Features/Sommaire

- CSRT Position Paper on AA
- Board of Directors Candidate Statements
- President’s Message
  *Mot du président*
- Radon Induced Lung Cancer

On Air/À l’affiche

- Perspectives on International Health
- Michener 50th Anniversary
- RT Week
- New CSRT Staff

Respiratory Therapists Awareness Week

The journal for respiratory health professionals in Canada

La revue des professionnels de la santé respiratoire au Canada
VBM Cuff Controller
Automatic Cuff Pressure Gauge for tracheal tubes with high volume, low pressure cuffs
~Allows to seal with lowest pressures to reduce the risk of mucosal ischemia and pressure necrosis,
~Set pressure is automatically maintained, independent of patient position.
~Compensates leaks to reduce the risk of aspiration with the possibility of pneumonia.
~Alarm system in case of leaks or disconnection.
~Auto-Set Function inflates cuff automatically to 25cmH2O.
~Pressure changes through touch pads.
~Large LED Display is easy to read.
~Battery back-up in case of power failure.
~Pressure adjusts with changing altitude making it ideal for transport.
~Universal Clamp for fixation to the standard rail.

Part No. VBM55-13-500
Cuff Controller $1,299.00 each
w/ battery and 100cm connecting tubing
- with Universal Clamp

Part No. VBM54-04-000
Pocket Control Inflator $159.99 each
when you purchase 5 or more units
50mm (2") Ø scale

Special pricing available until December 31, 2008
## Table of Contents

### On Air

A l’affiche

### President’s Message

Mot du président

### CSRT News

Nouvelles de la SCTR

### Special Interest

20

### Scientific News

The CJRT acknowledges the financial support of the Government of Canada, through the Publications Assistance Program (PAP), toward our mailing costs.

---

### Cover Photo — Denise Picanco

---

### Advertiser’s Index

- Carestream
- Capital Health
- Lung Association
- Meloche Monex
- Michener
- RC Education
- Roxon
- Philips Healthcare
- GE

---

CSRT membership inquiries / Questions concernant l’adhésion à la SCTR:

102 – 1785 Alta Vista Dr.,
Ottawa, Ontario, K1G 3Y6
1-800-267-3422

membership@csrt.com
www.csrt.com
About This Issue

The Autumn issue of the journal brings us closer to our annual celebration of the profession of respiratory therapy. October 25 to November 1, 2008, is Respiratory Therapists Week. RTs across the country focus on promoting respiratory therapy and what makes the profession such a dynamic vocation.

The CSRT is offering complimentary kits of items for members to distribute to interested parties – as you discuss who we are, and how RTs make an enormous difference in the lives of patients. Check information on the CSRT home page for instructions on how to get a kit.

We are finding more and more RTs taking the leap to offer their expertise in developing countries. Jason Nickerson discusses the challenges of working in Ghana where healthcare infrastructure is rudimentary at best.

There is also important information in this issue regarding our up-coming special AGM. The AGM will take place in Ottawa on December 5, 2008. Please take the time to read over candidate statements for the position of President-Elect and familiarize yourself with the new voting procedure. We need the support of our membership to ensure the Society can proceed in a united and effective manner.

We are pleased to publish the CSRT Position Paper on Anesthesia Assistants. The CSRT supports the role of the respiratory therapist as an anesthesia assistant as it falls within the scope of practice of Respiratory Therapy.

In the science section of the CJRT we have two articles - a discussion paper on the risk of radon induced lung cancer by Dr. Jing Chen; and from Les Matthews, “Clinical Simulation Terminology within the Context of Respiratory Therapy Education”.

Rita Hansen
CJRT Managing Editor

Dans ce numéro

Le numéro de l’automne de la RCTR signale que notre célébration annuelle de la profession de la thérapie respiratoire arrive à grands pas. À l’occasion de la Semaine de la thérapie respiratoire, qui se déroulera du 25 octobre au 1er novembre 2008, les TR d’un océan à l’autre feront la promotion de la thérapie respiratoire et de ce qui fait de notre profession une vocation aussi dynamique.

La SCRT offre des trousses gratuites d’items que les membres peuvent distribuer aux personnes intéressées tout en discutant de qui nous sommes et de l’énorme différence que font les TR dans la vie de leurs patients. Consultez la page d’accueil du site Web de la SCRT pour savoir comment obtenir une trousses.
Respiratory Therapists Week

October 26 – November 1, 2008

Time to celebrate the respiratory therapy profession!

The new CSRT two-sided poster is just off the press and has been enclosed with this issue of the CSRT, along with a handy desk calendar. If you are looking for give-away items for your booth or workplace display, the CSRT offers some complimentary items as well. Check the home page (www.csrt) for details.

How are you spreading the word? Send us your RT Week photos for publication in the winter issue of the CJRT – rhansen@csrt.com

Also available in French

La semaine de la thérapie respiratoire

du 26 octobre au 1er novembre 2008

Il est encore temps de commander des fournitures pour assurer la promotion de votre profession, par exemple, notre nouvelle affiche recto-verso : un côté illustre la fierté d’être thérapeute respiratoire et l’endos est un calendrier jusqu’à la fin de 2009.

Consultez la page d’accueil de notre site Web (www.csrt.com) pour accéder au catalogue de la TR. Vous pouvez également demander une trousse gratuite de matériel promotionnel.

Aussi disponible en français
In May of 2007, while still in the early stages of my career as a respiratory therapist and an anesthesia assistant, I set out on a journey to better understand the complexities and the challenges of providing basic (and advanced) medical care in a different environment. After a great deal of planning, preparation and some apprehension—I set forth, destined for the Cape Coast Regional Hospital in Cape Coast, Ghana. This was a truly educational experience, and I hope that the following can serve as a resource and a source of inspiration for my colleagues in the field of respiratory therapy.

Like all great adventures, it’s not as simple as finding an established need and setting foot on an airplane. There’s a great deal of planning that is necessary to be able to travel safely and to mitigate some of the culture shock that no doubt ensues when one leaves a modern healthcare facility, destined for a less-than-modern hospital. Thankfully, I had a traveling companion—my mother, a hospital pharmacist from New Brunswick—and between the two of us, we were able to sort out which vaccinations were required, recommended or unnecessary. We were also able to collectively source out information about our destination. A thorough travel health consultation, though expensive, is truly an advisable service. We required multiple immunizations, malaria prophylaxis and also traveled with a series of antibiotics in the event of illness (trust me—these were useful).

As you can imagine, after several rounds of vaccinations, an expensive purchase of anti-malarial medications and a gamut of antibiotics, you begin to wonder what you may have gotten yourself into. It’s all quite daunting and until you arrive, it’s difficult to place all of the relevant information in an appropriate context.

Ghana was a wonderful country to visit. Though somewhat turbulent, the country is effectively politically stable and is a safe country to visit. All in all, it was a fantastic foray into international healthcare. Unfortunately, determining specifics about the healthcare infrastructure and the general composition of the healthcare system before we left was a difficult process, and even with the aid of the foundation that we were volunteering with, we arrived in Accra still at least a little unsure of where we were going and what was to be expected.

Our arrival was lengthy—over 30 hours of flying, an overnight stay in Accra and a four-hour bus ride to our final destination. But when we finally arrived, we were greeted by our hosts and eventually began to gain a general sense of where we were and what we were to be doing.

The Ghanaian healthcare system is quite thoughtfully structured and appreciates the range of services that can be provided in different remote areas of the country where a lack of even basic infrastructure and access are problems. The system operates through a series of referrals that sees a patient transferred to facilities with increasingly greater capacity to handle more complex or urgent cases. The hospital we worked in was a regional hospital, among the most advanced in the continuum of Ghanaian healthcare, though there was a community clinic across the street from where we stayed and a district hospital nearby.

The hospital was a facility with roughly 200 beds that serviced a population of over one million people, along with the aforementioned clinics and smaller hospitals. I would note that the district hospital and community clinic would both be roughly the size of a community health clinic in Canada and the combined services of all levels of available healthcare institutions certainly do not guarantee timely nor equitable access to services.

My role was somewhat ambiguous; Ghana has seen generations of colonial rule from the Dutch to the British (from whom they gained independence in 1957) and the European structure of
Each case received a kit with the available medications. Many drugs were generic and labeled in Portuguese.

The healthcare system is evident. That is, they had not heard of a respiratory therapist, nor did they know what role I could potentially serve. After some discussion, it was decided that I would be best suited to assist the hospital's two anesthesiologists and two nurse anesthetists, as well as working with a young physician who managed the hospital’s outpatient asthma clinic and assisting in the intensive care unit (ICU) should there be any patients.

The hospital was a pleasant departure from the Canadian hospitals that I have worked at, which were designed to withstand a Canadian winter. The Cape Coast hospital consisted of outdoor terraces and walkways that connected different wards, which were all separate buildings, through flower gardens and rolling lawns. The ICU was, like the surgical, neonatal and medical wards, a separate building dedicated to assessing and treating the most critical patients who arrived at the hospital. The ICU had a charge nurse, a series of ICU nurses, some monitoring equipment and - I had heard – a ventilator. However, for the duration of the time I was there, not a single patient was admitted to the ICU.

The hospital ran as best it could, given the particular circumstances of the location. My time spent in the operating theatres was a mix of frustration and frequent chaos. An extra pair of skilled hands does not remain idle for long in a place such as this. Of the four theatres in the hospital, only two had monitoring equipment that would be comparable to a Canadian hospital. The others had a mix of equipment that was, in most instances, older than I was. Manual blood pressure cuffs, no cardiac monitoring and often no pulse oximeter were all standard features of a Ghanaian anaesthetic.

Our surgical procedures were often lengthy procedures that made for a challenging anesthetic. Working with the rest of the anesthesia team made for an interesting learning experience. Respiratory therapists are often known for their creativity in piecing together equipment to achieve a desired function — I assure you that this skill is exponentially more useful in a resource-poor environment. Equipment was frequently taped together, the endotracheal tubes were reused so often that the lettering was worn off and I brought the hospital’s first gum elastic bougie with me.

Outside of the operating theatres was much of the same. While in the asthma clinic, we would routinely see 15-20 patients in a matter of hours and the majority of them would not have any respiratory symptoms or illness. We were an intake for an outpatient population seeking medical attention and would routinely treat patients with urinary tract infections and other illnesses that were best dealt with by a primary care facility. The patients who were accessing the clinic for medical services were often unable to afford the cost of their medications and when they could, compliance was consistently an issue, along with the relatively few choices for treatment.

I’ve deliberately chosen to skip over a number of pertinent facts that may help to contextualize the kind of healthcare that these dedicated professionals are capable of providing, choosing to leave the “bigger” questions for the end. While we were in Ghana, the country was undergoing a series of rotating power outages that sought to reduce consumption of electricity by simply shutting the power off for 12 out of every 48 hours, rotating through different regions. Regrettably, the hospital was not exempt from these power outages and thus, for 12 out of every 48 hours the hospital was without electricity. A power generator was available, though it often failed and was unable to sufficiently supply all of the energy necessary to operate a tertiary facility. Beyond this, the hospital was severely resource-limited and supplies were scarce. Morphine was unavailable and was not even on the hospital formulary, though pethidine (meperidine) was available for select cases.

These examples highlight only a few of the realities of life in Ghana. During my short time working alongside my Ghanaian colleagues, we experienced a drought that left the hospital without running water, we ran out of oxygen and were frequently unable to access essential medicines. During one of the days without piped-in oxygen, running water or electricity, I was called to the accident & emergency room to help assess a young pregnant woman requiring urgent caesarian section. Without running water, steam sterilization was impossible and there were no clean instruments available. After a few moments, it was decided that we should transport her to the smaller district hospital where we could potentially safely perform the operation.

I was loaded into an ambulance, with
CSRT Welcomes New Staff

It’s been a summer of change at the CSRT Head office. Many new faces have appeared over the last month. The expanded staff is energized and looking forward to a busy and productive timetable.

Christiane Ménard, is the new Executive Director of the Canadian Society of Respiratory Therapists. Ms. Ménard comes to the CSRT from the Canadian Association of Medical Radiation Technologists with an impressive career in the private and public sector. She is fluently bilingual, a noted strong communicator and is excited to lead the CSRT in its’ strategic plan.

Monique El Azzi, CSRT’s new Administrative Assistant speaks English, French and Arabic. Monique is a recent graduate from Business Marketing at Ottawa University.

Ellen Sullivan has taken on the challenges of accounting duties for the CSRT. Ellen comes from a varied background including association book-keeping. Ellen is very knowledgeable of computerized accounting systems.

Magdalena Quirion, RRT comes on board as Director of Professional Practice. This new part-time position will be working closely with our Director of Professional Advocacy Maggie will provide the RT presence at Head Office.

COPD Update Slide Kit available on-line!

This resource provides an overview of the 2008 Update: Recommendations for the Management of Chronic Obstructive Pulmonary Disease (COPD): Highlights for Primary Care from the Canadian Thoracic Society (CTS). The slide kit was developed by members of the CTS COPD Guidelines Committee and is endorsed by the CTS.

The Slide Kit can be downloaded at http://www.lung.ca/cts-sct/guidelines-lignes_e.php.

Sleep Apnea 2008 Update

New Medical Search Engine

SearchMedica.com, the leading search engine for medical professionals, announced the availability of PubMed’s MEDLINE abstracts at SearchMedica.com. Healthcare professionals can access abstracts from the 5,200 journals included in U.S. National Library of Medicine’s MEDLINE index. SearchMedica’s MEDLINE abstracts link back to the Pubmed.gov Web site, which allows easy access to journal Web sites, including associated full text articles whenever available online, providing fast access to the most practical MEDLINE abstracts.

SearchMedica.com indexes only authoritative medical information, approved for inclusion by medical editors and a physician editorial board. Medical professionals receive more relevant, smaller sets of search results from SearchMedica.com than from mainstream engines, which contain consumer-oriented, paid testimonials and other types of unreliable information. Since SearchMedica.com is advertiser supported, medical professionals pay nothing to use the search engine. All SearchMedica search results are independent and unbiased. They contain well-known, credible journals, peer-reviewed research, and evidence-based articles written for practicing healthcare professionals. SearchMedica is currently available at www.SearchMedica.com.

Fifty Years of Excellence

In 2008, The Michener Institute for Applied Health Sciences is celebrating its 50th anniversary. This significant milestone will be marked with a number of celebrations, events and activities. Michener provides some of Canada’s foremost post-secondary education in the areas of medical technology, respiratory and other therapies and other areas of health care.

To review some of their celebration events go to http://www.michener.ca/50th/events.php
Depending on the day, or for that matter, the time of day, I know I exceed my limits. In my short tenure as President of the CSRT, I have felt overwhelmed at times with the volume of information and the amount of consultation which I am asked to provide.

One of my first tasks as President was to be part of a recruitment team to look for a new Executive Director for our organization. Dan McPhee (Treasurer), Sue Jones (a Past-President) and I worked together to screen, shortlist and select a candidate to be ratified by the Board of Directors as the next full-time Executive Director of the CSRT.

I am pleased to announce the hiring of Christiane Ménard as the new Executive Director of the Canadian Society of Respiratory Therapists, effective August 25, 2008. Christiane comes to us from the Canadian Association of Medical Radiation Technologists and has a varied and extensive background in the not-for-profit sector. She is fluently bilingual and is well known in the Ottawa area for her communications and public policy work. Please join me in welcoming Christiane to our fine organization.

I would be remiss to not acknowledge the hard work of Tracy Taylor, the current Director of Operations and Membership Services. Tracy stepped up and acted as the interim Executive Director during our time of transition to find a permanent replacement for Douglas Maynard. In addition to her role as the interim Executive Director, Tracy continued to perform her role in Operations and Membership services and assist with our national Educational Conference and Trade Show in Saskatoon, SK. I would like to extend a formal thank you to Tracy for her dedication to our organization and a job well done.

As many of you are aware, the Annual General Meeting of the CSRT in Saskatoon was not able to be held due to the lack of a quorum (attendees + proxies submitted). A special meeting of the Society will be held on December 5, 2008, in Ottawa, ON. A formal notification with an associated invitation to attend will be distributed to all members during the early fall.

If you are unable to attend this meeting, please review all enclosed materials and complete a proxy that is to be submitted to the CSRT head office as soon as possible. This is necessary to elect Directors and Officers to the Society, approve the budget and amend or approve any by-laws communicated and to provide all members with a voice in the direction of their national organization. I am confident that our quorum will be met and that we will move forward with our business.

Fall is back to school time. As the kids are back in school and you notice their enthusiasm, take a moment and ask how you can capture some of that enthusiasm and demonstrate it during National Respiratory Therapy Week October 26 - November 1, 2008. I still love what we do 20+ years after graduating. I hope you can share some of my passion.

Ray Hubble RRT, M.Ed.
CSRT President

---

Par certaines journées, et même par certains moments de la journée, je suis conscient que je dépasse mes limites. Pendant mon bref mandat à titre de président de la SCTR, il m’est arrivé de me sentir débordé par le volume de renseignements et la quantité de consultations auxquels on s’attend de moi.

Une de mes premières tâches à titre de président consistait à faire partie d’une équipe de recrutement à la recherche d’un nouveau directeur général pour notre organisme. Dan McPhee (trésorier), Sue Jones (une ancienne présidente) et moi avons travaillé ensemble en vue de présélectionner les candidats, d’en dresser une liste restreinte et enfin, d’en choisir un qui serait entériné par le
Conseil d’administration à titre de prochain directeur général à temps plein de la SCTR.

J’ai le plaisir d’annoncer l’embauche de Mme Christiane Ménard à titre de nouvelle directrice générale de la Société canadienne des thérapeutes respiratoires, à compter du 25 août 2008. Christiane nous arrive de l’Association canadienne des technologues en radiation médicale et elle compte à son actif une expérience variée et approfondie auprès des organismes à but non lucratif. Parfaite-ment bilingue, elle est bien connue dans la région d’Ottawa pour son travail aux chapitres de la politique publique et des communications. Je vous prie de vous joindre à moi pour accueillir Christiane au sein de notre superbe organisme.

Ce serait négligent de ma part de ne pas reconnaître le travail acharné de Tracy Taylor, l’actuelle directrice des Opérations et des Services aux membres. Tracy est passée au poste de directrice générale par intérim durant la période de transition pendant laquelle nous recherchions un remplaçant permanent pour Douglas Maynard. Outre son rôle à titre de directrice générale par intérim, Tracy a continué à remplir ses fonctions aux Opérations ainsi qu’aux Services aux membres, en plus de préter main forte en vue du Congrès éducatif national et Salon commercial à Saskatoon (Saskatchewan). Je remercie Tracy formellement pour son dévouement vis-à-vis de notre organisme et pour son travail remarquable.

Comme plusieurs d’entre vous le savez, l’Assemblée générale annuelle de la SCTR n’a pas eu lieu à Saskatoon puisque le quorum (participants + procurations soumises) n’a pas été atteint. Une assemblée spéciale de la Société est prévue le 5 décembre 2008 à Ottawa (Ontario). Un avis formel accompagné d’une invitation à y participer seront distribués à tous les membres au début de l’automne.

S’il vous est impossible de participer à cette assemblée, vous êtes prié de lire tous les documents que vous recevrez, de remplir un formulaire de procuration et de le soumettre au bureau chef de la SCTR aussitôt que possible. Cette étape s’avère nécessaire pour élire les directeurs et les administrateurs de la Société, approuver le budget et modifier ou approuver tout règlement. Elle assure également à tous les membres une voix vis-à-vis de la direction de leur organisme national. Je suis confiant que le quorum sera atteint et que nous pourrons traiter les affaires de la Société.


Ray Hubble, TRA, M.Ed.
Président de la SCTR

---

Calendar of Events

**November 1 – 2, 2008**
3rd Annual Heart Failure & Arrhythmias: From Prevention to Cure
San Diego CA
[http://www.scripps.org/conferenceservices](http://www.scripps.org/conferenceservices)

**November 5 – 8, 2008**
Pediatric Emergency Medicine
Philadelphia PA
[http://www.chop.edu/cme](http://www.chop.edu/cme)

**November 5 – 8, 2008**
World Congress on Asthma
Monte Carlo, Monaco
[http://www.aim-internationalgroup.com](http://www.aim-internationalgroup.com)

**November 6 – 12, 2008**
Allergy, Immunology, Pulmonary Medicine
Seattle, WA
[http://www.acaai.org](http://www.acaai.org)

American Heart Association Scientific Sessions 2008
New Orleans LA
[http://www.myamericanheart.org](http://www.myamericanheart.org)

**November 11 – 12, 2008**
American College of Allergy, Asthma & Immunology, 2008
Seattle, WA

**November 12 – 16, 2008**
6th International Conference on Pain Control and Regional Anaesthesia
Havana, Cuba
[www.paincontrolandanaesthesia.comRegistration URL](http://www.paincontrolandanaesthesia.com)

**November 12 -15, 2008**
International Society for Traumatic Stress Studies, 2008 Annual Meeting
Chicago, IL

**November 17 – 19, 2008**
Ontario Hospital Association, 2008 Convention & Exhibition
Toronto, ON

**November 19 – 22, 2008**
Thoracic Society of Thailand 13th Congress of the Asian Pacific Society of Respirolog
Bangkok, Thailand

**November 30 – December 3, 2008**
8th Canadian Immunization Conference
Toronto, ON

---

Notice to CSRT Members

SPECIAL ANNUAL GENERAL MEETING
EDUCATIONAL PRESENTATION AND RECEPTION
OTTAWA — DECEMBER 5, 2008 AT 15:30 HOURS

Date: Friday, December 5, 2008
Location: Embassy West Hotel (free parking available)
1400 Carling Ave, Ottawa, ON
Agenda:
15:30 Annual General Meeting
16:15 Presentation on the Implementation of Electronic Health Records
Canada Health Infoway
17:00 Wine and Cheese Reception

Purpose

15:30–16:15 — Special Annual General Meeting

1. To vote on essential business issues deferred from June AGM (no quorum)

It was not possible to vote on essential issues at the June 2008 AGM because there was no quorum. According to our by-laws, it is essential to have a vote from the membership on motions to:
- Adopt reports from the Directors
- Adopt the 2007 audited financial statements
- Approve the appointment of McCay, Duff, as the CSRT auditors for 2008 financial statements.

2. To vote on motion to revise by-laws relative to quorum requirements

Over the past few years, it has been very difficult to conduct business for the CSRT because the quorum is not achieved at the Annual General Meeting. The Board of Directors is putting forward a motion that would set the quorum at the Annual General Meetings at 50 voting members in good standing of the society to be present in person. According to our current by-laws: “two persons present in person and ten percent (10%) of voting membership of the Society, present in person or represented by proxy, shall constitute quorum.”

The revised by-law would state: “50 voting members in good standing, present in person, shall constitute a quorum”.

The use of proxies will continue to allow members who cannot attend the meeting to have the same power of vote as members attending the meeting. Further information on the proposed by-law change and the rationale is available on the CSRT web site.

3. Announcement of Results of Election for President-Elect

Ray Hubble, the CSRT President, will announce the name of the individual elected to the position of President-Elect. The CSRT has implemented a one member–one vote process for the election of the President-Elect. Each and every member is provided with the opportunity to vote. Please note that other positions were available on the Board of Directors but were filled “by acclamation” since only one person was nominated for each of the positions. Further details about the election process and the candidates nominated for this position are available in this publication and on the CSRT web site.


16:15–17:00 hours
Presentation: Establishing Electronic Health Records
Jason Murphy, Canada Health Infoway

Many elements contribute to the evolution of the Canadian health care system. Respiratory therapists are front-line health care workers that most deal with the emergence of newer technologies and the constant evolution of clinical application of technologies. Learn how the establishment of electronic health records will set the foundation for a significantly improved and modern healthcare system.

17:00 – 18:00 hours — Wine and cheese reception

This is a good opportunity for members attending this casual event to meet the incoming members of the 2009 CSRT Board of Directors as well as the new CSRT Executive Director (Christiane Ménard).

Most importantly, it provides an opportunity to network and interact with your colleagues from this region and other provinces and learn more about your profession.

Lots of Great Door Prizes!!
Proxy Voting Instructions

Proxy forms must be received by mail or by fax no later than 15:00 hours EST on December 4, 2008. Proxy forms are available on the CSRT web site. Or you may follow the example provided below.

On a plain white sheet of paper please include the following statement:

I ____________________________, a current registered / honourary member in good standing of the Canadian Society of Respiratory Therapists (CSRT) residing in _______________________ in the province of ______________________________ hereby appoint _______________________ , registry number _______ as my proxy to vote on my behalf as directed below at the Special Annual General Meeting of the CSRT which will be held on Friday, December 5, 2008, in Ottawa, Ontario.

________________________________ ________________________________ ______________________________
Print your name Signature CSRT registry number

Signed this ________________ day of __________________________________, 2008.

Assigning your proxy vote: You may assign your proxy vote to any current registered or honourary member in good standing of the Canadian Society of Respiratory Therapists. Your proxy holder must be present at the meeting. To facilitate the process, you may assign you proxy vote to one of the members of the Board of Directors* who will be in attendance at this meeting. The following are their names and CSRT registry number:

Robert Leathley Saint John, NB CSRT Registry number:  0749
Lisa Butcher-Mostowy Kelowna, BC CSRT Registry number:  7029
Jeff Dmytrowich Saskatoon, SK CSRT Registry number:  5896
Cary Ward Garson, ON CSRT Registry number:  1447
Patty Wickson Calgary, AB CSRT Registry number:  3591
Dan McPhee Staffa, ON CSRT Registry number:  3248
Wade Norquay Charlottetown, PEI CSRT Registry number:  5888

* Please note that the CSRT President was not included in the above list. The CSRT President is the Chairman of the Annual General Meeting. In case of a tie vote the Chairman of the Meeting shall have a deciding ballot.

Agenda items requiring a vote include: (the proxy form and information on the motions is are available at www.csrt.com)

1. Motion to approve the audited financial statement for the period ending December 31, 2007, as outlined in the CSRT 2007 Annual Report .

For _____ Against _____ At the discretion of proxy _____ (Please mark your vote with an “X”)

2. Motion to appoint McCay Duff & Company LLP, of Ottawa, Ontario, as the CSRT’s auditors for the 2008 fiscal year.

For _____ Against _____ At the discretion of proxy _____ (Please mark your vote with an “X”)

3. Motion to approve changes to CSRT by-law Section VI–4 from: “two persons present in person and ten percent (10%) of voting membership of the Society, present in person or represented by proxy, shall constitute quorum.” The proposed by-law would state: “50 voting members in good standing, present in person, shall constitute a quorum”.

For _____ Against _____ At the discretion of proxy _____ (Please mark your vote with an “X”)

Proxies must be received at least 24 hours prior to the start of the AGM.

Please fax to (613) 521-4314 or mail to the attention of Executive Director, CSRT, 102-1785 Alta Vista Drive, Ottawa, Ontario, K1G 3Y6
Avis aux membres de la SCTR
ASSEMBLÉE GÉNÉRALE ANNUELLE SPÉCIALE PRÉSENTATION ET RÉCEPTION
OTTAWA — LE 5 DÉCEMBRE 2008 À 15 H 30

Date : Le vendredi 5 décembre 2008
Lieu : Hôtel Embassy West (stationnement gratuit disponible) 1400, ave. Carling, Ottawa, ON
Ordre du jour :
- 15 h 30 Assemblée générale annuelle
- 16 h 15 Présentation sur la mise en œuvre des dossiers de santé électroniques Inforoute Santé du Canada
- 17 h 00 Vin et fromage
Objet
15 h 30 à 16 h 15 — Assemblée générale annuelle spéciale
1. Voter sur les questions d’affaires essentielles reportées de l’AGA de juin (absence de quorum)
Il n’a pas été possible de voter sur les questions essentielles lors de l’AGA de juin 2008 puisque le quorum n’a pas été atteint. En vertu de notre Règlement, il est impératif de procéder à un vote des membres sur les propositions qui ont pour objet :
   • d’adopter les rapports des administrateurs
   • d’adopter les états financiers vérifiés de 2007
   • d’approuver la nomination de McCay, Duff, à titre de vérificateurs des états financiers de 2008.
2. Voter sur une proposition de modifier le Règlement relativement aux exigences en matière de quorum
Au cours des dernières années, il s’est avéré très difficile d’expédier les affaires de la SCTR puisque le quorum n’est pas atteint lors de l’Assemblée générale annuelle. Le Conseil d’administration présente une proposition qui établirait le quorum aux Assemblées générales annuelles à 50 membres votants en règle de la Société, présents en personne. Selon notre Règlement actuel : « deux personnes présentes en personne et dix pour cent (10 %) des membres votants de la Société, présents en personne ou représentés par procuration, constitueront le quorum. »
Le Règlement révisé se lirait ainsi : « 50 membres votants en règle, présents en personne, constitueront le quorum ». Le recours aux procurations assurera toujours aux membres qui sont dans l’impossibilité d’assister à une assemblée le même droit de vote que les membres qui y assistent. Des renseignements supplémentaires au sujet de la modification proposée au Règlement et de son bien-fondé sont disponibles dans le site Web de la SCTR.
3. Annonce relative aux résultats de l’élection au poste de président désigné
Ray Hubble, président de la SCTR, annoncera le nom de la personne élue au poste de président désigné. La SCTR a mis en œuvre un processus « un membre — un vote » pour l’élection du président désigné. Tout membre a l’occasion de voter. À noter que les autres postes qui étaient disponibles sur le Conseil d’administration ont été comblés « par acclamation » puisqu’une seule personne a été nommée pour chacun des postes. Un complément d’information relatif au processus électoral et aux candidats nommés au poste de président désigné est disponible dans la présente publication et dans le site Web de la SCTR.
16 h 15 à 17 h 00 — Présentation : La mise en œuvre des dossiers de santé électroniques
Jason Murphy, Inforoute Santé du Canada
Nombreux sont les éléments qui contribuent à l’évolution du système canadien de soins de santé. Les thérapeutes respiratoires sont les professionnels de la santé de première ligne le plus souvent confrontés aux nouvelles technologies et à l’évolution constante des applications cliniques de la technologie. Apprenez comment la mise en œuvre des dossiers de santé électroniques établit la base d’un système de soins de santé moderne et grandement amélioré.
17 h 00 à 18 h 00 — Vin et fromage
Une belle occasion pour les membres qui participent à cette activité informelle de rencontrer les nouveaux membres du Conseil d’administration de la SCTR pour 2009 ainsi que la nouvelle directrice générale de la SCTR (Christiane Ménard).
Par dessus-tout, il s’agit d’une occasion de créer des réseaux et d’interagir avec vos collègues de la région et d’autres provinces et d’en apprendre davantage au sujet de votre profession.
Instructions liées au vote par procuration

Les formulaires de procuration doivent être reçus par la poste ou par télécopieur au plus tard à 15h00 HNE le 4 décembre 2008. Les formulaires de procuration sont disponibles dans le site Web de la SCTR. Vous pouvez également suivre l’exemple ci-dessous.

Sur une feuille de papier blanc ordinaire, inscrire l’énoncé suivant :

Je ____________________________, actuellement membre agréé / honoraire en règle de la Société canadienne des thérapeutes respiratoires (SCTR) qui habite _______________________ dans la province de _______________________________, nomme par la présente _______________________ , numéro d’agrément _______ à titre de fondé de pouvoir pour voter en mon nom tel que précisé ci-dessous lors de l’Assemblée générale annuelle spéciale de la SCTR qui aura lieu le 5 décembre 2008, à Ottawa, en Ontario.

________________________________ ________________________________
Nom en lettres moulées   Signature    Numéro d’agrément SCTR

Signé en ce ______________________________ jour de _________________ 2008.

Assignation de votre vote par procuration : Vous pouvez assigner votre vote par procuration à tout membre actuel agréé ou honoraire en règle de la Société canadienne des thérapeutes respiratoires. Votre fondé de pouvoir doit être présent à l’assemblée. Afin de faciliter le processus, vous pouvez assigner votre vote par procuration à l’un des membres du Conseil d’administration* qui sera présent à cette assemblée. Voici une liste de leurs noms et numéro d’agrément à la SCTR :

- Robert Leathley, Saint John, N.-B.  Numéro d’agrément à la SCTR : 0749
- Lisa Butcher-Mostowy, Kelowna, C.-B.  Numéro d’agrément à la SCTR : 7029
- Jeff Dmytrowich, Saskatoon, SK  Numéro d’agrément à la SCTR : 5896
- Cary Ward, Garson, ON  Numéro d’agrément à la SCTR : 1447
- Patty Wickson, Calgary, AB  Numéro d’agrément à la SCTR : 3591
- Dan McPhee, Staffa, ON  Numéro d’agrément à la SCTR : 3248
- Wade Norquay, Charlottetown, Î.-P.-E. Numéro d’agrément à la SCTR : 5888

* Veuillez noter que le président de la SCTR ne figure pas dans cette liste. Le président de la SCTR préside l’Assemblée générale annuelle. Advenant l’égalité des voix, le président de la réunion a la voix prépondérante.

Points à l’ordre du jour qui exigent un vote : (formulaire de procuration, renseignements liés aux propositions disponibles au www.csrt.com)

1. Proposition d’approuver les états financiers vérifiés pour l’exercice se terminant le 31 décembre 2007, tels que publiés dans le Rapport annuel de la SCTR.
   Pour _____  Contre _____  À la discrétion du fondé de pouvoir _____  (Indiquez votre vote à l’aide d’un X)

   Pour _____  Contre _____  À la discrétion du fondé de pouvoir _____  (Indiquez votre vote à l’aide d’un X)

3. Proposition d’approuver les modifications à l’article VI - 4 du Règlement de la SCTR de : « deux personnes présentes en personne et dix pour cent (10 %) des membres votants de la Société, présents en personne ou représentés par procuration, constitueront le quorum » à ce qui suit : Règlement proposé : « 50 membres votants en règle, présents en personne, constitueront le quorum ».
   Pour _____  Contre _____  À la discrétion du fondé de pouvoir _____  (Indiquez votre vote à l’aide d’un X)

Les formulaires de procuration doivent être reçus au moins 24 heures avant le début de l’AGA.
Important Notice to CSRT Membership  

**ELECTION — CSRT President-elect**

All registered and honorary members of the CSRT are invited to participate in the election of the president-elect. There are two candidates nominated for the President-Elect position: (1) Richard Culver and (2) Dan McPhee.

The person elected will begin their one-year term as president-elect in 2009, will complete a one-year term as CSRT President in 2010, followed by a one year term as past-president in 2011. The CSRT is implementing a one-member one-vote process for this election.

**The election will run from Saturday, November 1 to Sunday, November 30, 2008.**

CSRT registered / honourary members in good standing will be provided with three options:

1. **On-line voting** — Members for which we have an e-mail address will be sent an e-mail early on November 1 inviting them to vote on-line: Go to the www.csrt.com and click on the link to “ELECTION”.

2. **Voting by mail** — Members for which we have no e-mail will be sent a ballot by mail and provided with a postage-paid, pre-addressed envelope to:
   
   **CSRT President-Elect Election**
   
   **CSRT, 102-1785 Alta Vista Drive,**
   
   **Ottawa, ON K1G 3Y6**

3. **Voting by fax** — Members may select to fax their ballot to the CSRT office. Once received, the ballot will be held in a confidential file under lock and key by the scrutineer. Please transmit your faxed ballot to: 1-613-521-4314.

**All votes will be held in strict confidence.**

The CSRT national office will recruit two scrutineers and the votes will be counted during the last week of November. Each scrutineer will sign a confidentiality agreement. The scrutineers will be responsible to enter ballots received by mail and fax on the database. The votes received on-line will be automatically entered in the database. Members can only vote once as the registry number will be used to register votes.

Results will be placed in a sealed envelope to be opened by the President at the Special Annual General Meeting on December 5th and the winner of the election will be announced at that time.

Please review the brief statement by each candidate included in this journal regarding why they think they would be a good CSRT President.

Avis important aux membres de la SCTR

**ÉLECTION — Président désigné de la SCTR**

Tous les membres agréés et honoraires de la SCTR sont invités à participer à l’élection du président désigné. Deux candidats ont été nommés pour le poste de président désigné : (1) Richard Culver et (2) Dan McPhee.

La personne élue entamera son mandat d’un an à titre de président désigné en 2009, complètera un mandat d’un an à titre de président de la SCTR en 2010, puis un mandat d’un an à titre de président sortant en 2011. La SCTR introduit un système un membre – un vote pour cette élection.

**L’élection se déroulera 1 novembre au 30 novembre 2008.**

**Les membres agréés / honoraires en règle de la SCTR auront trois options :**

1. **Vote en ligne** — Les membres dont nous avons une adresse de courriel recevront un courriel tôt 1 novembre les invitant à voter en ligne : rendez-vous au www.csrt.com et cliquez sur le lien « ÉLECTION ».

2. **Vote par la poste** — Les membres dont nous n’avons pas d’adresse de courriel recevront par la poste un bulletin de vote et une enveloppe préaffranchie, préadressée à :
   
   Élection au poste de président désigné de la SCTR
   
   SCTR, 102-1785 prom. Alta Vista,
   
   Ottawa, ON K1G 3Y6


**Tous les votes sont strictement confidentiels.**

Le bureau national de la SCTR recruterà deux scrutateurs et les votes seront comptés durant la dernière semaine de novembre. Chacun des scrutateurs signera une entente de confidentialité. Les scrutateurs seront responsables d’inscrire les bulletins reçus par la poste et par télécopieur dans la base de données. Les votes reçus en ligne seront inscrits automatiquement dans la base de données. Les membres ne peuvent voter qu’une fois puisque le numéro d’agrément servira à enregistrer les votes.

Les résultats seront insérés dans une enveloppe scellée que le président ouvrira lors de l’Assemblée générale annuelle spéciale le 5 décembre et le gagnant de l’élection sera annoncé à ce moment.

Veuillez lire les brefs énoncés de chacun des candidats publiés dans cette revue, faisant état des raisons pour lesquelles ils constituent un bon choix pour le poste de président de la SCTR.
Candidate Statement for Dan McPhee

Hello colleagues, it is with pleasure that I address you again in the CJRT, this time as a nominee for President-Elect of the CSRT. We are acclaiming or voting positions at the board level. As you are all aware, we were unable to have our election this past spring and are now doing so in December. I am currently the Treasurer for the CSRT and am running for the position of President-Elect.

I have been a member of the CSRT for nearly two decades. In that time I have worked in many areas of the field, and in several locations. My first full-time position as a Registered Respiratory Therapist was in a regional hospital in Newfoundland (note: Our National CSRT Conference and Trade Show is to take place in St. John’s in 2010). From there I spent significant time at a new hospital known as London Health Sciences Centre or LHSC where my practice included a broad range of teams and responsibilities.

After a number of years gathering experience in the city I moved north (Bruce, Grey and Huron Counties) to try a different line of healthcare. For 10 years I worked with a group of rural health care centres. This past summer, because of my broad base of knowledge, my congenial personality and my desire to continue to make a difference I was recruited to work with a great group of people in the sales and customer support industry, providing you with the equipment, tools and supplies needed to do your job everyday.

My experience at the Board level with the CSRT goes back almost three years now. I was encouraged by mentors to accept a nomination for a position on the board for 2006 and did so at that time. In January of 2006 I traveled to Ottawa to attend an open house at the newly renovated and expanded head office of the CSRT on Alta Vista Drive. I was welcomed there by the Executive Director and introduced to the board members, the CSRT staff and various other stakeholders and guests. The atmosphere was very positive in celebration of the achievements of many people working together over the past forty-one years (1964). After attending this event, I was sure that as part of the board for the CSRT, I would be able to have a part in taking the society and its membership further over the next several years. In the spring of 2006 I joined the board as the Treasurer for the society.

In these past three years I have learned a great deal about past, current and future issues that have impacted our profession and prove to continue to challenge us as we move forward as a group. In this time I have worked alongside some very dedicated people, have had a part in making some difficult decisions, shared in the accomplishments of many in achieving the first successful CSRT million dollar annual budget goal (~2/3 from non-dues revenue) and experienced the significant pain of losing a great colleague.

We have many challenges as a profession, but I believe with your support, we can continue to evolve as a strong voice in the healthcare field. As President-Elect of the CSRT (and subsequently President) I look forward to continuing to serve you through leadership, advocacy and unity as we continue to overcome hurdles and enjoy success.

Chers collègues, j’ai le plaisir de communiquer avec vous encore une fois par le biais de la RCTR, cette fois-ci en qualité de candidat au poste de président désigné de la SCTR. Comme vous le savez, il n’a pas été possible de procéder à l’élection au printemps et nous prévoyons le faire en décembre. Je suis présentement le trésorier de la SCTR et je brique le poste de président désigné.

Je suis membre de la SCTR depuis près de deux décennies. Durant ce temps, j’ai travaillé à plusieurs endroits et dans de nombreux domaines de la profession. Mon premier poste à temps plein a été une position de thérapeute respiratoire agréé dans un hôpital régional à Terre-Neuve (note : le Congrès national et Salon commercial de la SCTR aura lieu à St. John’s en 2010). Après, j’ai travaillé longtemps à ce qui est désormais connu sous le nom de London Health Sciences Centre (LHSC) où ma pratique comportait une gamme variée de tâches et de responsabilités.

Après avoir accumulé de l’expérience en milieu urbain pendant des années, je me suis dirigé vers le Nord (comtés de Bruce, Grey et Huron) afin d’expérimenter un autre domaine des soins de santé. Pendant 10 ans, j’ai travaillé avec un groupe de centres de santé ruraux. Cet été, grâce à mes vastes connaissances, ma personnalité sympathique et mon désir de continuer à faire une différence, j’ai été recruté pour travailler avec un groupe dynamique dans l’industrie des services de santé et du soutien à la clientèle, à vous fournir l’équipement, les outils et les fournitures nécessaires pour faire votre travail quotidien.

Mon expérience au Conseil d’administration (CA) de la SCTR s’échelonne sur près de trois ans. Des mentors m’ont encouragé à accepter une mise en candidature pour un poste au CA en 2006, ce que je fis. En janvier 2006, je me suis rendu à Ottawa afin d’assister aux portes ouvertes du bureau chef nouvellement rénové et agrandi de la SCTR sur la promenade Alta Vista. J’ai été accueilli par le directeur général et présenté aux membres du CA, au personnel de la SCTR et à d’autres intervenants et invités. L’atmosphère était très positive alors qu’on célébrait les réalisations de nombreuses personnes qui avaient travaillé ensemble pendant les 41 dernières années (1964). Ma participation à cette activité m’a convaincu qu’a titre de membre du CA de la SCTR, je pourrais prendre part à l’avancement de la Société et de ses membres au cours des prochaines années. Au printemps 2006, je me suis joint au CA à titre de trésorier de la Société.

Au cours des trois dernières années, j’en ai appris beaucoup au sujet des enjeux passés, actuels et futurs qui ont eu une incidence sur notre profession et qui continuent à poser des défis au fil de notre progression comme groupe. Pendant ce temps, j’ai travaillé avec des gens très dévoués, participé à la prise de décisions difficiles, partagé les succès de nombreuses personnes en atteignant l’objectif du premier budget annuel de la SCTR d’un million de dollars (dont ~2/3 provenaient de revenu autre que les cotisations) et vécu l’expérience douloureuse de perdre un collègue bien-aimé.

Bien que nous soyons confrontés à de nombreux défis comme profession, je suis convaincu qu’avec votre soutien, nous continuons à évoluer à titre de voix puissante dans le domaine des soins de santé. À titre de président désigné de la SCTR (et par la suite, de président), j’anticipe continuer à vous desservir par le biais du leadership, de la défense des intérêts et de l’unité alors que nous poursuivons nos efforts visant à surmonter les obstacles et que nous connaissions le succès.
Candidate Statement for Richard Culver

It is with a tremendous sense of pride that I have accepted the nomination for President-Elect of the Canadian Society of Respiratory Therapists. I appreciate the support of my nominators who felt I was worthy of this challenge. I am indeed honoured to be given the opportunity, to join with others, to make a difference in the future of this organization and in the future of Respiratory Therapists across Canada.

My past experience includes being a member of the CSRT Board, Chair of the CSRT’s National Continuing Professional Development Program, Chair of the CSRT’s House of Delegates, President of the Respiratory Therapy Society of Ontario and six recent years on the RTSO Board of Directors.

My years of involvement at the executive level of the national and provincial professional societies have helped me to appreciate that there will always be external issues which impact on the profession of respiratory therapy. But currently, there is an issue internal to the profession that must be acted upon. I speak specifically of the need for our national organization to reach out to members. We need to make our society inclusive to all members across Canada. At the 2008 annual national CSRT forum we did not have enough members present to constitute a quorum for the AGM. Sadly, we did not have enough members attend the AGM in the preceding year in Montreal, which was one of the highest attended forums the CSRT ever hosted. I have been told that it is “a reflection of apathy of the members” resulting in these low member turnouts. I am not surprised that voters feel apathetic and excluded. I believe a good example of this is the inequity in our presidential voting process related to the proxies which may result in member’s feelings of exclusion.

My first order of business as a candidate in this election was to ask that the current proxy form be changed to encourage individuals to participate. The current proxy form does not list the candidates in this election. This mandates that the holder of the proxy decide for whom to vote. Individuals unable to attend the meeting and who do not designate a proxy holder are asked to sign the proxy form and have the President decide how to vote. Normally, the President would only vote in case of a tie. I have asked that the CSRT change the proxy form and/or investigate the concept of a one member/one vote system for elected officers. In this age of electronic communication, I believe that we could have an online vote. I am delighted by the favourable response to this proposal, which I have received from Rita Hansen, Communications Manager/Editor CJRT and Christiane Ménard who is our new Executive Director, CSRT. Please stay tuned for voting instructions from the CSRT.

I believe that I have shown the dedication and commitment to the profession that would qualify me as the choice for President of the CSRT. I believe that this opportunity is not just for me, but it is also an opportunity for all Respiratory Therapists from across Canada to make a difference in our profession. I urge you to get involved so that together we can make a difference. I thank you not just for your support in this election but also for your ongoing support to make Respiratory Therapy such a great profession.

I can’t promise a ride to the polling station but if you have comments or questions I would be glad to hear them.

RichardMCulver@gmail.com

C’est avec un immense sentiment de fierté que j’ai accepté la mise en candidature au poste de président désigné de la Société canadienne des thérapeutes respiratoires. J’apprécie le soutien des gens qui, d’avis que je suis digne de ce défi, ont proposé ma candidature. Je suis honoré d’avoir l’occasion de me joindre à d’autres pour effectuer une différence vis-à-vis de l’avenir de cet organisme et de l’avenir des thérapeutes respiratoires d’un bout à l’autre du Canada.

Parmi mes antécédents, j’ai siégé au Conseil d’administration (CA) de la SCTR, président le Programme national de perfectionnement professionnel permanent de la SCTR, président la Chambre des délégués de la SCTR, agi à titre de président de la Société de la thérapie respiratoire de l’Ontario (STRO) et siégé, récemment, au Conseil d’administration de la STRO pendant six ans.

Mes années d’implication à la direction des sociétés professionnelles nationale et provinciale m’ont permis de comprendre qu’il y aura toujours des enjeux externes qui font impact sur la profession de la thérapie respiratoire. Mais à présent, un enjeu interne à la profession nous oblige à passer à l’action. Je parle de la nécessité pour notre organisme national de tendre la main vers ses membres. Nous devons veiller à ce que notre Société soit inclusive envers tous les membres d’un océan à l’autre. Lors du forum national annuel 2008 de la SCTR, trop peu de membres étaient présents pour constituer le quorum à l’AGA. Malheureusement, trop peu de membres ont assisté à l’AGA à Montréal l’année précédente, en dépit de la quantité sans précédent de membres de la SCTR qui ont assisté à ce forum. On me dit qu’il s’agit du « reflet de l’apathie des membres », ce qui explique leur faible participation. Je ne suis pas surpris que les votants se sentent apathiques et exclus. Je crois que l’iniquité des modalités de vote, dont les votes par procuration, lors d’élections à la présidence peut entraîner des sentiments d’exclusion de la part des membres.

Ma première tâche à titre de candidat à cette élection a été de demander que l’actuel formulaire de procuration soit modifié afin d’encourager la participation des gens. L’actuel formulaire n’ennumère pas les candidats à cette élection, ce qui permet au fondé de pouvoir décider pour qui voter. On demande aux personnes qui ne peuvent assister à l’assemblée et qui ne désignent pas un fondé de pouvoir de signer le formulaire de procuration et de permettre au président de décider pour qui voter. Normalement, le président ne voterait que dans l’éventualité d’une égalité des voix. J’ai demandé à la SCTR de modifier le formulaire de procuration et/ou d’étudier la notion d’un système « un membre / un vote » pour les membres élus du CA. Dans l’ère des communications électroniques actuelle, je suis d’avis que nous pourrions voter en ligne. Je me réjouis à la réaction favorable que j’ai reçue de Rita Hansen, directrice des communications/rédactrice en chef de la CJRT et de Christiane Ménard, notre nouvelle directrice générale, relativement à cette proposition. Surveillez l’arrivée d’instructions sur le vote en provenance de la SCTR.

Je crois avoir démontré le dévouement et l’engagement envers la profession qui me qualifient à titre de président de la SCTR. À mon avis, il s’agit d’une occasion non seulement pour moi mais pour tous les thérapeutes respiratoires d’un bout à l’autre du Canada de faire une différence au sein de notre profession. Je vous demande avec insistance de vous impliquer afin qu’ensemble, on puisse faire une différence. Je vous remercie de votre soutien lors de la présente élection, ainsi que de votre soutien continu visant à faire de la thérapie respiratoire une profession exceptionnelle.

Je ne suis pas surpris que les votants se sentent apathiques et exclus. Je crois que l’iniquité des modalités de vote, dont les votes par procuration, lors d’élections à la présidence peut entraîner des sentiments d’exclusion de la part des membres.

Je ne suis pas surpris que les votants se sentent apathiques et exclus. Je crois que l’iniquité des modalités de vote, dont les votes par procuration, lors d’élections à la présidence peut entraîner des sentiments d’exclusion de la part des membres.

RichardMCulver@gmail.com
We are going to the next level! The CSRT is committed to offering practical education and tangible sessions at our annual conference. Sessions offered will address common issues in the field of respiratory therapy – from pandemic planning to the latest guidelines on COPD. A series of educational workshops will be available, to provide information and knowledge on state-of-the-art respiratory equipment including sessions on ventilators, oximetry and VAP.

Morning plenary session will be translated and some afternoon sessions will be in French. Along with our sessions and workshops we will have a number of social functions, including a complimentary Wine and Cheese Reception for the opening of Exhibits on May 28th; there will be a Fun Night activity on the Friday Night – likely a boat cruise on the Ottawa River; the President’s Banquet will take place on Saturday night, the 30th – where the CSRT will recognize it’s award-winning students. This is an excellent networking opportunity for RTs and like-minded individuals to come together to discuss and share ideas, opinions and best-practices.

Registration includes two breakfasts, two lunches and a coffee break. All meals will take place in the exhibit hall where you can explore the latest equipment in the marketplace as well as various services offered by our exhibitors. There will be approximately 75 booth positions.

Gatineau, Quebec will be the site for the 2009 National Respiratory Therapy Conference and Trade Show. Just across the river from Ottawa, this venue gives delegates access to the beauty of the Gatineau Hills as well as all the downtown activities of the Nation’s Capital.

Once the preliminary programme is finished it will be posted and regularly updated on our website.

Confirmed speakers include:

Dr. Kayvan Amjadi – Critical Care
Dr. Redouane Bouali – DNR Status/End of Life Care
Dr. Jean Bourbeau – COPD Guidelines and Management
Dr. Peter Brindley – Cardiac Arrest – What Matters in the End
Dr. Gerarda Cronin – Patient Safety
Dr. Alan Kaplan – Asthma Guidelines and Management
Dr. Jack Kitts - Anesthesia 2030
Carole LeBlanc – Rehab Management
Dr. Brigitte Lemyre - NeoNatal Pediatrics
Dana Oakes – Heroes – The Past, Present and Future of Respiratory Care
Dr. Peter Papadakos – Trauma and ICU
David Swift – Is Your Department Ready for a Disaster - Can It Go the Distance Beyond Yo-Yo 72?
Dr. Homer Yang - Conscious Sedation Outside the OR

CSRT CORPORATE MEMBERS 2008-2009

CAREstream Medical
GE Healthcare
Philips Healthcare
McArthur Medical
RC Educational
SeQual Technologies
VitalAire

Hilton Lac Leamy and Casino
Photo credit: Société des casinos du Québec
Position Paper on Anesthesia Assistants
An Official Position Paper of the Canadian Society of Respiratory Therapists

The Canadian Society of Respiratory Therapists (CSRT) is dedicated to promoting the profession of Respiratory Therapy as being essential to the safe delivery of health-care in Canada. We believe that the following position, as outlined, serves both the interest of the public as well as the CSRT membership.

BACKGROUND
For several decades, Registered Respiratory Therapists (RRTs) have worked alongside Anesthesiologists in Canadian operating rooms. The traditional role of the Operating Room Respiratory Therapist has included providing technical support to the Anesthesiologist for the proper use and maintenance of the anesthetic gas machine, in addition to providing airway management. Over the past several years, this role has evolved into a more advanced and specialized practice with increasing responsibilities. In many Canadian hospitals, RRTs have undergone additional training in order to perform these duties, all under the authority of their respective Departments of Anesthesia. As well, a number of educational institutions have now developed programs supporting the specialization of RRTs for anesthesia support.

The title for this role varies within institutions and jurisdictions across Canada. Although the title of “Anesthesia Assistant” is not a legislated protected title, it is associated with this role in many facilities, as well as having been recognized by the CSRT and the Canadian Anesthesiologists’ Society (CAS). The CSRT has determined that an individual with a diploma and/or degree in Respiratory Therapy is the most appropriately qualified practitioner to fill the role of Anesthesia Assistant, that the concept of Anesthesia Assistant is consistent with an advanced scope of practice RRT and should be able to use Registered Respiratory Therapist (Anesthesia Assistant), or RRT(AA), as a designation.

POSITION STATEMENT
The CSRT is of the position that the role of Respiratory Therapist as Anesthesia Assistant falls within the scope of practice of Respiratory Therapy. As well, the RRT functioning as an RRT(AA) works within the framework of the team providing the delivery of anesthesia care, under the direction of the attending anesthesiologist. Furthermore, the CSRT believes that RRT(AA)s assuming the role and responsibilities of Anesthesia Assistant is in the public’s best interest and can improve the safety and efficiency of anesthetic care. As such, the CSRT has supported and will continue to support its Members and academic institutions in their endeavors with provincial Ministries of Health and provincial regulatory bodies to recognize and facilitate the role of RRTs as anesthesia assistants in Canada.

As accountable professionals, our Members are committed to the delivery of safe and ethical health care. Some employers across Canada have chosen to provide formalized training and certification processes for their RRTs who practice in the area of anesthesia. As well, numerous educational institutions offer or are developing programs specific to training in the specialty of anesthesia assistance. Although the CSRT does not specifically require additional certification or formalized training from its Members to carry out or to enhance their practice, the CSRT supports and encourages a consistent and measurable process to advance the skills of its Members. Continuing competency and ongoing quality improvement initiatives are supported and encouraged by the CSRT in accordance with provincial licensing bodies in providing excellence in the delivery of Respiratory Therapy.

Recommendations from the Anesthesia Assistant Task Force
Training and Education of Anesthesia Assistants

In March of 2005 the CSRT hosted a meeting of stakeholders in Ottawa to review and update a proposed curriculum document. At the meeting, the stakeholders, comprised of representatives from several schools involved in, or about to create, anesthesia assistant programs as well as representatives from the regulators and the CSRT, made significant changes to the original curriculum document created in 2003. The schools indicated their willingness to use the revised document for their programs.

Currently there are six schools across Canada providing advanced programs in Anesthesia at the post-diploma level. They are; Thompson Rivers University in Kamloops, British Columbia, University of Manitoba in Winnipeg,
Manitoba, The Michener Institute in Toronto, Ontario, Algonquin College in Ottawa, Ontario, Fanshawe College in London, Ontario and Dalhousie University in Halifax, Nova Scotia. In addition, the CoARTE accredited schools in Quebec provide additional didactic instruction and clinical exposure to anesthesia practice within their respiratory therapy programs. As more schools express interest in developing a program, it is becoming apparent that the lack of a common foundational knowledge document with which to create a curriculum is resulting in a lack of consistency in the training of anesthesia assistants across Canada. It is imperative therefore, that if we are to develop anesthesia assistants to the level demanded that there be national standards. Given the previous acceptance of the Foundation Knowledge for Assisting in Anesthesia Document by the schools and the significant amount of work already expended in its creation, it is proposed that this document be again reviewed in order to establish it as the standard to be used in further curriculum development.

Accreditation of Anesthesia Assistant Training Programs
The CSRT, through the Council on Accreditation for Respiratory Therapy Education (CoARTE), provides a national accreditation program for schools offering a respiratory therapy training program. This program has proven itself to be highly successful. As all the schools offering, or planning, an anesthesia assistant training program are also accredited respiratory therapy schools, it is proposed that an accreditation program for anesthesia assistants be piggybacked onto the current CoARTE process. This would eliminate the need to reassess various academic policies and procedures protecting students’ rights and ensuring appropriate documentation which would be common throughout the institution’s educational programs. To facilitate this proposal, it is suggested that CoARTE could add one more content specific expert to the current accreditation review team. The CAS will be approached for a list of suitable interested anesthesiologists. One benefit of this proposal should be the significant reduction in the cost of accreditation over the development, from the ground up, of a new, entirely independent system.

Examination and Certification
The Canadian Board for Respiratory Care (CBRC) currently provides a national registry exam for respiratory therapy based upon the National Competency Profile. With the further development of the Foundation Knowledge for Assisting in Anesthesia Document as the basis of a common curriculum, it is hoped that a national standard for training can be established. Once this has occurred, a profile of the required competencies can be drawn up and used as the matrix for a national exam. With the CBRC’s established expertise in this area, they will be approached to assist in the development of both the competency matrix and an exam. Further, as a means to establish a national standard for Anesthesia Assistants, Human Resources and Social Development Canada (HRSDC) will be approached to assist in the development of a national job profile.

Scope of practice
The specific job descriptions and duties of AAs may differ according to geographic area and local practice. Provincial legislation or board of medicine regulations or guidelines may further define the job descriptions of AAs. As a means to develop the direction under the governance of a qualified anesthesiologist. The CSRT believes that the Canadian Anesthesiologists’ Society statement on the Recommended Scope of Practice of Anesthesia Assistants be adopted. The statement may be found at: http://www.cas.ca

The AA’s functions include, but are not limited to, the following:

Technical Duties

The Anesthesia Assistant shall:
1. Assist with or perform airway management, including insertion of laryngeal masks, tracheal intubation, and mask ventilation.
2. Assist with regional anesthesia procedures.
3. Assist with or perform airway management, including insertion of laryngeal masks, tracheal intubation, and mask ventilation.
4. Assist in the positioning of the patient under the direction of the anesthesiologist.

Clinical Duties

The Anesthesia Assistant shall:
1. Assist in the preparation of the patient for surgery and perform pre-operative assessments as requested by the anesthesiologist.
2. Assist with or perform the insertion of devices such as nasogastric tubes, intravenous, and intra-arterial catheters.
3. Assist with the insertion of Swan Ganz catheters and central venous catheters.
4. Assist with regional anesthesia procedures.
5. Assist with or perform airway management, including insertion of laryngeal masks, tracheal intubation, and mask ventilation.
6. Assist in the positioning of the patient under the direction of the anesthesiologist.
7. Adjust therapies (e.g., ventilation, temperature control devices, etc.) as directed by the anesthesiologist.
8. Administer prescribed pharmacological agents to the patient under the direction of the attending anesthesiologist, observing for side effects and efficacy of treatment during anesthesia to ensure the patient responds appropriately.
9. Assess the patient’s physiological status during anesthesia by performing duties such as monitoring vital signs and anesthetic gases and advising the anesthesiologist of the patient's status.
10. Assist at emergence from anesthesia by performing duties such as aspirating secretions from the trachea and pharynx, removing LMA's, and tracheal extubation of the patient. Remove monitoring equipment after surgery.
11. Assist with the transfer of ventilated and/or anesthetized patients between areas of the hospital as required.
12. Transfer post-operative patients to the Post Anesthesia Care Unit under the direction of the anesthesiologist.
13. Monitor patient progress in the Post Anesthesia Care Unit, update anesthesia monitoring records, and report patient status to the anesthesiologist, as requested.
14. Provide diagnostic data for the anesthesiologist by performing duties such as blood sampling and analysis, pulmonary functioning testing, end tidal CO2 monitoring, pulse oximetry, and transcutaneous monitoring.
15. Prepare fiber-optic bronchoscopes and other equipment as required, and assist the anesthesiologist during bronchoscopy with equipment set-up, preparation of and instillation of medication, and sample procurement.
16. Assist the anesthesiologist with difficult intubations.
17. Assist the anesthesiologist with cases in locations out of the operating room.
18. Respond to cardiac arrests in OR, PACU or other locations according to hospital procedures and policies.

Administrative Duties

The Anesthesia Assistant shall:

1. Establish and conduct a preventive maintenance program.
2. In conjunction with the Anesthesiology and Biomedical Engineering Departments, maintain a variety of anesthetic equipment by performing duties, such as receiving and assessing equipment, testing and identifying malfunctions and determining whether repairs should be made on-site or equipment returned to vendor. Carry out minor maintenance following manufacturer’s and Canadian Standards Association guidelines and verify vendor repairs to ensure equipment is operating in a safe and effective manner.
3. Where appropriate, meet with medical equipment and pharmacological sales representatives to organize trials and evaluations of new equipment and drugs according to hospital protocol. Gather and collate feedback and participate in purchase decisions.
4. Arrange and coordinate servicing and repair of equipment.
5. Communicate with and act as a liaison with supply companies.
6. Remain current with available supplies and equipment and make recommendations for changes/improvements.
7. Maintain supply inventory.
8. Source out supplies and equipment.
9. Assist the Department of Anesthesia with capital equipment budget by conducting equipment needs assessments and research.
10. Assist in Quality Assurance activities.

Education and Orientation

The Anesthesia Assistant shall:

1. Participate in the orientation of new OR and PACU staff and students.
2. Participate in teaching of students.
3. Participate in In-service sessions for nursing staff and physicians on new equipment and supplies.
4. Attend training programs as required.

If you have any questions or comments regarding the role of Respiratory Therapists as Anesthesia Assistants, please contact the Canadian Society of Respiratory Therapists in Ottawa, Ontario.

Continuing Education Courses

www.RCECS.com

100 AARC APPROVED COURSES

Available For Self-Regulatory And Mandatory Competency Requirements

CSRT Members receive 20% Discount
Use Discount Code: CSRT

RC Educational Consulting Services, Inc.
16781 Van Buren Blvd, Suite B
Riverside, CA 92504-5798

(877) 367-6877 www.RCECS.com
Exposé de principe sur les assistants en anesthésie

Un exposé de principe officiel de la Société canadienne des thérapeutes respiratoires

La Société canadienne des thérapeutes respiratoires (SCTR) est vouée à la promotion de la profession de la thérapie respiratoire à titre de composante essentielle de la prestation sécuritaire des soins de santé au Canada. Nous sommes d’avis que l’exposé suivant, tel qu’il est énoncé, sert à la fois l’intérêt public et celui des membres de la SCTR.

HISTORIQUE

Depuis plusieurs décennies, les thérapeutes respiratoires agréés (TRAs) travaillent aux côtés des anesthésiologistes dans les salles d’opération canadiennes. Le rôle traditionnel du thérapeute respiratoire en salle d’opération englobe le soutien technique offert à l’anesthésiologiste en vue de l’utilisation et de l’entretien appropriés de l’appareil d’anesthésie par inhalation, ainsi que la prise en charge des voies respiratoires. Au cours des dernières années, ce rôle a évolué vers une pratique davantage avancée et spécialisée qui comporte des responsabilités accrues. Dans plusieurs hôpitaux canadiens, les TRAs ont complété une formation additionnelle afin d’exercer ces fonctions, le tout sous l’autorité de leur Département d’anesthésiologie respectif. De plus, bon nombre d’établissements d’enseignement ont désormais élaboré des programmes qui viennent appuyer la spécialisation des TRAs dans le domaine du soutien anesthésique.

Le rôle accordé à ce rôle varie selon l’établissement et la province ou le territoire au Canada. Bien que le rôle « assistant en anesthésie » ne soit pas protégé par la loi, il est associé à ce rôle dans de nombreux établissements, en plus d’avoir été reconnu par la SCTR et la Société canadienne des anesthésiologistes (SCA). La SCTR a décrété que la personne qui détient un diplôme et/ou un baccalauréat en thérapie respiratoire est le praticien le plus convenablement qualifié pour jouer le rôle d’assistant en anesthésie; que le concept de l’assistant en anesthésie est conforme au TRA en pratique avancée; et qu’il/elle devrait être autorisé à utiliser la désignation Thérapeute respiratoire agréé (assistant en anesthésie) ou TRA(AA).

DÉCLARATION DE PRINCIPE

Selon le point de vue de la SCTR, le rôle du thérapeute respiratoire à titre d’assistant en anesthésie s’insère dans le champ d’activité de la thérapie respiratoire. De plus, le TRA qui travaille comme TRA(AA) est encadré par l’équipe qui assure la prestation des soins anesthésiques, sous la direction de l’anesthésiologiste traitant. Par surcroît, la SCTR est d’avis qu’il est dans le meilleur intérêt du public que les TRAs(AAs) assumment le rôle et les responsabilités de l’assistant en anesthésie et que cela peut améliorer la sécurité et l’efficacité des soins anesthésiques. Ainsi, la SCTR a appuyé et continuera d’appuyer ses membres ainsi que les établissements d’enseignement dans les efforts qu’ils déploient auprès des ministères provinciaux de la Santé et des organismes de réglementation provinciaux en vue de reconnaître et de faciliter le rôle du TRA à titre d’assistant en anesthésie au Canada.

En qualité de professionnels responsables, nos membres sont voués à la prestation de soins de santé sécuritaires et éthiques. Certains employeurs à travers le Canada ont choisi d’offrir des modalités formelles de formation et de certification à leurs TRAs qui œuvrent dans le domaine de l’anesthésie. De plus, de nombreux établissements d’enseignement offrent ou sont en voie d’élaborer des programmes de formation qui ciblent la spécialité de l’assistance anesthésique. Bien que la SCTR n’exige pas expressément que ses membres obtiennent une certification additionnelle ou qu’ils suivent une formation formelle pour exercer ou pour rehausser l’exercice de leur métier, la SCTR appuie et encourage un processus uniforme et mesurable visant à parfaire les compétences de ses membres. Les initiatives liées au maintien de la compétence et à l’amélioration continue de la qualité sont appuyées et encouragées par la SCTR en conformité avec les organismes de réglementation provinciaux dans l’optique d’assurer l’excellence de la prestation de la thérapie respiratoire.

Recommandations du groupe de travail sur les assistants en anesthésie

Formation et programme d’études des assistants en anesthésie

À l’heure actuelle, six établissements d’enseignement au Canada offrent des programmes avancés en anesthésie au niveau des études supérieures, soient : l’Université Thompson Rivers à Kamloops, en Colombie-Britannique, l’Université du Manitoba à Winnipeg, au Manitoba, The Michener Institute à Toronto, en Ontario, le Collège Algonquin à Ottawa, en Ontario, le Fanshawe College à London, en Ontario, et l’Université Dalhousie à Hali-

**Agrément des programmes de formation à l’intention des assistants en anesthésie**

La SCTTR assure, par l’entremise du Conseil pour l’agrément de la formation en thérapie respiratoire (CoAFTR), un programme d’agrément national à l’intention des écoles qui offrent un programme de formation en thérapie respiratoire. Ce programme a connu beaucoup de succès. Puisque toutes les écoles qui offrent, ou qui prévoient offrir, un programme de formation à l’intention des assistants en anesthésie sont également des écoles de thérapie respiratoire agréées, il est proposé qu’un programme d’agrément pour les assistants en anesthésie soit jumelé au processus actuel du CoAFTR. Cela éliminerait la nécessité de réévaluer les diverses politiques et procédures académiques qui visent à protéger les droits des étudiants et à assurer une documentation appropriée, lesquelles seraient communs à tous les programmes pédagogiques de l’établissement. Afin de faciliter cette proposition, il est suggéré que le CoAFTR ajoute un autre expert en matière du contenu à l’actuelle équipe de révision de programme. Une liste d’anesthésiologistes intéressés et convenables sera demandée de la SCA. Parmi les avantages de cette proposition, les coûts de l’agrément devraient être grandement réduits comparativement à la création, à partir de la case de départ, d’un nouveau système complètement autonome.

**Examen et certification**


**Champ d’activité**

Les descriptions de poste et les tâches spécifiques des AAs peuvent différer selon la région géographique et la pratique locale. La législation provinciale ou les règlements ou directives des commissions médicales peuvent définir davantage les descriptions de poste des AAs. Les AAs exercent sous la direction d’un anesthésiologiste qualifié. La SCTTR est d’avis que le Guide d’exercice de l’anesthésie de la Société canadienne des anesthésiologistes devrait être adopté. Le guide est disponible au : http://www.cas.ca.

Les fonctions de l’AA englobent ce qui suit, sans toutefois s’y limiter :

**Tâches techniques**

L’assistant en anesthésie devra :

1. Mettre en place, vérifier, calibrer et actionner les moniteurs physiologiques tels que les postes de travail d’anesthésie, les dispositifs d’intubation ou de maintien des voies respiratoires, les fibroscopes, les moniteurs de l’état physiologique et les appareils de perfusion.

- Effectuer les vérifications requises de l’équipement et tenir à jour des registres des problèmes afin d’assurer la sécurité de l’équipement.

- Remplacer et changer les fournitures en ce qui a trait à l’équipement anesthésique conformément à un programme d’entretien de routine.

- Maintenir l’approvisionnement de médicaments et d’équipement des postes de travail d’anesthésie.

2. Dépanner l’équipement anesthésique.

- Corriger les problèmes découverts et/ou assurer le suivi avec les techniciens en génie biomédical ou les représentants de l’entretien.

3. Surveiller les niveaux de pollution liée aux traces de gaz.


Tâches cliniques

L’assistant en anesthésie devra :

1. Aider à la préparation du patient en vue de la chirurgie et effectuer les évaluations pré-opératoires à la demande de l’anesthésiologiste.
2. Effectuer ou aider à l’insertion d’appareils comme les sondes nasogastriques, les perfusions intraveineuses et les cathéters intra-artériaux.
3. Aider à l’insertion de cathéters de Swan-Ganz et de cathéters veineux centraux.
4. Aider lors de procédures d’anesthésie régionale.
5. Effectuer ou aider à la prise en charge des voies respiratoires, y compris l’insertion de masques laryngés, l’intubation endotrachéale et la ventilation au masque.
7. Ajuster les traitements (par ex. : la ventilation, les appareils de contrôle de température, etc.) tels que demandé par l’anesthésiologiste.
11. Aider au transfert des patients ventilés et/ou sous anesthésie entre les différents secteurs de l’hôpital, tel que requis.
12. Transférer les patients en phase post-opératoire vers l’unité de soins post-anesthésiques, sous la direction de l’anesthésiologiste.
14. Fournir des données diagnostiques à l’anesthésiologiste en accomplissant des tâches comme les analyses et les prélèvements sanguins, les épreuves de fonction pulmonaire, la surveillance du CO2 télé-expiratoire, la surveillance du saturomètre et des paramètres trans-cutanés.
17. Assister l’anesthésiologiste pour les cas effectués à l’extérieur de la salle d’opération.
18. Répondre aux arrêts cardiaques qui surviennent dans la salle d’opération, dans l’unité de soins post-anesthésiques ou à d’autres endroits selon les procédures et les politiques de l’hôpital.

Tâches administratives

L’assistant en anesthésie devra :

1. Établir et effectuer un programme d’entretien préventif.
2. Conjointement avec le département d’anesthésiologie et le service de génie biomédical, veiller au maintien d’un assortiment d’équipements anesthésiques par l’accomplissement de tâches comme recevoir et évaluer l’équipement, vérifier et détecter les malfonctionnements, et déterminer si des réparations doivent être effectuées sur place ou si l’équipement doit être retourné au manufacturier. Effectuer l’entretien mineur selon les recommandations du fabricant et les lignes directrices de l’Association canadienne de normalisation et vérifier les réparations faites par le manufacturier pour s’assurer que l’équipement fonctionne de façon efficace et sécuritaire.
5. Contacter les fournisseurs et servir de liaison.
7. Tenir à jour l’inventaire des fournitures.
8. S’approvisionner en fournitures et en équipement.
10. Aider aux activités de l’assurance qualité.

Formation et initiation

L’assistant en anesthésie devra :

1. Participer à l’orientation des nouveaux employés et étudiants en salle d’opération et à l’unité de soins post-anesthésiques.
2. Participer à la formation des étudiants.
3. Participer aux séances d’information sur le nouvel équipement et les fournitures, qui sont présentées au personnel des soins infirmiers et aux médecins.
4. Assister à des programmes de formation si nécessaire.

Si vous avez des questions ou des commentaires au sujet du rôle des thérapeutes respiratoires à titre d’assistants en anesthésie, n’hésitez pas à communiquer avec la Société canadienne des thérapeutes respiratoires à Ottawa, en Ontario.
A discussion on the Risk of Radon Induced Lung Cancer
Dr. Jing Chen
Radiation Protection Bureau, Health Canada

Abstract: Radon is a radioactive gas that is formed naturally by the radioactive breakdown of uranium in rocks and soils. Recent studies of people exposed to radon have confirmed that radon in homes is a serious health hazard. The recent pooled studies all agree on the magnitude of the risk estimates, and are consistent with the downward linear extrapolation from studies of radon exposed miners. While policy makers and scientists specialized in risk assessment are quite satisfactory with the consistent findings of radon risk among various studies, many people are still puzzled with the differences in risk expressions and risk projections. A discussion is given here with the hope to achieve a better understanding of the risks of radon induced lung cancer, and the risk variation among different populations.

INTRODUCTION
Radon is a naturally occurring radioactive gas generated by the decay of uranium-bearing minerals in rocks and soils. With a half-life less than 4 days, radon is normally dissipated harmlessly in the outdoor air. However, in some confined spaces, such as homes, it can accumulate to harmful levels (1). The concentration of radon in a home depends on the amount of radon-producing uranium in the underlying rocks and soils, the routes available for its passage into the home and the rate of exchange between indoor and outdoor air. Because it is radioactive, radon decays further to form additional radioactive particles called radon progeny. Radon concentration is measured in units of Bq/m$^3$ (becquerels per cubic meter), i.e. number of atoms decaying per second per cubic meter of air. Radon gas and its progeny in the air can be breathed into the lungs where they break down further and emit alpha particles. Alpha particles release small bursts of energy which are absorbed by nearby lung tissue. This results in lung cell death or damage. When lung cells are damaged, they have the potential to result in lung cancer. Recent studies of people exposed to radon have confirmed that radon in homes is a serious health hazard (2). Radon is the second leading cause of lung cancer after tobacco smoking. However, for non-smokers, radon is the first leading cause of lung cancer.

The most important information concerning the radon risk comes from epidemiological studies of underground miners. The National Research Council, Biological Effects of Ionizing Radiations (BEIR) VI committee analyzed results from 11 miner cohorts (3) and developed risk models for radon induced lung cancer. Recent publications, such as the combined analysis of 7 North American residential case-control studies (4) and the collaborative analysis from 15 European case-control studies for radon in homes (5), reveal a statistically significant excess risk of lung cancer at indoor radon levels. The pooled studies all agree on the magnitude of the risk estimates, and are consistent with the downward linear extrapolation from studies of radon exposed miners reported by the BEIR VI committee.

Even though all studies agree on the magnitude of estimated radon risk, there are differences in risk expressions, as well as risk projections. While policy makers and scientists specialized in risk assessment are quite satisfactory with the consistent findings of radon risk among various studies, many people are somehow puzzled with the differences, as shown during the public consultation on changes to Canada’s radon guideline (6). A discussion is, therefore, given here with the hope to achieve a better understanding of the risks of radon induced lung cancer, and the risk variation among different populations.

RISK ESTIMATE – incremental risk per 100 Bq/m$^3$
The most direct way to assess the risks posed by radon is to measure radon exposures among people who have lung cancer and compare them with exposures among people who have not developed lung cancer. Risk estimate is focused on the estimate of the dose-response relationship. In the case of radon, the dose-response relationship is the relationship between radon exposure and the risk of developing lung cancer. Recent pooled studies have increased the statistical power of risk analysis, and confirmed a linear relationship between exposure and risk, which represents the increment to the excess lung cancer risk beyond background resulting from radon exposure. The slope of the exposure-risk relationship is often expressed as an incremental risk per 100 Bq/m$^3$.

Radon risk can be and was expressed in different terms in the publications. The slope of the exposure-risk relationship was characterized by an excess relative risk (ERR) in the BEIR VI report and the European pooled analysis. The risk was estimated with an excess odds ratio (EOR) in the North American pooled study. In terms of an incremental risk per 100 Bq/m$^3$, there are 0.12 from the BEIR VI report, 0.16 from the European pooled analysis, and 0.18 from the North American pooled study. The major pooled analyses agree well on the magnitude of the risk estimate. These separate pooled studies conducted by different investigators with different data sets, different methodologies and different assumptions arrived at very similar conclusions, and provide direct evidence of an association between residential radon exposure and lung cancer risk. These pooled analyses have strongly increased our confidence on the dose-response relationship between radon
Scientific news

and lung cancer. The risk of lung cancer increases linearly with increasing radon concentration.

The above discussion concerns the key parameter of radon risk estimate, the slope of the exposure-risk relationship. The estimated incremental risk of lung cancer per 100 Bq/m³ ranges from 0.12 to 0.18. This type of risk estimate is only possible with thousands of cases (radon exposures among people who have lung cancer) compared with thousands of controls (radon exposures among people who have not developed lung cancer). The estimated exposure-risk relationship is not population specific, and does not directly apply to individuals. However, the estimated risks, such as 0.16 per 100 Bq/m³, are used in the calculation or prediction of lifetime risk for a population.

RISK CALCULATION – lifetime relative risk
Lifetime risk is the risk of developing a disease during one’s lifetime or dying of the disease. Lifetime risk of lung cancer is often described as the probability of developing and/or dying from lung cancer.

Even though the estimated risks are quite similar between the BEIR VI report and recent pooled studies, the derived lifetime risks can differ significantly for those who are exposed lifelong to the same radon concentration. To understand the reasons behind the difference, we need to look at how lifetime risks are calculated.

The formulae for the calculation of lifetime risk of lung cancer are described in the BEIR IV report (7). The risk of lung cancer mortality associated with radon exposure is a function of the exposure duration and of the age, because of competing risks of death from other causes. The lifetime risk of lung cancer is given by the sum of the risks of lung cancer death for each year i:

\[ R_i = \frac{1}{\text{age}} \sum_{i=1}^{\text{age}} \left( h_i + h_i^* \right) \exp \left( -\left( h_i + h_i^* \right) \right) \left[ 1 - \exp \left( -\left( h_i + h_i^* \right) \right) \right] \]

where \( R_i \) is the lifetime risk of lung cancer under a given exposure pattern; \( h_i \) and \( h_i^* \) are the lung-cancer and overall mortality rates for age \( i \), respectively, and \( e_i \) is the excess relative risk due to exposure to radon for age \( i \). A lifespan of 110 years is assumed here. To predict the risk by age of 65, the summation should be over all years \( i \) from 1 to 65. It was noticed in previous publications (9-11) that the summation part over years 65 to 110 contribute very little (generally less than 3%) to the lifetime risk.

In the above equation, \( e_i \) is the excess relative risk due to exposure to radon for age \( i \). In all calculations cited here, the radon risk model developed by the US EPA (an unified model of the BEIR VI risk models) was used (8).

The computation of lifetime risks depends on the age-specific lung-cancer rates and overall mortality rates, \( h_i \) and \( h_i^* \). Those mortality rates often differ for different populations, and even differ between men and women within the same population. Therefore, even though the excess relative risk of radon exposure is not population specific, the lifetime risk of radon induced lung cancer can be quite different for different populations. Examples are given in Table 1, which shows the lifetime risks for men and women in the US, Canada and Japan who are exposed lifelong to a given radon concentration (9 - 11). Among the three populations, Canadians have, surprisingly, a higher risk of developing lung cancer during their lifetime.

Table 1. Lifetime risks for men and women in the US, Canada and Japan exposed to three different radon concentrations, 0, 100 and 400 Bq/m³.

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th></th>
<th>Women</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 Bq/m³</td>
<td>100 Bq/m³</td>
<td>400 Bq/m³</td>
<td>0 Bq/m³</td>
<td>100 Bq/m³</td>
</tr>
<tr>
<td>USA</td>
<td>0.0676</td>
<td>0.0901</td>
<td>0.154</td>
<td>0.0253</td>
<td>0.0345</td>
</tr>
<tr>
<td>Canada</td>
<td>0.0806</td>
<td>0.102</td>
<td>0.161</td>
<td>0.0469</td>
<td>0.0605</td>
</tr>
<tr>
<td>Japan</td>
<td>0.0655</td>
<td>0.0803</td>
<td>0.123</td>
<td>0.0254</td>
<td>0.0309</td>
</tr>
</tbody>
</table>

Table 2. Lifetime relative risks for female smokers and non-smokers in the US, Canada and Japan exposed to three different radon concentrations, 100, 200 and 400 Bq/m³.

<table>
<thead>
<tr>
<th></th>
<th>Smokers*</th>
<th>non-smokers#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100 Bq/m³</td>
<td>200 Bq/m³</td>
</tr>
<tr>
<td>USA</td>
<td>1.3</td>
<td>1.5</td>
</tr>
<tr>
<td>Canada</td>
<td>1.2</td>
<td>1.4</td>
</tr>
<tr>
<td>Japan</td>
<td>1.2</td>
<td>1.3</td>
</tr>
</tbody>
</table>

*: the baseline risks of lung cancer for smokers are 0.0618 for US females, 0.121 for Canadian women, and 0.158 for Japanese women.

#: the baseline risks of lung cancer for non-smokers are 0.00538 for US females, 0.0109 for Canadian women, and 0.0147 for Japanese women.
One can see clearly from examples in Tables 1 that the actual computed lifetime risks depend on the age-specific lung cancer rates and overall mortality rates in referent populations. Lifetime risks for smokers and non-smokers depend also on the smoking prevalence pattern of the population, as well as the model describing combined effect between radon and smoking. Therefore, risk projections for different populations could differ significantly. However, the ratios of lifetime risks to baseline values are rather stable across populations, and represent the lifetime relative risks discussed below.

The lifetime relative risk (LRR) is defined as $LRR = R/R_0$, where $R_0$ is the lifetime risk of lung cancer when exposed to the background radon level, i.e., the outdoor radon level. The LRR is a very good term to describe the proportional increment in lung-cancer risk posed by indoor radon exposure beyond the baseline risk. There is always $LRR \geq 1$.

Lifetime relative risks for female smokers and non-smokers in the US, Canada, and Japan are given in Table 2. Here it is accepted that smoking and radon exposure combine in a fashion that is submultiplicative on the relative-risk scale, i.e., less than the anticipated effect if the joint effect were the product of the risks from radon and smoking individually, but more than if the joint effect were the sum of the two individual risks, as recommended by the BEIR VI committee. For a given radon concentration, the values of lifetime relative risks for different populations differ to a certain extent as well. However, the values are rather stable across populations. The lifetime baseline risks of lung cancer are much higher for smokers than for non-smokers. Due to significantly different baseline risks, the lifetime relative risks are then higher for non-smokers than for smokers, as demonstrated in Table 2. The lifetime risk of lung cancer for a non-smoker lifelong exposed to 200 Bq/m$^3$ is roughly the doubling of the corresponding baseline risk, that is $LRR=2$.

As discussed above, the only known health risk associated with exposure to high levels of radon in indoor air is an increased lifetime risk of developing lung cancer. The effects depend on the levels of radon and how long a person is exposed to these levels. Since radon is found in almost every home in varying concentrations, the only way to find out if a home has a radon problem is to measure the radon concentration inside. Remedial measures should be undertaken in a home whenever the average annual radon concentration exceeds 200 Bq/m$^3$ according to the new Canadian radon guideline (12). Radon in homes is a serious health hazard. However, the problem can be fixed as illustrated in the newly revised booklet “Radon – a guide for Canadian homeowners” (1).

**REFERENCES**


Clinical Simulation Terminology Within the Context of Respiratory Therapy Education

A discussion paper

L. R. Matthews, Assistant Professor of Respiratory Therapy, Thompson Rivers University
T. Yachemetz, Associate Professor and Head of Respiratory Therapy University of Manitoba - School of Medical Rehabilitation, Faculty of Medicine

Respiratory Therapy has had over three decades of practical experience using clinical simulation to teach student respiratory therapists. It has remained an integral part of our educational process. In the 1970s recording Resusci Annie dolls would provide a printed record of compression depth and respiratory volume and rate to be used as a skill performance assessment tool. We have used intubation heads to teach airway management skills and lung/patient simulators to teach concepts of mechanical ventilation, ventilator setup and ventilator control interactions. Our patient care labs have been using patient scenarios to teach protocol management for decades. The Advanced Cardiac life support program developed in the 1970s and the Advanced Trauma program developed in the 1980s are examples of the success of practice through simulation. These subsequently spurred further similar successes in neonatal resuscitation (NRP) and pediatric advanced life support (PALS).

We have always used simulating and testing through a case history based approach to prepare our students for clinical practice before we even consider “see one - do one - teach one. Unfortunately we have few if any publications to document our long history of experience and developed expertise. With more recent interest and investment in simulation as an education tool within the health care industry, it is important for us to validate the effectiveness of our approaches and contribute to this emerging body of knowledge. Today, a Google search will retrieve 6,700,000 hits on ‘medical simulation’ and 47,400 hits for ‘high fidelity medical simulation’. When searching for peer-reviewed publications from 1980 to 1996 there are three publications retrieved for “Medical Simulation” in Medline. From 1996 to 1999 there are 15 publications. There are approximately 10 publications per year from 2000 to 2002. After 2002, 20 or more per year are cited until Medline retrieves about 40 publications for medical simulations for 2007. CINAHL reveals 24 in total, of which 3 are CJRT publications. This either demonstrates the volume of non-peer-reviewed activity on this topic or the volume of peer review publication on the horizon.

Educational objectives in most respiratory therapy educational programs are accomplished with a mix of low and high fidelity simulations. When students are first introduced to a topic, the knowledge and skills are broken up into manageable sections or ‘bite size chunks’. Once the basic concepts and skills have been mastered by the students, more comprehensive scenarios are used for teaching and testing. It is through a well thought out educational process that incorporates the concept of increasing complexity over time that the students become safe and competent therapists in the clinical environment.

There is a need for national collaboration on the use of simulation in Respiratory Therapy education. Educators can begin by coming to a consensus on the terminology we will use to describe the varying levels or forms of simulation. Deciding for ourselves what constitutes low, medium, and high fidelity is important. It may be possible to organize the variety of skills to be acquired by new practitioners both individually, and in sets. The skills could be prioritized in terms of skill complexity and risk. Respiratory therapy educators should come up with terminology and methodology that can be agreed on. Those of us utilizing simulation in education should be speaking the same language as a prerequisite to further discussions. This should help avoid misunderstandings.

For example, the hierarchy of educational experience/scenario might look like this:

<table>
<thead>
<tr>
<th>Level</th>
<th>Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Real patient</td>
</tr>
<tr>
<td>2.</td>
<td>State of the art fidelity (virtual reality)</td>
</tr>
<tr>
<td>3.</td>
<td>High fidelity (computer enhanced)</td>
</tr>
<tr>
<td>4.</td>
<td>Intermediate fidelity (multiple unit scenario integration)</td>
</tr>
<tr>
<td>5.</td>
<td>Low fidelity (single skill or fragmented multiple units)</td>
</tr>
<tr>
<td>6.</td>
<td>Skill introduction (single skills)</td>
</tr>
<tr>
<td>7.</td>
<td>Patient actors</td>
</tr>
</tbody>
</table>

**1. Real Patient**

Real patients will always provide the best general experience. However, they cannot be controlled, modified or organized to accommodate an optimal comprehensive educational experience. It may also be unethical to let totally inexperienced students practice in this environment. Also, in a growing number of settings patient experience does not occur in sufficient numbers to sustain general competence for the entire spectrum of patient scenarios.
This problem is amplified by the increasing numbers of students many educational programs are having to deal with.

2. Simulation Fidelity or Level 1 (SF1)
State of the Art High Fidelity - This is the computer aided mannequin that interacts with the team and becomes a part of or directs the scenario. It simulates a real clinical experience in most conceivable aspects.

3. Simulation High Fidelity or Level 2 (SF2)
High Fidelity – A combination of technology and scenario development, this level involves complex scenario development and sophisticated, possibly multiple mannequins, which could be incorporated into appropriate phases to simulate real life scenarios. This could involve ventilator setup and trouble shooting. In high fidelity simulation a serious attempt is being made to make the experience clinical in all aspects. This can also include a well trained actor (‘simulated patient’) that is capable of simulating a specific condition or disease.

4. Simulation Intermediate Fidelity or Level 3 (SF3)
Simple scenario development which would include a series of procedures put together to make this experience similar to that found in a clinical setting. Multiple integration of procedures may be used in combination for authenticity.

5. Simulation Low fidelity or Level 4 (SF4)
This level is still meant to simulate a clinical scenario but is less complex. It could be simulation of airway management on an intubation head. Scenario development would be simple and easy to understand with straight forward goals and objectives. Skill demonstration would be the most important outcome.

6. Skill introduction (single skills)
‘Skill introduction’ relates to the individual components of each skill. Before an entire skill can be taught it must be dissected and described in detail to put it in its simplest form. This is an introductory stage and it allows the student to focus on individual skills within the procedure.

7. Patient Actors (Simulated patients)
An actor that is well trained in a professionally staged environment can provide a well controlled, modifiable and organized scenario to accommodate a comprehensive educational experience. Invasive procedures are difficult to incorporate into the scenario without compromising authenticity.

Scenarios, procedures, manikins, environments and timing all need significant investigation and discussion. However, before proceeding it is critical for us to establish a framework for definitions and terminology in Respiratory Therapy clinical simulation. In that regard, the Canadian Advisory Council on Education in Respiratory Therapy (CACERT) has planned to devote its 2009 conference to this discussion topic. Although the theme of the sessions will be quite generic “Current Trends in the use of Simulation in Medical Education” the focus will nevertheless be on finishing the day with some common understanding.

Hopefully we will have agreement on common nomenclature, possibly develop a hierarchy or classification of simulation strategies and perhaps even some preliminary discussion on what levels of simulation should be acceptable for establishing competency using the national competency profile (NCP). This latter objective would be of interest to the ‘regulatory authorities’ who largely rely on education programs to establish entry level competency for the discipline.

The education of respiratory therapists in Canada has in recent years been subject to a great variety of pressures. Increasing numbers of students, increasing costs of education, decreasing clinical resources, and the need to implement curricular changes in a timely fashion represent just a few of our challenges. Many educational programs have had difficulty in addressing some of the requirements imposed by external sources. Timing issues between being told what the performance expectations are of our graduates and deciding how we need to address these expectations from an educational perspective also presents a very real problem. Even though respiratory therapy practitioners across Canada are very similar in their education and practice, there remain some regional differences in practice which need to be addressed creatively through educational programs and may be at least partially leveled by simulation.

This is an important time for Respiratory Therapy Educators to step up to the plate and provide leadership in creating a sound framework for education and to contribute to this emerging body of knowledge. This among other things can assist in measuring the attainment of a common set of national competencies for our students and for the public who depend on us.
After Code Orange “A” - What Is Your Plan “B”

November 19, 2008 – 12:00-1:00 ET

David Swift

Strengthen your professional credentials! CSRT’s November workshop offers relevant information as RTs confront emerging issues in the respiratory profession.

The first response to situations that exceeds the routine capacity of the emergency department or a facilities critical care capacity is to initiate a “CODE ORANGE” – internal/external disaster protocol. “CODE ORANGE” represents a facilities PLAN ‘A’ and represents a short term response to an emergency. PLAN ‘A’ reflects the philosophy of YOYO 72 –you are on your own for 72 hours. During this period of time, the facility is expected to be self sufficient with regards to physical resources and human resources. After 72 hours, it is hoped that external resources will become available- the reality is that you need to develop a PLAN “B”.

PLAN “B”
An emergency situation of large scope, that exceeds 72 hours, will rapidly challenge the resources of most hospitals & RT departments. on-hand supply levels maintained within a hospital varies from facility to facility. The larger the facility the more likely it is to have more than 72 hours of resources (in normal circumstances) on-hand. The smaller hospital is more limited in its abilities (financial & physical) to maintain larger inventories on-hand. The key to success is develop a plan “B” that offers long-term sustainability and a phased approach to resource utilization.

Key philosophy for PLAN “B” is that: “ALL PATIENTS” will receive care in a fair and equitable manner and on the basis of prioritized resources

Check the CSRT home page for a registration form for this informative workshop.
For more information contact Pam Hicks, phicks@csrt.com

Generously sponsored by:

CoARTE Update

This fall there are three upcoming accreditation site visits; Conestoga College Institute of Technology and Advanced Learning, QEII/Dalhousie University School of Health Sciences, and the Collège Communautaire du Nouveau-Brunswick – Dieppe. A thank you to the program reviewers who have volunteered their time to participate on these upcoming accreditation visits, and to the programs for their hard work in preparing to host the program reviewers.

I would also like to welcome Susan Dunington to the CoARTE council as the – Respiratory Therapist Didactic Representative. Susan will be replacing Tom Dorval on Council after the annual meeting in November. CSRT would like to thank Tom Dorval for his hard work during his two terms on Council, where he served as both Chair and Vice-Chair.

If you are interested in participating as a program reviewer, or would like additional information on the accreditation process, please feel free to contact Pam Hicks at phicks@csrt.com, or (800) 267-3422 ext 26.
Professional Development Workshops

After Code Orange A - What is Your Plan B?

This workshop will be held November 19th, 2008 from 12:00 pm until 1:00 pm; the cost is $75.00 + GST per site for CSRT members and $100 + GST per site for non-members.

<table>
<thead>
<tr>
<th>Institution Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site(s):</td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>CSRT File Number:</td>
</tr>
<tr>
<td>Payment Amount (please circle): Members: $78.75 ($75.00 + GST) Non-Members: $105 ($100 + GST)</td>
</tr>
<tr>
<td>E-mail Address:</td>
</tr>
</tbody>
</table>

**METHOD OF PAYMENT**

Cheque/money order payable to CSRT (enclosed) [ ]
VISA [ ] Mastercard [ ]

*Charges apply on all NSF transactions.*

Credit Card Number:
___________________________________________

Expiry Date__________________________________
___________________________________________

Signature
___________________________________________

Total ___________
Find yourself at
Alberta Health Services
– Capital Health

Your career. Your life. Your choice. At Alberta Health Services – Capital Health, you choose the way you want to work and live. With such a vast array of roles, disciplines and locations available, you can find your perfect balance. Within our integrated health care model, we offer rewarding positions in a wide variety of areas, from nursing to nutrition, allied health to administration, and IT to research. Whatever your career focus, Alberta Health Services – Capital Health is a great place to work. Choose to live in a rural, small town or big city location, while contributing to public health, acute, long-term or community care. As Canada’s largest academic health region, we’re leading the way in quality of care, medical advances and career opportunities. Discover career fulfillment and get more out of life in the Edmonton area.

Apply today:

www.capitalhealth.ca • careers@capitalhealth.ca
Cold Weather and COPD

The Canadian winter can be a beautiful season to enjoy the outdoors. But for people with COPD, the cold weather can translate to days of indoor confinement while the rest of the world goes about its normal daily activities.

Cold Air Inhalation

Cold temperatures represent unique challenges to the cardio-pulmonary system. When temperatures drop to near-freezing and below, exposure to this environmental condition causes increases in cardiac and pulmonary stress. Some of the easily measurable and observable stresses brought about by cold air inhalation are rapid increase in blood pressure, decrease in heart rate, increase in cardiac output, increase in pulmonary resistance, and pain in the chest and airways. Any of these indicators of stress may not be cause for alarm to a normal healthy individual, but for individuals suffering from COPD, these changes represent increases in risk of a potentially serious medical event.

The best way to help improve comfort during cold exposure is to wear a facemask specially designed to warm the air. A new, affordable, easy-to-use CT Mask has been designed specifically for people with cardio-pulmonary illnesses who suffer negative physiological effects from breathing cold air.

How It Works

The CT Mask uses a proprietary heat and moisture exchanging mesh to warm the air that is about to be inhaled. The thermal medium used in the CT Mask is a fine copper mesh (with antimicrobial properties) which has a high thermal exchange coefficient. When a patient exhales through the thermal medium, their breath is near body temperature and at 100% relative.
Industry News

Paul Hernandez, MDCM, FRCPC
Chair, CTS COPD Guidelines
Dissemination and Implementation Committee

The prevention and management of exacerbations and new algorithms to ensure patients are receiving optimal therapy appropriate to their disease severity are two of the most significant areas addressed by the recently released “2008 Update: Canadian Thoracic Society recommendations for management of chronic obstructive pulmonary disease- Highlights for Primary Care”.

To help communicate this key information to patients and caregivers, the Canadian Thoracic Society COPD guidelines dissemination and implementation committee has developed a number of effective strategies and tools, including: continuing medical education programs for health care professionals; point-of-care physicians’ aids; and self-management tools that empower patients to better self-manage their disease.

Interactive, accredited continued medical education (CME) activities (both face-to-face and on-line course format) are being developed by a group of specialists, family physicians and other respiratory health professionals from across the country. The CME program design allows an event facilitator to select content from a large array of slides based upon the specific needs of a given group. Three case studies, formulated to facilitate maximum interactivity, are designed to provide opportunities for practical application of the updated data.

To improve patients’ ability to recognize and react appropriately to an exacerbation, we looked at a number of innovative chronic disease self-management strategies. The Cochrane review has reported that the use of action plans promotes disease self-management and allows patients to adjust their treatment in response to changes in severity and stability of their condition. For patients, an Action Plan created with the help of their physician and lung health educator is a great starting point for knowing what to do to prevent and self-manage exacerbations and when to seek medical treatment. For physicians and other health care professionals, an Action Plan is a practical reminder of the clinical evidence-based guidelines and best practices.

The COPD Action Plan is designed to be printed in three parts to facilitate communication and continuity of care among the patient, physician and pharmacist. It can be downloaded from www.copdguidelines.ca, www.respiratoryguidelines.ca, RESPTrec and www.lung.ca websites. Other educational tools, such as the COPD Slim Jim, COPD Guidelines Slide Kit, and articles such as the Highlights for Primary Care, can also be freely downloaded for personal use from www.copdguidelines.ca or www.respiratoryguidelines.ca. Hard copies are currently being distributed to physicians and health care professionals across Canada via mail outs and at professional conferences. Copies can be sent to individuals upon request, by contacting ldingwell@lung.ca.

Winter Suggestions for Patients

- have vaccinations each year to protect against flu and pneumonia
- keep active and exercise at the age-appropriate level with consideration for individual health situations
- dress properly in insulated winter apparel and layers of clothing
- wash hands often and take extra precautions to avoid exposure to possible contaminants
- avoid contact with sick individuals to reduce risk of catching a cold or the flu
- drink plenty of fluids to properly hydrate and defend against infections and viruses
- cover head and face to provide extra protection against breathing cold air – even during short exposures

humidity. The thermal medium retains some of this heat and moisture, and stores it in the copper mesh. When the patient inhales cooler, dry air, the thermal medium, which is now at a higher temperature and relative humidity, transfers some of the stored heat and moisture to the inhaled air prior to being delivered to the patient, thus putting less strain on their respiratory system.

Using the CT mask can greatly reduce the adverse effects of cold weather on COPD patients, and provide them greater independence during long winter months.

For more information about the CT mask, contact Roxon Medi-Tech at 1-800-361-6991 or visit www.roxon.ca

COPD Action Plan
the patient and a student nurse, and off we went with lights and sirens blaring down the highway as we frantically re-
suscitated our patient. All was well in the end, but as this transpired during my final days with the hospital, it left me with a lasting memory.

I firmly believe that health is a human right and that access to healthcare a human necessity. The disparity that was so blatantly evident when comparing life in Canada to life in Ghana was staggering and highlighted the injustices imposed by a drastic lack of basic infrastructure to support development. I, like many others, told myself that despite my best intentions, my motivation, my background, my education, that I knew that I was but one person trying to make sense of a myriad of injustices and that I wouldn’t be the one to turn it all around. I’d like to say that I believed myself, but it wasn’t until I was able to appreciate the complexity of international healthcare issues and the challenges of international development that I was fully able to realize the breadth of the work that must be done to truly support development in certain regions of the world.

As healthcare professionals, we are integral to the effective provision of healthcare, and by virtue of our involvement in the healthcare world should be seeking to strengthen the Canadian healthcare delivery system, but should also be strong advocates of universal access to healthcare. Though distance separates us from the consequences and realities experienced by our healthcare colleagues in developing nations, ideology should unite us.

There are several directions through which respiratory therapists can and should become involved in international health development work, ranging from advocacy at home in Canada to work on the ground in other countries. Having lived both of these, I will say that both can be equally rewarding and frustrating at times. For those interested in international travel, in my experience I would recommend trying to identify specific needs of the area that you plan to visit and then establishing what aspects of the local healthcare infrastructure the host country is trying to develop. From there, the larger context will become clearer and you will be better suited to establish how you can help and what to expect. I would highly recommend traveling with a group to help share the workload, for different clinical perspectives and levels of experience, as well as for the psychological benefits of traveling among friends. Having someone to bounce ideas, thoughts, emotions and experiences off of was invaluable to me.

I present the above as the beginnings of what I hope to be an ongoing discussion among members of the respiratory therapy community in Canada and abroad. As stewards of our profession and of respiratory health in Canada, we stand to not only strengthen our profession but to reaffirm the notion of equitable access to healthcare as a universal right and not merely a benefit of the privileged. Respiratory therapists have always been known for their resourcefulness and for being compassionate members of the healthcare team that offer a professional expertise that is valued and respected by our colleagues; applying this expertise and the unified voice of a profession to international health issues could be invaluable in the context of advocacy and development.

My experiences have been but a brief snapshot of the truly remarkable work being done at home and abroad by dedicated professionals, volunteers and grassroots activists, alike. It is to those who live and fight the good fight every day that I am truly grateful, for they are the ones who are changing perspectives, ideologies and the world.

“We make the road by walking” – M. Horton, Freire, P. (1990) (1)

1. Department of Educational Studies, The University of British Columbia
2. Department of Anesthesia, St. Paul’s Hospital, Vancouver, British Columbia

Continued from page 7

De plus en plus de TR prennent la décision de contribuer leur expertise à des pays en développement. Jason Nickerson discute des défis qu’il a encourus en travaillant au Ghana ou l’infrastructure des soins de santé est rudimen-
taire pour en dire le moins.

Ce numéro contient également des renseignements impor-
tants au sujet de notre prochaine AGA spéciale qui aura lieu à Ottawa le 5 décembre 2008. Veuillez prendre le temps de lire les déclarations des candidats au poste de président désigné et de vous familiariser avec la nouvelle procédure de vote. Le soutien des membres s’avère es-
sentiel pour permettre à la Société de progresser de façon unie et efficace.

Nous sommes heureux de publier l’Exposé de principe de la SCTR sur les assistants en anesthésie. La SCTR ap-
puie le rôle du thérapeute respiratoire à titre d’assistant en anesthésie puisqu’il s’insère dans le champ d’activité de la thérapie respiratoire.

La section science de la RCTR renferme deux articles : un document de travail sur les risques du cancer du poumon provoqué par le radon rédigé par Jing Chen; et Clinical Simulation Terminology within the Context of Respira-
tory Therapy Education par Les Matthews.

Rita Hansen
Rédactrice en chef, RCTR

Continued from page 4
“This is my SOLUTION.”

As a member of the Canadian Society of Respiratory Therapists, TD Insurance Meloche Monnex offers you high-quality home and auto insurance products, preferred group rates and exceptional service.

Being involved in an accident or falling victim to theft can be very stressful. Get added peace of mind by adding our NEW Goodbye Deductible™ protection to your automobile policy. That way, you’ll have ZERO deductible to pay in the event of an eligible claim. We will handle all covered expenses from start to finish. Contact us to add this feature to your policy today!

Enjoy savings through PREREFERRED GROUP RATES:

MelocheMonnex.com/csrt
1 866 269 1371
1. In 2008 there will be over 9,000 hospital visits, 30,000 emergency department visits and 620,000 doctor’s office visits due to air pollution.

CMA http://www.cma.ca/index.cfm/ci_id/86830/la_id/1.htm

2. Asthma is the most common respiratory disease in Canadian children. Asthma is responsible for one-quarter of school absenteeism and is the leading cause of hospitalizations of children up to the age of 14. Statistics show there is a 200% surge in hospital visits in the third week of September – commonly referred to as the September Spike epidemic.


3. Tobacco use is the most significant cause of preventable disease, disability, and premature death in Canada, responsible for more than 47,000 deaths every year. Tobacco kills three times more Canadians each year than alcohol, AIDS, illegal drugs, car accidents, suicide, and murder -- all combined! http://www.nnsw.ca/about.html

4. Pneumonia and other acute lower respiratory infections Globally, pneumonia and other acute lower respiratory infections represent the single most important cause of death in children under five years. Exposure to indoor air pollution more than doubles the risk of pneumonia and is thus responsible for more than 900 000 of the 2 million annual deaths from pneumonia. WHO http://www.who.int/mediacentre/factsheets/fs292/en/index.html

5. Women make up almost half of Canada’s physicians under 40 years of age. Canadian Institute for Health Information - www.cihr-irsc.gc.ca

6. Motor vehicle collisions are the second most common cause of injury resulting in deaths that occur in Canadian hospitals—unintentional falls are the first. www.cihi.ca

7. In 2008, 21,000 Canadians will die from the effects of air pollution, a figure projected to rise to 710,000 by 2031; Canadian Lung Association

8. Respiratory diseases account for approximately 40% of the 92,000 emergency department visits in 2008 linked to air pollution – a figure projected to rise to 152,000 by 2031; Canadian Lung Association

9. Worldwide, a woman dies every minute due to complications during pregnancy and childbirth - more than 500 000 women per year. In developing countries, pregnancy and childbirth are the second leading causes (after HIV/AIDS) of death among women of reproductive age. WHO
Simplicity is getting all of the $\text{SpO}_2$ performance for a fraction of the cost.

Philips single-patient-use and reusable $\text{SpO}_2$ sensors can help you reduce your cost of pulse oximetry — while delivering top clinical performance. Our exceptionally durable single-patient-use $\text{SpO}_2$ sensors are tested to last the entire length of the average patient stay, while our broad family of reusable sensors is warranted for up to 18 months. Each is validated with a wide variety of popular patient monitors, including our own. Make the cost-effective choice — Philips.

www.philips.com/supplies