Canadian Anesthesiologists' Society Presidential Interviews
Dr. Peter Duncan, interviewed by Archives & Artifacts Committee Member Dr. Sonya Soh
November 25, 2022

Sonya
As an introduction, Dr. Duncan, you began your medical education in Manitoba and then you went on to learn and practice medicine from places including California, Ontario, Winnipeg, Saskatoon, Kingston, and finally Victoria, from where you retired from active practice in 2015. You were President of the Canadian Anesthesiologists' Society from 1988 to 1989. Prior to this, and afterward, you were involved in many subcommittees in the CAS as well. In 2018, the CAS commemorated your contributions to the field of anesthesia with the Emeritus membership award, and you joined the ranks of anesthesiologists such as Dr. Earl Wynands, Dr. Harold Griffith, Dr. Wesley Bourne, Dr. Philip Bromage, who are all very big names that every resident at McGill University at least, are very familiar with.

During your career, you were also a very avid researcher. Your main interests were in epidemiology and health care outcomes, as well as standards of practice in anesthesia. I can tell from your very long and impressive list of publications that you were involved in anything from basic science research to research involving MH [malignant hyperthermia], et cetera. It is such a great honor to have this opportunity to sit down and chat with you.

Let's go all the way back: would you mind describing for us your childhood and your family background?

Peter
First of all, thank you very much for asking me to be part of this. I think this is a great initiative. I hope it's successful for the CAS to develop their archives and have people learn a little bit from the past.

Getting back to my own self, I was born in Dawson City in the Yukon. I bet you will not see another person in Canada who was like that because few people were born up there. My father was a doctor and he graduated from Manitoba in 1939, then immediately entered the military until 1945. Looking to make some money so he could do his residency in pediatrics, he went up to the north, where his brother had been a physician prior to the World War.

My father carried on a solo practice in a community that was very isolated for eight months of the year. Unless you had the steamboats coming in with tourists, you had nobody around to help you. I was not really aware of the difficulties of being in solo practice until I heard a story, that the doctor (two prior to my father) had actually died of a perforated appendix simply because there was nobody around to take it out for him! So, it was always a fear in my father's and his brother's mind before him – how do you take care of your own family or yourself if you're the only doctor in the community and you have no opportunity to evacuate? It was a constant concern.

I made my first acquaintance with anesthesia when I had to have my tonsils removed while in the Yukon. My father poured the ether, and my uncle snatched my tonsils during the summer. The belief was that if you didn't have your tonsils taken out by then, you might get a respiratory infection. There were few antibiotics at the time, and this was one way that they thought they could prevent upper respiratory infections. As to ether, I can still remember [having it] as a four-year-old child. It's not very pleasant, but it worked. It was a very safe drug.

Our family eventually settled in Regina where I did high school. It was around that time when Medicare was introduced in Canada, in 1962 in Saskatchewan. My father, being a physician and a politically active

individual, advised me that there is no way you should stay in Saskatchewan because that horrid Medicare was coming. So, I took off to Manitoba, and that's where I started my medical studies.

Sonya
That's amazing. Did you have any siblings growing up?

Peter
I had four. I was the middle child. My two older sisters sort of ruled the roost. My younger brother, and younger sister, well they got the attention and I just sort of schlepped my way through. I was the middle child and totally ignored!

Sonya
Were you just in Dawson City [while] in the Yukon, or did you move around up there at all?

Peter
It was for the first five years of my life that we lived in Dawson City. There are many stories told about Dawson City. Some of them are even true! My uncle wrote a book about practice in Dawson entitled *Medicine, Madams, and Mounties* because the role of the physician there was to take care of the RCMP, [who] were up there to make sure the madams of the houses that kept the miners comfortable were healthy and clean. He practiced medicine in a way that very few people would, like real frontier medicine. [He was] doing surgery, obstetrics, pediatrics, cataracts, all sorts of things! It was really a very unique experience. It is fascinating to think of the isolated medical position that existed in rural Canada at the time.

Sonya
So, since your father and your uncle were both physicians, was it a given that you would also pursue medicine as well?

Peter
It was more or less implied! You know, I could do other things but this was something they chose to do, so [I thought] I should as well. I think there is that tendency to follow in parental footsteps if you can, because you understand that particular professional practice.

Sonya
Did you have any other sort of educational or vocational background prior to pursuing medicine?

Peter
Not really. Out of childhood revolt, when I went to the University of Manitoba, I started off in honors chemistry rather than medicine because I wanted to look at another science. But I very quickly changed my mind when I saw what chemists actually did and decided to go the way of medicine. [I otherwise had] nothing really in the way of aspirations beyond that.

Sonya
What experiences were most influential in choosing anesthesia as a practice?

Peter
When I finished medicine and went off to California to intern, I had full intention to become an internal medicine specialist. They were very cerebral; they were very smart! I thought I could be one of those guys, so I entered internal medicine, did a couple of years of that in California, then came back to

Winnipeg. When I was doing internal medicine, I happened to do some time in a very progressive intensive care unit in Winnipeg. I was mentored by people who were not internists, but rather anesthesiologists. Particularly one fellow, Dr. Joe Lee, who was a legend in Manitoba practice.

I got confused, so I decided to go and do family practice in Kenora, Ontario. I was able to do the rudiments of anesthesia insofar as I could run an intensive care unit. They were short of people to give anesthetics, so I would do. I knew how to intubate, how to ventilate, how to paralyze. All I had to do was throw a little bit of hypnotic in there and some analgesia, and I was away. So, with virtually no training, I started to do anesthesia!

I thought this was sort of neat. Then I thought, well, I'll go back and do intensive care and I'll do it via anesthesia. So, I went back and did that. I quite enjoyed it. I then picked an MRC [Medical Research Council of Canada, superseded by Canadian Institutes of Health Research (CIHR)] Research Fellowship, went off to Seattle and did immunology. At the time immunology was sort of an up-and-coming field, and I thought that was great. So, I became a researcher in immunology while I was in Seattle under the tutelage of Dr. Bruce Cullen, who wrote one of the big books of anesthesia [with Drs. Paul Barash and Robert Stoelting].

When I returned to Manitoba, they needed somebody to run the pediatric intensive care unit, so I went and did pediatric intensive care, learning pediatrics on the job. There were no fellowships [in pediatric intensive care] at that time! In order to do the intensive care, I decided I'd do pediatric anesthesia as well.

So, *that's* where I got my career started.

Sonya
Were there any mentors or sponsors in your career that were especially memorable or influential?

Peter
The first person was Dr. Joe Lee, [who] I met in intensive care in Manitoba. Dr. John Wade was a pioneer in anesthesia in Manitoba. Dr. Bruce Cullen is a leader in anesthesia in the United States and an academic leader. He is still in Seattle – not in practice – but I still see him pretty regularly. There are other people, like Drs. Doug Craig and George Gregory. I encountered an awful lot of people, and they were all very solid individuals with much to offer.

Sonya
During your career as an anesthesiologist, how did you eventually become involved with the CAS?

Peter
I got involved with the CAS because there were very few people in Manitoba that were active politically. I was active in the Manitoba Medical Association. Anesthesia was in very short supply there and I was quite vocal in trying to negotiate better remuneration for anesthesiologists, so we could recruit to Manitoba. As a result of that I got a little, you might say, involved in the politics of medicine. So, it followed, to join the national group as well as the provincial [organizations].

Sonya
Can you describe some of the roles you had leading up to your presidency?

Peter
If you look at the problems with anesthesia at the time, one of the biggest was malpractice. Malpractice fees were very high: we were up there with the neurosurgeons and the obstetricians. And dreadful practices were [going on]: we were so short staffed that almost anybody was allowed to give an anesthetic – as I had when I went to Kenora! I was a general practitioner who could give an "ICU" anesthetic to anybody. That's the way I was trained as an internist, and the idea of throwing in a little bit of analgesia was not so difficult. Other people, though, didn't have my background in intensive care and would go into anesthesia because they were the lowest person on the medical totem pole. As a result, there were some dreadful anesthetic outcomes. It wasn't just the community hospitals. In downtown Toronto, several hospitals were abusing foreign trainees. They would bring in so-called fellows, who would be made to sit in front of an anesthetic machine and watch some vital signs under tutelage with one staff person who was really covering 3 or 4 rooms. I mean, that's dreadful practice. We'd never think of it now, but that was going on. As a result, there were disasters, and disasters led to malpractice. The settlements were very large indeed!

The second issue that we had, was getting anesthesia recognized as being a field that was deserving of support! We did get a little attention in some quarters because we were killing people, there's no other way to put it! The death rate was high in anesthesia. As a result, we needed to solve the problem of adequate anesthesia manpower together with patient safety.

Pardon me if I get a little sidetracked here and discuss the evolution of training requirements for anesthesia in Canada.

Let's look back at the recognition of anesthesia in Canada, and when the Royal College of Physicians and Surgeons of Canada decided to set up specialty training programs right after the Second World War. Representatives from the various specialties were gathered together. Figuratively, they would turn to the head of internal medicine and say, "How long does it take to train an internist?" The internist would say, "We've got a lot of knowledge. It's going to take a long time to get that knowledge. Let's say four years." So, four years was the duration of training to become an internal medicine specialist.

They then would turn to the surgeon and say, "How long would it take to train a surgeon?" "Oh well, we've got to do all sorts of things. We've got to cut and sew and so many body organs to fix - four years, it takes four years."

Then it came to anesthesia, and they said, "Well, how long is it going to take you?" Everybody knew that it was two years to get an FFARC [now, FRCA] in the UK, and two years to get a degree down in the US. But our forefathers in Canadian anesthesia just said, "Let's see: Internist – four years. Surgeon – four years. We also need four years of training, and then we'll have a good anesthesiologist." The Royal College said, "Okay! We'll give you the same length of time as these two specialties."

So, anesthesia started out with an equal training requirement to all the other specialties, but we didn't have the content to fill the time. We added a year of internal medicine as part of our four years. That took care of one year, then what else should we do? So, we studied silly things like surgical anatomy and all those other things came into the bailiwick of anesthesia training. Nothing to do with anesthesia, but it killed the time, and it gave us credibility. We were equal to all the other medical specialties at least from the time that you have to spend in training. Furthermore, when subspecialties such as obstetrics, pediatrics, ICU, and pain management came around we had room to absorb them into the anesthesia curriculum.

But we never were able to get equality in the eyes of other specialists because of some of the practices that were going on. If you take somebody who comes from a foreign land who can barely speak English, set them down in front of an anesthetic machine, and arbitrarily call him an anesthesiologist, you're degrading our specialty. So, what we had to do was to change the attitude of anesthesia supervisors and anesthesia providers to have respect for themselves and respect for their field, so that we would end up being again the equal of all those other specialties. That was the background of where things were going off the rails when I was around with the CAS.

At that time, pulse oximeters and capnography were still new. We now take them for granted, but they weren't invented when I started. You actually had to touch the patient and look at the color of their skin. Clinical signs worked, but you had to stay in the room to see them. If that didn't happen, then disasters would befall. So, that's why we had to get departments to advocate for standards of practice, and for using pulse oximetry and capnography. Healthcare administrators were not used to putting money towards their anesthesia department, because they didn't really respect what the specialty entailed and what we were doing.

Sonya
That's so interesting to hear about these challenges at the time. Now, what would you consider to be the biggest accomplishment you had in the CAS?

Peter
I think the biggest accomplishment was getting bright young people to come into anesthesia, to have the field respected by the students that became the future substrate of the specialty. We had other achievements as well. I took a great deal of pleasure watching the CMPA [Canadian Medical Protective Association] dues go down as anesthesiologists practiced better medicine. And I felt very pleased when I saw some of the old practices disappear. For example: some teaching hospitals would run four rooms with one staff person – I mean these things were terrible! But we had to do a lot of manipulation along the way to make it so that things would work within our manpower situation.

Healthcare administrators were a real problem. For instance, there was one hospital in Saskatchewan where they would run four operating rooms in the morning using four general practice anesthetists. Then, in the afternoon, the operating rooms would be empty. They wanted to get full time anesthesiologists, but they didn't give them full time work. “Right” I said, “Why don't you run two rooms all day and you'll get two anesthesiologists because they’ll have enough employment?” And the administrators would say, “Well we can’t do that, we've always done it this way!” That was the type of problem that we had. I spent a lot of my time consulting with administrators, telling them what was the matter. “Why can't you get specialized anesthesiologists?” At the same time, I was trying to improve the lot of the individuals that they recruited, so I was very flattered to see the changes that happened over the ten to twelve years that I was associated with the CAS and with ACUDA [Association of Canadian University Departments of Anesthesiology].

Sonya
You did a lot of work with patient safety. What does patient safety mean to you in this context, having seen the changes in anesthesia?

Peter
That's an interesting and difficult question. I always felt that anesthesia by itself had no therapeutic value to any disease. What we did was facilitate the care provided by others, but in so doing it could be said that we had no value per se. At least as measured in the broadest context of disease-adjusted years of survival.

We do not do anything to improve your disease, so we should not do anything to distract from your well-being. You should be able to go in, experience anesthesia – and, during that time, experience the remediation of whatever medical or surgical procedure you undergo – then, come out at the other side at least as intact as you went in.

Patient safety should oversee that. We should add no morbidity, no mortality. That's the only thing we can possibly offer. Unfortunately, it's almost impossible to guarantee that. You can't guarantee anything when throwing drugs at the kind of sick folks we often have for patients.

But we also need to be psychologically supportive within the constraints of informed consent. I used to say to medical students who were coming on the service – I would walk up and shake their hands and say, "Hi! I'm Dr. Duncan. I'm here to paralyze you. But don't worry, you're going to be okay. We had a guy just yesterday survive." That's not a good way to relax a patient coming for surgery. In comparison, saying, "Full disclosure, I'm going to use muscle relaxants for you," That would be much less stressful. There is a way to approach patients that doesn't generate psychological distress and reassures them that the chances of physical morbidity and mortality are minimal. That's the practice of patient safety.

Sonya
Very well said. Now, I'm really excited to ask you this question; can you describe for us a typical anesthetic that you would deliver in your first-year practice and compare it against the last anesthetic that you delivered?

Peter
Well, you'll probably not recognize the names of many of the drugs that we would use. When I first came back after getting my fellowship and went to work at Winnipeg Children's Hospital, it was very popular to use a drug called cyclopropane. It was an explosive anesthetic gas with physical properties similar to sevoflurane. Two or three breaths and the child went to sleep. It was really nice for the children because you just establish a fresh gas flow into your hand, hold it underneath their nose and their mouth, and they would take a few whiffs, and be off to sleep. But it was explosive, so you couldn't use it in the presence of any monitors, lights, or anything else electrical on in the operating room! So, we would begin with the cylinder attached to the side of the anaesthetic machine, use a flowmeter, induce them with cyclopropane, switch over to some other drug – halothane most often – then, the circulating nurse would take the cyclopropane out of the room. We would then turn on the lights, turn on the monitors and the child would be asleep with halothane breathing spontaneously. We would intubate with succinylcholine because it got the job done fast. Then, if we needed further relaxation for the surgery, we would give some curare. We would throw some narcotic at them because regional analgesia was not well developed. At the end of the case, we would wake them up, usually extubating the child deep to avoid croup, and away we went to the recovery room. That was an anesthetic. It took quite a while and had some unique characteristics, but we got pretty good at it. Notice that we had no monitors then, the patient was just breathing spontaneously on a handful of cyclopropane but it worked. It worked quite well.

I taught medical school students for quite a few years. The one thing that I tried to emphasize is, if you have somebody who you wonder whether they're able to breathe at all, because they've got a restricted airway or anything like that, there's an old rule: "bad breath was better than no breath at all!" We used a lot of bad breath with cyclopropane and halothane and, as long as the patient was breathing, they were safe. As an aside, it is one of the reasons why ether was so popular for so long. Because people anesthetized with ether had stable respiratory and cardiovascular systems; they kept breathing and they maintained their airway. Mind you, they salivated all over the place, but they were still very safe. And that type of anesthetic that I was using when I first started was similarly safe, because at no time until I

was ready to give them some succinylcholine to intubate them, did I stop them from taking care of themselves.

Sonya
What do you think is the advancement in anesthesia or in medicine that had the greatest impact on your practice during your career?

Peter
On anesthesia in general, it's the quality of the provider. No doubt at all! The people going into anesthesia now are so different than the people that were around when I began practice.

The other thing is the patient information, the data sets we have. We used to have, as a sole monitor, a precordial stethoscope. This I connected by a piece of IV tubing to my ear, and it allowed me to listen to the heart sounds and breath sounds. It must have appeared strange to see me holding my ear while I was talking to others in the operating room, but I could tell an awful lot from it. But now, anesthesiologists have things like pulse oximeters and capnographs to pick up airway disasters. That has made just an amazing difference in where we are now in anesthesia.

Sonya
It's amazing to hear. Just to switch gears a little bit, talking less about anesthesia and more about you. As I mentioned earlier, you moved around a lot during your career in medicine: Ontario, Manitoba, Saskatchewan, British Columbia, the United States. What prompted you to move around in practicing medicine? Where do you consider home?

Peter
I guess you could say I'm still a Roughriders fan, though I never worked in Regina itself. I consider the prairies, particularly Winnipeg, still home. Why did I move around? It was because I was always looking for something new to do: going from intensive care to pediatrics; pediatric practice to administration of a department in Saskatchewan; then to administration at Queens; from Queens out to Victoria where I was working in the community. I'm always looking for new challenges and horizons.

A real advantage of practicing anesthesia is you don't have to take years and years to build up a patient clientele. You can pick up your shingle, go to a hospital, and you'll have a full list tomorrow. There is no reason why you can't. If you have a wanderlust for places you want to go and live, just do it! It's all the better for you.

As I was saying when we started this interview, the person who's traveled around picks up tricks from everywhere he or she goes, then disseminates them to others. That's one of the good things about our specialty. It's always a delight to work with anesthesiologists on locums for short times: from Britain, from the United States, from other parts of Canada. Ask them what they do and how they cope with this or that problem, and they will have a unique twist on things. I always felt I was enjoying the broad spectrum of medical practice too much to stop doing it.

Sonya
I also wanted to ask, so you have a very impressive list of research publications. As you mentioned, you completed a research fellowship. What drove you at the time to pursue research as part of your career?

Peter
At the time anesthesia, did not have a great track record for securing research grants. I thought maybe I could get trained as a basic researcher and contribute in that way while still practicing anesthesia. I still had in the back of my mind an interest in intensive care, but my desire was starting to dwindle a little bit away from that. When I was an internal medicine resident, I was amazed by immunology, which was a new field at the time. It seemed to be the place where things were going to happen in the future, so when I met Dr. Cullen and picked up the MRC research funding, I could go to Seattle on my own ticket, and he was willing to take me. We worked together in some interesting aspects of anesthesia, at the cellular and immunological level, but we didn't rewrite any of the great books. We had fun though.

At the same time, I missed the excitement of the operating room and the intensive care unit, and I missed the patient contact. So, I didn't follow up much on immunology, though I maintained interest in the cellular effects of anesthetics. That's why we got a grant and published [an article] looking at women who were pregnant while receiving anesthetics to see whether there are teratogenic effects. We couldn't identify any adverse outcomes, but it was a very well received study at the time because nobody had ever had an opportunity to do that sort of epidemiological research. It all spun off from the cellular effects of anesthetics, which was the basis for my lab research.

Sonya
Can you describe your life after retiring from anesthesia practice? Are you still involved at all, or have you kind of moved on to other aspects of your life?

Peter
For the first couple of years, I was still Professor Emeritus and had privileges in Victoria. I didn't keep my malpractice insurance going, because I didn't want anybody to coax me to come in. For the time I was in Victoria, which was 17 years of practice, I and at most one other person did all the pediatric challenges. If somebody got into trouble, they would generally phone me whether I was on call or not and ask me about their case. So, I continued to consult in that way. I would just say, "You know I'm not licensed to practice anymore so I can't see the child with you, but why don't you think of this, this, and this?" That was sort of fun. After a while, I thought, well I'm not going to meetings. I'm not staying abreast. I can give them the benefit of experience, but not new knowledge. So, I tapered off from that. Since then, I've worked on just personal things. I'm interested in history and genealogy, and I've got a house with a big yard and lots of things to do. It's funny how you find time to do what you didn't do before.

Sonya
What advice would you have for the next generation of trainees and anesthesiologists?

Peter
I guess the number one thing is to have fun. There was a fellow I worked with, a pediatric surgeon in Winnipeg. He would say: "We're members of the 'surgery-can-be-fun' club. And what we want to do is to focus, not on my technical role or my medical rule, but the fact that I have a role with a team that was doing a very enjoyable occupation of which we should be proud, where we take somebody who's sick and we make them better. We're all members of this team. We're all equals, let's celebrate each other. He would celebrate something that I would do. And, in turn, I would say, "Geez, that was a great case you just did."

Similarly, if I went to another room and saw the ophthalmologist doing something I hadn't seen before, I was just amazed at it. It was fun! It was growth! It kept me in awe of the rest of medicine. And in turn, they would do the same with us. And as I said at the very first of this interview, the biggest change I saw

in anesthesia was the respect that others gave you. A major part of that was respecting what's happening as part of the team. I think I'm probably the guy who least sat down in the operating room while giving an anesthetic. Most of the time I'd be standing behind the drapes watching. Part of it was pediatrics, because you had to be constantly observing the patient; you had to pick up on a problem just when it happened, not when the monitor changed. But in so doing, I was watching the surgeon and chatting with him about what he's doing, praising him where appropriate, counseling him otherwise, and he would be doing the same with me. You were part of the team and so were the nurses. That was the fun part. *That is always what you should focus on*: ***enjoying your practice***.

The second thing I would say is, ***don't forget about the patient***. All this technology is now coming into the room. When I used to work with residents, they would be looking at the EKG, for example, and comment "Oh gosh, bigeminy up here, what's going on?" And they'd stare at the EKG, so I'd take the EKG and turn it backwards so they couldn't see it. And I would say, "So now go look at the patient." And they'd say, "Oh yeah, I forgot! There's *a slip down the right mainstem there and my pulse ox is wrong*." Anyway, it was trying to get them to look at the patient, which is actually the origin of all those things. If you put the patient first, always first, then you're going to do just fine.

One of the only ways to find out about how you are doing, though, is talk to the patient. I used to go and see as many as I could on the ward post-op. Many of the patients that I couldn't see on the ward, perhaps because they went home, I would just phone and say, "Mrs. Jones, how are you doing today? I'm your anesthesiologist from yesterday." What's interesting is, you learn what they experienced, and they also learn that you're an interested professional. They're very pleased in getting any sort of information.

Those are the two things I'd say. Have fun! Put the patient higher on your list and find out how the patient did so you can do better next time.

Sonya
That's excellent advice. I'm curious, what other piece of advice would you have for young trainees? I think you've experienced it yourself in your career, where we have to be adaptive throughout our careers as new technologies and new methods develop. What advice would you have for trainees to keep up with changes in our field, take up new technologies and new techniques?

Peter
Rephrased: "How do you do that?" During your training program, of course, the program usually provides the insight. It's when you graduate and you go out to practice, you don't get a chance to be exposed to the practice of others. I would recommend staying migratory, as I did. Go do locums. Talk to people in the staff room: "How did you handle that patient the other day? How did it work out?" It's amazing what you can find out just by talking, by being there. And having fun with medicine, being interested in medicine and being interested in what other people are doing as well. With that you'll get perspective, and you'll have no trouble adopting things that are important to adopt. There are a lot of things that come around and are gone again within a couple of years. But the things that are important usually have a pretty rapid up-take, are evaluated by others, and you can evaluate for yourself.

I don't know whether that answers your question. It is difficult. But you can't be isolated in one operating room in one hospital doing the same thing 365 days a year and expect to stay abreast. Go to meetings and play the games. It's good fun! It's recreational! And you'll get a chance to see what's out there.

Sonya
One more question, it's something that I think our field struggles with nowadays. That is, trying to provide good quality anesthetic care to all the rural and regional areas in Canada. Do you have any ideas about how we as a specialty can tackle this?

Peter
Previously I was speaking about how quality was down because the healthcare administrators wanted every small town to have an operating room and to have an anesthetic service. We know that can't be the case. We know that, in the prairies, where I have a lot of my background, people didn't hesitate to drive two hours to go to the discount grocery store. It was just part of living. Well, why can they not drive two hours to go and get an operation, which is a very risky thing to have done in their life? There is no need to keep old, tiny hospitals open. I would advise the administrators to look rationally at regionalizing and consolidating differing anesthetic and surgical services. The profession should take the position that we will have individuals trained appropriately to the surgical program that is around, but we will not do it in every small town.

I was a great supporter of the GP anesthesia program when I was around Saskatoon and Winnipeg. The programs were very well designed, targeted for good family practitioners who developed this other interest in doing anesthesia. The GP anesthesia practitioners would do a minimum volume that was acceptable. They were well trained in the basics, very well trained in risk management, and what usually happened is they did that for about five years and then they would come back and do the full anesthesia program. So, we had a cadre of anesthesiologists that were in fact formerly GP anesthesiologists and I think that just spoke to how to make the program interesting and valued, and a practice that had pride associated with it. I would challenge the administrators of anesthesia not to give in to the political realm. If I have a hospital here that needs one anesthesiologist and I want to do obstetrics, even though there's another hospital 30 minutes away, there should be a practical realignment of service. In this era of modern transportation, you do not have to have a hospital for every Tom, Dick, and Harry with every service. It's just not necessary.

Sonya
That's an interesting perspective.

Peter
It's an argument that's been going on for a long time. As I say it, it started in my life when, under the age of five, I received an ether anesthetic by my father so my uncle could take out my tonsils. They shouldn't have been doing it! Now I know that they shouldn't have been doing it. But, at that time, it was the accepted thing. You don't want to be doing that now or having people delivering babies where there's only one or two babies a year in that particular health care institution. They shouldn't be doing that! They're very parallel, high-risk procedures.

Sonya
Thank you so much for taking the time to chat with us, for an interesting interview, the perspectives and experiences that you have to bring. I think they're super valuable for everyone at the CAS, especially for people at my level of training. Being able to look into the past and the history of anesthesia through people like yourself is very valuable. So, thank you very, very much for your time.

Peter
You're most welcome. I wish you well because, as I say, you folks are the future. You are the ones that made such a difference from the 1970s and '80s to now, in what constitutes anesthetic practice. Your

challenges are going to be different ones than the ones we faced, but at every level there's going to be manpower issues. There's going to be technical issues. The technical issues can be solved with money. Manpower issues have to be solved by keeping the field on a very high level of respect by medical students.

What was really quite interesting when I first got into administration - this is a sideline - but when I first got into administration in Saskatchewan, they used to have a career night for medical students. Anesthesia rotations by the students were well received but they didn't happen until the end of the fourth year, by which time people had chosen their residencies. So, they had a career night for the third-year medical students and the dean would buy pizza and say a few general things about making a specialty decision.

Then he'd ask some people that were important to speak, like the department heads. The head of family medicine would come up and say, "Well, you all have a family doctor and you all love Dr. Jones. He was so lovely, and you want to be caring, and you want to be able to be in the community as a respected member and they'll buy you a beer when you go to the curling club. Won't that be nice? So come into family medicine."

And then the head of internal medicine will come up and say, "Well, you've got a brain? If you think you've got a brain, come into internal medicine because we're the thinkers. We don't do anything, but we think and diagnose, and we can tell you all sorts of good things."

And then of course, the surgeon comes in and he's got a lab coat, with blood on it usually. He comes and says, "Well, I was just in the operating room saving another life, stamping out more organs. You know, you oughta come into surgery because if you like to do things and make people better and heal them, come into my field."

Then, I'd ask, "When is anesthesia going to be presenting? We're the third biggest medical specialty in Canada, behind general internal medicine and general surgery. Numerically, we're here."

And the dean would say, "Oh well, we didn't have anything for you in the program, but there's a telephone booth down the hall, and if anybody is interested, we can send them down to you."

I used to think, this is crazy! We've got a public relations problem here. Our own fellow academics don't understand who we are and what we are. We have to make some big moves on that, and the only way we're going to do that is if we practice well, continue the divestment of anesthetic services out into the pain clinics, the OB wards, all the other things we do, and take part in administration and in teaching. Those are things that we have to do so that people continue to subscribe to the study of anesthesia.

Sonya
I think it's still kind of an issue in our field, at least in my experience. Even here in Quebec, at McGill, anesthesia is a presence that's not well appreciated or well understood. I think a lot of people that are contemplating anesthesia or even out doing anesthesia residency have taken issue with that too. Sometimes they feel like they're not appreciated or respected. So, it's definitely something that I agree, I think that we should put ourselves out there. I think we should be more involved in medical school teaching, as our surgeons or internists are.

Peter
One of the things to say as the first words to new grads, is that anesthesia and surgery can be fun! Go and participate! Praise the surgeon! Don't get antagonistic with him and he will praise you back. It's human

nature to create a dialogue and then we all respect each other. If an internist comes and sees a patient and is worried about the assessment, talk to him. Let him know our concerns about the internal medicine problems he has, because chances are he doesn't know what the hell goes on in the operating room. But tell him and he's liable to say, just as much as you say, “Wow, that's important.” He's liable to say the same thing, and [thus] your field is elevated in respect. As I said before, when I started my practice, the body count was high, malpractice was around, and morbidity and mortality existed. We got rid of that therefore, to many people, we’re not important because we are not a problem anymore. We were important as a problem then, but not now. However, we can still be of benefit, and we can still contribute to the team. And we want to make sure people know about it.

Don't do things in secret!

Do it so that the others understand our value!

Sonya
Thank you so much.