with their Certificates. Meanwhile the Royal College had established a Certificate of Special Competence in Endocrinology and Metabolism, open to certified internists and pediatricians. The CAGS President wrote to the College to point out that general surgeons also have an interest in this field of work and should be considered for the Certificate.

All this led to a more general discussion on the subject late in 1984. The Royal College already had Certificates of Special Competence in Medical Oncology and Radiation Oncology. Striving to achieve a broad certificate in Surgical Oncology might be more difficult than establishing a certificate in General Surgical Oncology. Each of the specialties would have different training but there would be a common body of knowledge. However Allan MacDonald, Halifax, doubted if there were many surgeons who had an in depth knowledge of tumor biology, basic oncology research, clinical trials and all forms of adjuvant therapy to attain a comprehensive knowledge of the treatment of malignant disease. Several members of the Board agreed that while specialties are necessary, this did not necessarily imply a special certificate. In fact the American College of Surgeons was moving away from all forms of special certification and substituting Accreditation of Training Programs Without Certification. The individual programs would then recognize satisfactory completion of training by issuing a Certificate. The matter was referred to the CAGS Education Committee and after much deliberation, they decided that there was no need for a Certificate of Special Competence in Surgical Oncology but at the same time they emphasized that there was a pressing need to ensure that Surgical Oncology teaching was done well. All these views were passed on to John Duff, London, who chaired a Royal College Committee to review the whole matter and later produced a position paper entitled “The Certificate of Special Competence - Problems and an Alternative”. This paper can be summarized as follows:

“In recent years Royal College Certificates of Special Competence have been awarded in some newly defined areas within Medicine, Surgery or Laboratory Medicine. There is considerable doubt as to whether unrestricted proliferation is desirable. Indeed in the 1960s the Royal College Council had set up a “Fragmentation..."
Committee”. Although such specialty qualifications are claimed to improve patient care, teaching and research, it can give rise to problems such as pseudo-licensure, disputes on hospital privileges, fee schedules, grandfathering and the ever increasing cost of the examination. Furthermore hospitals, lawyers and paying agencies can use such certificates for their own purposes. John Duff’s committee suggested that Certificates of Special Competence be replaced by a “Certificate of Higher Training” to be awarded after satisfactory completion of special training in an approved program. There would be no examination and the certificates would not apply to training taken outside Canada.”

The CAGS Board accepted the Duff Report in principal although a minority were still anxious for a Certificate of Special Competence in Surgical Oncology now that Medical Oncology was recognized. In the end, the Board agreed to establish a CAGS Surgical Oncology Committee with a request that it define the essential requirements for Surgical Oncology training and make recommendations to the Royal College. The Committee was chaired by Henry Shibata, Montreal, with members from the University of Toronto and the University of Manitoba. These universities were in the process of setting up Surgical Oncology Training Programs.

By 1986 the Royal College had formally agreed to the principles set out by John Duff for Certificates of Higher Training Without Examination to replace Certificates of Special Competence. The University of Toronto had a fellowship training program in colorectal surgery which was also recognized and approved by the American Board for Colorectal Surgery. There was also a move to have a Certificate of Special Competence in Critical Care Medicine which would be open to the specialties of Anesthesia, Internal Medicine, Pediatrics and Surgery. Tom Todd, Toronto, approached CAGS on behalf of the Critical Care Society for permission to invite members to join the Critical Care Society. This was granted as the Board realized if general surgeons were poorly represented in that society it would likely be reflected in the in the membership of any committee appointed by the Royal College to administer such a certificate.

Towards the end of 1986 the Royal College introduced a pilot project to assist the emerging specialties to develop training
requirements and accredit programs. Three specialties were accepted, namely Colorectal Disease, Critical Care and Surgical Oncology. One year of the two year period of additional training could be completed while the candidate was in the basic specialty training program provided the Program Director was aware in advance of the fact and would design the training accordingly. The guidelines for a Certificate in Surgical Oncology were to be ready for the CAGS Board to review by February 1987. All the recommendations made by the Society for Surgical Oncology were in line with CAGS policies. There was a general feeling that it would be inadvisable to integrate Head and Neck Surgery training into Surgical Oncology training.

The Canadian Society for Surgical Oncology was established by the members of the CAGS Committee on Surgical Oncology. They had invited 50 CAGS members, known to have a special interest in Surgical Oncology, to join and by the end of 1987 30 members had applied and been accepted and members of other surgical disciplines were being invited to join. By the beginning of 1988 Accreditation Without Certification for Surgical Oncology had been approved by the Royal College.

There were still some unease on the part of the Royal College Council concerning the matter and they wrote to all the National Specialty Societies inviting them to offer comments on “The Proliferation of New Specialties”. The statement issued by the American Board of Medical Specialties in 1986 supported the CAGS view.

“There is no requirement or necessity for a diplomat in the recognized specialty to hold a special certificate in a subspecialty of that field in order to be considered qualified to include aspects of that subspecialty within a specialty practice. Under no circumstances should a diplomat be considered unqualified to practice within an area of subspecialty solely because of the lack of subspecialty certification.”

The CAGS reply to the Royal College recommended that the College should affirm its support for the American statement. CAGS also urged the College to accept the concept of new specialties being replaced by new areas of special expertise within an existing base.
specialty. Furthermore the Royal College should have a major responsibility and involvement in the process of developing criteria to recognize when such areas of special expertise with a critical mass of new knowledge and skills requiring special training had evolved.

Zane Cohen, Toronto, informed the CAGS Board in September 1989 that the Training Program in Colorectal Surgery at the University of Toronto had been reviewed by the Royal College and fully approved. Other programs at McGill and the University of Alberta were anxious for similar recognition and would likely take the necessary steps. Surgical Oncology within the specialty of General Surgery was recognized in March 1989 for inclusion in the pilot project of Accreditation Without Certification. The Chairman of the related committee would be a member of the Royal College Specialty Committee for General Surgery. A year later, Wally Temple, Calgary, said that Surgical Oncology was now recognized by the Royal College for Accreditation Without Certification. Training involved two years although one of the five years in General Surgery might be acceptable. The two years would consist of a year of Surgical Oncology, three months of Radiation Oncology, three months of Medical Oncology leaving six months of elective time. Within a year, there were three funded positions for training in Surgical Oncology in Montreal, Toronto and Calgary. The first meeting of the Canadian Society for Surgical Oncology was held in Toronto in April 1992 in conjunction with the National Cancer Institute Trials meeting.

The Canadian Society for Surgical Oncology, by September 1993, had over 100 members. Most were general surgeons but all the Canadian surgical disciplines including Orthopedics were represented. Their annual meeting held in conjunction with the NO meetings in April of each year, gave them a good chance to meet and mingle with the medical and radiation oncologists. Even though there were several vacant positions for surgical oncologists in Canada in 1993, there was little interest and at that time, all the postgraduate Fellowship positions in the country were not filled. It seemed that Canada was following the situation in the United States that medical and radiation oncologists were essentially dictating the care.

Training in Critical Care Medicine, by 1995, was not only through Internal Medicine, General Surgery and Anesthesia but a track was available through Cardiac Surgery, Emergency Medicine and at a
future date possibly Neurosurgery and Urology. There was a separate track through Pediatrics to Pediatric Critical Care. All this suggested a move away from the concept of the general intensivist. Members of the CAGS Board were generally happy with the Accreditation Without Certification programs but they emphasized the need for vigorous evaluation and detailed review of training programs during the accreditation process. But all was not plain sailing for general surgeons wishing to take further training in Critical Care Medicine. The original requirements were defined as two years of training beyond certification in the base specialty. A senior year, either the fourth or fifth year in General Surgery might qualify but in 1995 the Royal College Committee for Critical Care laid down that the overlap year could only be considered in the final year of residency training, and a year as Chief Resident in General Surgery would not be acceptable. A general surgeon would therefore require two years of additional training. While this was disappointing, there was no call by CAGS Board members for further representations to the Royal College.

Up to the end of the 20th century little more was heard about additional niches of specialty practice. The more that the practice of Medicine is subdivided the more difficult it is to find a physician who will look after a patient as opposed to a particular organ or system.
At its meeting in May 1978, the CAGS Executive Committee asked Charles Burns, Winnipeg, to make a presentation and share his views on Trauma Care. He had worked hard over several years to improve the management of trauma in and around Winnipeg. In addition he had developed an effective local registry of trauma cases and so was able to speak with authority. He was disappointed to find that the Royal College Committee on Trauma was inactive and he urged the formation of a CAGS Committee on Trauma. There was general agreement for Charlie Burns to strike a small ad hoc committee which he would chair and the Board agreed to meet the expenses of a small nucleus committee of five to which corresponding members might be added. Many other professionals, in addition to general surgeons, have an interest in the management of trauma and the hope was that the CAGS Ad Hoc Committee on Trauma might eventually evolve into an independent Canadian Trauma Association.

At a meeting of the Executive in Montreal in October 1978 Charlie Burns outlined his plan. He emphasized that trauma is the number one health care problem, that Canadians are at a higher risk than Americans of having a road accident and that 50% of those who are killed on the road are between the ages of 15 and 39. The overall care of a patient with multiple injuries is regarded as a responsibility of general surgeons and therefore it was appropriate that a National Trauma Committee should develop under the auspices of CAGS.

He envisaged the development of a National Trauma Service in four phases.

**Phase I:** A Trauma Committee consisting of key members from each province would develop national standards.
Phase II: The Provincial representatives would develop a provincial Trauma Committee in order to establish a number of regional trauma units serving a population of approximately one million.

Phase III: The formation of Provincial Accident Registries or Institutes which could then be brought together in Phase IV under a National Accident Institute.

Manitoba had already entered Phase II but there was little activity elsewhere in the country. Eventually a National Trauma Institute might develop with representations from transport, health, engineering, social welfare, police, in addition to the medical and related interests. Possibly the American Association for automotive medicine could also be represented. The committee advocated 21 Trauma Centres across Canada but by October 1979 there were only seven and some of these were in a very rudimentary phase.

Charlie Burns was able to say in June 1980, that the organization of the care of trauma patients had developed rapidly during the preceding 12 months. All regions were being encouraged to develop regional Trauma Committees whose aims were to publicize the best trauma care through local symposia and national meetings.

The Trauma Committee at the Royal College had by now been reactivated and was renamed the Coordinating Committee on Trauma, chaired by Charlie Burns with three other members from CAGS, one member from each of the Associations representing orthopedic surgery, neurosurgery, emergency medicine, plastic surgery and pediatrics. There was one member from the Royal College and one from the CMA. Additional resource people from nursing, anesthesia, the armed forces and the ambulance services attended. Once proper programs had developed within the provinces a central national data agency would be established. In the meantime the Federal Government would be kept informed through both the Ministry of Health and the Surgeon General’s office.

The Coordinating Committee would meet twice a year and each Association would pay the appropriate expenses for its representatives. CAGS also agreed to the sum of $500. for office expenses of the Coordinating Committee. With some reluctance, the
Executive also agreed to fund the four CAGS members of the Nucleus Committee for two meetings a year. Meanwhile Trauma Centres were being established in Montreal, St. John, Edmonton, Calgary, Saskatoon, Thunder Bay and Kelowna.

A successful Symposium was held in the 1981 Scientific Meeting and during the three hour program Canadian contributors covered injury scoring, spinal injuries, pelvic fractures, shock trousers, accidents and crash prevention and intervention. A second Trauma Symposium was to be held in the 1982 Scientific Program. Unfortunately this had to be canceled because of the shortening of the Royal College Program by one day. This was a bitter disappointment for those involved.

The Coordinating Committee on Trauma met on the 20th of February 1982. After reviewing the establishment and applications for new trauma centres, data collection, educational program and the publication of the ’81 Trauma Symposium proceedings in CJS, they deplored the canceling of the 1982 Trauma Symposium and directed that the Chairman, Charlie Burns, to investigate the procedure necessary to form a Canadian Association for the Surgery of Trauma which would give those interested a better opportunity to control the national agenda. Meanwhile some members of the CAGS Executive were anxious that the Ad Hoc Committee on Trauma be made a standing committee of the Association in order to maintain a close interest in all matters relating to trauma. It was later combined with Critical Care, Surgical Infections and Surgical Nutrition into one multi-purpose committee.

A Trauma Symposium in the 1983 Royal College Annual Meeting in Calgary was supported by CAGS and the Canadian Association of Pediatric Surgery. Preparations were being made for the inaugural meeting of the Canadian Trauma Association to be held in Calgary. The founders included Charlie Burns, Robert McMurtry, (COA), Peter Laine (CAEP), Arnis Freiberg (CAPS), David Mulder and Bob Hallgren and Leon Dontigny from CAGS. Don Trunkey, Portland, OR, took part in the ’83 Symposium and the Royal College was anxious to arrange a telephone conference with Dr. Trunkey which was channeled to each Department of Surgery at the cost of $40. each. It turned out to be very successful and those taking part
appreciated the opportunity of carefully preparing and directing questions to Dr. Trunkey.

When the CAGS Executive met in Calgary they received the Constitution and By Laws of the Trauma Association of Canada (ACT/TAC) combined with a request to have half a day of the CAGS program and a full day of the Royal College program, which seemed a little ambitious. Within the year the established Trauma Association of Canada had 181 members; 145 were general surgeons. They now had the full support of COA. David Mulder outlined the Scientific Program for the annual meeting of TAC in 1984 in Montreal as part of the Royal College program. Federal and Provincial Ministers of Health or their senior representatives were invited to attend.

Jean Fauteux, President of CAGS, moved a vote of thanks to Charlie Burns for his pioneering work as Chairman of the Trauma Committee. In spite of some occasional lack of enthusiasm by some members of the CAGS Board he had succeeded beyond expectation.

In 1984 CAGS received a letter from the President of the Roads Foundation in Kingston. The Foundation had been established by friends and admirers of Bill Ghent, who had done so much to improve the care of trauma patients in the Kingston area and their Board offered to fund an annual lecture in the CAGS program devoted to some aspect of trauma management. The lecture was to be in memory of Bill Ghent who had died recently. The sum of $1,000. a year would be available to fund the lecture, which was incorporated into the CAGS programs starting in 1987. Funding for the lecture continued at $1,000. a year until 1998 when the Foundation said that they were no longer able to support the Ghent Lecture on the CAGS program and wished to restrict their charitable giving to the Kingston area. Many groups are keenly interested in the organization and management of Trauma Care and so the advent of the Trauma Association of Canada was a correct and inevitable development. CAGS played its part well.
HEAD AND NECK SURGERY COMMITTEE

The Board met in February 1982 with the President, Neil Watters, Toronto, in the Chair. He said that the Board had received several letters from members including George Konok, Halifax, Ted Young, Hamilton, and Merv Deitel, Toronto, urging that the Association take a firm stand to hold back any further encroachment from ENT surgeons in head and neck surgery. There and then it was decided to include a symposium on head and neck surgery in the September 1983 Scientific Program. In the meantime the Board agreed to set up a subcommittee on Head and Neck Surgery and Ted Young was to be approached as the Chair.

At that time Ted Young was running a two year Fellowship program in head and neck surgery at McMaster University and a number of young general surgeons from Western Canada took advantage of the program and the first class clinical experience that they received. In his letter to CAGS, Ted Young said he was so upset by the lack of any emphasis on head and neck surgery by the Association that he was considering resigning. Soon after, a Board member met with Ted Young as they walked down towards Fisherman’s Wharf after a long day at the American College of Surgeons meeting in San Francisco. He did not need much persuasion and readily agreed to chair the CAGS Head and Neck Committee. Other members of the subcommittee were John Hinchey, Montreal, Irv Rosen, Toronto and Wayne Beecroft, Winnipeg. They gave much thought to consolidating the position of general surgeons in head and neck surgery and had prepared a symposium for the September 1983 CAGS meeting in Calgary.

For some years the chairman of the Royal College Examination Committee in General Surgery, Don Willoughby, Halifax, had commented on the poor performance of Canadian trainees in general surgery with questions on head and neck surgery in the Fellowship
examinations. This was not surprising as some centres had more or less abandoned the surgery of the thyroid, parathyroid and salivary glands to the Otolaryngologists. However most ENT surgeons do comparatively little major surgery and their training is not suited to the type of surgery that gives good results in head and neck malignancy. In 1983 75% of all head and neck surgery in Canada was done by general surgeons.

Ted Young’s committee made a number of recommendations.

1. All Royal College candidates should have a working knowledge of head and neck surgery. The thyroid should be considered the gallbladder of the neck.

2. Head and neck surgery should be part of all Canadian training programs.

3. All larger hospitals should have a recognized head and neck service.

4. Residents should rotate through such a service to acquire knowledge and experience for Certification.

5. In five years a special Certificate in head neck surgery might be considered.

To further their aims the Committee suggested that:

1. Lectures and symposia on head and neck subjects at the CAGS Annual meetings should be given by general surgeons.

2. General surgeons should make a point of teaching the clinical examination of the head and neck.

3. Articles by general surgeons in General Practice journals should be encouraged.

4. There should be close cooperation with the radiotherapists.
The 1983 symposium in Calgary included the following — staying out of trouble in head and neck surgery, parathyroid surgery, neck lumps, dangers of spreading cancer in the neck, the facial nerve and tracheostomy. It was followed by a symposium on thyroid cancer with Dr. Oliver Beers, Mayo Clinic, taking a leading part.

Ted Young had also surveyed Canadian general surgeons and found that 63 had a particular interest in head and neck surgery and some centres had otolaryngologists and plastic surgeons in a head and neck service, ideally under the direction of a general surgeon.

The Head and Neck Symposium at the Calgary meeting had an excellent attendance of 120 general surgeons. With this encouragement the subcommittee agreed to organize a second symposium on “Controversies in the Management of Thyroid Cancer” in the 1984 scientific program. They also felt that they were now ready for a full scale postgraduate course on head and neck topics in the 1985 meeting. A summary of the 1984 Head and Neck Symposium was printed in the Annals of the Royal College. Another symposium on the Surgical Management of Intraoral Malignancy in association with the Canadian Association of Plastic Surgeons was included in the 1985 meeting. Looking ahead, an all day Postgraduate Course was suggested for the 1986 program.

The subcommittee had drawn up “Training Guidelines in Head and Neck Surgery for General Surgeons” and this had been circulated to all Canadian Program Directors with a plea for a constructive reply. Only five schools responded which may have been an indication of the low priority which many Program Directors placed on head and neck surgery.

At the 1985 Royal College meeting in Vancouver, a meeting of general and plastic surgeons interested in head and neck surgery took place but there was no move to form a separate society.

A report from the American Board of Surgery in the summer of 1986 recognized a deficiency in 45% of candidates in that they had either inadequate or no training whatever in head and neck surgery. They pointed out that even though many general surgeons would not undertake specialized head and neck surgery, they should have a
solid knowledge of the subject. The CAGS subcommittee was also concerned to ensure that there were general surgeons experienced in head and neck surgery that would provide proper teaching in undergraduate programs. Medical School curriculum committees are virtually controlled by physicians with the help of basic scientists. Practising general surgeons are poorly represented and their attendance at meetings is at best sporadic. So it is not surprising that, in many Medical Schools the teaching of the surgery of the head and neck is commonly handed over to otolaryngologists and this has a great influence on the referring practitioners of the future. Earlier in 1987 the Canadian Society for Otolaryngology had renamed itself as “The Canadian Society of Otolaryngology and Head and Neck Surgery”. This reinforced the need for CAGS to remain active and aggressive in promoting head and neck surgery.

Lorne Rotstein, Toronto, organized the 1986 Postgraduate Course dealing with thyroid, parathyroid and the salivary glands. A second course planned for 1987, arranged by Wayne Beecroft, Winnipeg, would centre on controversial areas in thyroid disease and head and neck trauma. This was to have been a shared course with members of the Trauma Association of Canada but unfortunately TAC was holding its annual meeting along with the American Association for Trauma in Montreal. So instead of head and neck trauma the focus was on common head and neck problems. The September 1987 meeting was the last one that Ted Young would attend as the Chair of the subcommittee on head and neck. His place was taken by Wayne Beecroft but Ted Young said he would continue as a member of the committee. Ted Young had been an inspiring and motivating Chairman of the Head and Neck Committee and his splendid efforts to retain head and neck surgery within the realm of general surgery was much appreciated by the Board and by the membership at large.

Wayne Beecroft pointed out that the Committee on head and neck surgery had organized either a symposium or a postgraduate course each year from 1983 to 1987 but they would start again with a Postgraduate Course on head and neck trauma in the 1990 Scientific Program. There was good evidence of increasing interest in head and neck surgery since the advent of CAGS’ educational programs. In September 1990 Wayne Beecroft stepped down as the chair of the subcommittee on head and neck surgery to be succeeded by Lorne
Rotstein, Toronto. Wayne had not been well for many months and died the following year.

The September 1990 Postgraduate Course was somewhat disappointing. Thirty-one attended, 19 of whom were residents so there was an overall loss of $3,000 on the Course. Nevertheless those that attended gave the course an excellent evaluation. This led to some discussion by the Board. It was agreed that devoting a whole day to a relatively restricted area of surgery was a mistake, especially as many of the topics had been covered once or twice in the previous seven years. The concensus was that Postgraduate Courses in the future might be more attractive if they consisted of two half day courses and should consist of a number of short presentations rather than a few long ones. This eventually became CAGS policy.

However all was not well. Jean Couture, Quebec, in his Presidential Address in September 1990, had clearly shown that the role of general surgeons in head and neck surgery had declined in the province of Quebec over the last 10 years. Lorne Rotstein, Toronto, said that his Committee would embark on a survey of general surgery training programs to see how the Quebec experience was reflected in other provinces.

The new name of the “Canadian Society of Otolaryngology and Head and Neck Surgery” was discussed at the level of the Council of the Royal College. Royal College regulations stipulated that the name of an affiliated National Specialty Society cannot include the name of another affiliated Society. This item was on the agenda of the Royal College Council for a number of years without any decision. In the end victory went to the otolaryngologists.

Lome Rotstein’s Committee sent out questionnaires to all registered Canadian general surgeons to assess the head and neck content of their practice. Many of these were retired or semi-retired or were practising outside the field of general surgery. So the 600 replies represents a high proportion of actively practising general surgeons. The analysis was reported to the Board in February 1995. Head and neck surgery forms a small but significant part of general surgical practice in Canada. Surgeons doing head and neck surgery tend to be community rather than University based and 90% of those surveyed
strongly held that head and neck surgery training should be an integral part of general surgery training. Nevertheless year after year the Chairman of the Royal College Examining Board in General Surgery emphasized that candidates were not well versed in head and neck surgery which must reflect on the teaching they had received. Some candidates even went so far as to blithely state that they would refer even simple problems in head and neck surgery to otolaryngologists.

In his report to the Board in February 1994, Richard Nason, Winnipeg, the new Chair of the Head and Neck Committee, said he and his Committee were reviewing the goals and objectives for training in head and neck surgery at various levels. Wally Temple, Calgary, and his colleagues on the Surgical Oncology Committee had prepared a similar document several years previously. Rick Nason emphasized that head and neck surgery needs a good home and a closer association with surgical oncology would certainly be very acceptable.

Goals and objectives for head and neck surgery training were originally drawn up by Ted Young in 1985. They were never formally adopted by the Royal College but included, for the most part, in general surgery training requirements. Rick Nason said that cooperation with otolaryngology and plastic and reconstructive surgery was desirable for proper training in head and neck surgery within general surgery. Teaching should include head and neck examination, endoscopy, tracheostomy, head and neck trauma, early oral cancer, neck dissection and the three important areas to general surgery, salivary gland surgery, thyroid and parathyroid surgery. The ability to carry out accurate indirect and direct laryngoscopy was essential. In September 1995 Rick Nason and his committee presented their very comprehensive report “Recommendations for Training in Head and Neck Surgery for General Surgeons”. This was based on their own thoughtful deliberations and the previous CAGS documents and underlined the importance of a cooperative effort by the various interested parties. These recommendations were endorsed by the Board and circulated to all General Surgery Program Directors.

How much effect these recommendations had in the 16 surgical training programs in Canada is open to question. What is actually
claimed on paper to be the local policy may not be the same as what takes place in practice. A lack of knowledge of head and neck surgery in the Royal College oral examination may not have been sufficient cause to fail the examination, especially if performance in other areas was good. This in the end comes down to a vote by the members of the Examining Board. It is not enough for the chair of the Examining Board to complain about poor head and neck teaching if he is not backed up by the members of the Board. Teaching programs that have lost or are losing head and neck surgery out of their general surgery programs may have had undue influence within the Royal College. The pity of it is that no where else in general surgery is a knowledge of the anatomy, the gentle handling of tissues and accurate hemostasis more amply rewarded with good results.

Roger Tabah, Montreal, took over from Rick Nason in September 1997. He was pleased that Rick Nason would remain on the Committee and he emphasized that they would strive to keep head and neck surgery within the realm of general surgery through educational programs and symposia. He was encouraged by the very successful Head and Neck Postgraduate Course in Halifax in September 1996. The Halifax course drew 125 registrants and was a financial success.

Unfortunately other forces were at work. The report to the CAGS Board in February 2002 by the Chairman of the Royal College Committee for General Surgery said that the Committee had withdrawn “exposure to head and neck surgery” in its objectives for training for general surgery. Thyroid and parathyroid glands would be included under endocrine surgery. The CAGS Committee for Head and Neck Surgery was renamed the Committee for Head and Neck and Endocrine Surgery, chaired by Janice Pasieka, Calgary.

Looking back it was really the encroachment of the otolaryngologists into the surgery of salivary glands, thyroid and parathyroid that started all the discussion within CAGS. General surgeons, with few exceptions, are not particularly interested in the extensive head and neck resections which were usually the result of recurrences following radiation treatment for primary lesions. These lesions can only be properly managed by a team of general surgeons, plastic and reconstructive surgeons, otolaryngologists and radiation oncologists.
From the first CAGS Board meeting in June 1977, colorectal surgeons had always been well represented on the CAGS Board. Indeed the feature lecture at the inaugural meeting in Toronto was given by Professor John Golligher, London, England, one of the foremost colorectal surgeons in the world at the time.

A group of Canadian surgeons especially interested in colorectal surgery met in Chicago in October 1982 at the meeting of the American College of Surgeons. They were led by Phil Gordon, Montreal, and agreed to form an Executive of the Canadian Society of Colorectal Surgery (CSCR). Within a few months 65 members had signed up. There was never any intention to break away from CAGS but rather to form a special interest association closely allied with CAGS. The CAGS Board agreed to strike a CAGS Colorectal Committee, the chair of which would be recommended by CSCR to the Nominating Committee.

From that time onwards the cooperation between the Colorectal Committee and other committees of CAGS, especially the Program Committee, the Education Committee and the Research Committee was complete, a fine example of surgical symbiosis. CSCR arranged a symposium on Outpatient Procedures in Colorectal Surgery for the 1983 meeting in Calgary and a symposium on Controversies in Colorectal Cancer Management a year later. A symposium on “Alternatives to Conventional Ileostomy in Ulcerative Colitis” was part of the 1985 CAGS Annual Scientific Meeting.

In 1986 CAGS received a request from the Canadian Society of Colon and Rectal Surgeons to join with CAGS and have their annual business meeting and scientific program as part of the CAGS program under the auspices of the Royal College. Gradually, over the years, the time devoted to colorectal surgery and the colorectal
guest lecturer increased and this arrangement was much simplified when the system of concurrent rooms was developed in later years. Each year the colorectal program was looked forward to by CAGS members and very well attended.

As early as 1985, the colorectal surgeons were anxious to carry out a nation-wide study on sepsis following colorectal surgery and the efficacy of antibiotic prophylaxis. At first there was much enthusiasm and applications for funding were made to a number of sources. However by 1988 the project was abandoned as adequate funding was hard to get and it was evident that the task was far beyond the ability of a few busy surgeons to complete with any hope of getting meaningful results.

Phil Gordon stepped down as the Chair of the Colorectal Committee after five years of excellent work to be succeeded by Zane Cohen, Toronto, in September 1987.

The first Canadian Postgraduate Training Program in Colorectal Surgery began in January 1984 at the University of Toronto, through the efforts of Bernie Langer, Zane Cohen and Robin McLeod. The two year program was accredited by the American Board of Colorectal Surgery and was intended for individuals with Certification in General Surgery who had made a firm commitment to return to an academic centre. CSCR applied to the Royal College in 1988 for the training program in Toronto to be included in the Royal College pilot project “Accreditation Without Certification”. The Royal College Committee on Specialties formally endorsed the U of T program in 1990. The two year program included 12 months of clinical surgery and 12 months of electives either in research or clinical work. Two fellows were accepted per year, one funded by the Ministry of Health and the other by the program. The program was open to both Canadian and U.S. trainees. The Royal College Committee on Specialties formally resolved in 1991 that Colorectal Surgery be a subspecialty of General Surgery by Accreditation Without Certification. The Chair of the Colorectal Specialty Committee would be an ex officio member of the Specialty Committee in General Surgery. The Colorectal Committee would develop specialty training requirement and guidelines for the program.
The Royal College procedure for Accreditation Without Certification required:

a) A statement of training objectives.

b) An outline of specific requirements and guidelines for accreditation of the program.

c) An outline of criteria for evaluation of the program.

Zane Cohen was followed by Bob Thorlakson, Winnipeg, as chair of the Colorectal Committee to be followed in 1992 by Paul Belliveau, Montreal.

By 1994 the membership of the Canadian Society of Colorectal Surgeons stood at 70. They were cooperating fully with CAGS for a course on the large intestine at the following annual meeting in association with the Canadian Society for Surgical Oncology (CSSO). The American Society for Colorectal Surgery planned to meet in Montreal in 1995 with Phil Gordon as its President.

Colorectal Training Programs were also active in both Montreal and Edmonton, but neither applied for “Accreditation Without Certification”. It was a question of “why jump through all the hoops for relatively little advantage”. Paul Belliveau announced that as from 1995 the Canadian Society of Colorectal Surgeons had agreed with the Royal College to meeting as a free standing Society on the Saturday as part of the Royal College Annual Scientific Meeting with papers in the morning, a symposium in the afternoon with a guest lecturer. They had also received recognition by CJS as a sponsoring society. Earlier in the year, the Coat of Arms of the Canadian Society of Colorectal Surgery was presented to the Royal College. Paul Belliveau stepped down as President of the Society to be succeeded by Ernie Wiens, Edmonton, with Robin McLeod, Toronto, as Vice President.

At his first meeting in 1995 as a member of the CAGS Board, Ernie Wiens commented on the excellent cooperation between CAGS and CSCR. He did raise some points of concern.
1) Colonoscopy training was largely in the hands of gastroenterologists and CSCR would very much like to play a larger role. Furthermore even when young surgeons had received training in colonoscopy they encountered difficulty in getting privileges at their hospital.

2) Anorectal conditions are not well taught to General Surgery residents.

3) There were 600 cases of rectal cancer in the province of Alberta in the last five years. These were treated by over 50 general surgeons with the largest personal experience being 50 cases. The overall local recurrence rate was 30%; ideally it should be no higher than 10%. This discrepancy could be attributed to a number of causes - inadequate technique, poor case selection and a desire to avoid a colostomy at all costs; older CAGS members will remember how much easier it is to train a colostomy than an irritable weak ano- rectum.

The September 1996 Postgraduate Course on anorectal surgery was very successful and a good example of the use of Postgraduate Courses to overcome deficiencies in surgical training.

The External Financial Review of the Royal College in 1997 recommended that the Royal College annual meeting should divest itself of the Specialty Society programs as soon as possible; the Annual Meeting was losing increasing amounts of money each year. The earliest date for such a change was 2001 as commitments had already been made to a number of cities for the interim meetings. However the Royal College also stated that the services of their “Meetings Section” would be at the disposal of National Specialty Societies on a fully cost recovery basis.

From that time onwards, Robin McLeod, Toronto, and Carol Ann Vasilevsky, Montreal, enthusiastically represented CSCS along with CAGS in negotiations for an independent meeting of the “Canadian Surgery Forum” in Quebec in 2001. The Colorectal program in the Canadian Surgery Forum was to become one of the most popular and best attended sections o the Forum.
Those of us old enough to remember using the semi-rigid Herman-Taylor gastroscope, will recall the misery and difficulty of its use to both patients and the operator. In fact, without a good x-ray the gastroscopy reports were of little value. Few internists were interested.

With the advent of the flexible gastroscope in the late 1950’s the picture changed completely. These instruments were based on the basic work of Professor Hopkyns of London, England. He showed that there was minimal loss of light transmitted along a glass cylinder, whereas there was a significant loss of light when transmitted along a metal tube. This led to the well known Hopkyns system used in rigid choledochoscopes and bronchoscopes where the refracting surfaces are formed by air filled spaces in a solid glass cylinder. This provides superb optics with slender instruments. He also pioneered the development of light transmission along bundles of flexible glass fibres giving a punctate image combined with flexibility. His discoveries were profitably developed by others. It is no exaggeration to say that the flexible gastroscope was an important influence in the development of the specialty of gastroenterology.

The CAGS Education Committee met for a whole day in October 1978 and much of the discussion centered on the difficulty that most general surgery training programs were having in providing endoscopy training for residents; gastroenterologists and the Canadian Association of Gastroenterologists (CAG) were not helpful. As a result CAGS made a recommendation to the Royal College Committee for General Surgery that knowledge of and competence in upper and lower endoscopy be a requirement for certification and that candidates must be examined in these fields. The recommendation was accepted.
It was therefore no surprise that the CAGS President received a letter from CAG asking that it be consulted before any recommendations were made to the Royal College regarding the training of surgical residents in endoscopy. The CAG guidelines stated that competence in GI endoscopy is recognized by attaining the Fellowship in Gastroenterology of the Royal College or training leading to a Fellowship in a recognized specialty or subspecialty which includes a minimum of 100 upper GI endoscopies and 25 colonoscopies, all performed under supervision. However CAGS was content with the official position of the Royal College who had accepted the CAGS recommendation that training in general surgery include upper and lower GI endoscopy and that competence would be required for Certification. There was no mention of numbers and achieving competence would depend on the aptitude of the resident and the quality of the instruction. Since 1980, questions on GI endoscopy have been included in the Fellowship examination for general surgery residents and this proved to be a strong stimulus to the teaching programs. There was some concern in some quarters that there would be an insufficient number of cases for resident training in general surgery and gastroenterology but the CAGS position was that there was ample work and if necessary, combined facilities could be established.

To consolidate the CAGS position a Committee on Endoscopy was struck in 1981 chaired by Roger Keith, Saskatoon, with Ken Bowes, Edmonton, Andre Duranceau, Montreal, and Ted Mullins, Ottawa. They produced two questionnaires — one to be circulated to the membership as a whole and the other to Chiefs of Surgery in the larger hospitals. This would provide an up-to-date picture of the role of endoscopy in general surgical practice. The cost of some $2,000. was borne by the Association. Meanwhile it was recognized that many general surgeons in practice wished to engage in endoscopy but required further training and the Committee was asked to designate a number of centres where such training would be available; this information was circulated to the membership in the Newsletter. Both Roger Keith and Ted Mullins were also members of CAG and so were privy to their views.

The analysis of the answers to the surveys were made known in September 1983. It gave very detailed information and it was
encouraging that, on the whole, there was an increasing trend for some general surgeons, especially those recently trained, to do their own endoscopy. It was evident to the Committee that there was a sufficient volume of endoscopy to satisfy all the interested parties.

At the September 1984 meeting of CAGS in Montreal, the program included a Postgraduate Course on “GI Endoscopy for Surgeons”. Over 100 surgeons pre-registered and the all Canadian faculty covered a wide field. The ’84 course was a great success all around and made a modest profit for CAGS. A similar turnout was expected for the 1985 Endoscopy Course.

Later in 1984, the Endoscopy Committee received a letter from Dr. Thibert complaining that the Royal College Specialty Committee for Gastroenterology and CAG had not been appropriately consulted. A strong reply from Dr. Keith insisted that the Royal College regulations demand knowledge and competence in GI endoscopy, that only General Surgery Program Directors can ensure the adequacy of training and that competence is determined by the Royal College Examining Board.

A year later Dr. Keith and his Committee came up with a definition of competence in GI Endoscopy:

“Competence in gastrointestinal endoscopy requires thorough training in the technical skills and knowledge of the principles of endoscopic investigation of diseases of the GI tract. Satisfactory knowledge of the normal and pathological conditions affecting the digestive system, acquired through surgical and endoscopic experience, is required to competently document observations by endoscopic examination. Sound interpretation of observations and appropriate application of therapeutic measures by the endoscopist are necessary requirements of complete competence. Certification of Competence in GI Endoscopy is based on training approved by the Royal College of Surgeons of Canada and certified by the Royal College Examining Board in General Surgery.”

In 1985 Dr. Keith had corresponded with Dr. Ian Cleator, Vancouver, a general surgeon and President of CAG, regarding the guidelines for practice of GI endoscopy in Canada. The CAG document, produced
by Dr. Aubrey Groll did not cover general surgery adequately. Nevertheless the objective of the CAGS Endoscopy Committee was to ensure that all general surgeons received adequate training in endoscopy.

The title of the Endoscopy Postgraduate Course for 1986 was “Intervention in Pancreatic and Biliary Disease - Integrating Rays, Scopes and Scalpels”. Dr. Keith had encouraged attendees from gastroenterology and there were several non-surgeons on the faculty. The Postgraduate Course was highly rated but incurred a slight loss due to lower than expected registration; it competed with a Postgraduate Course on Breast Disease and a free CAG Postgraduate Course all running simultaneously. The preparations for a Postgraduate Course on Colonoscopy and Laparoscopy for general surgeons was well underway for the 1987 meeting with full cooperation of the Canadian Association of Colorectal Surgeons.

The Endoscopy Committee prepared guidelines for an ideal unit for GI endoscopy training which were circulated to Program Directors. In general, it was well received but the standards could be difficult to achieve in smaller centres. CAGS was asked by the CAG Endoscopy Committee to help to develop a consensus document on training and competence. Dr. Keith advised that such cooperation would be redundant, and the Board agreed.

In 1986, Roger Keith’s Committee circulated a questionnaire for all general surgery residents to assess their exposure to GI Endoscopy. Although the replies to the various questionnaires indicated that general surgery residents were getting satisfactory training in endoscopy, the Committee was anxious to undertake site visits from coast to coast to be funded by the individual Departments of Surgery and Endoscope makers. These visits were to be done on a regional basis from September ’88 to February ’89 using local CAGS members.

In February 1990 Ron Passi, London, the new Chair of the Endoscopy Committee, circulated the summary of the National Survey of GI Endoscopy Training in General Surgery that had been prepared by Roger Keith. It showed that general surgery residents received a good exposure to upper and lower endoscopy in 10 out of
the 16 programs; some problems were apparent in the remaining six. The report was circulated to all General Surgery Program Directors for their information and comments. A few programs were upset by comments in the survey and asked for a repeat review which was duly granted. General Surgery Program Directors meet together twice a year and the information shared between them significantly contributed to better endoscopy teaching. The local arrangements in any particular centre depended very largely on the personal relationships between Program Directors and gastroenterologists.

The late 1980s were the years in which laparoscopic surgery and especially laparoscopic cholecystectomy was introduced across Canada. There were diverse teaching programs from coast to coast, some organized by University Departments, others by enthusiastic individuals with or without the help of instrument manufacturers and experts from the United States. Like most things that work well for patients and surgeons alike, laparoscopic surgery was quickly adopted so that within five years there were candidates at the Royal College examination who had never seen an open cholecystectomy. Consequently the name of the Committee was changed in 1991 to the Committee on Endoscopy and Laparoscopic Surgery. The Committee drew up guidelines for laparoscopic cholecystectomy which were circulated to Surgical Chairmen and General Surgery Divisional Directors. They stated that training for laparoscopic cholecystectomy should be available to all surgeons who were interested. Nevertheless privileges for performing laparoscopic cholecystectomy remained a responsibility of the individual Hospital Board.

At the Quebec meeting in September 1991, a course on Laparoscopic Cholecystectomy was organized by the newly formed Canadian Society for Laparoscopic and Endoscopic Surgery that conflicted with part of the CAGS program. This was a disturbing development as the Board felt very strongly that CAGS should represent endoscopy and laparoscopic surgery by general surgeons in Canada. Ron Passi was asked to contact the organizers and discuss the situation. He met with Michel Gagne, Montreal, the prime mover of CSLS who said he had no desire to fragment General Surgery in any way and that his main objective was to create an organization which would include many specialists interested in laparoscopic
surgery including urologists, thoracic surgeons, gynecologists and general surgeons. CSLS, which was organized in the summer of 1991, had asked for official participation in the Royal College annual program but were told that any such participation would only be under the auspices of a national specialty society.

CSLS organized a second Annual Congress in Ottawa in September 1992. It was Dr. Passi’s recommendation that an invitation be extended to the new society to cooperate with CAGS in putting on a first class, well advertised course at the ’93 CAGS meeting in Vancouver. Meanwhile the CAGS Committee on Endoscopy and Laparoscopic Surgery increased its membership by including Jonathan Meakins, Montreal, Michel Gagne, Montreal, Dmetrius Litwin, Saskatoon, Steve Strasberg, Toronto, Alex Nagy, Vancouver, and Marvin Wexler, Montreal.

The Directors for 1993 Postgraduate Course on Endoscopy and Laparoscopic Surgery held in Vancouver were Michel Gagne and Ron Passi. Ron Passi reported that both Dmetrius Litwin and Michel Gagne were extremely helpful in arranging the course. The invited speakers were Professor Cushieri from Dundee, Scotland and John Hunter from Atlanta, Georgia. CSELS had organized an independent program at another venue on the previous day but they agreed in future to support CAGS Postgraduate work and if they did arrange another independent program, it would be at another time of year and in another place. As it happens, both Drs. Gagne and Litwin accepted appointments in the United States within the year. It is very much to Ron Passi’s credit that the whole matter was dealt with straight-forwardly and without rancour.

A survey of laparoscopic cholecystectomy by Canadian general surgeons carried out by Marvin Wexler and McGill University with the full cooperation of CAGS produced a preliminary report in September 1992. In all 750 general surgeons replied. 85% had learned and practiced laparoscopic cholecystectomy. 15% had no interest or were retired. Most had learned the procedure at University sponsored courses. 7% carried out routine cholangiography and 35% never. There were 27 bile duct leakages, 4% bile duct injuries, 4% peritonitis and 3 deaths. The Board allocated the sum of $5,000 to help this study continue.
The International Federation of Societies for Endoscopic Surgery, IFSES, was established in 1992 in Bordeaux, during the Third World Congress of Endoscopic Surgery. Canada was originally considered as part of the United States and was represented by SAGES (Society of American Gastroenterological Surgeons). IFSES was aware of some differences between CAGS and CSELS and once these had been settled, IFSES would consider an application for direct Canadian representation. By 1993 IFSES was now in a position to agree that CAGS should represent Canada on their Executive with the three representatives — Roger Keith, Ron Passi and Murray Girotti. IFSES holds a World Congress every two years. Originally they were to be held all over the world but because 80% of the laparoscopic equipment is produced in the USA, the Federation decided to hold 80% of its meetings in the USA. Each affluent affiliated Society contributes to the Congress.

In 1989 Julius Stoller, Vancouver, asked that CAGS develop a policy on External Shock Wave Lithotripsy for biliary calculus disease. The referral patterns for these patients varied across the country as did their care if complications developed. Dr. Stoller was asked to strike an ad hoc committee on lithotripsy and advise the Board. The Committee stated that ESWL was a new and evolving procedure, should be considered investigational and that consent forms should reflect this. CAGS should not endorse direct referral by family practitioners or other specialists except general surgeons or medical gastroenterologists. However it seemed acceptable for radiologists to treat outpatients from another institution. Within the same institution any inpatient must be cared for primarily by a general surgery team headed by a suitably trained staff member. General surgeons could operate ESWL after appropriate training and demonstration of clinical competence. These views were accepted by the Board and circulated through the Newsletter.

The same committee drew up guidelines for interventional techniques by percutaneous or related means and stated that the assessment and selection of general surgical patients for such treatment should be in the hands of general surgeons with the help of other specialists. Furthermore the primary and continuing care of these patients should be in the hands of general surgeons. If there was a possibility that the patients would need to be admitted after...
treatment they should first be seen by a general surgeon in consultation. These guidelines were also circulated in the Newsletter and the work of the ad hoc Committee came to an end.

The American College of Surgeons had developed “a statement on laparoscopic and thoracoscopic procedures”. This was approved by the Board and was widely circulated through the CAGS Newsletter, CMAJ and the Annals of the Royal College.

Mark Marcaccio, Hamilton, the new Chair of the Committee, reported that the ’93 Postgraduate Course on laparoscopic and endoscopic surgery was very well received by over 100 registered members and 22 faculty. The Committee hoped to have courses on laparoscopic surgery for the next two years at least. Meanwhile the Committee was working on guidelines for the training and credentialling in minimal access surgery.

The period from 1995 to 2002 was one of education, consolidation and facilitation for the Committee. The successive Chairs were Mark Marcaccio, Gerry Fried, Montreal and Hugh Taylor, Winnipeg. The guidelines for training and credentialling in endoscopy and laparoscopic surgery were reviewed and revised on three occasions as the practice in Canada evolved. Those who have written guidelines will know what a frustrating experience it can be. If they are too general they are of little value and if too detailed they are virtually unenforceable. But they can be of considerable help to the Hospital Committees in coming to decisions.

In 1997 the basic conflict with CAG came to life in Alberta. The President of the Alberta Association of General Surgeons and the President of the Alberta Association of Gastroenterologists exchanged letters. AAG had written to Hospital CEO’s and Ministers of Health outlining their requirements for credentialing in flexible endoscopy and combing this with specific number of cases. The President of CAGS, Ed Monaghan, Montreal, and Gerry Fried, Montreal, composed a joint letter clearly outlining CAGS position which was distributed with the same circulation as the original AAG letter. This led to a letter from the Royal College Specialty Committee for General Surgery to that for Gastroenterology reaffirming the position of the Royal College and CAGS. They
reiterated their objection to specific numbers of procedures before Certification. Program Directors were advised again that it was vital for trainees to keep an accurate record of their endoscopic experience. An analysis of the results of a questionnaire sent to general surgery trainees in 1996 revealed that they were getting a sufficient exposure to diagnostic endoscopy although the position with therapeutic endoscopy was not quite as satisfactory.

The CMPA in 1997 said they had 160 cases of common bile duct injuries during laparoscopic cholecystectomy to defend which should have a severe impact on insurance rates. Gerry Fried made a plea for surgeons to be completely accurate in the OR reports. Furthermore if a surgeon makes a video of a laparoscopic cholecystectomy each one should be stored individually. Erasing a record leads to great difficulties in court. In 1999 the Committee planned for a strategy to diminish the complications of laparoscopic cholecystectomy, including vascular injury, bile duct injury, cautery injury, delayed recognition of complications and inadequate consent. Based on the CMPA information and using all the facilities available at the Annual Scientific Meeting and the Canadian Surgery Forum, three questions were addressed - open insertion of the initial trochar, the use of monopolar cautery and recommendations for certain steps to be performed during the operation which must be accurately documented.

Looking back over the 25 years, the first 13 years were full of anxiety and political activity to maintain the scope of general surgery followed by 12 years of consolidation and continuing education. New graduates in general surgery from Canadian programs are confident and technically adept in the simpler laparoscopic operations have a good experience in flexible endoscopy.
In September 1985 CAGS held its annual meeting in association with the Royal College in Vancouver. Part of the CAGS program included a mock trial of a surgeon for surgical misadventure held on the Sunday in one of the Vancouver Law Courts. At the time the number of legal cases against surgeons was increasing rapidly and there was an obvious need for CAGS to take part in informing and educating its membership in that field. The demonstration court case was very well organized and orchestrated by Julius Stoller, Vancouver. Later he and Nis Schmidt, Vancouver, made an appeal to the CAGS Board regretting the general lack of awareness among general surgeons about litigation activities within their own specialty and called for action. They suggested that a CAGS Medical Legal Committee be struck to research, review and inform the membership. The Board quickly agreed and at the annual business meeting in September 1987 the committee was formally struck with Nis Schmidt as the Chair.

The committee members along with other CAGS representatives had met with officers of the CMPA to discuss a number of topics including facts and figures, informed consent, defensibility, the assessment of damages, the CMPA fee structure and how it is developed. The Committee stressed that it was seeking to work with the CMPA and other surgical organizations in educating surgeons on medical legal implications. Information was disseminated to the membership in the Newsletter and the Canadian Journal of Surgery.

The resulting successful symposium in the annual program took place in Ottawa in September 1988 and a number of physicians on the CMPA staff took part. The Canadian Medical Protective Association has served the profession well over the years. Each year it calculates the cost of settlements in ongoing cases and estimates
the cost of future settlements. A five year sum to cover future costs always has to be on deposit and in 1987 this sum amounted to one hundred million dollars.

In 1988 a Federal/Provincial Malpractice Review Commission headed by Dean Pritchard of the Faculty of Law, University of Toronto, was holding hearings across the country. There were high hopes that this might lead to some reforms in Tort law, but in the end, it was a disappointment. Nis Schmidt also advised the Board that surgical residents should be encouraged to take out supplementary insurance coverage even if the hospital policy covers them for their hospital work. There was always the risk that a hospital might leave a resident high and dry and furthermore, moonlighting was a common practice. He also pointed out that the CMPA guarded their statistics very carefully and while they were always prepared to speak in general terms they refused to enter into detailed specifics.

At each CAGS Board meeting there was always a lively discussion on medical legal matters. Denis Bernard, Montreal, said that CMPA was taking an active role in the education of medical students and that at the University of Montreal each resident received six hours of instruction. Bill Pollett, St. John’s, informed the Board that the CMPA runs a series of excellent seminars for interested surgeons so that they can, in turn, return home and instruct their colleagues. A little worrying was the information that, should the proceedings of M&M committees be duly recorded, the minutes could be used as evidence in court.

The three major problems leading to legal actions against general surgeons are nerve damage associated with lymph node biopsy in the neck, mistaken diagnosis and common bile duct injuries in that order. Nis Schmidt was proud that CAGS was the first specialty association to show an interest in medical legal matters. He said that the CMPA dealt with about 800 cases in 1990/91 and it was of interest that the percentage of pretrial settlements had increased to about 70%. At that time the Pritchard Report on “Litigation in Canadian Health” had not been made public but the author in some of his speeches had let it be known that he believed that hospitals have as much responsibility as doctors when problems do occur. The CAGS Committee arranged for
a successful lunchtime symposium entitled “Pitfalls in Surgery”; the keynote speaker was Dr. Robson of the CMPA.

Nis Schmidt stepped down as the Chair of the Medical Legal Committee in September 1991. He and his Committee had worked hard and with success to educate the Board and the membership on all aspects of medical legal litigation. It was a good example of how a small committee dedicated to the cause can get things done. He was succeeded by Julius Stoller, Vancouver and as a member of the Committee from the start in 1987 and he had worked hard to make it the success that it had become. In September 1993 a significant portion of the Postgraduate Course on Laparoscopic Surgery was devoted to the medical legal aspect. When Julius Stoller became the Secretary Elect in September 1994 and the Secretary in 1995, he was succeeded by Gilles Beauchamp, Montreal, as Chair of the Medical Legal Committee. The Committee agreed that they would concentrate on the ethics of surgical treatment and, with the help of the CMPA, the legal aspects. In September 1997 the Committee organized a very well attended Symposium on “Medical Ethics for Surgeons”. Prior to that the Committee had sent a questionnaire on Ethics in Surgical Practice to all CAGS members and 60% replied. 31% were community surgeons, 18% were in rural surgical practice and 51% were University surgeons. 93% were men and 64 of these had been in practice for more than 16 years. Of the total, 53% had no background in medical ethics and 42% said they often faced ethical decisions, especially in regard to informed consent and the rationing of surgical services.

There was an interesting Symposium in September 1998 on “The Safety of Laparoscopic Cholecystectomy, other Laparoscopic Procedures and the Use of Electrocautery and Electricity in the Operating Room”. The Committee had the help of Gerry Fried, Montreal, Chair of the Endoscopic and Laparoscopic Committee and Martin Gagnon, Ottawa, from the CMPA.

Gilles Beauchamp stepped down as the Chair of the Medical Legal Committee in 1999 following his appointment as the Chair of the Department of Surgery at the University of Montreal. His thoughtful approach to ethical and legal matters was duly noted and appreciated by the CAGS Board.
The new Chair of the Committee was Dennis Pitt, Ottawa. He had the advantage of having important contacts at the CMPA. Dr. Pitt emphasized to the Board the great importance of better documentation of informed consent. At the first Canadian Surgery Forum in Quebec in September 2001 the Committee organized a well attended and important Symposium on “How to Survive a Lawsuit”. The younger surgeons in the audience found this particularly helpful in alleviating the anguish and hurt usually felt by surgeons involved in these long drawn out legal contests.

Dennis Pitt explained that Jacques Guilbert, an experienced general surgeon, had joined the staff of the CMPA and had given several excellent presentations to surgeons and residents on legal issues. The modular lecture program developed by Dr. Jacques Guilbert and Dr. Louis Dionne of the CMPA can be expanded or contracted to fit various time slots. It is included in the two year cycle in the Principles of Surgery program at Ottawa and the CMPA is willing and has the resources to provide it to all Canadian teaching programs.

Practising general surgeons were sent a questionnaire along with the Summer 2001 Newsletter. There were nearly 400 replies more than half of which had extensive comments. The analysis of the questionnaire helped the Committee in organizing a Symposium in the 2002 Canadian Surgery Forum entitled “Waiting List - Management, Legalities and Ethics”. At the same meeting there was a poster prepared by the Committee giving a detailed analysis of the answers to the questionnaire.

The Committee was interested in so-called “peer review of lawsuits”. For some years there had been a program in Alberta developed by the Alberta Medical Association whereby a physician who is sued could be “budded” with a senior colleague who had been through the mill more than once. An interesting fact emerging from the Alberta program was that virtually no surgeon is sued solely on the basis of incorrect or inappropriate procedures or even lack of continuing medical education. Of much greater importance is communication with the patient, good rapport, good bedside manner and timely and accurate documentation.

In the year 2002 the CMPA increased the dues for general surgeons in Ontario by 15% and it seemed likely that they would increase by 15% per year for the next two years. The Pritchard Report had not led to any
tort reform. Meanwhile the Ontario government were undecided about covering CMPA dues for Ontario physicians. Although they did accept the concept of funding CMPA dues, the question was for how many years or in perpetuity. The Provincial Government and the Federal Government realized that if the CMPA failed in Ontario the entire organization would collapse. The Ontario Medical Association had looked into the possibility of switching to private insurance but none of the companies could match, even closely, the service provided by the CMPA.

Australia has no private coverage for medical malpractice and the Government now bears the cost entirely. In the United States where private coverage flourishes, malpractice insurance in many States is in crisis. Interestingly, since California introduced tort reform the dues demanded by private companies have decreased and are now in the same range as those in Canada.

2001 saw the introduction in Quebec of a trial initiative between the profession and the Minister of Health to introduce compulsory declaration of complications and medical errors with a penalty for not doing so combined with a no fault legal system.

How things will work out in the Medical Legal field over the next 25 years is anyone’s guess but, come what may, the Medical Legal Committee will continue to make an important contribution in educating surgeons.
Early in 1988, Marvin Wexler, Montreal, and CAGS Secretary, received a letter from Jonathan Meakins, Montreal, strongly urging CAGS to become involved in critical care and advocating that the Association should strike an appropriate committee. Later that year at the September ’88 meeting of the Board, Dr. Stewart Hamilton, Edmonton, was asked to attend the Board meeting as a representative of the Critical Care Society. Critical care was one of the disciplines selected by the Royal College for the pilot project of “Accreditation Without Certification”. The guidelines had been approved by the Royal College and involved two years of further training which could include one year of critical care training or its equivalent in the basic specialty. The Canadian Critical Care Society represents many specialties including physicians and surgeons in many subspecialties, anesthesiologists, pediatricians and also representatives from several non-medical groups; it closely resembles the Trauma Association of Canada in its organization. Stewart Hamilton pointed out that there were factions within the Critical Care Society that were pushing for two years of further training in addition to the basic specialty training which would present difficulties for surgeons.

In September 1988, the CAGS Committee for Critical Care was struck with Stewart Hamilton as the Chair. By the year 1990 the Royal College Specialty Committee for Critical Care Medicine was functioning although no program surveys had been conducted. The Royal College Committee for Critical Care was adamant that no training before the R3 level in a primary specialty should be considered acceptable towards the requirements for training in Critical Care Medicine. Nevertheless in actual practice rotations in Thoracic Surgery, Cardiovascular and Thoracic Surgery or on a surgical unit with a high proportion of tertiary care patients were being accepted. Meanwhile it was considered that a review of all the
Critical Care Teaching Programs from coast to coast would take at least two years to complete. In September 1991, the CAGS Committee on Critical Care was expanded and asked to take on the added responsibilities of surgical infections, surgical nutrition and trauma. This was in an effort to tidy the committee structure of CAGS and group areas of common interest together.

The five year pilot study by the Royal College was ended in 1994. It was evident that in Internal Medicine it was relatively simple to have a third or fourth year in the program considered eligible for Critical Care training. On the other hand, requirements for the final year of training in a General Surgery Program made it difficult for it to be accepted as one of the two years required for training.

In 1993 Stewart Hamilton stepped down as the Chair of the Committee. He had been appointed to the Chair of the Department of Surgery at the University of Alberta. The new Committee Chair was Merv Deitel, Toronto.

Merv Deitel had been a strong advocate in the field of surgical nutrition for many years and he and his Committee organized a Postgraduate Course on Surgical Nutrition for the September 1994 meeting. Although the Postgraduate Course was well planned and well presented, the appeal to the membership was limited and the course incurred a deficit of $4,500. The CAGS Committee also arranged for a half day concentrated course on recent developments in trauma in the September 1995 meeting. Merv Deitel and his Committee were in full support of the TAC Trauma Program Accreditation Guidelines which had been forwarded to the Canadian Council for Health Facilities Accreditation and to the Royal College and approved by both.

By the year 1995 the Royal College Committee for Critical Care Medicine were happy with Accreditation Without Certification even though it called for more vigorous evaluation and detailed review of training programs during the accreditation. There were no plans for a certifying examination. Meanwhile most Canadian Training Programs in Critical Care Medicine had moved to a two year training format irrespective of previous training in the base specialty and it seemed more than likely that, eventually this would also be the Royal College requirement. Training in Critical Care Medicine can take place not only
through Internal Medicine, General Surgery and Anesthesia but tracks were available through Cardiac Surgery, Emergency Medicine and likely at a future date, Neurosurgery and Urology. Pediatrics is the route to Pediatric Critical Care. The trend was away from the general intensivist.

Stewart Hamilton reported to the Board on behalf of the Committee in September 1995. He said that although the Royal College Committee for Critical Care Medicine had expressed their satisfaction with Accreditation Without Certification in 1994, there was now a strong push to make it a “real specialty”. This would then lead to a formal examination and certification. The entry route would be through a complete training in General Medicine, General Surgery, Anesthesia, Pediatrics or Emergency Medicine. Thoracic Surgery had applied but not Cardiac Surgery. Urology was turned down. Looking back over the years this development was probably inevitable from the beginning. The CAGS Committee then lapsed into a period of reflection and reconsideration.

David Evans, Montreal, was appointed to the Chair of the Committee in September 2000. He told the Board that the CAGS Committee on Critical Care/Trauma/Infectious Diseases/ Nutrition had three objectives.

1. To facilitate Continuing Medical Education in these various disciplines. They would form important parts of the Surgery Forum Program either as Postgraduate Course or perhaps better as Symposia.

2. To optimize the critical care training of residents in General Surgery Programs and the surgical component of Critical Care Fellowship Programs.

3. To promote the discipline of Critical Care among general surgeons. General surgeons doing critical care work spend on the average 12 weeks per year in the discipline. There is room for an expanded role for surgeons in the Canadian Critical Care Society. While there is a general feeling that critical care is well remunerated, the same is not true for trauma care.

The concept of Critical Care units developed in the 1950s and early 1960s when efficient automatic ventilators to maintain respiration
became available. The units were usually in the charge of pulmonologists or anesthetists and later internist and surgeons became interested. This proved to be an efficient way of allowing patients with serious co-morbidities to survive major operations. The idea was much less successful in enabling patients to survive operations that developed complications. Some maintained that the advent of critical care could even be harmful. While it was certainly a convenience for surgeons when their ailing postoperative patients were moved to a Critical Care Unit, it made it much more difficult for surgeons to fret, worry and bleed along with the patients and their families. The medicolegal implications are obvious as the many participants did not necessarily read from the same page.
During the first 25 years of CAGS existence, nearly half of all the research prizes given to surgical residents concerned some aspect of transplantation. Nevertheless, practising general surgeons were not particularly interested, especially in the earlier years.

In September 1984 the CAGS’ Board received a letter from R. D. Guttman, Montreal, the Director of Transplantation at McGill University and Nestor McCallum, Ottawa, at the Royal College, regarding the development and organization of special training in transplantation surgery. The letter went on to point out that as transplantation moved into full swing in many areas, there was a fundamental core of knowledge that applied to all types of transplantation and it was important that surgeons and physicians receive some rational form of education and clinical experience in the field. Simply defaulting on the matter and leaving organ transplantation to individual subspecialties was perhaps not the best plan and the letter wondered if CAGS had a position on this matter. The Board strongly supported the development of standards of training in transplantation but felt that this should be done by the Royal College. The CAGS Board did not favor a Certificate of Special Competence in Transplantation.

Renal transplantation starting in the late 1950s was firmly in the hands of urologists with very few exceptions. Similarly, cardiac transplantation, starting in the late ‘60s and early ‘70s, was the work of cardiac surgeons. But when liver, pancreas and small bowel transplantation became possible with good success, the CAGS Board felt that the time had come to establish a Transplantation Committee and did so in September 1998 with Allan MacDonald, Halifax, as its Chair. Allan MacDonald had been a member of the CAGS Board in various capacities off and on since the beginning. Whenever he had
an opportunity he made a plea for more interest in transplantation and he was a natural choice as the first Chair. His quiet but wise and cogent remarks at Board meetings were always listened to intently by the members.

Overall control of transplantation in Canada, at the end of the 1900’s, was firmly in the hands of physicians and immunologists. On the other hand in the United States surgeons took a leading role from the beginning. In the United States transplantation has proved to be a very profitable source of income for hospitals whereas in Canada hospital administrators viewed transplantation as a large consumer of scarce resources. Allan MacDonald said that in 1998 a select committee of the House of Commons considered the state of organ transplantation in Canada. They concluded that Canada has the worst record in the West for organ transplantation and does not have enough transplantation surgeons, again in contrast to the United States.

Successful transplantation depends on many things — appropriate matching between donor and recipient, careful organ retrieval and preservation, accurate installation with good arterial supply, venous drainage, the necessary arrangement for secretions, the intelligent use of immunosuppression and good patient follow up. Although there have been many technical advances the real success of transplantation has resulted from advances in genetics, immunology and the development of immunosuppressive drugs.

Allan MacDonald gave another review to the CAGS Board in February 2000. He pointed out that organ donations in Canada are 14 per million, in the United States it is 24 per million while in Spain it is as high as 35 per million population. Advances in immunosuppression have reduced rejection to as low as 2%. The cost of patients on dialysis is three times of that of those who receive a kidney transplant. In 2000 renal dialysis amounted to 1.3% of the total health budget and was projected to increase to 2.5% by 2004. One important reason for the low donation rate in Canada is insufficient beds in Intensive Care Units to resuscitate patients from emergency departments. In Canada transplantation continues to struggle with global budgets and competes with other disciplines for funding. In the United States funding is successfully dedicated to transplantation programs.
The CAGS Transplantation Committee carried out a survey of transplantation in Canadian Medical Schools. Many of their findings were not unexpected. Heart transplantation is incorporated into the daily activities of cardiac surgery while lung transplantation is either combined with the heart in cardiac surgery or on its own in thoracic surgery. Where kidney transplantation is the only transplant procedure carried out, it lies within the Division of Urology. No Canadian program has any involvement of surgeons in the teaching of clinical transplantation to undergraduates. Allan MacDonald extolled the value of multi-organ retrieval as a superb surgical experience for teaching surgical anatomy and general surgical competence. However no program has a formal rotation for General Surgery residents on any transplant service. His Committee strongly recommended that where multi-organ transplant programs exist, training rotations for General Surgery residents should be organized.

The question of rotations in transplantation surgery was discussed by the CAGS Education Committee and the CAGS Board. It was agreed that such rotations should be elective particularly as multi-organ retrievals tended to occur in the early morning hours. In the CanMeds 2000 rewrite of the Objectives For Training in various aspects of General Surgery, the items are classified as either to “be expert in” or “have knowledge of”. Transplantation falls into the second group.

By the end of 2002, the Royal College Specialty Committee for General Surgery formally recognized the importance of transplantation and endorsed the guidelines for training produced by the CAGS Transplantation Committee. The Committee continued to press for training programs to encourage experience in transplantation. Only McGill formally corporates transplantation into residency rotations but even there the senior residents are often bumped by Transplantation Fellows. There is no Canadian program in which Urology residents are not exposed to kidney transplantation.

Once again, a young CAGS Committee had made its mark with some success.
THE CAGS COMMITTEE ON SURGERY IN THE DEVELOPING WORLD

All physicians hold ideals. Most of them think about them, many generously contribute money towards them, a few write about them but only a small number actively get involved. After graduating in Medicine from UBC, Dr. Ron Lett and his wife spent a number of years working in African Mission Hospitals before completing full training in General Surgery at the University of Alberta. This had included one year of research on schistosomiosis at Michigan State University. After entering practice he formed the Canadian Network for International Surgery as a charitable organization with its headquarters in Vancouver, the Governor General as its patron, a dedicated group of interested surgeons from coast to coast and a very valuable group of lay members that make regular contributions.

The objective of CNIS is to teach basic surgical skills to health care workers in the remoter areas of Africa where such help does not exist. Interested surgeons are encouraged to spend a few weeks in Africa giving the appropriate instruction. There are now a number of centres in Ethiopia and East Africa where these courses are given and received with enthusiastic support from the local medical schools, surgeons and governments. Ron Lett is to be commended for his tenacity and effort in establishing CNIS and making it a success.

Meanwhile a number of Canadian surgeons had regularly spent weeks or months in the Third World instructing and helping to provide surgical services; most of these were personal projects.

In 1997, Julius Stoller, Vancouver, Secretary of CAGS, aware of the good work that Bob Taylor, Vancouver, had done in Africa and Central America for many years, persuaded Bob to give serious thought to organizing a CAGS outreach program to help develop surgical services in the Developing World.
Bob Taylor’s proposal was favorably considered by the Board and led to the establishment of a CAGS Committee on Surgery in the Developing World to be chaired by Dr. Taylor. The winter CAGS Newsletter in 1999 carried a detailed account of the CAGS initiative and led to responses from 17 surgeons in Canada, 12 of whom had prior experience in the developing world.

The Committee decided on two initial projects selected on the basis of Bob Taylor’s previous experience and subsequent correspondence.

1. St. Mary’s Hospital, Gulu, Uganda.

The hospital in Gulu was founded by the Italian Holy Order of The Carboni Brothers and is presently owned and run by the Order. An Italian pediatrician, Dr. Piero Corti, was a member of the staff of the Gulu Hospital. He was in Montreal for further postgraduate training when he met a Canadian surgeon, Dr. Lucille Teasdale, and persuaded her to move and work at the Gulu Hospital. They happily married and worked together at the Mission where Dr. Teasdale’s work received universal acclaim. The story has a sad ending as Dr. Teasdale contracted HIV from a needle stick and eventually died in 1996. She was awarded a posthumous Order of Canada in 1997 and a Canadian stamp was issued in her honour in the year 2000. Gulu lies in the northern part of Uganda in an area of incessant fighting between rebels and government and in addition has a large camp of refugees from Southern Sudan close by. The hospital has 500 beds and two certified surgeons on staff. They perform over 3,000 major surgical operations a year and would welcome any form of partnership with CAGS.

2. The McKenzie Hospital, Linden, Guyana

The hospital was originally built by an aluminum company for its employees. When the company closed down its business the hospital fell into relative disuse and disrepair. The hospital has 125 beds with a large outpatient department and two operating rooms. Linden lies about 100 miles south of Georgetown, the capital of Guyana where the University established a Medical School in 1984. The original plan proposed by the Committee and the Georgetown University was to develop a surgical training program in the Medical School and to use the hospital in Linden as a teaching facility.
Bob Taylor visited both these centres in the year 2000 and came back to give a promising report to the Board. By the year 2000 Eric Webber, Vancouver, had spent a very productive time in Gulu and several other surgeons were lined up for subsequent visits.

John Kraulis, Chatham, visited Linden. It was apparent that some strategic planning and changes are required before there is another visit. Furthermore arrangements with the University of Guyana Medical School have made slow progress.

These reports illustrate the ease of working with an established Mission as compared to government hospitals and universities.

Bob Taylor arranged for CAGS to become an organizational member of CNIS. While there were many ways in which CNIS and CAGS could help each other, there was also a financial advantage. CAGS surgeons traveling to Gulu or Linden are able to channel their traveling and other expenses through CNIS as charitable donations.

By the end of the year 2000 the CAGS Liaison Committee for Surgery in the Developing World had made a very good start under the able chairmanship of Bob Taylor and the future augured well.
Surgical oncology was first discussed at the CAGS Board meeting in February 1984. At the time, the Royal College already had a Certificate of Special Competence in Medical Oncology based on further training and examination. CAGS Board members felt that a surgical equivalent was desirable although they thought that having a Certificate of Special Competence in Oncology to include both surgical and medical disciplines might be easier to achieve; while the training would differ in the different specialties, there would be a common body of knowledge. Allan MacDonald, Halifax, with his usual wisdom, doubted if there were many surgeons who had an in-depth knowledge of tumor biology, basic oncology research, the organization of clinical trials, all forms of adjuvant therapy and a comprehensive knowledge of all methods of treating malignant disease.

The Board agreed that, although special people are required, this did not necessarily imply a special certificate. In fact the American College of Surgeons was quickly moving away from limited special certification and the Royal College was having second thoughts. Denis Bourbeau, Montreal, and his Education Committee were asked to discuss the matter and come up with a position paper.

This led to the setting up of a CAGS Committee on Surgical Oncology with Henry Shibata, Montreal, as the Chair and members from across Canada. Reporting to the CAGS Board, Henry Shibata said that although general surgeons are members of a multidisciplinary team, they must be engaged in the followup of their patients instead of abrogating their responsibilities to cancer centres. He said that a certificate indicating special training is becoming more and more necessary in the job market. They were not in favor of a Certificate of Special Competence in Surgical Oncology but they did...
accept the general concept of special training in Surgical Oncology. They also advocated that trainees in Surgical Oncology in Canada should be encouraged to spend time in more than one centre in order to develop a broader outlook. The Committee then went on to develop guidelines for training programs in Surgical Oncology which were interpreted by the Royal College as guidelines to accredit training programs. Personnel changes at the College added some additional confusion.

Meanwhile the Royal College had embarked on a pilot project to assist emerging specialties to develop training requirements and gain program and trainee accreditation without certification through examination. One year of the special training could be completed while a candidate was still in the basic specialty training program provided the Program Director was aware in advance of the ultimate goal.

In September 1987 the inaugural meeting of the Canadian Society for Surgical Oncology was held with 45 invited interested surgeons present. Henry Shibata was elected the first President. The aim of the new Society was to foster Oncology training in University centres, to encourage the role of general surgeons in multidisciplinary teams, to provide optimum care to patients and to cooperate with organizations including the Royal College, CAGS and the Canadian Oncology Society to accomplish this.

The initial submission from the CAGS Committee to the Royal College which included the guidelines for training in Surgical Oncology and steps to achieve Accreditation Without Certification was turned down by the College as it did not comply with all their guidelines. In fact it seemed that the Director of Training Evaluation at the Royal College was under the impression that CAGS support’d Certification of Special Competence rather than Accreditation Without Certification. It was hoped that the revised brief, although arriving somewhat late, would be acceptable.

A year later the whole matter was still under discussion by the Royal College. Meanwhile the Canadian Society for Surgical Oncology was a going concern and had assumed the role of representing Surgery within the Canadian Oncology Society. CAGS hoped that Dr. Shibata
would influence the Royal College to recognize General Surgery Oncology but failing that, CAGS would support Surgical Oncology to include all surgical disciplines. Most of the members of the Canadian Society for Surgical Oncology were general surgeons. Orthopedic surgeons and urologists were open minded but the otolaryngologists were firmly opposed.

After much effort by the CAGS Committee for Surgical Oncology the Royal College finally accepted Accreditation Without Certification for Surgical Oncology within General Surgery as a part of their pilot project. The Chair of the Specialty Committee for Surgical Oncology would be a member of the Royal College Specialty Committee for General Surgery. There were four other members from General Surgery and representatives from Medical Oncology and Radiation Oncology. The Royal College Committee set up guidelines and objectives for training. There would be two years of additional training although one of the five years of training in General Surgery might be acceptable. The two years would consist of one year of Surgical Oncology, three months of Radiation Oncology, three months of Medical Oncology with six months of elective time. At this time, Wally Temple, Calgary, had taken over as Chair of the CAGS Committee from Henry Shibata. It was early 1992 before the Royal College finally approved Accreditation Without Certification for Surgical Oncology.

Over the next ten years the Chair of the CAGS Committee in Surgical Oncology passed from Wally Temple to John MacFarlane, Vancouver, to Hartley Stern, Ottawa and David McCready, Toronto. The hard work in goading the Royal College to approve Accreditation Without Certification for Surgical Oncology was now complete. By 2002 there were three fully accredited programs at McGill, U of T and U of C with six funded positions. There were never sufficient applications to fill all the training spots. Although there was an increasing demand for surgical oncologists on both sides of the border, Medical and Radiation Oncologists were increasingly dominant in dictating care.

During this period of consolidation the CAGS Committee for Surgical Oncology was busy cooperating with the CAGS Program Committee in arranging Postgraduate Courses and Symposia.
By 1995 the Canadian Society for Surgical Oncology had 117 members and all the surgeons who had been Chairs of the CAGS Committee on Surgical Oncology had also chaired the Canadian Society. CSSO is affiliated with the Canadian Oncological Society which has representatives from Medical Oncology and Radiation Oncology and they all get together under the auspices of the National Cancer Institute every April. This meeting also provides an opportunity for the various groups to hold annual business meetings.

The CAGS Committee for Surgical Oncology has been effective in securing official recognition of the work of general surgeons in cancer care, in helping to establish three training programs in Canada and in its ongoing efforts to keep Canadian general surgeons informed about advances in cancer treatment.
The first sign of impending problems with the Canadian Journal of Surgery was a report to the CAGS Board in October 1980 by Richard Railton, Welland, who was both the CAGS Treasurer and the representative to the Canadian Medical Association. He said that at the 1980 Annual Meeting of the CMA there was a question from the floor that criticized the Board of CJS for a deficit of $7,000 in 1979 and deplored the fact that the Journal was not selfsupporting. In reply the Executive Director of the CMA explained that CJS is owned and published by the CMA and that the deficit was diminishing each year.

The CMA owns a number of medical journals including the very profitable CMAJ. CJS was financed by grants from the CMA and the Royal College and from advertising. As more and more surgical journals were being launched, many with large circulations, it became more difficult for CJS to attract advertisers. Furthermore many nonsurgical members of the Royal College and the CMA believed that supporting CJS was not appropriate use of their annual dues.

The Editorial Board of CJS had been aware of financial problems for many years. In 1978 Lloyd MacLean, Montreal, co-editor of CJS with C. Barber Mueller, Hamilton, had appealed for financial support from all the Canadian Surgical Departments. However by the time the funds were forth-coming, a further review of the financial position did not warrant accepting these monies; this supported the statement by the Executive Director of the CMA.

The trump card of CJS was the fact that it was an indexed publication in the Cumulative Index Medicus. Should CJS cease publication because of lack of funding and then start up again later
with new financing, it would have to reapply for indexing and this would be virtually impossible to achieve.

The arrangements for the financing of CJS continued unchanged for a number of years. Each year questions were asked at the CMA Annual Meeting and the Royal College Council and the showdown was getting closer. In September 1984 the Board of CAGS reaffirmed its support for the *Canadian Journal of Surgery* and even urged its editors to push for monthly publication.

In late 1984 the Royal College announced that abstracts from its annual meeting would be published in a single issue of *Clinical and Investigative Medicine* at a charge of $30 per abstract. This did not go down well with the CAGS Board. They wished to have the surgical abstracts published in the *Canadian Journal of Surgery* and they were upset that the change was made without any prior consultation. The position of CAGS was very clearly spelled out by Marvin Wexler, Montreal, the CAGS Secretary, in the ensuing correspondence with the Royal College. If matters could not be worked out to the satisfaction of CAGS, then it might be forced to withdraw its participation in the Royal College annual scientific meeting. Nevertheless the College remained adamant that all abstracts accepted by the College (whether or not they were accepted by CAGS) were to be published in *Clinical and Investigative Medicine*, could not be published elsewhere and that there would be a processing fee for publication.

The Royal College did unbend slightly. The $30 “processing fee” was only obligatory if the author wishes to have the abstract published. If not, then there would be no fee but the abstract could still be considered for a paper presentation. The Royal College was anxious to avoid having abstracts published in two locations and if CAGS was accommodated, other specialties would soon request a similar option. In February 1986 the CAGS Board considered the whole matter at some length but was unable to come to a decision and merely asked for Marvin Wexler to make further representations to the College. A letter from the College suggested that CAGS was not expressing the views of general surgeons across the country but only the Executive; as it turned out, the majority of general surgical authors had in fact paid the fee to the Royal College.
Evidently the time had come for representatives of the Royal College Executive and the CAGS Executive to meet and resolve these issues. The result was that CAGS ended up with an agreement with CJS to have the general surgery abstracts published as “tear sheets” in the centre of the July 1987 issue of CJS. These would be over printed and made available at the annual meeting for those interested and were not receiving CJS. The cost would be approximately $900. and the Board considered this worthwhile. The $30. processing fee for accepted abstracts would go to CJS and not CIM. This result was a tribute to Marvin Wexler’s tenacity.

Financial matters came to a head in September 1989. The Royal College announced it would withdraw its subsidy for CJS over a period of three years. Also the CMA were no longer prepared to cover any deficits and unless some means could be found to raise $70,000 per year by August 1990, publication of CJS would cease. If the matter were left to CAGS alone it would mean a contribution of $60. per member per year. There was general agreement by Board members that every effort should be made to save the CJS by establishing a consortium of surgical specialties that would enter into an agreement with the CMA.

Jean Couture, Quebec City, President Elect of CAGS, was asked to look into the matter and report back in February 1990. The Board felt that CAGS members would support a subscription fee of $25 to $30 added to the annual dues provided the majority of other surgical specialties were equally supportive. Jean Couture reported back in February 1990. He said the Royal College support would end by 1992 and that the CJS deficit in 1989 was just under $100,000. The CMA published three other medical journals and the Publication Department as a whole was making a profit contrasting with the loss on CJS. There was also strong possibility that the CMA would drop CJS at the next annual meeting even if a satisfactory funding formula could be worked out.

Jean Couture had some success. The Cardiovascular and Thoracic Society and the Vascular Society agreed to help. The Canadian Orthopedic Association, the Plastic Surgeons, the Neurosurgeons, the Canadian Association of O&G and TAC all refused. There was no response from the Urologists. The CAGS Board agreed that Jean
Couture’s efforts should be supported and he was empowered to take whatever steps that were necessary up to a contribution of $75 per year from each Active member of CAGS. Meanwhile the Canadian Society for Surgical Oncology had joined CVT and the Vascular Society to support CAGS. But most of the members of these societies also belonged to CAGS and would be unlikely to agree to making two contributions.

A special meeting of the National Surgical Specialty Societies with the CMA and the Royal College in February 1990 recommended that the Royal College consider supporting CJS through a specifically requested voluntary subscription of $25 per year from the Fellows of the Division of Surgery who are not members of CAGS or the three supporting societies. They would be sent a separate invoice from the College accompanied by a personal appeal by the President, Jean Couture. The Council of the College voted against this plan.

It then transpired that some reorganization in the CMA Publications Department and improved advertising revenues for CJS had reduced the CJS deficit very significantly in 1990. The CAGS Board then agreed to increase the annual dues from $100 to $125 to provide the extra funds to support the journal.

A year later the Board heard the good news that the four supporting societies for CJS were now being joined by COA. Originally the COA had been anxious to establish its own journal or to attain a designated segment in the journal of Bone and Joint Surgery. This had not worked out and they therefore decided to support CJS. The CMA remained the owners of CJS but the editorial structure was reorganized so that the supporting societies had proper representation. Compared with the doom and gloom that pervaded discussions in 1989, the future of the Canadian Journal of Surgery seemed assured.

For the next five years there were no further financial developments. CAGS contributed $35,000 per year towards CJS. CAGS received an invoice in January and CJS agreed this could be paid in June or July after the first dues notices for the year had been sent out. The problem was that each year a different person in the CMA Publications Department was in charge of CJS affairs so that each year this concession had to be re-negotiated. Also the CMA legal department insisted that
CAGS sign a legal document confirming its financial support for CJS whereas CAGS simply maintained they were only buying subscriptions; these documents were never signed.

The new editors for CJS, appointed in 1992, were Jonathan Meakins, Montreal, and Roger Keith, Saskatoon. The CJS Editorial Board had been informed that from 1993 to '96 CJS had been running a deficit of $30,000 a year. This was largely due to the decision of the Canadian Orthopedic Association in 1993 to withdraw its official support for CJS and make any contributions from its membership voluntary and also the fact that advertising revenues were declining as was the case with all scientific journals, especially those with small circulations. CAGS members were contributing $25 per year for CJS amounting to a little over $4 per issue. CAGS was informed that if they were prepared to double the contribution to $50 per year then the publication of CJS would continue. CJS is one of only three Canadian medical journals that are indexed and any break in publication would lose this privilege. It is the only Canadian avenue for surgical publication and has enjoyed favorable reviews in independent audits. The CAGS Board considered the options. Taking over the ownership from the CMA and publishing it independently would involve borrowing at least $200,000 as start up costs; it would be very risky. It was therefore agreed that CAGS members would be asked to increase their subscription from $25 to $50 per year increasing the annual dues from $125 to $150. This could not be put into effect until May 1997 after approval at the 1996 annual business meeting. The plan was to make a contribution of $35,000 in January 1997 and a similar sum later in the year. Needless to say, this put a severe strain on the finances of CAGS.

In late 1996 Roger Keith stepped down as one of the co-editors to be replaced by Jim Waddell, Toronto. Jim Waddell was the chairman of the Department of Orthopedic Surgery at the U of T and was the incoming President of the Canadian Orthopedic Association. There was every hope that this would lead to more enthusiastic support by COA.

So by February 1997 it was apparent that the annual contribution from LAGS to CJS might be in the region of $70,000 with the prospect of an additional $18,000 if the Journal was sent to general
surgery residents. Bill Mackie, Edmonton, CAGS Treasurer, explained that each year for the past four years the CAGS reserve fund had decreased by more than $10,000 and this could not continue. The invoice from CJS for 1997 came to $61,000 and this would wipe out the Association’s reserves.

At the Board meeting in February 1998 the whole matter was carefully reconsidered. From 1992 to 1996 the contribution from CAGS to CJS was a little over $30,000 a year. Unfortunately the increase from the $25 to the $50 contribution from CAGS members had not produced the expected increase in revenue, but had increased the number of members that were delinquent in paying their dues. If members did not pay their dues after the second mailing notice, they would still remain on the Active list for several months until they received letter from the Treasurer. Naturally this led to differences between the CJS list of CAGS members and the list in the Secretariat of paid up Active members. Bill Mackie made strenuous efforts to try and reconcile the two lists and with the full cooperation of all parties this was achieved late in 1998.

But this did not help the Association to settle its $61,000 bill with CJS. However an odd thing occurred with the receipt of the 1997 invoice. Enclosed with it was a financial statement for CJS for the 1996 year showing that CJS had made a modest profit over that year despite the loss of funding from the Royal College. It was therefore decided that CAGS should negotiate with CJS and to send a cheque for $30,000 forthwith with a promise to pay another $10,000 in June. All Board members felt that this was a reasonable settlement for the year 1997. The cheque was forwarded with the request that the CMA review the correspondence over the last ten years and that their large Legal Department be reminded once again that the relationship between CAGS and CJS was simply understanding to purchase subscriptions and not a binding contract.

In the Spring of 1998 the Canadian Orthopedic Association under the leadership of Jim Waddell, Toronto, the new President of the COA and a coeditor of CJS re-established their official support for CJS and contributed $25 per year per member. This was increased to $35 per member in 1999 onwards. The CAGS invoice for 1999 was down to $36,000 with a request to sign a binding legal contract which was again
declined. The crisis was averted once again. The Board also agreed that members who are more than two years late in paying their dues would no longer receive the Journal and would get a letter of explanation pointing out that when their dues were paid up they would go back on the CJS list.

From 1992 onwards the Editors and the Editorial Board of CJS were anxious that some means be found to finance the sending of CJS to third, fourth and fifth year general surgery residents. The estimated cost varied from $10,000 to $18,000. Funding this from the CAGS treasury was impossible during the critical years of negotiation. In February 2002 Bill Mackie was able to negotiate a price of $20 per year for CJS subscriptions for the RIII, RIV and RV general surgery residents. The cost was to be covered by the grant of $5,000 a year for two years from Merck Frosst with a likely extension for a number of years afterwards. The Journal would be delivered to their home addresses in a plastic envelope with the compliments of Merck Frosst.

CAGS can be justifiably proud of its role in maintaining the continued publication of CJS in spite of all the financial problems. With the support of all Canadian surgeons and enlightened work by the Editors and the Editorial Board, the Canadian Journal of Surgery should have a bright future as a unique interdisciplinary surgical publication.
Prior to the CAGS inaugural meeting in June 1977, Neil Watters, Don Wilson, Irv Koven, and Bernie Langer, all of Toronto, met to convene as a Nominating Committee to present a suitable list of general surgeons for the Executive and the Board of the new Association. With Bernard Perey, Sherbrooke, President, E. Bruce Tovee, Toronto, President Elect, Richard Railton, Welland, Treasurer, all from the East, the Secretary had to be from the West. It would be advantageous if the Secretary had access to good secretarial support and even better if virtually the whole cost could be quietly shouldered by a University surgical department without any fuss or bother. Tom Williams, who had recently been appointed Chairman of the Department of Surgery at the University of Alberta, was asked to accept the position and he agreed. Dorothy Stark, the recently appointed secretary to the Department of Surgery at the U of A, with her common sense, energy, efficiency and accuracy was largely responsible for giving the Association a good start.

Membership rose quickly. Those who had joined CAGS in June 1977 were asked to encourage their colleagues to join. All those listed as general surgeons in the Canadian Medical Directory were sent an application form and a covering letter from the President. Within a year the total membership had risen to 712 and there was $27,000 in the bank account. By October 1979 the total membership was 967 of which 95 were Senior members, who do not pay annual dues. The CAGS assets had risen to $43,000.

On reflection, it is interesting that the number of Active members increased by less than 5% over the next 20 years. The figures represent a balance between members who died or achieved senior status and the young surgeons who entered practice. These figures
would be much less satisfactory were it not for the efforts of several CAGS secretaries and membership committees and three secretariats during that period. Detailed studies in the smaller provinces have shown that no more than 60% of general surgeons listed in the Canadian Medical Directory were in active general surgical practice. About 10% of general surgeons in active practice are not members of CAGS; some of these refuse to join anything on principle, others procrastinate indefinitely and the third group consider CAGS to be an ivory tower organization run by University surgeons for their own edification.

In 1981 CAGS was approached by Mr. Gerry Nason, Toronto, who headed a management company that specialized in looking after the affairs of national organizations. He had previously been the permanent secretary of the Canadian Ophthalmological Association and had a excellent reputation which was confirmed by several inquiries. Nason and Associates also managed the affairs of several organizations in Ontario including the Ontario Teachers Association. The office on Bloor Street was well equipped with the latest computers and word processors. Furthermore they were able to conduct business in either English or French with equal facility. A sum of $5,700 plus expenses per year was quoted for the CAGS business. The Board, meeting in February 1982, agreed to this proposal as it would free the Association for having to appoint a secretary who had easy access to University secretarial facilities. A contract was duly signed.

Nason and Associates started working for CAGS in February 1982 but by March 1983 it was evident that they had under-estimated the initial quote. For the year starting in March 1983 the quote was a little over $10,000 which the Board accepted.

In September 1983 Tom Williams had completed his two three year terms as Secretary of CAGS. There had been several informal discussions between members of the Executive and the Chairman of the Nominating Committee and all agreed that the next Secretary should come from McGill University. With the informal approval of Lloyd MacLean, Marvin Wexler was selected. He was well known from coast to coast and had played a prominent role in all the CAGS scientific meetings. A year previously, Jean Fauteux, Montreal,
accepted the position of President Elect on condition that the Board agreed to Tom Williams continuing as Secretary for one extra year. The result was that in September 1983 Marvin Wexler was appointed Secretary Elect and Tom Williams Secretary for a seventh year.

The cost of the contract with Nason & Associates had increased from $10,500 in the year 1983/84 to $15,500 in the year 1984/85. The original contract was drawn up on a basis of 60 hours of office work but in fact 100 hours had been billed. There was also a 6% increase for the inflation of overhead costs. This new agreement was agreed to with some reluctance.

Meanwhile the financial position of CAGS had deteriorated significantly. At the end of December 1983 it had a deficit of just under $1,000. Two members of the Executive loaned $7,000 to the Association to cover the gap in cash flow. The unsatisfactory financial position of CAGS was largely due to two factors — the engagement of Nason & Associates, Toronto, and the increasing costs of Board meetings at the time of very significant national inflation. At the suggestion of Bill Onerheim, Red Deer, Treasurer, the Board agreed that the membership year be changed from the calendar year to coincide with the CAGS fiscal year which was July 1 to June 30. This meant that members received two invoices in 12 months with the dues remaining at $75. This would solve the cash flow problem as the heaviest expenses occurred during and after the annual meeting in September. The additional dues notice was sent out with a letter of explanation and, strangely enough, there wasn’t a single complaint. The financial crisis had been avoided.

The Board agreed to change Mr. Nason’s title from “Coordinator, CAGS Secretariat” to “Executive Director”. The Board also agreed to hire Nason & Associates to carry out a review of their financial, administrative and planning functions of CAGS at the rate of $500 a month for one year, to be reviewed in 12 months. The Executive Director was added to the list of current CAGS officials (President, Secretary and Treasurer) who were authorized to sign cheques. The signature of only one of the four would be required for cheques up to $1,000 and two signatures for cheques over $1,000. In February 1987 Marvin Wexler reported to the Board that the services of Nason & Associates in the year 1986 / 87 had been exemplary and as a
result the Board approved the 1987 / 88 contract. However Nason & Associates announced to the Board in February 1988 that they would be going out of business and closing their Toronto office at the end of August 1988. It was agreed that management services would continue until the end of August at the same rate as the previous year.

The Board discussed the options:

1) Hiring a new management firm.

2) Providing a full time secretary for the CAGS Secretary’s office.

3) Hiring a former officer to assume the role as a paid Executive Director. It was agreed that Tom Williams would be approached to consider this. If he did not agree, a firm in Toronto or Montreal would be sought to replace Nason & Associates. Meanwhile the annual dues were increased from $75 to $100 effective in June 1988.

Bernie Langer, President, was asked to explore the possibilities. After some discussion Tom Williams agreed to take over the duties of Nason & Associates with similar contract for managing CAGS but at a much reduced cost for managing the Research Fund. As it happened, Dorothy Stark, who had risen in the ranks to become the Administrative Professional Officer of the Department of Surgery, University of Alberta, had taken early retirement. She agreed to set up the Secretariat at her home in Edmonton. It is much to Dorothy Stark’s credit and a testimony to her efficiency that she continued to serve CAGS for the next 15 years without any increase in salary. The new arrangement in Edmonton was similar to that of the International Society for Surgery who engaged Professor Martin Algower, a well known retired general surgeon, as its Secretary General in 1981, moving the office from Brussels to Basle, Switzerland. (The ISS has approximately 3,000 Active members and membership includes a subscription to the World Journal of Surgery). The new Secretariat managed the routine affairs of CAGS over the next 15 years with a reasonable efficiency. The main problem was the very large call on CAGS funds to support the Canadian Journal of Surgery. But by the end of the century these difficulties were over.
During the year 2000 it became obvious that the life of the Secretariat in Edmonton was coming to an end. Both members of the Secretariat felt it was time for them to move on and the Board agreed. One solution would have been to arrange a similar system to that which existed in Edmonton somewhere else in Canada. Around the same time the Royal College Office for National Specialty Societies asked if they might make a proposal to manage the affairs of CAGS. Consequently in February 2001 the Executive met with Mary Dallimore and received a well thought out proposal but the cost was double that of the Secretariat in Edmonton. No decision was made at the time.

The Royal College announced in 1999 that it would no longer invite National Specialty Societies to hold their annual scientific meeting along with the Royal College. CAGS had already contracted the Meetings Management Office of the Royal College, to help in the organization of the first Canadian Surgery Forum which was held in Quebec in September 2001. There was every hope that the Surgery Forum would attract significantly more corporate support. It therefore seemed appropriate to accept a less expensive proposal from the Royal College for their National Specialty Society management services. At the end of December 2002 the Secretariat was transferred from Edmonton to Ottawa.
THE CANADIAN SURGICAL RESEARCH FUND

The Fund, originally called the Canadian Fund for the Advance ment of General Surgery (CFAGS), was incorporated on the 24th of August 1983 in Toronto. The first special meeting of the Fund was held in the Westin Hotel, Calgary, on the 18th of September 1983. Those present were: Don Willoughby, Halifax, Jean Fauteux, Montreal, Neil Watters, Toronto, Tom Williams, Edmonton, Bill Onerheim, Red Deer and Dick Railton, Welland. These mem- bers, who were the Executive of CAGS at the time, became the Directors of the Fund. Don Willoughby was elected President, Jean Fauteux, Vice President, Tom Williams, Secretary and Bill Onerheim, Treasurer. Gerry Nason, CAGS Executive Director, acted as the recording secretary. The remaining members of the CAGS Board became the members of the Fund. Gerry Nason was also appointed an officer of the Fund with the title of Executive Director and he would manage the day to day affairs in accordance with policies and instructions. The head office of the Fund was established in Suite 480, 151 Bloor Street West, Toronto, M5S 1T3. Two signatures of four of the following persons would suffice on cheques of the Fund, namely the President, Vice President, Treasurer and Executive Director. The end of the financial year was to be the last day of June and it was agreed that CAGS should provide $5,000 as start up costs.

Gerry Nason was authorized to make application under the Income Tax Act for charitable status. Dick Railton and Neil Watters were to act as the Planning and Development Committee and report in February 1984. Once again the prime mover for getting the Fund underway was Neil Watters helped by Dick Railton and Gerry Nason. Most of the other Specialty Surgical Associations in Canada had established Research Funds to attract corporate donations and tax deductible donations of the membership. CFAGS achieved the status of a tax exempt registered charity in December 1983 with the official
registration number of 0664490-21-13. The registration was back-dated by Revenue Canada to July 8, 1983 to accommodate any funds accumulated since the Fund’s incorporation.

The Canadian Government recognizes three types of charity - private foundations, public foundations and the third group, in which CFAGS belonged, Charitable Organizations. Normally, public and private foundations make donations to charitable organizations which then fund specific projects of their choice. All three groups must dispose at least 80% of their annual receipted income in the following year and no more than 20% can be used for administration without special permission of the Charities Branch of Revenue Canada. In addition to the $5,000 contributed to the Fund from CAGS for start up costs, each member of the Fund was asked to give a tax deductible “lead donation” of $200 immediately, to demonstrate their commitment. Bilingual brochures were prepared and five of these, accompanied by a letter from the President of CAGS, were sent to all CAGS members to help solicit donations from the membership and their patients.

Nason and Associates were engaged for management services for the 1984/85 year for an annual fee of $15,000; this arrangement could be terminated with 30 days notice on either side.

The By Laws were approved in September 1984 and two key committees were struck — the Fund Raising Committee and the Projects Committee. Jack Barrow, Toronto, was appointed to chair the Fund Raising Committee and John Duff, London, the Projects Committee. Jack Barrow was the retired CEO of Sears Canada. He was a personal friend of Neil Watters and the two had discussed the establishment of a research fund over many months.

The mood was still very upbeat when the Board of Directors met in September 1985 in Vancouver. Mr. Barrow said that he and John Ployart, the CEO of Davis & Geck Canada had recruited several important business people to serve on their Fund Raising Committee, and already the committee had raised or had been promised $45,000. Much of this was in the form of unreceipted donations which were especially valuable to the new organization. Mr. Barrow was confident that a goal of $250,000 could be raised in the year 1985/86. This
was broken down to $110,000 from the corporate sector, $15,000 from surgeons, $75,000 from grateful patients and $50,000 from other foundations. Neil Watters had recruited over 100 surgeons from coast to coast who were willing to participate in soliciting donations from their patients. However the financial report for the year 1984/85 showed that the income of the Fund amounted to $30,000; $5,000 was earmarked for research projects but the management costs (including the basic management fee and other additional expenses — photocopying, printing, postage and telephone) amounted to nearly $23,000.

John Duff’s Projects Committee came up with a number of projects, to be funded according to the monies available.

1. CAGS Annual Research Conference in 1986. The first Research Conference was held in 1985 and was a great success. The 1986 Research Conference would take place in June 1986 at the Rocky Crest Resort, Muskoka, Ontario, organized by Max Cohen, Vancouver. This would be funded up to $5,000. Organizers were to be encouraged to secure local corporate donations towards the meeting and CFAGS would make up any difference.

2. CFAGS Research Fellowships from $20,000 to $35,000 per annum. The Fund never had sufficient funds for this item.

3. Seed money for research projects — up to $7,500 each.

4. General surgical achievement awards - up to $5,000. Selection would be difficult and the idea was never really implemented.

Jack Barrow and his Fund Raising Committee, in spite of their initial enthusiasm, had made several appeals to corporations with little success. It was by now evident that if they could not show that general surgeons were enthusiastically supporting the Fund, most corporations would not give CFAGS a second thought. Furthermore, the agreement for the 1986/87 management services was to be at the same high level as the previous year unless there was a demonstrable increase in work load, plus reimbursement for office expenses. To increase the CFAGS income, the CAGS Board, in February 1986, agreed that an additional line on the 1986/87 CAGS dues invoices
would ask for a $50 voluntary donation to CFAGS which would be duly receipted. The $50 voluntary contribution from the membership together with amounts collected by fund raisers improved the financial situation somewhat such that the equity of CFAGS increased from $1,500 at the beginning of the year to $31,000 on June 30, 1986. But this did not take into account the required charitable spending. Revenue Canada agreed that the Fund could have a temporary reprieve on meeting the 1985/86 spending requirements if it undertook to meet both the ’85/’86 and the ’86/’87 quotas by June 30, 1987. In practice this meant that the receipted donations in ’84/’85 and ’85/’86 must be spent on projects by June 30, ’87 making a total of $61,000 of required disbursements, which in turn called for an all out effort to raise the funds. All this added to the mounting anxiety of the CFAGS Directors.

Towards the end of 1986 Neil Watters and Gerry Nason had produced a well written report on the Form, Function and Need for CFAGS, to be used as background information for fund raising volunteers rather than campaign literature.

The targets of the Fund Raising Committee could be broken down into:

1. Patients.
Many surgeons found this difficult to do and very easy to forget. CFAGS was trying to develop this at a time when the majority of hospitals already had very active fund raising projects run by professional fund raisers.

2. Surgeons.

3. Individuals.


5. Foundations, which had so far produced 12 donations totaling $900.

The CFAGS Board agreed that some consideration be given to a change of name so that there would be no misunderstanding that
CFAGS is trying to raise money for general surgeons rather than to advance research and knowledge within general surgery. In February 1987 action was taken to change the name from “The Canadian Fund for the Advancement of General Surgery” to “The Canadian Surgical Research Fund”. This was duly arranged by a Toronto legal firm, Tilley, Carson & Findlay. On the same day, a special meeting of CFAGS was called and a resolution, according to the By Laws, to alter the name of the organization, was unanimously approved.

Early in 1987 the Board was a little more optimistic, but there was a general feeling that the Fund was on a never ending catchup. The Treasurer of the Fund, Denis Bernard, Montreal, warned that the Fund Raising Committee would be required to raise at least $72,000 in 1987 to cover the required charitable spending plus the Fund’s operating costs. It should be noted that the 80% charitable spending quota is based on the previous year’s donations.

A breakdown of the donations from July 1, 1986 to the end of January ’87 showed that out of the approximately $50,000 that was raised, patients contributed $6,500, surgeons $13,000, individuals $11,000, corporations $7,000 and foundations $10,500. The contribution from surgeons through their $50 annual donation was a significant amount and the Board agreed that the $50 charitable donation request along with the dues notices should continue. The Pharmaceutical Manufactures Association of Canada (PMAC) and the Canadian Association of Manufactures of Medical Devices (CAMMD) were being approached to see if they would sponsor Research Fellowships. However approaches to non-medical corporations were on hold until the Fund could show a stable and a more impressive track record. The order of importance for the Fund Raising Committee’s priorities would be — Surgeons, medical corporations and non medical corporations.

In 1986, Jack Barrow stepped down as the Chairman of the Fund Raising Committee and his place was taken by Neil Watters who was also appointed the President of the Fund for a period of three years in order to ensure some continuity. Neil Watters said that another brochure was being prepared to outline how contributions to the Fund could be left in an individual’s will as “living bequests”. These are insurance policies with tax deductible premiums with the Research
Fund as the beneficiary. He said that Jack Barrow had already done this and the Fund was listed as the beneficiary of $125,000 on the life of Mrs. Barrow with premiums to be paid by Jack Barrow or his widow. Meanwhile the basic administration costs had increased from $15,000 to $21,000.

At the next meeting of the Board of CSRF in February 1988, Gerry Nason, the Executive Director, presented an impassioned report. He acknowledged that in 1985 the idea of engaging a professional fund raising company had been discussed at some length. The Board decided against this move on the grounds that, in the short term, it would only significantly increase the financial strain on the Fund. He was unhappy that CSRF was giving priority to soliciting funds from surgeons and their patients to the exclusions of corporations and foundations. He said that hard won momentum gained in the previous year had been lost and that the Fund must learn that, to succeed, it must advance simultaneously on all fronts in its early years. He appreciated the efforts of a number of the Board members and its Fund Raising Committee but without a well planned, well coordinated, well organized and an adequately manned team effort, even heroic measures by general surgeons would not yield any long term results. Nor, regrettably, would they do anything to ensure the Fund’s survival beyond 1988 or 1989. It should be remembered that when the Research Fund was initially established there was every hope that within a few years the fund would have an income of between a quarter to half a million dollars a year at a conservative estimate. Unfortunately that time coincided with the beginning of the down turn in the economy which continued throughout the 1980’s. Jack Barrow and John Ployart had originally been very confident of significant support from the corporate sector but by 1985 they both said it was becoming increasingly difficult to interest any corporation. It is easy to understand Gerry Nason’s despondence. The rapidly increasing rents and costs of business on Bloor Street had forced him to close the office and go out of business in August 1988. A healthy and vibrant Research Fund, which money pouring in from all sides, could well have saved his business.

In August 1988, the CAGS Secretariat was transferred to Edmonton to be looked after by Tom Williams and Dorothy Stark, they agreed to look after the business side of the Fund as well. They also agreed that the administrative costs of the Fund would not exceed 10% of
revenue and that no charges would be made until the Fund had met all its obligations to Revenue Canada and the Fund was stable. Early in 1989 Lederle Pharmaceuticals announced that they were contributing $30,000 a year for two Fellowships in Surgical Infections and a similar sum in the following year. The cheques from Lederle Pharmaceuticals were made out to CSRF with the request that they be passed on to the selected investigators. This money was gratefully acknowledged but did not require a CSRF receipt and was used to eliminate any accumulated debt to Revenue Canada.

John Duff announced with pride that the Fund had awarded $95,000 from 1985 — 1989 to a number of promising investigators and had supported four projects totaling $40,000 in 1990/91. The new Treasurer, Marshall Hunting, Edmonton, said that the cash balance of the Fund in 1991 was approximately $56,000.

From 1989 until 2001 the revenue of the Fund consisted of the $50 voluntary contributions from the membership together with an annual generous contributions from one surgeon, all of which CAGS collected and passed on to the CSRF. The CSRF and CAGS Boards agreed that the function of the Project Committee of the Fund be taken over by the Chair and members of the CAGS Research Committee. The average annual income was around $20,000, and each year the Research Committee was able to award two grants of $10,000 in advertised open competition. In addition, ever since the first year of the Fund, it made a small contribution each year to the Annual Resident Research meeting.

Every year CSRF complied with the legal and financial obligations to the government. The report of the CAGS Research Committee to the CAGS Board was accepted as a report of the Project Committee of the Fund and the report of the CAGS Treasurer included a review of the financial position of the Fund. The Immediate Past President of CAGS continued as the President of the Fund, the Executive of CAGS as the Directors of the Fund and the CAGS Board as the members of the Fund. The Fund was audited annually and for ten years the auditing fee remained the largest item in the administrative costs.

In this scaled down way, CSRF carried on, waiting for better times. The Canadian Orthopedic Association have a compulsory research
levy with their dues and this might be worth considering. Neverthe-
less the Fund did good work and, as John Duff pointed out, the list of
recipients of CSRF research grants reads like a Who’s Who of Cana-
dian General Surgery.

With the advent of the Canadian Surgery Forum and the possibility of
CAGS acquiring significant amounts of money, the time may have
come for a review of CSRF function along the lines drawn up by Neil
Watters and Gerry Nason in 1984.
Roger Keith, Saskatoon, became President of CAGS in September 1997. Reporting to the Board in February 1998 he said the time had now come to develop a Corporate Council. The plan was to invite a number of leaders of industries associated with health care to meet with the Executive so that each could benefit from the others knowledge and experience. Three CEO’s had already endorsed the idea, namely Erskine Simons of Merck Frosst, Martin Rosenbaum of Davis & Geck and Brian McKinley of Johnson & Johnson/ Ethicon. The idea, the initiative and all the work was Roger Keith’s.

In 1998 the Executive met with corporate representatives on the Council in April and again in September immediately prior to the biannual meeting of the Executive. Draft guidelines were discussed in detail and with minor revisions they received unanimous support.

Corporate members were comfortable with an annual contribution of $5,000 for membership for at least three years in addition to their ongoing support for Fellowships, prizes and awards. CAGS were looking for help in funding annual scientific meetings and various aspects of maintenance of competence in General Surgery while the Corporate members looked forward to being able to anticipate future trends in General Surgery and a ready source of information as to the thinking and aspirations of general surgeons.

In February 1999 two Corporate representatives namely Erskine Simons of Merck Frosst and Brian McKinley of Johnson & Johnson attended the Executive meeting. Both felt that access to the deliberations of the CAGS Executive was a valuable asset and in fact that was all that they expected to receive. Meanwhile the Council agreed that in addition to the $5,000 a year membership fee, they would be
expected to support CAGS activities in the region of $15,000 to $30,000 a year. Johnson & Johnson were already, contributing $30,000 a year towards the Evidence Based Reviews in Surgery and Merck Frosst were contributing $16,000 a year in the Merck Frosst Residency Teaching Awards.

By February 2000 the Corporate Council had four corporate members — Brian McKinley of Johnson & Johnson, Erskine Simons of Merck Frosst, Eugene Starr of TYCO and Richard Frizzell of Pfizer. However, both TYCO and Pfizer were undergoing significant reconstruction and their representatives had not attended a Council meeting so far. Nevertheless the forthcoming independent Canadian Surgery Forum was of great interest to industry.

By September 2002 Merck Frosst and Ethicon continued to be loyal members of the Council represented by Martine Drolet and David Methot, respectively. TYCO was laboring under a cloud and Pfizer seemed to lack some enthusiasm.

With the advent of the Canadian Surgery Forum, a change was inevitable. In order to secure a booth at the Exhibition, companies had to negotiate directly with CAGS and not indirectly through the Royal College. This provided an opportunity for companies to be approached to sponsor specific events in the Scientific Program or other educational activities of CAGS to be designated platinum, gold or silver, depending on the level of sponsorship. Furthermore as corporate budgets were prepared in August or September for the following year the importance of approaching Corporations at the time of the Forum, traditionally held in September could not be over emphasized. The CAGS Board also realized that every effort should be made to provide the best possible space and location for the exhibits and there should be adequate time in the Program for delegates to visit the exhibition hall and talk to representatives. Corporate support would be recognized in the program of the Scientific Meeting and in Newsletters.

Whether the Corporate Council will continue as a designated body remains to be seen.
PRESIDENTS OF CAGS

May 11, 1977, Royal York Hotel, Toronto
Dr. Bernard Perey, Sherbrooke, Quebec
The appointment of the President of a new professional organization needs very special consideration to ensure that matters get off to a good start. Bernard Perey was an excellent choice by the Nominating Committee, chaired by Neil Watters, Toronto. Born in France, he was fluently bilingual. He received his surgical training at McGill University and after an appointment to the staff at McGill, he was selected as the first Chairman of the Department of Surgery at the new medical school in Sherbrooke in 1966. He was appointed President Elect of the Royal College of Physicians and Surgeons of Canada in 1977 and had been involved in the committee structure of the College for many years. As an excellent committee chairman with an outgoing sense of humor, he made sure that the CAGS Executive and the Board got down to the business of writing and approving the By-Laws and establishing the standing committees. It was at Bernard Perey’s suggestion that the Board agreed that Presidents be chosen from regions of the country in a six year rotation following the example of the Royal College — (Quebec, Ontario, the West, Quebec, Ontario, the East and repeat).

January 25, 1978, Hotel Vancouver, Vancouver, B.C.
Dr. Bruce Tovee, Toronto
Bruce Tovee was widely recognized as the finest teacher of clinical surgery in Toronto. He was a quiet, kindly and friendly man and an accomplished musician. He had never been particularly interested in the politics of surgical practice but under his guidance the Board meetings ran smoothly and quietly. At the 1978 annual general meeting he stressed that there was nothing so potentially divisive as referring to general surgeons as academics and nonacademics. He assured the membership that present and future Nominating Commit-
tees would make a real effort to involve community general surgeons from coast to coast in the Executive and Committees of CAGS. However he was well aware that a special effort was necessary to avoid the Association gravitating into the hands of an “ivory tower” Executive. He outlined four goals for CAGS:

1) CAGS must be very active in fostering Continuing Medical Education of its members.

2) The Association should take measures to assess the standards of practice in General Surgery in the country and continue active involvement in manpower studies and the economic affairs of its members and potential members.

3) To have a united body of members from coast to coast which can represent General Surgery in dealing with national and provincial governing bodies, government agencies and insurance corporations.

4) CAGS should strive to achieve anything that is good for General Surgery and general surgeons.

February 7th, 1979, Chateau Champlain Hotel, Montreal
Dr. N. Tait McPhedran, Calgary
Tait McPhedran was appointed in 1966 as the first Chairman of the Department of Surgery at the new Faculty of Medicine at the University of Calgary. A native Calgarian, he took all his medical and surgical training in Toronto and was a member of the surgical teaching staff at the University of Toronto before moving back to Calgary. CAGS took several important steps under his leadership; the Residents Research Prize was established. the Test Committee for the Annual Resident Intraining Examination began its work and the first examination was offered in February 1980, the Royal College Committee for General Surgery now required all General Surgery residents to be competent in GI endoscopy, the first Postgraduate Course in Anorectal Surgery organized by Walter Yakimets, Edmonton, formed part of the June 1980 Annual Scientific Program. It was evident that the main effort of the Association was in a wide range of educational activities.
June 4th, 1980, Skyline Hotel, Ottawa

Dr. Jacques Cote, Quebec

Jacques Cote was a well known Quebec general surgeon with a special interest in Pediatric General Surgery. The CAGS Board was delighted when he agreed to join the CAGS Executive in 1978 at a time when he was also President of the Quebec Association of General Surgeons. The QAGS had been established in the early 1960’s and was a thriving organization; membership in the Association was a requirement for the practice of General Surgery in Quebec, as, according to the Rand Formula, the Association represented general surgeons in fee negotiations with the Federation of Medical Specialists of Quebec.

All the general surgeons in Quebec received a letter early in 1977 encouraging them to attend the inaugural meeting of CAGS in Toronto; the response from the Francophone surgeons in the province had been disappointing and Jacques Cote agreed to do what he could to encourage more interest. As the President of QAGS he wrote a personal letter to all Quebec general surgeons, who had not already joined CAGS, asking them to reconsider. The response was moderate at best.

Jacques Cote reporting on the work of the Board, listed the highlights: the setting up of a CAGS Endoscopy Committee, a long discussion on “The Definition of General Surgery” and the CAGS Ad Hoc Committee on Trauma developing into the Canadian Coordinating Committee on Trauma and the Trauma Association of Canada with the cooperation of the Royal College and many other interested organizations.

September 15, 1981, Toronto Harbour Castle Hilton Hotel

Dr. Neil Watters, Toronto

Neil Watters was the driving force in bringing a group of general surgeons to Toronto in June 1977 to form the inaugural meeting of the Canadian Association of General Surgeons. He chaired the first Nominating Committee of the Association and with the help and encouragement of Don Wilson, Toronto, he was truly the founding father of the Association. He was the Chief of Surgery at the Wellesley Hospital in Toronto and a loved and respected clinical teacher. He represented General Surgery at the Royal College as the
Chair of the Royal College Committee for General Surgery. All the General Surgery Program Directors are members of this Committee and so Neil Watters had a unique opportunity to hear the opinions of General Surgeons from coast to coast.

In his report on the affairs of the Association to the annual business meeting, Neil Watters said that over the years General Surgery had divested itself of many former activities but there was a feeling that the slimming down process was now largely completed; hence the importance of defining the scope of modern General Surgery. General surgeons are diagnosticians who plan the entire care of their patients and operative treatment is only part of this. Head and neck surgery had become a jurisdictional battlefield and CAGS was taking steps to strengthen its position in this area both in education and practice. The Royal College had already established Certificates of Special Competence in Pediatric General Surgery, Thoracic Surgery and Vascular Surgery and depending on local circumstances, they may become free standing specialties or practiced in combination with General Surgery. CAGS did not support a Certificate of Special Competence in Colorectal Surgery and was pleased to see that the Royal College had changed its policy and would no longer support further steps in subspecialization through Certificates of Special Competence. He was very gratified to see that his initiative in 1977 had developed so quickly.

Neil Watters chaired Board meetings with gentle authority. His quiet voice, helpful but short remarks and his complete grasp of the affairs of General Surgery made the business run very efficiently.

September 14, 1982, Convention Centre, Quebec

Dr. Don Willoughby, Halifax

He graduated in Medicine from the U of T., served in the Royal Canadian Navy during and after World War II and later enrolled in the Gallie Surgical Training Program, receiving his FRCS(C) in 1972. When he retired from the Canadian Forces he joined the surgical teaching staff of Dalhousie University. He became an invaluable member of the Royal College Examining Board in General Surgery. He was a strong supporter of CAGS from the beginning and along with Stevens Norvell, Halifax, he was responsible for the very successful CAGS Annual Intraining Examination for General Surgery residents.
The annual meeting in September 1983 was held in Calgary. This was a conjoint Scientific Meeting between CAGS and the Association of Surgeons of Great Britain and Ireland. The visitors made an excellent contribution to the program and the discussions. As President of CAGS, Don Willoughby was the perfect host.

**September 21, 1983, Convention Centre, Calgary**

**Dr. Jean Fauteux, Montreal**

Jean Fauteux was a general surgeon with a special interest in Thoracic Surgery and was the Chair of the Department of Surgery at the University of Montreal. He had an international reputation for his work on cancer of the esophagus.

The 1984 Annual Scientific Meeting was held at the Queen Elizabeth Hotel, Montreal, and Jean Fauteux arranged for an important meeting between the CAGS Board and representatives of the national and provincial Ministers of Health. They discussed General Surgery manpower, training and funding for General Surgery residents.

Jean Fauteux did his best to encourage Quebec general surgeons to join CAGS with similar results to the previous efforts that had been made. Quebec general surgeons seemed to be completely satisfied with their own provincial organization.

**September 11, 1984, Queen Elizabeth Hotel, Montreal**

**Dr. Richard Railton, Welland**

Dick Railton was the first Treasurer of CAGS. He had been involved in the affairs of the Canadian Medical Association for many years and was well aware of the financial risks that a new professional organization might encounter. He was a busy general surgeon in Welland and a well respected member of the community.

The annual meeting in September 1985 at the Hotel Vancouver, Vancouver, was the first time that CAGS had received corporate donations to offset some of the costs of the annual business meeting. The result was that the CAGS treasury ended the year with a surplus of $25,000 instead of the budgeted deficit of $8,000.

During Dick Railton’s watch, the Fund for the Advancement of General Surgery was established. $45,000 had already been raised.
and there was an ambitious target of $250,000 set for 1985/86.

**September 11, 1985, Hotel Vancouver, Vancouver**
**Dr. H. Thomas Williams, Edmonton**

Tom Williams was in his tenth year as the Chairman of the Department of Surgery at the University of Alberta. He had been the first Secretary of CAGS, a position he held for seven years. The responsibility of the Secretary of a new professional organization includes making sure that the various committees continue to work throughout the year and not just display bursts of activity at Board meetings.

1986 marked the first formal address of the President to the membership which was delivered at the annual business meeting. In subsequent years the addresses were to form part of the Annual Scientific meeting before members and guests. Arrangements were made for all CAGS Presidential Addresses to be published in the Canadian Journal of Surgery.

**September 3, 1986, Harbour Castle Hotel, Toronto**
**Dr. John Hinchey, Montreal**

John Hinchey completed his surgical training at the Montreal General Hospital and was appointed to the staff. He became a well liked and respected member of the Department of Surgery at McGill University.

In 1978 he and two other members of the Royal College General Surgery Examining Board, Frank Turner, Edmonton, and Roger Keith, Saskatoon, wrote a letter to the Association urging that they hold an independent annual meeting instead of continuing to meet each year along with the Royal College. The letter was well written and very persuasive but the attraction of attaching the CAGS meeting to a multidisciplinary meeting was too great and also many members felt a certain allegiance to the Royal College. The letter foretold the future. All three authors became Presidents of CAGS and John Hinchey was the first.

At the annual business meeting John Hinchey had the pleasure and privilege of introducing Dr. Fraser Gurd, Montreal, his teacher and mentor, for Honorary Membership. John Hinchey’s President Address entitled “The Future of General Surgery” should be reread by all general surgeons.
September 11, 1987, Holiday Inn, Winnipeg
Dr. Bernard Langer, Toronto
Bernie Langer was the Professor and Chairman of the Department of Surgery at the University of Toronto. He was a general surgeon with a special interest in hepatobiliary and pancreatic surgery and he had established a specialized unit in this discipline at the Toronto General Hospital. He was known and respected from coast to coast in Canada and enjoyed an international reputation. The Surgeon Scientist Program, which he established in Toronto, was much admired and copied in a number of other Canadian Universities.

During his term of office, Bernie Langer and the Secretary, Marvin Wexler, Montreal, had a difficult problem to solve. Nason and Associates, Toronto, who ran the Secretariat for CAGS from 1982 were going out of business. Gerry Nason had been appointed the Executive Director of CAGS and was shouldering increasing responsibilities as the years went by. A replacement had to be found. Using an arrangement similar to that used by the International Surgical Society in Berne, Switzerland, Tom Williams and Dorothy Stark in Edmonton were persuaded to take over the management of the affairs of CAGS until a more permanent arrangement could be worked out.

September 23, 1988, Congress Centre, Ottawa
Dr. Fred Murphy, Moncton
Fred Murphy had been a member of the Board of CAGS for a number of years and was liked and respected for his common sense contributions to discussions. Coming from a smaller surgical centre he viewed matters from a different perspective to many previous Presidents but was a well trained and an accomplished clinical surgeon through and through.

At the annual business meeting in September 1989 the members were addressed by Dr. Frank Phillbrook, the Medical Director of Lederle. The company was anxious to expand their activities in supporting research in Universities, especially in surgical infectious diseases and he announced they had established two Fellowships each worth $15,000. for two years, to be awarded through open competition.

September 22, 1989, Convention Centre, Edmonton, Alberta
Dr. Jean Couture, Quebec City
Jean Couture was the Professor and Chairman of the Department of Surgery at Laval University, Quebec. He had a special interest in the surgery of malignant disease, particularly that of breast cancer. He was well known throughout the Western World as a critical thinker and an honest and kindly surgical colleague. He had recently established a cancer treatment centre in China which was to blossom in subsequent years.

Jean Couture had long been one of Quebec’s representatives at the Royal College and had recently stepped down as the President of the College.

During his year of office the finances of the Canadian Journal of Surgery were in crisis. There was a real risk that publication of the Journal would cease. Jean Couture was instrumental in putting together a consortium of surgical associations, led by CAGS, to provide the required financial support.

September 14, 1990, Toronto Convention Centre, Toronto

Dr. John Duff, London.

John Duff was the Professor and Chairman of the Department of Surgery at the University of Western Ontario, London. He had a deep interest in the management of critically ill surgical patients and the organization of intensive care units. The general surgeons that he trained through the Western program were well known for their judgment and skill.

John Duff had been a strong supporter of CAGS from the beginning and was the second Chair of the Research Committee which compiled a Canadian General Surgery Research Register and established a process whereby research grants and prizes were appropriately awarded. He was also the first Chair of the Research Committee of the Fund for the Advancement of General Surgery. The re-establishment of the Lederle Fellowships were largely due to John Duff’s efforts.

In his report at the business meeting, John Duff was pleased to announce that the Canadian Journal of Surgery was now on a firm financial footing sponsored by the consortium of Associations put together by Jean Couture.
September 20, 1991, Convention Centre, Quebec

Dr. Frank Turner, Kelowna, British Columbia

Frank Turner received his surgical training at the University of Alberta and was appointed to the staff at the University Hospital, Edmonton. He was an excellent clinical surgeon and teacher and a very meticulous and smooth operator. He moved to Kelowna in 1979 and Kelowna’s gain was Edmonton’s loss. He developed a happy and successful surgical practice in Kelowna, an area of British Columbia that was expanding by leaps and bounds. Frank Turner is one of the few Canadian surgeons that had first hand experience of practice both in a University Hospital and a smaller city community hospital and he enlightened the membership with his views in his excellent Presidential address.

September 13, 1992, Congress Centre, Ottawa

Dr. Marvin Wexler, Montreal

Marvin Wexler was an easy choice for the Nominating Committee. He had served six years as the second Secretary of the Association. In that capacity he had weathered a number of storms including the closure of the Secretariat at Nason & Associates, the penny pinching attitude of the Royal College and the acute decline in health care funding from coast to coast. He represented CAGS with success in a forthright manner. A valuable member of the teaching staff at McGill University, he was based in the Royal Victoria Hospital.

During his short acceptance speech he remarked that he had never heard so much gloom and doom from the Provincial Representatives on the Board as in 1992. He sincerely hoped that things would improve.

September 10, 1993, Vancouver Convention Centre

Dr. Fred Inglis, Saskatoon

The nomination of Fred Inglis for the CAGS Presidency was a breakaway from the Royal College regional six year rotation that CAGS originally adopted. Whether this was a good move or not remains to be seen but it does make it more difficult for the Nominating Committee to select future presidents.

However, Fred Inglis was eminently qualified for the post. He had moved from Montreal to Saskatoon to take over the position of
Chairman of the Department of Surgery at the University of Saskatchewan. Over the years he had worked hard for both the Royal College and CAGS. He had chaired the Principles of Surgery Test Committee of the Royal College, the Royal College Test Committee for General Surgery and the CAGS Resident Intraining Examination Test Committee. For many years he was examiner in General Surgery for the Royal College and his expertise in the field was widely recognized. He was a very effective Chairman of the Royal College Specialty Committee for General Surgery. He had also been an excellent Chair of the Manpower Practice and Economics Committee of CAGS and had completed a number of manpower studies for Canadian General Surgery, all of them pointing to a serious deficiency within 10 years.

September 16, 1994, Toronto Convention Centre
Dr. Chris Heughan, St. John’s
Chris Heughan was appointed to the staff of the Department of Surgery at the new medical school at Memorial University in the late 1960’s. He moved up in the ranks to become a Professor of Surgery and a very well liked and respected general surgeon. He had served on the Board of CAGS for a number of years, had chaired the Manpower Practice and Economics Committee and later became the Chair of the Test Committee. He was in the process of taking over the management of the CAGS Resident Intraining Examination which was moving from Halifax to St. John’s. This difficult handover was a critical step in the life of the examination, a process which he was to complete with ease and efficiency.

September 15, 1995, Montreal Convention Centre
Dr. Bryce Taylor, Toronto
Bryce Taylor was the Head of General Surgery at the Toronto Hospital and a much sought after surgical consultant. His General Surgery Teaching Program in Toronto ranked very highly in the country in spite of the turmoil associated with hospital closures and reorganization. As a committee chairman he had few equals.

His Presidential address which took the form of a beautifully written open letter to Ministers of Health, added to, summarized and reinforced what other CAGS Presidents had said in previous years.
September 27, 1996, World Trade and Convention Centre, Halifax  
Dr. Ed Monaghan, Montreal  
After retiring from the Royal Canadian Navy Ed Monaghan joined the surgical staff at McGill University and the Royal Victoria Hospital. He was a born teacher and did much to enhance the level of emergency surgical care. As chairman of the Royal College Specialty Committee for General Surgery he was an ex officio member of the Executive of CAGS; this formed a very useful diplomatic bridge between the two organizations. Few people spoke with as much authority at Board meetings but Ed Monaghan’s contributions were always well thought out, concise and invariably helpful. His understanding of the present and future changes in General Surgery training and the various influences that were at work, was legendary.

September 26, 1997, Trades and Convention Centre, Vancouver  
Dr. Roger Keith, Saskatoon  
Roger Keith had succeeded Fred Inglis as the Professor and Chairman of the Department of Surgery at the University of Saskatchewan, Saskatoon.

He had been involved in the workings of CAGS from the very beginning and was the last of the trio that wrote a letter to the Association in 1978 urging that CAGS hold an independent annual scientific meeting, to become a CAGS President. He was very much Xan ideas man and he realized that if one plants a good idea and nurtures it carefully, it will eventually come to fruition. He was for many years an examiner in General Surgery for the Royal College and one of the original members of the CAGS Test Committee eventually becoming the Chair. He was the Secretary of CAGS for six years and later the representative to the American College of Surgeons.

September 25, 1998, Metro Toronto Convention Centre  
Dr. William Pollett, St. John’s.  
Bill Pollett was a general surgeon with a special interest in colorectal surgery and a Professor of Surgery at Memorial University. For some years he represented Newfoundland as a CAGS Provincial Representative and later became the Chair of the Manpower, Practice and Economics Committee which was later renamed the Clinical Practice Committee.
His committee had represented CAGS in protracted discussions on the provision of surgical services in rural areas along with several other bodies including the College of Family Practice of Canada, the Royal College, the Society of Rural Physicians of Canada and Ministers of Health, both Provincial and National.

A quiet speaking but very astute man, Bill Pollett was probably one of the best Chairmen of the Review Committees of the Royal College for General Surgery. This is a position that requires a great deal of common sense, tact and diplomacy, all of which he had in abundance.

**September 24, 1999, Convention Centre, Montreal**

**Dr. Eric Poulin**

Eric Poulin was a Professor of Surgery at Laval University and in his earlier years was very interested in surgical nutrition. When laparoscopic surgery was introduced in the late 1980’s he took up the challenge immediately and he soon became one of the leading laparoscopic surgeons in North America. He was a thinker by nature with excellent organizational skills as well. As the Chairman of the CAGS Program Committee for a number of years, he introduced the present scheduling CAGS Annual Scientific Program with the use of concurrent rooms which worked so well.

**September 22, 2000, Shaw Conference Centre, Edmonton, Alberta**

**Dr. John MacFarlane, Vancouver**

A graduate of McGill University, John MacFarlane took his General Surgery training at Montreal General Hospital and was appointed to the staff. He later accepted the position of Chief of Surgery at St. Paul’s Hospital, Vancouver, the major downtown hospital in Vancouver and an important surgical teaching centre. As a general surgeon he had a special interest in surgical oncology and head and neck surgery and was well known in North America and along the Pacific Coast for his contributions to a number of surgical Associations.

Although John MacFarlane had been involved in the affairs of CAGS for many years and, and had been the Chair of the Program Committee and also in charge of Local Arrangements for the relatively frequent CAGS meetings in Vancouver, he had been out of the loop for a few years before his appointment as President Elect. It was at his suggestion that the Board adopted the plan of appointing two
Presidents Elect - primus and secundus - so that the appointee would have an extra year to catch up with the affairs of the Association before assuming office.

The meeting in Quebec, over which John MacFarlane presided, was the first meeting of the Canadian Surgery Forum when CAGS met as an independent association and not part of the Royal College annual meeting. This was a historic occasion.

**September 8, 2001, Convention Centre, Quebec**

**Dr. Michel Talbot, Coteau-du-Lac**

Michel Talbot was the President of the Quebec Association of General Surgeons and had been a member of the Board of CAGS for many years and a diligent and effective chair of the Clinical Practice Committee. He had long been involved in the affairs of the Canadian Medical Association and represented CAGS at their annual meeting. He was proud of the fact that, in many ways, the reorganization of surgical services in Quebec led the country. General practitioner surgery had been eliminated, regionalization of medical services had been achieved and innovative steps to provide skilled surgical treatment in the more remote parts of Quebec had been established.
CLOSING REMARKS

It may seem inappropriate to write a closing section for an interim history of a rapidly developing organization but a few words might be in order.

Over the years the basic organization of the Association functioned well and its activities were kept within the limits of the available funds.

Reading through the accounts of the various Committees and initiatives of CAGS it is evident that some were more successful than others. Some Committees were struck with a specific purpose in mind while others had a more general function, reacting to the many stresses and strains encountered in the provision of general surgical services. What influence the many and various letters and position papers had on Governments is an open question.

It is not surprising that CAGS had little influence on the economic standing of general surgeons. Although several attempts were made to bring together General Surgery Provincial Fee Negotiators, there was little interest on the part of the provincial representatives as they could see no useful purpose. Fee negotiations are an entirely provincial matter and any relative advantage for general surgeons enjoyed in a province is a closely guarded secret whereas the disadvantages are widely proclaimed.

It should be remembered that when the health service was introduced in the early 1960s, the remuneration of surgeons was approximately at the same level, give or take ten percent. Slowly but surely, in each province, the disparities between the remuneration of the various surgical specialties developed as some procedures became redundant, others became simpler and quicker and new specialties with new
procedures were introduced. It is apparent that the fewer the number of practitioners within a surgical specialty, the more closely knit they are, the better they negotiate changes to the fee schedule with the Provincial Medical Associations. All attempts to introduce relative value scales have failed.

The adjective “general” has always tended to belittle general surgeons. The dictionary definitions range from “completely or approximately universal” through “adequate, sufficient for practical purposes” to “vague, indefinite”. “General” as an antithesis to “special”, demeans in the understanding of the public, more so in French than English. Perhaps the time has come for the matter to be revisited in the light of the move by the Quebec Association of Surgeons to drop the adjective “general”.

The matter is more than of academic interest. Surgeons with a broad training have always had special interests and this was recognized by their colleagues. However, in recent times and in the larger centres, the trend has been for surgeons with a broad training to restrict their practice to a particular area, look after “emergencies” within that area but claim that they are no longer prepared or indeed capable of taking hospital surgical emergency call. At some future date there may only be two groups of surgeons — those with limited training, who do only elective surgery and those with broad training, who deal expeditiously with emergency situations with one or two special interests on the elective side. This latter group will have most of the fun (= excitement and satisfaction) and most of the inconveniences of surgical practice; unquestionably they provide more economic value to the community which they serve.

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