Queen's University

Senate Committee on Academic Development
Report to Senate – Meeting of March 26, 2009

Proposal to change the name of the Department of Anaesthesiology to the Department of Anaesthesiology and Perioperative Medicine

Introduction

The proposal to change the name of the Department of Anaesthesiology to the Department of Anaesthesiology and Perioperative Medicine in the Faculty of Health Sciences was reviewed by the Senate Committee on Academic Development (SCAD) at its meeting of February 25, 2009. J. Parlow, Head of the Department of Anaesthesiology, attended the meeting to speak to the proposal and answer questions from members of SCAD. A copy of the letter approving the proposed name change by the Faculty Board in the Faculty of Health Sciences, and a letter from J. Parlow to the Dean of the Faculty of Health Sciences are attached to this report.

Analysis and Discussion

The following should be noted:

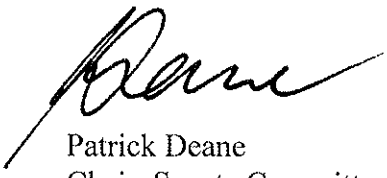
- the proposed name change of the Department reflects the evolution and expansion of the field of anaesthesiology which includes perioperative assessment, acute and chronic pain management, trauma and patient safety;
- the proposed name change is more precise and clearly signals the Department's future direction to prospective students;
- the proposed name change is consistent with similar changes being made in departments across North America.

Conclusions/Recommendation

Recommendation:

that Senate approve the proposal to change the name of the Department of Anaesthesiology to the Department of Anaesthesiology and Perioperative Medicine in the Faculty of Health Sciences, effective immediately, and to inform the Board of Trustees of this change.

Respectfully submitted,



Patrick Deane
Chair, Senate Committee on Academic Development

Committee Members:

Members
C. Baker
J. Coates
P. Deane (Chair)
M. Hoidas
M. Lombardi
D. McKeown
K. O'Brien (Secretary)
P. Oosthuizen
M. Roberts
D. Stockley
M. Whitehead

Memo

Queen's UNIVERSITY

TO Patrick Deane, Chair, Senate Committee on Academic Development

FROM Georgina Moore, Secretary of the Senate

DATE February 9, 2009

SUBJECT Proposed name change for the Department of Anesthesiology

UNIVERSITY SECRETARIAT
Mackintosh-Corry Hall, Room B400
Queen's University
Kingston, Ontario, Canada K7L 3N6
Tel 613 533-6095
Fax 613 533-2793
www.queensu.ca/secretariat

The Department of Anesthesiology is proposing to change its name to the *Department of Anesthesiology and Perioperative Medicine*. The Faculty of Health Sciences Faculty Board approved the proposed change at its February 5, 2009 Faculty Board Meeting.

As outlined in Dr. Joel Parlow's (Head, Department of Anesthesiology) covering letter, the proposed name change indicates more clearly the expanding scope of the discipline. Dr. Parlow should be contacted directly for any additional information you may require. You may contact him directly at ext 81-6098 or by email at parlowj@queensu.ca

Please review the proposal and report back to the Senate with your committee's recommendation.

Thank you for your attention to this matter.

Georgina Moore
Secretary of the Senate

c.c. J. Parlow, Head, Department of Anesthesiology
K. O'Brien, Secretary, SCAD + copy of submissions
D. Walker, Dean, Faculty of Health Sciences

David R. Edgar
Secretary
Faculty Board
e-mail facsec@queensu.ca

Tel: (613) 533-6000 ext. 77938
Fax: (613)533-6884

February 6, 2009

Ms. G. Moore
University Secretariat
B-400 Mackintosh-Corry
Queen's University

Dear Ms. Moore:

Please find enclosed a request on behalf of all members of the Department of Anesthesiology requesting the name of the department be changed to the "Department of "Anesthesiology and Perioperative Medicine." A letter to Dean Walker from J. Parlow, Head of the Department of Anesthesiology along with a briefing note detailing reasons for the proposed name change is attached as supporting documentation.

The request has been reviewed by their departmental committee and the committee's recommendations have been incorporated into the letter. The request has been approved by our School of Medicine Executive, School of Medicine Academic Council and Faculty Board. The motion approving the name change to the Department of Anesthesiology and Perioperative Medicine by Faculty Board is,

"K. Nakatsu ***moved*** and ***seconded*** by T. Massey that Board approve and forward to Senate for their consideration that the name of the Department of Anesthesiology be changed to the Department of Anesthesiology and Perioperative Medicine."

CARRIED

Thank you for your attention to this matter.

Yours sincerely,

David R. Edgar
Secretary, Faculty Board

Encl.

Joel Parlow MD, MSc, FRCPC
Associate Professor and Head
Department of Anesthesiology
Queen's University

Kingston General Hospital
76 Stuart Street
Kingston, Ontario K7L 2V7

Tel: 613 533-2952
Fax: 613 548-1375
E-mail: parlowj@kgh.kari.net
Website: www.anesthesia.ca

Dr David Walker
Dean, Faculty of Health Sciences

November 18, 2008

Dear David,

As you know, the field of Anesthesiology has been expanding in scope steadily and significantly over the past decade. Specifically, outside the traditional "anesthesia" environment, anesthesiologists have become heavily involved in enterprises such as preoperative assessment, acute and chronic pain management, trauma and RACE initiatives, simulation, patient safety, etc. A recent trend among Anesthesiology departments is the recognition of this expanded perioperative role by rebranding their departments as departments of "Anesthesiology and Perioperative Medicine". There are practical as well as philosophical advantages to this sort of initiative. I am attaching an article outlining the experience of an American department in this regard.

With this in mind, the department members would like to request a change in the name of our department to the Department of Anesthesiology and Perioperative Medicine. I would appreciate it if this proposal comes before the next School of Medicine Council.

Thanks for your guidance in this, and please let me know if you require anything further.

Best regards,

Joel Parlow
Head, Department of Anesthesiology

Nov 25/08. OK with me

Anesthesiology

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Anesthesia and Perioperative Medicine: A Department of Anesthesiology Name [Contemporary Issues Forum]

Alpert, Calvert C. MD; Conroy, Joanne M. MD; Roy, Raymond C. PhD, MD

(Alpert) Associate Professor; Clinical Director.

(Conroy) Professor of Anesthesiology; Vice Chair.

(Roy) Professor of Anesthesiology; Chair.

Received from the Department of Anesthesia and Perioperative Medicine, Medical University of South Carolina, Charleston, South Carolin publication September 22, 1995. Accepted for publication January 4, 1996.

Address correspondence and reprint requests to Dr. Roy: Department of Anesthesia and Perioperative Medicine, Medical University of So Avenue, Charleston, South Carolina 29425-2207. Address electronic mail to: royr@anest1.mhs.musc.edu.

ON August 11, 1995, the board of trustees of the Medical University of South Carolina approved changing the name of the Depart to the Department of Anesthesia and Perioperative Medicine. The impetus to include perioperative medicine in our name came fr were the proposals of Greene and Saidman in their respective 31st and 33rd Rovenstine lectures at the 1992 and 1994 annual m Society of Anesthesiologists (ASA) that a name change for the specialty was in order. Greene believed that anesthesia had move the profession to a confining one. To make the point that many of us were involved in much more than anesthetic administration, not esoteric tack of creating a new word, metesthesia, which he defined as everything we do. [1] Saidman, although recognizing t observation, suggested dropping all derivatives of the term "anaesthesia." He proposed perioperative medicine and pain manage unambiguously described the full extent of our activities. [2].

Second, there was the fear that external economic pressure would soon be exerted on us to "right-size" our department. By assur for more aspects of the system that cares for the surgical patient, we become the right people to keep around to manage the deliv In the current fee-for-service system, there is a financial disincentive to spend nonrevenue-generating time performing tasks outsi that are essential to the delivery of quality anesthesia care and for which we are legally and ethically held accountable. When glot systems become the norm, we no longer want our share to be based solely on anesthesia time and the performance of specific p want to be reimbursed for our decisions on what should be done and for our management of the consequences of these decision will be more than willing to accept our activities in this area when they realize (1) we are reducing their "at risk" costs, (2) they mu operating room and clinic, and (3) they are no longer being reimbursed fee-for-service for reading electrocardiograms, providing c patient-controlled analgesia. As Rosenthal stated, "With the many changes in health care delivery, the future survival of anesthesi well depend on the acceptance that perioperative involvement, rather than sole intraoperative anesthesia practice, is the purview anesthesiologists." [3].

Third, there was the appreciation of the more subtle contributions of anesthesia to perioperative mortality and morbidity. [4] When epidural-general with epidural analgesia and general with parenteral analgesia, no statistically significant difference was observed incidence of traditional anesthesia-related complications. However, when all complications, such as major infection, organ system were included, the total incidence was significantly less in the epidural group. [5] Thus, perioperative complications formerly consi surgical were shown to have an anesthesia component. Subsequent studies have demonstrated that techniques we apply intraop analgesia and care we are responsible for postoperatively significantly affect morbidity [5,6-10] and that morbidity increases cost For example, events occurring on postprocedure days 1 and 2 are recognized as clinical indicators of an anesthesia care system improvement. [12].

Fourth, there was the success of recent interdepartmental collaborative efforts. We seriously considered the recommendations of Accreditation of Healthcare Organizations that our department be actively involved in the review and implementation of policy and conscious and deep sedation administered anywhere in the hospital or clinic. We developed subspecialty calls for pediatric, cardi transplant anesthesia and for intensive care and have designated specific anesthesiologists as liaisons between our department

specialties. We worked closely with pulmonary medicine in the medicine intensive care unit, with trauma surgery in the emergency intensive care unit; with cardiology in the treatment of patients with intractable angina and the provision of intraoperative transesop echocardiography; with pediatrics in the development of pain treatment protocols, introduction of laryngeal mask airways to the pe provision of general anesthesia for pacemaker insertions, transesophageal echocardiography, and cryoablation procedures, and s sedation for bone marrow biopsies and cerebral spinal fluid aspirations and injections; with neurology for intraoperative neurophys psychiatry for electroconvulsive therapy; with obstetrics in labor and delivery; with gastrointestinal medicine for the provision of ge endoscopic retrograde cholangiopancreatography; and with radiology for magnetic resonance imaging and invasive radiologic pro productive joint research efforts with cardiology, [13] cardiothoracic surgery, [14–16] vascular surgery, [17] pediatric dentistry, [18] are working closely with hospital administration to improve patient flow, change from a small anesthesia preoperative evaluation a preadmission clinic, improve our inventory control, and reduce total patient operating room, recovery room, intensive care, and ho costs. These efforts have not progressed as far as those described by Macario et al. [20] and critiqued by Orkin. [21,22]

Fifth, there was an evaluation of our faculty effort distribution. Based on an average 52-h week of clinical time, including in-house vacation time, the percentage of time spent in the operating room was 68% for faculty assigned full time to the operating room. Th involved in clinical care activities outside the operating room for one-third of their time. An unresolved problem is how much more the current salary structure and number of faculty. Each department member takes more call hours because of the subspecialty c the nonoperating room activity is accomplished through longer daily time commitments. We have not hired additional staff specific may effectively be doing so when we recruit anesthesiologists to administer anesthesia in place of residents because of a reductio residency. The hospital administration is helping to defray some of our salary burden on the promise that productivity in the area c will reduce their costs and patient care charges. However, their pockets are not as deep as they once were.

Why change from anesthesiology to anesthesia? Anesthesiology is classically defined as that branch of medicine that studies ane anesthesiologist originally was anyone who studied the anesthetic state and anesthetic agents. An anesthetist originally denoted t anesthetic state. Now anesthetists and anesthesiologists refer respectively to nurses who administer anesthesia and physicians w supervise the administration of anesthesia. By changing from anesthesiology to anesthesia, we became inclusive of everyone inv administration of anesthesia and intravenous sedation at our institution.

Although we agree with Saidman that perioperative medicine and pain management is the most ideal name, we were not prepare for several reasons. First, the word anesthesia carries an amount of tradition. Second, anesthesia is the hub from which the spoke perioperative medicine, pain management, and critical care are derived. It is our area of acknowledged special expertise. Our train monitored by an anesthesia residency review committee; we are certified by the American Board of Anesthesiology; we are memt societies with anesthesia in their names; and we publish primarily in journals with anesthesia in their titles. Third, the majority of o operating room, and most of our revenue is derived from a fee-for-service anesthesia practice. Fourth, we have yet to define what perioperative physician (see below). Fifth, once a consensus definition of perioperative medicine is reached, we will need to mark profession that anesthesia is only part of what we do as perioperative physicians. Sixth, dropping anesthesia completely is more li suspicions of our medical colleagues that we are invading their turf when we are only filling a current vacuum in informatics, mana cost-effectiveness and efficiency efforts, and patient relations.

We also elected not to add pain management or critical care to our department's name. Neither is always perioperative, but we pa activities. Adding either or both would make our name unwieldy. We have achieved recognition of our roles in acute, chronic, and and in critical care units. The Accreditation Council for Graduate Medical Education accredits anesthesia critical care medicine pro pain management programs, and the American Board of Anesthesiology grants certificates for special qualifications in critical care qualifications in pain management. However, recognition does not mean market share. Although chronic pain management servic standing clinic status with reasonable recognition, referrals, and reimbursement, they may evolve into regional multidisciplinary co might not be the manager unless we make a concerted effort to maintain our current leadership role. It is difficult to regain a prese relinquished. This fate has befallen many critical care units, but we still have a strong core of programs. [23]

The process we followed to secure the name change involved four major steps. First, we did not change our name and immediate responsibility. Rather we assumed additional responsibility and after several years asked to have our name changed to reflect the discussed the ramifications of a name change at the departmental level, reached a consensus, voted unanimously in favor of the documented this in the minutes of our meeting. This was important because part of the motivation was to influence our own beha change was discussed with the respective chairs of the departments of surgery and medicine and with the dean. The chair of med the division heads of cardiology and pulmonary medicine, with whom we have had very constructive and productive collaborative 3 yr. With their support, a letter was sent to the dean formally requesting the name change. The dean relayed the request to the p for academic affairs with an accompanying letter supporting us. The provost presented it to the board of trustees, who discussed t subcommittee. "During the preliminary meeting of the Subcommittee on Education, Faculty, and Student Affairs, there was a thor topic. Questions were raised and addressed about whether the name change implied any expansion of responsibilities in patient c with other disciplines. Ultimately, the Subcommittee concluded that the proposed new name better reflected the services currently department and unanimously endorsed the change."*

During this discussion, we assumed that the definition of the term perioperative medicine is so intuitively obvious that it requires n what it means in practice today in medical centers across the country would reveal a range in definitions on a patient-care level (fr anesthesia alone to total care of the surgical patient [24]), on a managerial level (from no input into the operating room schedule t scheduling), and on a research and informatics level (from no activity to sophisticated program projects). We have described the r one department, which we know is not unique. At many institutions such as ours, perioperative activity within the department 3 yr now. Thus, not only is local interpretation of the definition not uniform from medical center to medical center, it is evolving within e

special training will be required will depend on the responsibilities assumed. Beattie envisions a revision of the residency program base year, to reflect an ambitious, didactic research and clinical program in perioperative medicine.** Physical diagnosis skills ma personnel and business management skills developed, and outcome-based health services research performed. An organized eff medicine from the perspective of an anesthesiologist needs to emerge from the academic medical centers and from the ASA.

In summary, we propose a series of time-dependent departmental name changes from anesthesiology to anesthesia and periope perioperative medicine and pain management. The rate of change will depend on when we can achieve a consensus definition fo and how successful we are in our efforts to convince those outside the profession of the validity of this project. Our name change acknowledgement that the members of our department have taken a major step toward recognition as perioperative physicians

* Greenburg R: Personal communication. 1995.

** Beattie C: Personal communication. 1995.

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