As I am writing this message, we have concluded the 30th CSDMS Annual General Meeting (AGM) and Educational Conference in Halifax, Nova Scotia. I would like to thank everyone who attended for their support. I hope that you enjoyed the opportunity for education, networking, and fun.

On behalf of the CSDMS Board of Directors, I would like to again thank the Halifax local planning committee for their tireless efforts. The conference was a tremendous success thanks to a great many passionate volunteers.

We had 367 participants attend this year’s conference and our largest number of exhibitors to date! Thank you to all of our sponsors for the continued support.

The CSDMS Board was proud to host an exceptional awards luncheon in Halifax recognizing the achievements of our members, both students and sonographers. It was wonderful that all of the recipients were in attendance to personally receive their awards. Congratulations on your successes. I would also like to encourage all members to investigate our awards for the coming year. This information is available on the CSDMS website. We have recently worked to improve the depth and accessibility of the CSDMS awards and I hope to see many of you take advantage of this exciting opportunity.

Again this year, many of the conference lectures were recorded to be included in our CSDMS library. Lectures will be available from September through July on our website. We invite you to investigate this professional development opportunity.

The CSDMS has a number of exciting projects ongoing and new initiatives beginning. The Board of Directors is dedicated to ensuring that we continue to improve our services to you in the coming year.

Priorities for the 2012/2013 year include growth and development of our communications at CSDMS, including improvements to the website, The Canadian Journal of Medical Sonography (CJMS), and the e-Interface publication. Kim Boles continues as our editor-in-chief of the CJMS and has recently taken on the e-Interface as part of his portfolio. We thank him for his dedication and continued contribution.

We will also see the beginning of the National Competency Profile revisions and revalidation this year. This project will be overseen jointly by CSDMS and CARDUP. We look forward to the opportunity to re-examine the profession and current practice across Canada.

I look forward to another busy year ahead. I hope to have many opportunities to connect with you throughout the year and welcome your feedback and suggestions always. Around the corner is the 31st annual AGM and conference, in Winnipeg from May 31 to June 2, 2013. This promises to be another outstanding event. We hope to see you there.

Wendy Lawson
RCA has been delivering specialized diagnostic imaging services and exceptional medical care for more than 100 years. With an ever-expanding network of clinics across western Canada, we are growing better all the time.

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It is with great pleasure that I am submitting my first report to the membership. I’d like to take this opportunity to thank you for electing me into this role; I look forward to serving the board over the next few years.

Currently, in echocardiography, we have many CSDMS members and non-members that can play a vital role in communication with the cardiac imaging community in Canada. I would like to encourage you to send me a contact name of your echo lab or private echo clinic in order to establish a more robust contact list to disseminate echo imaging information. I am hoping with your support and help this list can be compiled within the next month.

Member concerns over the administration of ultrasound contrast agents (UCA) have raised the board’s awareness to the lack of a CSDMS position statement over the preparation and delivery of the UCA. Currently, Definity contrast by Lantheus Medical is the only UCA approved by Health Canada, so in my report I will refer to this product only as the normal saline contrast bubble study. I have begun solicitation from many of our contrast agent physician experts to get their opinion on a draft position statement already created. Once we have input from our experts it will be brought before the board for final approval before amending our policy guide. Please look for this soon. We hope to alleviate any misconceptions about UCA and provide a guide for your echo lab or multi-discipline practice to develop your specific operational guidelines with the utmost care to patient safety and sonography professional conduct.

With the Halifax conference behind us we move forward to many discussions on regulation, organizational operations, and importantly professional liability. Please take the opportunity to pay close attention to the Eastern Director’s report on professional liability and all subsequent communications on this issue. I cannot begin to stress the importance of professional liability coverage as more and more sonographers have been involved in legal liability cases this past year. After discussions with our professional liability insurance carrier and review of the latest court cases it is crystal clear that our employer’s liability coverage varies significantly from employer to employer. After speaking with our legal department for Alberta Health Services, which covers the entire province of Alberta, it is critical to understand that physicians may not be accountable for negligent occurrences on behalf of the sonographer performing the ultrasound examination. What this means to us as sonographers is physicians will look after themselves first, and may opt for the medical association to represent them in order to maintain their license at all costs. I would encourage you to investigate your current employer’s professional liability coverage in order to gain insight into what you are covered for. An important criterion to raise awareness is the legal term aggregate coverage. Aggregate means the total amount that the policy will pay out during the year of coverage. For example: if the employer’s insurance has a 10 million dollar aggregate and several legal cases were paid out that consumed the aggregate, the employee would be legally responsible for his or her own legal case. I encourage you to speak to your colleagues and make an informed decision with regards to your own career and personal financial safety with respect to liability coverage.

Nationally, the NCPs (national competency profiles) will be re-surveyed this year. Please take the opportunity to encourage as many of your colleagues, staff, and administration to fill out the survey as the larger the response rate, the more representative the data are of our current national practice. This survey is a critical piece in education of our future sonographers keeping the training programs up to date with the latest national clinical practices. Taking roughly 20 minutes of your time; the benefits to the profession are immeasurable. I’d like to stress that the cardiac survey in particular is an opportunity to gain sound insights into current echo clinical trends such as 3-D, strain, contrast, stress echo, dysynchrony, pericardiocentesis, and many other disease specific quantitative measurements now being performed that were not 6 years ago.

In summary I would like to thank you again for your support and look forward to an informative year in cardiac imaging.

Dal Disler
Cardiac Director
I want to begin with a thank you to all the organizers in Halifax for hosting a great conference. It is always great to meet up with old friends and meet new ones. I am always interested in meeting colleagues from across the nation and sharing ideas and putting faces to names.

In this submission, I would like to share a link that I feel is a valuable resource for stroke prevention and helping to develop guidelines for carotid ultrasound exams: www.strokebestpractices.ca. This is an interesting and informative website that deals with all aspects of stroke patients and makes recommendations for treatment and required tests that help with stroke prevention. For ultrasound, patients that have had a TIA need to receive a carotid Doppler exam in a timely fashion. This is taken directly from the website (found under prevention, then carotid intervention):

**Carotid Intervention**

**2.7.1 Symptomatic carotid stenosis**
Patients with transient ischemic attack or non-disabling stroke and ipsilateral 50 to 99% internal carotid artery stenosis (measured by two concordant non-invasive imaging modalities) should be evaluated by an individual with stroke expertise and selected patients should be offered carotid endarterectomy as soon as possible, optimally within 14 days of the incident event once the patient is clinically stable [Evidence Level A].

- Carotid endarterectomy should be performed by a surgeon with a known perioperative morbidity and mortality of less than 6% [Evidence Level A].
- Carotid stenting may be considered for patients who are not operative candidates for technical, anatomic or medical reasons [Evidence Level A]. Interventionalists should have expertise in carotid procedures and an expected risk of peri-procedural morbidity and mortality rate of less than 5%.
- Carotid endarterectomy is more appropriate than carotid stenting for patients over age 70 who are otherwise fit for surgery because stenting carries a higher short-term risk of stroke and death [Evidence Level A]. Research shows that if they have had a TIA and have a carotid stenosis greater than 70% on the affected side and can have a carotid endarterectomy within 14 days, it will greatly decrease their incidence of having a catastrophic stroke. It is our job to help facilitate their exams in a timely manner to prevent this from happening. This website has all the information you need to help you sort out which patients will benefit from this timeline.

It is our practice at our institution to try and implement the carotid exam on this select group of patients within 24 to 48 hours after the patients’ visit to emergency (presuming they have sought medical attention immediately after experiencing their symptoms). The trick is to have a system in place to help facilitate this practice.

I hope this website will be helpful to some of you. If you have any questions after reading through this information that you think I can help clarify, please feel free to contact me at: liannebroughton.csdms@gmail.com

For those of you that might be interested, the Canadian Stroke Congress is being held in Calgary, September 29 to October 2, 2012. This is a multidiscipline congress I am sure will be both exciting and informative.

Lianne Broughton
Vascular Director
The initial months of my appointment as eastern director have certainly been busy, to say the least, but rewarding at the same time. To follow up from my last report, the proposed 3-year direct entry level ultrasound program at the College of the North Atlantic in Newfoundland has stalled at the doorsteps of government financial approval. The curriculum structure with regard to didactic and clinical instruction, I believe, has been completed. I do not have a specific timeline or deadline as to when and if government will approve the proposed program. Stay tuned.

I have made inquires to the chair of the Legislation Committee, Joanne Chapman, of the Nova Scotia Society of Diagnostic Medical Sonography (NSSDMS), regarding their ongoing work to establish self-regulation. She sent me a superb document referencing a historical timeline of events that have taken place since their initial investigation into self-regulation. Right now, it is in the hands of the Health Professions Regulation Review Committee of the Nova Scotia Department of Health where they first have to make a recommendation to Minister of Health Maureen MacDonald before proceeding any further with self regulating ultrasound as a profession.

It has been recognized throughout the history of the CSDMS that there has been a significant communication gap between the membership and our liability insurance policy. The majority of our membership, including myself, I believe, has a very vague understanding of what is actually included in our policy. I have been given the task of trying to reduce this gap so that our membership can receive a better understanding of how our current policy applies to them. More specifically, I have volunteered to be a direct liaison between Marsh, our current insurer, and our membership in an attempt to make a smoother transition of communication between both parties. I realize that more often than not we don’t recognize the importance of our liability insurance until the time comes when an actual claim has been initiated. Hence, it is without question that we could reduce the probability of a claim if in fact we had a better understanding of how the policy is defined and implemented within our current scope of practice.

I have contacted Marsh via teleconference and have spoken to our client representatives Adele Laurin and Michael Oulahen just on an introductory basis. I am hoping to get more involved as time progresses and it appears that these Marsh representatives are very knowledgeable and very open to membership questions and concerns. It is my hope that we can introduce a forum of communication via our e-Interface with Marsh and our members. Maybe we can discuss publishing some case examples so that our members can perhaps understand how important our liability insurance really is.

Sheldon Boyle
Eastern Director
My name is Stephanie Mugford and I am the student advisor for 2012-2013. I am from Charlottetown, Prince Edward Island, and have a bachelor’s degree in applied science in radiography from UPEI. I worked as an x-ray technologist in beautiful Cape Breton, Nova Scotia, before being accepted into the College of the North Atlantic Post Diploma Sonography program, in St. John’s Newfoundland. I decided to apply for the student director position with the CSDMS because I would like to gain experience and understanding as to how the CSDMS works and to meet ultrasound professionals from across the country. After completing my program I plan on returning to PEI for work, as well as spending some time on photography, hiking, skiing, and hanging out with my favourite golden retriever, Nellie.

Update from the Student Advisor

As of May 2012, I have taken over the student advisor’s position on the CSDMS board of directors from Jenn Denbok, a BCIT student. Jenn did an excellent job during her year on the board and allowed a smooth transition for me beginning my term. Many thanks Jenn!

My first exposure to the CSDMS happened at the national conference held in Halifax this past June. It was an amazing experience and one I will not forget! The first few days were busy with board meetings, and allowed me to see how the board runs and what each board member is responsible for. It was a lot of information to grasp over three days, but it was very interesting.

The conference ran from Thursday to Saturday, and was full of lectures for general, cardiac, and vascular disciplines. As a board member, I was responsible for greeting the guest speakers, and answering questions at the CSDMS booth. During free time, I attended many generalist lectures, and found them very educational and interesting. We were fortunate to have so many wonderful guest speakers who took the time to share with us information and experiences, and I learned a lot.

In between lectures, I spent time visiting the different booths. There were many booths offering information on products and equipment. Most importantly for students and aspiring employees, there were lots of job opportunities. I was able to make it to every booth and speak to people from different hospitals and clinics across the country, in order to bring job options back to students unable to make it to the conference.

The conference ended Saturday afternoon with the Awards Luncheon that recognized outstanding contributions to the profession from many people. I went back to St. John’s Saturday night tired, but busting with information and enthusiasm from such a positive and wonderful experience! Now to put what I have learned to work.

During my year as the student director, my main focus will be promoting our CSDMS student Facebook page. It is the best way for students across the country to get in touch with one another, ask questions, make contacts, and get answers.

At the conference, I tried to advertise it to students and teachers I met to spread the word and I am happy to say that since June we have had over 60 new members join!

My first task after leaving the conference was to put up a list of job opportunities and contact information from the people I met at the different booths. There are jobs from all across the country available, and even more offered on the CSDMS website.

I also will be putting up deadlines for CARDUP applications, as well as answers to any questions I may get on the Facebook page. Any new graduates are welcome to join too! The more information we can share, the better prepared we will be!

Also, heads up to any central sonography students, as of spring 2013, you could be the next student director! It is a fabulous way to meet people across the country and learn about the CSDMS! Interested? Any questions, feel free to ask!!

Of course, I will also be available by email at student.csdsms@gmail.com for any questions or concerns I can help with!
Spotlight on Students – East Coast

Since the 2012 CSDMS conference was held in beautiful Halifax, Nova Scotia, this past June, our interview participants are from our two most Eastern Schools, College of the North Atlantic, in St. John’s, NL, and Dalhousie University, in Halifax, NS.

Interview Participants
Melissa Dixon: College of the North Atlantic Post Diploma program, graduating autumn, 2012
Samantha Turnbull: College of the North Atlantic Post Diploma program, graduating autumn, 2012
Janet Belliveau: Dalhousie University, graduating in 2014
LaKrisha Evans: Dalhousie University, graduating in 2012
Johanna Verhagen: Dalhousie University, graduating in autumn, 2012
Amy McCallum: Dalhousie University, graduating in autumn, 2012

What made you decide to become a sonographer?
Melissa Dixon: I originally chose sonography because I liked the monitoring pregnancies aspect of it and looking at babies.
Samantha Turnbull: I was always interested in the medical field and really wanted to work hands on with the technology involved with medical imaging. I also really enjoy working one on one with patients.
Janet Belliveau: I stumbled across sonography as a position while I was deciding what to do with my life. I previously attended Acadia University for 3 years in biology and knew I did not want to do lab work for my life. I had applied to pharmacy and did not want to spend my entire life trying to get in. Then one day I stumbled across sonography and thought, “Hey, I think I would like that.” Turns out, I love it!
LaKrisha Evans: I was really into the idea of health care, and decided to look into options other than nurse or doctor. I think both positions are extremely important I just couldn’t see myself dealing with everything that a nurse has to deal with, the bed pans, the IVs, and I also couldn’t see myself going to school long enough to become a doctor. I began researching ultrasound online, and although I had never had an ultrasound, or seen anyone have an ultrasound, it sounded extremely interesting.

Johanna Verhagen: I liked the health care field.
Amy McCallum: I decided to become a sonographer because I wanted a job in health care, but I was not interested in becoming a nurse, doctor etc. I like the patient interaction we have with ultrasound, and the role we play in diagnosis. The job prospects for sonographers are also excellent, which is an additional bonus.

What was your first experience with sonography?
MD: My first hands on experience was this program, but I paid attention to it when working in x-ray and became interested.
ST: I experienced an 18-week ultrasound of a family member.
JB: When I was in my second year of university I had to go for an ultrasound and that was basically the only exposure I had ever had. I was not entirely sure what the profession entailed, but then I did some research to answer my questions.
LE: The first ultrasound I had ever seen was when our instructor took us down to lab in first few days of class in first year. I remember being amazed that she could see anything in the mess of grey, but after a short time I started to be able to see organs, and eventually very discrete pathology.
JV: Going for ultrasounds with my two children.
AM: My first experience with sonography is the day I spent job shadowing a sonographer after I had gotten into the program.

Which class do you enjoy most, so far?
MD: I enjoy the anatomy classes, and like learning how the body works.
ST: Obstetrical ultrasound is my favourite class and clinical rotation. It is a very interesting and in-depth learning experience.
JB: The classes that I enjoy the most are the ones where we learn about sonography in general, how things should look, and what can go wrong.
LE: I’ve enjoyed most of my classes so far. Obstetrical pathology was probably the most interesting class. It was sad to think of children with these horrible conditions and parents having to face these situations, but it was also incredibly fascinating. It also makes you realize how important the profession is, and that not long ago there were no ultrasound machines, and even when they became available they still couldn’t pick up some pathologies. To be able to find these abnormalities in a fetus and be able to prepare for their birth and have surgical teams ready to do immediate surgery for different conditions, has been a huge advancement in health care.

JV: I really enjoyed the obstetrics courses.

AM: It is hard to pick one class that I liked the best so far. I enjoyed learning about the different types of pathology (abdominal, obstetrics etc.).

What is the best part of your program, so far?

MD: The best part is the clinical portion.

ST: Clinical training allows you to apply your knowledge and experience scanning in the hospital environment.

JB: So far, my favourite part of the program is the clinical component. We get hands on experience and get exposed to so much! I also love our very small class size (6 students/year).

LE: The best part of my ultrasound program was how quickly we got into scanning. Immediately after we started we were in lab scanning each other, and shortly after were observing real patients being scanned. This immediate hands-on experience made me that much more interested in ultrasound.

JV: Meeting all the great people in my class plus working with great preceptors.

AM: I think the best part of our program is our small class size (6 people) makes it a great environment to learn in. I also enjoyed having some classes with the other health care disciplines (for example, x-ray, respiratory therapy) because we got to learn a little bit about other disciplines.

Where do you see yourself in 10 years, with regards to your profession?

MD: I am hoping to work at a clinic, and perhaps do some locums in different places.

ST: In 10 years I hope to be working permanent full time in diagnostic ultrasound.

JB: In 10 years, I see myself having a great job in a hospital somewhere in Canada loving life, wanting to wake up in the morning to go to “work.”

LE: I’m not really sure to be honest. I hope to keep furthering my education by going to different conferences and having radiologists teach me types of studies that I have little or no experience with. And hopefully my shoulder is still going strong!

JV: Working full-time plus I would like work with some of the ultrasound committees.

AM: It is hard to say for sure where I will be in 10 years because I am sure ultrasound will have changed quite a bit in 10 years’ time.

Do you have any advice for people considering entering sonography as a profession?

MD: It is a challenging, dynamic career. You’ll need to work hard, but you’ll never be bored.

ST: This program is very in depth and can be overwhelming at times, but in the end it is very rewarding and well worth all the hard work. Just stick with it!

JB: My advice to someone who is looking at sonography as a profession is to make sure you love talking with people as ensuring patient comfort is a big part of the job. Also, be prepared to really study.

LE: Do it! They should know that it is a demanding program, it requires lots of work and dedication, but it pays off in the end. It is one of the few things you can get into right out of high school and be guaranteed work afterwards.

JV: I would tell them there are a lot of job opportunities and you can work anywhere you would like.

AM: Although the course can require a lot of work at times, I would definitely recommend it to others. It is a hands-on program, where you start scanning the first week of school in the scan lab. We also have a lot of clinical time, so what you learn in class is very applicable to the real world. If you enjoy interacting with others, learning about anatomy/pathology, and are interested in a job in health care, it is a great field.
Male Sonographers Speak Up!

By Jenn Denbok

As promised, this is a “Special Edition” of the e-Interface student section: we have some male sonography students who were willing to share some of their insight in a female-dominated field!

Jesse Dawes was a paramedic for 4 years prior to entering the program, while Louie Ong is an avid videogamer and a big fan of the Call of Duty series. They are both in their second (and final) year of the BCIT Diagnostic Medical Sonography program, and will graduate in November 2012.

Dale Whynot studied computer engineering and worked in the field for several years. He then decided to go back to school and attended UPEI for two years before heading to Halifax to study sonography at Dalhousie University. He has finished his second year at Dalhousie University, graduating his program in June 2013.

Why did you choose sonography?

Louie: I was always interested in choosing a career where I get the chance to be of service to others. Sonography helped integrate my passion for medical science and interacting with people/patients.

Jesse: I chose sonography for a few reasons: First being, there is a huge demand for sonographers. Secondly I really enjoy that it’s an interactive/investigative exam. You take a history from the patient and combine that with previous images or other imaging modalities. As the sonographer, you’re required to find the pathology and take representative images that reflect the patient. The radiologist really depends on us; we’re their “eyes and ears” on the exam.

Dale: After working in computer engineering for several years I decided to change careers and wanted to enter into the health care profession and ultrasound appeared as the most interesting to me. I feel as if it was a great choice.

What is one piece of advice that you would give to someone entering a sonography program, especially a male student?

Louie: Do your research to make sure you know what you’re getting into. I consider sonography a very exciting and fulfilling career; however, I know it’s not for everyone.

Jesse: Be ready to hunker down. The program is a very demanding. It requires your time and attention for the better part of two years. Even though it is demanding, it is very rewarding.

Dale: Some advice I would give to someone entering the program is that it is hard work, but if you do the work, it will be worth it in the end.

What has been the hardest part of this sonography program for you as a male in a primarily-female field?

Louie: Some patients prefer a female sonographer to do the more sensitive scans like an endovaginal scan or breast scan, instead of a male. For learning purposes, it is a bit of challenge as I am not getting as much hands-on time on those particular scans as my female peers.

Jesse: The hardest part has been installing confidence in patients during practicum. Most people expect to see a female when they are about to have a scan done, especially during a pelvic/EV/breast exam. Some women upon seeing a male sonographer will request a female or refuse the exam all together. You can’t take it personally. I am not there to make the patient feel uncomfortable.

Dale: I don’t feel that there is anything that I find particularly hard being a male ultrasound student. The only situation that I have run into is when a female patient may not be comfortable with a male sonographer performing transvaginal or breast exams, but it is really just about ensuring the patient is comfortable.

Do you feel that you have any advantages of being a male in a primarily-female field? If so, what are they?

Louie: On that same note, I am able to do more
male-sensitive scans like scrotal scanning.

**Jesse:** As a male sonographer I don’t believe I do have any advantages. The job can be physically demanding on both men and women. I’ve seen both genders injured on the job. Both males and females are necessary, and being that there are primarily more females sonographers, employers may want to hire a male. But it truly comes down to your personality, skills, and knowledge base when it comes to getting hired.

**Dale:** I do not feel that there are any significant advantages or disadvantages being a male sonographer.

**Is there anything that the sonography community could do to make it easier and/or more appealing for males to choose this career?**

**Louie:** I don’t think so. I think the sonography program is already quite well known. It’s interesting to me, that given the obvious disparity between the number of female students versus male students in the program, I don’t quite observe that out in the real world. So far in my clinical rotations, I’ve met and seen a lot of male sonographers out there too!

**Jesse:** 9/10 people automatically associate ultrasound with obstetric exams. I think that if males knew that we also do scans ranging from MSK, vascular, thyroids, and cardiac there would be more of a draw to programs on a whole from males.

**Dale:** I feel that when people hear the word ultrasound they immediately think of babies (I admit that I did as well until I researched it further). I think promoting all the different types of exams that are done using ultrasound may help with encouraging more males to join the profession.

**What has been your favourite part of being a “sonographer-in-training?”**

**Louie:** Definitely the fact that you get to be a “detective” and are part of the team that is involved in coming up with a diagnosis for the patient. Also the fact that there is so much to learn and then applying what you’re learning out in the field.

**Jesse:** Putting all the knowledge and skills taught in the classroom to practical use. The hospital/clinics are such a different setting from the classroom. On more than one occasion I’ve caught myself saying, “Ohhh yeah! That’s what they meant.”

**Dale:** I think my favourite part of being a sonographer-in-training is how much I learn each day that I am in clinical. There is so much variety and you have no idea what your next exam will bring.

**Where do you see yourself in the long-term?**

**Louie:** I haven’t really given it much thought. I’m considering doing further studies in ultrasound, perhaps MSK or animal ultrasound, etc.

**Jesse:** The great part about sonography is that you never truly stop learning. There are multitudes of course that are very applicable to ultrasound, such as specializing in a certain scan type (i.e., echocardiography), working with US machine companies as a specialist in new upgrades, and selling US units, or even teaching. Ultimately I can see myself specializing/focusing in echo because I like the dynamics of cardiac scans.

**Dale:** During my clinical this summer I had a chance to view a few echo exams, which I found very interesting. After I finish my third year I will start working in general ultrasound and I may decide to specialize in echo in a few years.

**Any advice for the males out there who are thinking about becoming a sonographer?**

**Louie:** Go for it! There really isn’t as much limitations as you think being a male compared to a female sonographer. There are some instances where a female patient might prefer a female sonographer to do the more sensitive scans like an EV or breast scan, but it really isn’t a problem. You can just swap with someone and do another type of scan.

**Jesse:** This is a great field to work in!

**Dale:** If you are interested in the program, then attend an open house at one of the universities to learn more about ultrasound.

On another note, writing this column is my last contribution as your student advisor, as my term has come to its end. It has been a pleasure representing all the Canadian sonography students in this past year, and I have learned so much in doing so.

Your newest student advisor, Stephanie Mugford, is from Prince Edward Island and is studying in the Post Diploma Diagnostic Ultrasonography program at the College of the North Atlantic. Prior to this program, she earned a bachelor’s degree in applied science in radiography and is a CAMRT-certified medical radiation technologist. Please join me in welcoming her to the CSDMS student position!

As usual, you can reach her with any comments, questions or suggestions at the CSDMS student email address: student.csdms@gmail.com or on our Facebook page: https://www.facebook.com/groups/CSDMS.students/.

Jenn Denbok
Alberta Health Services (AHS) provides a full spectrum of ultrasound services, including general, small parts, vascular, obstetrics and gynecology, interventional procedures, teleultrasound, neurosonography, intraoperative and echocardiography. You can choose to work in a cutting-edge teaching centre in which leading technology, advanced practice, and research go hand-in-hand. Or choose to work in a smaller facility providing general ultrasound services to patients in a small community. We offer a challenging work environment that provides support and opportunities for personal achievement and career growth. Be a part of something big by joining one of the largest healthcare organizations in Canada – Alberta Health Services. AHS values the diversity of the people and communities we serve, and is committed to attracting, engaging and developing a diverse and inclusive workforce.

Alberta is a world-class province rich in arts, culture and entertainment with rural areas offering majestic mountains and sparkling rivers that attract outdoor lovers from around the world. Alberta does not charge Provincial Sales Tax and has the lowest personal income tax of any province in Canada. We are looking for Sonographers to join our team province wide.

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Echocardiography in the United Kingdom

By Jules Hobson

When I was asked by Josh Fraser to write an article for e-Interface, I wondered how I could benefit the readers of this informative journal. I decided that my background may provide an interest to those who may be thinking of taking a sabbatical to the UK while working as an echocardiographer or to those who may like to compare the Trans-Atlantic working practices.

Apart from the obvious differences like driving on the right in Canada, steering wheel on the left, and spending virtually no time at all in traffic. Being able to cross London in 20 minutes stress free! Apart from that, there may be some differences in how you scan or how a clinic is expected to run. I don’t have diverse exposure or experience in Canadian labs so I thought it best to talk about the reality over there and let you the reader make your own comparisons.

So if you are thinking of going over the pond to England, Scotland, Northern Ireland, or Wales this article may be a useful read. Please read it as a guide and not an authority.

Some Useful Contacts

Cardiac Output is a publication furnished with employment opportunities and includes contact information for agencies that provide employment.

British Society of Echocardiography is the accreditation society in Britain and can provide information to potential applicants on required qualifications.

British Heart Foundation can provide additional professional information and job listings.

British Cardiovascular Society can provide additional professional information and job listings.

Physiological Measurements LTD. can provide additional professional information and job listings.

Canadian Affair is a travel company that provides relocation information and assistance.

Where Are the Jobs?

There are different ways of acquiring a position within a lab; they are broadly speaking as follows:

- Agency employment
- Bank staff
- Part-time/full-time or casual employment

They will be in the following establishments:

- Secondary care facility (hospital based)
- Primary care facility (family doctors)
- Private clinic

An application for a position as an echocardiographer will usually require an accreditation qualification with the BSE (British Society of Echocardiography). Although ARDMS and CARDUP would be advantageous, today I am not aware of any employer that does not state the BSE accreditation or equivalent as a prerequisite in their recruiting criteria. That is not to say that someone who clearly has experience and holds ARDMS or equivalent will be precluded. The web can assist you by providing additional contacts and employment information with great links through the sites mentioned above.

Agency Work

The drawback to agency work is that it can be short term/temporary and at unpredictable locations. In addition you may be required to show insurance coverage; however, you can acquire this indemnity cover through the BSE. The plus side is that it is good pay and keeps you moving so you experience more diversity and clinical mix. You get to learn more dialects, accents, and culture, even if you only move 20 miles down the road.

The agency will manage your administrative needs including pay.

Primary/Secondary and Private Care Work

A primary/secondary care facility or private clinic will hold interviews for vacancies directly.

Pay

Through the agency, pay is 40 pounds per hour which is $60 in today’s exchange rate. The agency takes its cut and gives you that hourly rate. You can expect less from other employers.

An experienced echocardiographer at a hospital-based clinic will probably be paid about $50–55 an hour. Expect to be paid more in London due to increased living expenses, known as London weighting. So, if you secure a job as an echocardiographer in Harley Street then pay may be as much as $70 an hour.

Reports

All echocardiograms must have full reports complementing the acquired images. The cardiac ultrasonographer is responsible for the final report sent out to the referring physician. If this is a family doctor it should be written in a way that is non technical and useful for the GP (general practitioner/family doctor). Irrespective of referrer, all reports...
should be semi diagnostic in format and not just a technical descriptor. Essentially the sonographer is the final reporter. Only very occasionally will the cardiologist follow on with a further report. This is one of the big differences between British and North American sonographers.

Scan Times
When the government changed the working business practices of the NHS and introduced fund holding, some time ago, it had an impact on costings and consequently money saving. The intention to create more efficiency with financing and resources through fund holding has had a detrimental effect ultimately on patients. They seem to suffer from the effects of this due to “fund rationing” driven by non-medically-trained budget holders who find unethical ways to save money. The BSE recommends a 45 minute scan time to include complete report and for the most part this is adhered to; however, there are clinics that will still run 25 minute slots for echocardiograms. Although this increases the fundholder’s revenue it compromises quality for speed which affects ultimately both patient care and sonographer reputation. So be aware scan times can be inappropriately reduced for unethical reasons and you probably will not get a say in the matter. So good luck with that!

18 Week Waiting List Initiative
In addition the new waiting list initiative of 18 weeks from referral to treatment now means that all patients referred must have their diagnostic tests complete within 6 weeks. This usually means most facilities set a 2 week period for echocardiograms to be complete. This additional pressure that service providers are under again increases the chances of reduced time slots for echocardiogram investigations. If the providers fail to meet the government set deadlines they face fines and potential loss of status of awards like foundation trust titles. This consequently affects budget premiums when finances are awarded annually. Managerial financial pressure cascades down to increase the volume of completed tests to reduce fines and retain budget supply. This affects the patient and sonographer because the answer to achieve this is to reduce time slots for investigations. The divisional managers that control these concepts try to find different ways to assist with this waiting list bottleneck and have introduced weekend and evening clinics. So this can provide more work for agency, casual, or bank staff. In some diagnostic services like biomedical science a 24 hour, 7 days per week working practice is the only answer to adhere to the 18 week initiative.

Suffice to say that combined with the government set demands and the lack of supply of trained cardiac sonographers nationally and locally, the discerning amongst you should have no problem securing a position as a scanner.

Radiography and Cardiac Ultrasound
It may also be worth bearing in mind that unlike North America, in the UK the cardiac ultrasonography field is devolved from the radiography sector. The UK radiographers are not involved with any type of cardiac ultrasound and it is undertaken and administered by cardiac specialized departments only.

Machine Types
You will probably run into the following ultrasound machines: Phillips; IE 33; CX 50; HP 5500, 7500; GE; Vivid Series; Siemens; Acuson; Cypress.

Reporting Packages
Some labs may still use the machine for analysis and measurement, and still provide handwritten reports. However, most places use the following digitally networked reporting packages: Prism, EchoPAC, McKesson Cardiology, Horizon Cardiology, Hand written (measure on machine).

Working with the Echo Companies
Siemens, Phillips, and GE are always looking for application specialists to demonstrate their products around the country.

BSE Accreditation
You can find detailed information on accreditation and re-accreditation procedures at the BSE website. However, in general to attain Adult Trans Thoracic Accreditation with the BSE a candidate will successfully complete the following:

• Written examination, multiple choice of ultrasound physics and cardiac pathology in addition to an echocardiogram video reporting section.
• Log book complete with 250 cases of specified pathologies. Majority being in the valve disease and LV dysfunction categories. Each case must be written up as a full report.
• Video submission of 5 specific pathologies containing full study data set and optimal image processing. Full reports are to be attached for each study.

BSE – British Society of Echocardiography
The British Society of Echocardiography (BSE) was formed in 1990 to promote the study and advancement of cardiac ultrasound imaging and Doppler techniques, through professional representation, education, and quality benchmarking.

It is recognized in the UK and around the world as being the preeminent organization representing the interests of echocardiography and echocardiographers.

Having over 2,600 members, it is the largest of the professional groups affiliated to the British Cardiovascular Society. It also has functional links to the European Association of Echocardiography and the European Society of Cardiology. Although originally intended to cater primarily for the United Kingdom and the Republic of Ireland, the society now has members in over 30 other countries in
Europe, the Middle and Far East, North and South America, and Africa.

Two scientific meetings are held each year: one in the summer, in conjunction with the British Cardiovascular Society’s annual conference, and the other, the BSE Annual Meeting, in the autumn.

The society has a major interest in education and training of physicians and echocardiographers. It has published training guidelines and members can undertake a formal accreditation programme of written examinations and documented clinical experience. There are specialist options for adult trans-thoracic, trans-oesophageal, critical care and community echocardiography. These accreditations are accepted as evidence of competence by employers and those responsible for organizing higher medical training in cardiology. In order to encompass continuing rapid advances in ultrasound technology and clinical applications, there is a need for continuing professional education. This is being addressed through a programme of regular re-accreditation.

Members receive regular BSE publications containing articles on topical professional matters, details of meetings and training courses, reports of overseas meetings, news items, job vacancies, etc.

The society is a registered charity and is administered by a president and an elected council. Members are required to subscribe to the society’s rules and code of professional conduct.

Summary
In summary, be prepared to be the last stop between the report and the referrer. That means adapting your report writing between family physicians and consultants. And don’t be surprised if echo slot times wax and wane between different labs, as budget controllers face different pressures. ARDMS or equivalent should be adequate to secure a position as an echocardiographer, but have the breakdown of the accreditation ready just in case an employer has not heard of the qualification. Although work visas are not covered here you can find out more at this UK government website. Enjoy the culture, history, and diversity. And please remember you Canadians are extremely polite, nice people, so be prepared to stay that way.

If you have any specific questions or queries please drop me a line at Contact@juleshobson.com.

The Scan
Cardiac ultrasound labs within the UK subscribe to the minimum data set required by the BSE education council, this is outlined below.

1. Overview
It is recommended that any study is accompanied by a statement regarding the image quality achieved: good/fair/poor.

2. Identifying Information
The images acquired should be clearly labelled with patient identifiers, including the following: patient name, a second unique identifier such as hospital number or date of birth, and identification of the operator such as initials.

3. ECG
An ECG should be attached ensuring good tracings to facilitate the acquisition of complete digital loops. Loops should be examined and adjusted accordingly in order to ensure a clear representation of the image acquired.

4. Height/Weight/Haemodynamic Variables
Qualitative and quantitative evaluations of chamber size and function are major components of every echocardiographic examination. Chamber dimensions may be influenced by age, gender, and body size. Therefore, consideration should be given to the use of referenced ranges indexed to height or body surface area. Additionally, velocities measured using Doppler should take account of pulse rate and blood pressure. No recommendation is made to the routine use of indexed measurements but facilities should be available to sonographers to measure height, weight, pulse rate, and blood pressure at the time of an echocardiogram.

5. Duration
The time required for performance and reporting of a fully comprehensive transthoracic echocardiogram (TTE) following these recommendations is considered to be 40–45 minutes, although it is understood that some studies may take longer whilst others may take less time. The time taken for a standard TTE should include time to complete a report, and should also take into account the time taken for patient preparation.

6. Report
No standard TTE is complete until a report is released and is made available to the referring individual. The majority of studies performed in a department should be reported immediately on completion and a report available on discharge of a patient from the echocardiography facility.

It is recognised that there are times when a review of images and further consideration is required, for example when the individual performing the scan does not hold proficiency accreditation and the scan requires review prior to release, although this should be done as soon as possible.

7. Chaperones
A standard TTE is not considered an intimate examination
but performance still requires patient sensitivity. Chaperones should not usually be required for standard TTE but for all TTE studies, patients should be offered a gown.

List of Abbreviations

Views

- PLAX: parasternal long axis
- PSAX: parasternal short axis
- A4C: apical four chamber
- A2C: apical two chamber
- A5C: apical five chamber
- SC: subcostal
- SSN: suprasternal
- ALAX: apical long axis or apical three chamber

Modality

- PW: pulsed wave Doppler
- CW: continuous wave Doppler
- CFM: colour Doppler
- TDI: tissue Doppler imaging

Measurement and Explanatory Text

- LV: left ventricle
- LA: left atrium
- MV: mitral valve
- AV: aortic valve
- Ao: aorta
- LVOT: left ventricular outflow tract
- RV: right ventricle
- RA: right atrium
- PV: pulmonary valve
- RVOT: right ventricular outflow tract
- L/R PA: left/right pulmonary artery
- RI/RR/LL/LUPV: right lower/right upper/left lower/left upper pulmonary vein
- TV: tricuspid valve
- IVC: inferior vena cava
- STJ: sinotubular junction
- LVIDd/s: left ventricular internal dimension in diastole and systole
- IVSd/s: interventricular septal width in diastole and systole
- RVd: right ventricular cavity diameter in diastole
- VTI: velocity time integral
- PHT: pressure half-time
- RWMA: regional wall motion abnormality
- TAPSE: tricuspid annular plane systolic excursion
- MAPSE: mitral annular plane systolic excursion

Alberta Health Services

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In a large prospective study of consecutive patients with technically difficult studies \( n=632 \):²

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INDICATIONS

Echocardiography

DEFINITY® (perflutren injectable suspension) is indicated for contrast-enhanced ultrasound imaging of cardiac structures (ventricular chambers and endocardial borders) and function (regional wall motion) in adult patients with suboptimal echocardiograms.

CONTRAINDICATIONS

Do not administer DEFINITY® (perflutren injectable suspension) to patients with known:

• Hypersensitivity to DEFINITY® or its components (See WARNINGS - Hypersensitivity Reactions and ADVERSE REACTIONS - Post Market Adverse Drug Reactions).

• Right-to-left, bi-directional, or transient right-to-left cardiac shunts (see WARNINGS - Systemic Embolization).

DEFINITY® should not be injected by direct intra-arterial injection (see WARNINGS - Systemic Embolization).

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WARNINGS

WARNING: Serious Cardiopulmonary Reactions

Serious cardiopulmonary reactions, including fatalities, have occurred during or following DEFINITY® administration.

Assess all patients for the presence of any condition that precludes DEFINITY® administration (see CONTRAINDICATIONS).

Observe patients with unstable cardiopulmonary conditions for at least 30 minutes after DEFINITY® administration (see WARNINGS).

Always have cardiopulmonary resuscitation equipment and trained personnel readily available prior to DEFINITY® administration and observe all patients for acute reactions.

Please refer to the product monograph for complete prescribing information including information contained in the boxed warning.

REFERENCES:

1. DEFINITY® [Product Monograph]. Lantheus Medical Imaging, Montreal, QC October 2011

Getting to Know Future Sonographers from Across the Country

Names
• Jenn Roseboom & Lisa Euverman
• Junie Chansi

Program/Level
• Medical Sonography Program, Level 1
• Echographie Diagnostique

School
• British Columbia Institute of Technology (Burnaby, BC)
• Collège Boréal (Sudbury, ON)

Expected Graduation Date
• November 2012
• December 2012

What was your first experience with sonography?
JR: Job shadowing in the medical imaging department at a local hospital, where a nuclear medicine technologist encouraged me to “check out the ultrasound department.”
JC: When I was pregnant.

What drew you to selecting sonography as a profession?
JR: Since high school, I have been drawn to science, health science in particular. I was especially interested in diagnostic medicine, as I enjoy trying to solve problems and knowing (or at least trying to figure out!) how the body works.
LE: Sonography appealed to me because you are working one on one with patients and the fact that every day on the job is going to be something new - everyone’s body is different!
JC: I appreciated the contact with people, and in particular, the person who scanned me during my pregnancy.

What is the best thing about your program so far?
LE: The best part of my program so far is being able to practice scan and really get a feel for the career I’m entering.

Do you have any advice to people considering entering into a sonography program?
JR: Study hard and be curious – curiosity will keep your studies interesting and exciting!
LE: If you are considering entering into a sonography program, go into it with an open mind! It’s going to be a lot of work, but it will be one of the most rewarding things you have done in your life. There are other students in the same shoes as you and there is always support when you need it.
JC: Have compassion.

Anything else we should know about you? Best/funniest memory/moment thus far?
JR: My best moments are when we are shown an image and can actually see and understand what the structure is, what it does, and why. It’s really like a light bulb turns on!
Sonography: A Short Story

By Karen Rivers, CSDMS Western Director

On a busy diagnostic imaging summer day, full of “addons” to scan obscure lumps and bumps, I received a message that a patient scheduled for me was arriving by ambulance from a location two hours away would be arriving late. I was agitated and instantly filled with selfish thoughts, “There would be no lunch or break for me.” When the patient arrived, I grabbed the requisition and the accompanying paperwork from the EMT team and my brain went into fast forward. Where is the order? Why is the patient here? When was her previous ultrasound?

As my brain blurs absorbing the facts of the exam, the EMT team places the patient gently on the ultrasound stretcher. Without making eye contact I take the patient’s wrist and repeat her name out loud then ask her date of birth. A frail voice responds and then immediately apologizes as I see a brown stain on the sheets which simultaneously, drip, drip, drips onto the floor.

And so it begins! A lengthy cleanup while trying to keep the patient’s pride and body temperature intact. Still the incident results in much humiliation and anxiety for the patient.

Using a calm, reassuring tone, I begin the exam. Only then do I realize that the patient is watching my face. I note the bruises on her abdomen, the frail paper thin wrinkled skin of her arms but beyond this a kindness in her expression and sincerity in her eyes. I continue to scan very gently, searching for imaging windows.

Gently wiping the gel from her broken body, I look into her sunken eyes and continue on with my routine banter. At one time, her eyes sparkled like mine and her fine features probably lit the rooms she entered. A smile came over my face. A smile that meant I cared and she was in safe hands. The patient beamed back.

An innocent senior, grandmother, mother, sister, friend, in chronic pain and whose final summer days could be counted, smiling back at me. My heart shattered.

Sonographers face many challenges as humans, and members of the health care team. The health care assembly line is very easy to get caught up in, but let us never forget the challenges patients face as humans. Everyday make a difference in a patient’s life, make it as simple as a smile and a caring mannerism. This patient was in my life for 25 minutes and vividly reminded me to always look into a patient’s eyes with kindness. Consequently, this I will not forget.

Patient’s are “folks” looking for a kind ear and a professional who can be respected. Seniors are people who long to be loved. Ongoing is the pressure for increased patient numbers and diverse procedures along with the underlying pressure for profit, which easily precede the care sonographers inherently want to provide. Let’s ensure the profession of sonography continues to echo the traits of respect and compassion.
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All performed on - Siemens Sequoia 2000, GE Logiq E9, ATL 5000. Onsite training for less familiar studies. Important to us is the willingness of staff members to associate and communicate well with one another. Our small practice nurtures a comradery and sense of belonging.

ARDMS or CARDUP registration with active status is required. RW not a requirement.
MINUTES: CSDMS 30th Annual General Meeting

Thursday June 7th, 2012
16:00 to 17:00
Halifax, NS

Call to Order
Wendy Lawson called the meeting to order at 4:05 pm.

2.0 Introductions
The CSDMS Board and advisors were introduced:

**Board Members**
- Wendy Lawson President
- Josh Fraser Secretary
- Sheena Bhimji-Hewitt President Elect
- Sheldon Boyd Eastern Director
- Chantelle Dudek Central Director
- Karen Rivers Western Director
- Victor Lee General Director
- Dal Disler Cardiac Director
- Lianne Broughton Vascular Director

**Board Advisors**
- Stephanie Mugford Student Advisor
- Kim Boles Past President
- Dr. Christine Pham Physician Advisor

(unable to attend)

3.0 Affirmation of Quorum
Wendy Lawson affirmed that there were sufficient members present for quorum.

There were 65 members in attendance.

4.0 Approval of Agenda
Following a motion moved by Kim Boles and seconded by Cathy Babiak, the members unanimously approved the agenda as presented.

5.0 Adoption of Minutes from 2011 AGM, Kelowna, British Columbia
Following a motion moved by Kim Boles and seconded by Linda Guralski, the members unanimously approved adoption of the minutes from the 2011 AGM as presented.

6.0 Board of Directors / Executive Reports
Wendy Lawson noted that regional and discipline directors provide reports to the members through e-Interface. The floor was invited to ask questions of the directors. There were no questions from the floor; however, the president encouraged members to contact any of the directors with any issues they may have.

7.0 Internal Committee Reports

7.1 Communications: *Canadian Journal of Medical Sonography* and e-Interface
As editor of the *Journal* and e-Interface, Kim Boles appealed to the members for greater input to the *Journal*. He noted that there is lots of support available to assist members wishing to write an article, including support from members of the editorial board, the publisher, and himself. Feedback from article writers has been that the experience was very rewarding. What seems unimportant to you may be important to your colleagues across the country. Kim encouraged everyone to consider contributing adding that submissions are open to students, sonographers, and managers.

7.2 Education Council Liaison
Karen Rivers reported on the work of the National Education Committee. Karen noted that this committee reports to both CSMDS and CARDUP and that she co-chairs the committee with Cathy Babiak.

It was noted that the Awards Committee has an initiative to work more closely with the conference Local Planning Committee and with head office and that it wants to make the awards more obvious on the website.

It was also noted that a Conference Advisory Committee is in place to help facilitate conference planning. The committee consists of the past, present, and future chairs of the local planning committees, board liaison, and head office.

Karen invited any members with any questions to contact her for any questions related to NEC and Cathy Babiak for NEAC.

8.0 Working Liaison Committees
Wendy Lawson introduced this topic by noting that CSDMS maintains a number of relationships with external partners such as the SOGC (Society of Obstetricians and Gynecologists), diagnostic imaging team, ACCC (the Association of Canadian Community Colleges), the CMA (Canadian Medical Association) and the AHSP (Assembly of Health Science Professions), and that we participate in special projects with partners all in the name of collaboration.
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We are an office practice dedicated solely to diagnostic sonographic imaging. We are staffed with three enthusiastic radiologists dedicated to the excellence of sonographic diagnosis.

This is a practice with a wide diversity of exams. Along with general ultrasound exams, we serve as an emergent/urgent imaging center which expands the level of pathology encountered. We do extensive vascular work including pre and post op surveillance for the vascular surgeons of Calgary. We specialize in musculoskeletal and MSK intervention including alcohol sclerosis for plantar neuromas.

The highest level of sonographic diagnostic excellence occurs with exceptional radiologist supervision, education and staff compatibility. We foster a staff of technologists and radiologists that are cordial, enthusiastic, and enjoy a team environment. Our highest priority is in patient comfort and in contributing to an accurate final diagnosis.

We are looking for a technologist who has an eager attitude to learn and work as a team member; who can confidently perform routine abdomen, pelvic, obstetric and small part exams. Any skill in vascular and musculoskeletal exams is welcomed but not a prerequisite. Opportunity to expand skills through onsite teaching and, support for other learning.

We have 12 ultrasound machines with new Siemens sequoia 2000, GE Logiq E9.

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E-mail Dr. Steed - drsteed@telus.net
Kim Boles provided input on two such initiatives, the first of which was “Imaging Day” and the second, work on an ACCC led initiative on Sustaining the Allied Health Professions.

Imaging Day was a joint initiative of CSDMS, CAMRT, CAR, CIRA, CANM, and COMP. The focus was on appropriateness, which was defined as the right test, at the right time by the right people. Meetings to raise the profile of the imaging team were held with federal politicians including Caroline Bennett and Pat Davidson. More information can be found on the Imaging Team website http://www.imagingteam.ca/.

The findings of the ACCC work on sustaining the allied health professions were release the previous week in Halifax and links to it will be provided on the CSDMS website.

9.0 Finances of the Society
   9.1 Review and Approval of 2011 Audit Report
Wendy Lawson provided a review of the 2011 Audit Report. A question was asked from the floor as to why bank charges had doubled. In response, Wendy noted that the difference was attributable to a one time bank fee related to streamlining the credit card payment process.
A comment was made from the floor that the format of the financial presentation allowed for greater understanding and was appreciated.

On a motion moved by Laurie Arndt and seconded by Gary Kachur, the members unanimously approved the audited financial statements for the year ended April 30, 2011.

9.2 Approval of Auditor for 2012
On a motion moved by Judy Mercer and seconded by Ellen Johnstone, the members unanimously approved the appointment of WGP Professional Corporation – Chartered Accountants as the auditors for the Corporation for the next fiscal year.

10.0 Ongoing Business
   10.1 CME Online Submission
Wendy Lawson announced the introduction of online CME submissions. There was a question from the floor asking how fraudulent CME submissions will be prevented. Janice Scharf, CARDUP chair, noted that at this time what is being provided for is electronic submission, noting that there is no change in the actual validation process.

10.2 National Competency Profile Revisions
Wendy Lawson noted that the National Competency Profile (NCP) is a joint document of CSDMS and CARDUP that provided the – entry to practice standards that form the basis for curriculum across Canada. Wendy noted that these need to be revalidated every 5 years, the next update will be initiated over the coming year.

11.0 New Business ALL
Wendy Lawson introduced Tom Hayward as a consultant working with CSDMS and CARDUP on looking at new organizational structures.

There was question from the floor regarding the departure of the corporation’s executive director and what the situation was with regarding filling this position.

Wendy Lawson replied that, while of course all personnel issues are confidential, the board appreciates Kathleen’s valuable contributions to the organization over her six years in the position. They are grateful to her for her dedication and service and wish her well in her future professional endeavors. Regarding filling the position, Wendy stated that this will be addressed through the joint committee that has been established with CARDUP to look at the most effective business model moving forward.

There was a question from the floor regarding dropping ARDMS certification. In response, Wendy noted that CSDMS always recommends CARDUP certification. Other board members noted that dropping ARDMS certification is a personal decision based on personal circumstances including considerations such as mobility.

Janice Scharf noted that CARDUP has a mandate to make sure HR departments are supportive of CARDUP credentials. Janice asked that if any members are aware of any employers not requiring CARDUP credentials, that they let her know and she will arrange to discuss with the employers.

12.0 Adjournment
Following a motion moved by Lenny Kwasiuk, seconded by Jane St. Germain and unanimously approved by the members, the meeting was adjourned at 4:55 PM.
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