Canadian Anesthesiologists' Society, Archives and Artifacts Committee Presidential Interviews
Dr. Renwick Mann, interviewed by Archives & Artifacts Committee Member Dr. Karim Mukhida
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Dr. Renwick Mann served as president of the Canadian Anesthesiologists' Society from 2004 to 2006 and has also been extensively involved in the Ontario Medical Association and Canadian Medical Association. Currently, Dr. Mann primarily practices in Timmins, Ontario, while he spent most of his clinical career in Peterborough, Ontario.

Karim
Can you describe your childhood and family background?

Ren
I was raised in a small single-industry mining community near Kirkland Lake Ontario. My parents located there after World War II.

My paternal grandfather had been a mining prospector and entrepreneur – mining was in the family DNA.

The Kerr-Addison mine was in Virginiatown – and was for a time the largest gold producer in the country. My father and uncle worked at the mine and started a gas station / service station / car dealership / taxi business.

My parents were both quite involved in the community in various ways. They set a good example of citizenship. My siblings and I were encouraged and supported to do well in school and were given opportunities for music lessons, sports participation and outdoor activities.

I started helping at the gas station from age 7 or so while attending elementary school. It was a good experience for me. It taught me that I needed to stay in school. It was a great place to grow up.

High school was in Kirkland Lake. We were bus students. Grade 13 still existed. My grade 13 year was the first year my high school had a student prefect program, and I was vice-chair of that. We had some responsibilities for crowd control, monitoring the cafeteria at lunchtime and during assemblies. Near the end of the school year, the head prefect was hospitalized with appendicitis. With that, I was charged with organizing the last big assembly. That went well enough and probably helped with my principal's reference letter in support of my university applications.

I was accepted to Queen's pre-med. There were fifty of us accepted straight out of high school. We were the second to last class of dedicated pre-med at Queen's. What that meant was that we had a two-year program where all we had to do was pass all our courses, maintain a B average, and we had a guaranteed spot in first medical year, which of course people would kill for nowadays!

Fifty of us started pre-med in 1969. A few didn't make it through to the end of the second year. Then, they added others to make a class of 70 starting the first medical year – that was 1971 and I was class president. I would make class announcements at the end of Embryology lectures. It was a convenient size hall, and the acoustics were good. After I had done that a few times, the embryology prof said, "You know, you do a good job with this! You've got a clear speaking voice and you convey the messaging well."

This being the early '70s, with emerg docs being a relatively new specialty and only found in major teaching centers, Trenton Memorial Hospital, about an hour West of Kingston, would hire for the summer

three second-year medical students from Queens to staff their emergency room. They taught us how to suture simple lacerations, cast non-displaced fractures, look in kids' ears and throats, and triage a lot of the stuff that would come through emerg. The medical coverage for emerg was the family physicians in the community. Two classmates and I were hired to do that for the summer.

That was a great experience. We learned a lot of hands-on skills and saw a lot of clinical medicine. There were things that I saw in the four months in Trenton that I've never seen since. It was fascinating! There were specialists: four general surgeons, three OBs [obstetricians]. There were visiting specialists from Belleville including an orthopedic surgeon, a urologist and a pediatrician. In Trenton there was quite a good young internist. It was well-staffed, for the size of the community. We were welcome to do as much or as little as we wanted in any of these other services. I learned how to handle myself in an operating room, with sterile technique and so on. I had every intention by the end of that summer of going into a surgical program, probably general surgery. At that time, the only thing we had to scrub with was Bridine [povidone-iodine]. It turned out that Bridine and I did not get along. I developed quite a nasty case of nummular eczema. It was a terrible problem for my hands, so I needed to protect them and use topical steroid. It was also clear then that a surgical career was going to be out of the question.

Our final year was our clinical clerkship. At that time, it was one year consisting of five 10-week blocks among which were five weeks of psychiatry and five of specialties. The specialties were anesthesia, diagnostic imaging, therapeutic radiology – now called radiation oncology – otolaryngology and ophthalmology.

The very first block that I did in clerkship was the five weeks of specialties and my first week was anesthesia. I liked doing things with my hands, and that was one of the appeals of surgery. There I was in the operating room, doing things with my hands, airway management, vascular access, and so on. I enjoyed it and I think I demonstrated a bit of aptitude. The staff people that I worked with were encouraging.

I was dating a recovery room nurse at the time who was aware of my interest in anesthesia. She spoke with the professor and arranged for me to meet with him. Dr. Fred Wright was the prof at the time. When I met with Fred, he encouraged me to plan to join the residency program after completing my clerkship and doing a "straight internship" in internal medicine [direct entry].

I started my residency training program in 1976 having graduated in 1975 and completing a straight internship year of Internal Medicine. Three years later I sat my Royal College examination, and I became a certified specialist at age 28!

I had a lot of lucky breaks along the way that allowed that to happen.

I ended up in Peterborough with the help of an obstetric colleague two years ahead of me in medical school who had finished his training and was practicing in Peterborough. He called one evening to say his anesthesiologist colleagues had asked whether he knew of anyone finishing up anesthesia training who might be interested in a job in Peterborough.

I got in touch with the department up here and came for a visit. I was invited to come and join them which I did in mid-September 1979 after I completed my residency and the written portion of Royal College examination. I hadn't done my orals yet and the job was contingent on my successfully passing the oral examination which happened in November.

At that time, in the late '70s, Peterborough was a great place to work. We had a broad range of medical and surgical specialists. They had been very farsighted for a community of its size and location in terms

of building medical staff with a lot of very bright people and a broad range of specialties. We had vascular surgery, thoracic surgery – all the surgical specialties, except neuro and cardiac. We had a pretty good representation of internal medicine. We had a good OBGYN department, good psychiatry, good labs, and a good anesthesia program. Some of the people were getting up in years and were becoming less than state-of-the-art, but we worked our way through that. It was a great place in terms of volume and variety. As I'm sure you know, you come out of the training program having just taken the training wheels off the bicycle and you need to work for a bit to really consolidate your skills. Depending on the range of work you're doing and the volume, that may be a greater or lesser success. Peterborough turned out to be a great place to work because we had case variety and volume.

There have also been many changes in anesthesia practice. When I left my residency training, we had Tektronix ECG monitors, and you could monitor temperature. If you wanted anything more than manual blood pressure, you had to put in an arterial line. We had circuit oxygen monitors and pop-off valves to prevent you from over-pressurizing your circuit. That was it! All the other stuff came along after I finished my training.

The department members in Peterborough had a lot of foresight. They adopted in a timely manner all of the new things as they came along, oximetry, capnometry, non-invasive blood pressure [NIBP], all of the monitoring that's made our lives so much easier. We started doing lumbar epidurals and multimodal pain management for major things including vascular in the '80s, started doing blocks associated with knee and hip replacements and fracture work, eventually thoracic epidurals with thoracic surgery. We did all of that for most of the time that I practiced here. The anesthesiologists looked after our own patients in ICU. We did vent care. We were never Most Responsible Physician, but we had critical care in our scope as well. It was a great place to work and develop our skills along the way.

Over time I became involved with the local County Medical Society and that morphed into an executive position. I was president twice in the early '90s, with a year in-between. Through that I was also involved with the OMA [Ontario Medical Association]. The OMA's representational structure is a mix of geographic, where you practice, and sectional which is what you do no matter where you are in the province. I was a geographic rep to OMA council and started doing some committee work along the way. I had developed credibility with my colleagues in Peterborough as a representative.

At the same time, I was a member of the Ontario division of the CAS and the section of anesthesia at the OMA, largely the same group of people. Their executive started asking me whether I would get involved with the section. I didn't want to do that because the OMA had a fee determining role in distribution of money to different sections. Decisions about fee schedule changes would be debated and approved, or not, at OMA council, of which I was a part. I had developed some credibility with my colleagues who were not anesthesia providers as well as the anesthesia community in Peterborough. Involvement with the anesthesia section would present a conflict of interest. I turned them down two or three times. Then the board position on the CAS came up – the provincial representative on the board of directors of the CAS. We're now into about the year 2000. I thought, well the CAS is national. It's specialty oriented, but it doesn't have anything to do with money. I'll consider that! I found myself nominated to the board of directors of the CAS.

Karim
Right.

Ren
At that point, Dr. Rob Seal was the president and I think he was the first to do the two-year term. Prior to that, it had been a one-year term. The past president at that time was Dr. Serge Lenis from Québec. A couple of things happened during my first year. First the Ryten report. Eva Ryten was an academic nurse

in Toronto and the CAS had contracted her to do a human resources study of anesthesia. Very early on in my term on the board of directors, the ACUDA [Association of Canadian University Departments of Anesthesia] chair, Dr. Raymond Yip, from Saskatchewan presented the Ryten report. Health human resources was already a major problem and has continued of course to be so.

The other thing happening around that time was the Romanow *Royal Commission on the Future of Health Care in Canada*. Roy Romanow was a past premier of Saskatchewan who had been appointed by the Chretien federal government at the time. The Royal Commission was conducting its research. Amongst other things, they had asked the CMA [Canadian Medical Association] – to coordinate input from various portions of the medical profession. We as CAS board of directors were asked to comment and provide input. There was a homework package that we had prior to an upcoming board meeting. I thought that was worth putting some effort into, so I responded to the questions as they were framed and submitted this prior to the meeting.

When we got to that portion of the Board meeting. Rob Seal said, "You know, we asked for people to provide input. The only person that I heard anything from was Renwick Mann from Ontario." I think I got on the radar screen of the executive of the CAS courtesy of the Romanow Commission and the input that I provided to that!

We worked through Rob's two-year term. Serge Lenis serving as the past president, chaired the nominating committee. Sometime around the end of 2001, 18 months into Rob's two-year term, Serge contacted me to ask whether I would consider coming onto the executive as the vice president? At the time that was how presidential succession happened, with the secretary and the treasurer being executive positions separate from the presidential stream. So, technically, the vice president would be nominated and approved by the membership, serve a two-year term, and then succeed to the presidency for two years, and then become the past president for two years, and then you were done.

I thought about it for a little while, consulted some of the people that I knew who had done the job in the past and decided to accept that nomination. Then, in 2002, when Rob Seal completed his turn, Dr. John Scovil of New Brunswick took over as president and I became the vice president, succeeding John in 2004 as president.

The dominant issue affecting the Society during my term as president was access to care, the provision of care by specialist anesthesiologists or GP anesthetists in smaller places. It was basically the health human resources issue. That was a constant theme throughout my term as it had been at the OMA before I became involved with CAS and as it continues to be 20 years later.

In any medical leadership role, one can expect to have some involvement with the media. Shortly after I joined the board of directors as the Ontario rep, the phone rang at about 5 o'clock one morning. My wife – we always had the phone on her side of bed because she would wake up and I wouldn't – picked up the phone, said hello, and then gave me the elbow and handed me the phone saying, "It's for you. CFRB." CFRB was a major downtown Toronto radio station. The morning host actually did want to talk about health human resources because we were dealing with some shortages of anesthesia personnel even at that time.

My only direct contact with the national media that I can recall was being invited to appear on the CBC [Canadian Broadcasting Corporation] on their Sunday morning two-hour news special. The topic of the conversation was women being refused epidurals in labor when they had lumbar tattoos! I tried to divert them over to the fact that it was much more likely that women would lack access to lumbar epidurals in labor because of a shortage of anesthesia personnel, than because of tattoos!

The anesthesia assistant program was one way to provide some element of relief for staffing shortages, to allow us to extend ourselves in certain contexts. So, that policy was approved at the CAS during my term as President. The person that really drove that was Dr. Pierre Fiset, who was the Québec rep. Quebec had a program for years already, for anesthesia assistants. Their anesthesia assistants did a lot of technical stuff with the anesthesiologists in the OR. They would set up lines, look after equipment, and provide assistance. I don't think they did clinical work per se, but they helped. They would assist you with your inductions and organizing your airway management and so on. That helped to drive the development of the CAS policy, which we approved just towards the end of my term in 2006.

The other Romanow anecdote: I travelled to some regional meetings during my presidency. On one trip to Saskatchewan, I flew to Saskatoon. I stayed at the Bessborough Hotel, the old railway hotel in Saskatoon. I took a cab from the airport. It was a nice, warm star-lit evening. I think it was probably a Friday. The place was lit up. There were a lot of people in formal dress attending an event. Somebody opened the door of my cab before I had a chance to open it to get out. I look up and I'm staring at Roy Romanow, standing there with a tuxedo on!

I think he was just looking for a cab. I leapt out of the cab and grabbed him by the hand, "Mr. Romanow, it is so nice to meet you! I'm the president of the Canadian Anesthesiologists' Society. We're having a meeting and it's really kind of you to be here to meet me!" I played that up with my Saskatchewan colleagues, "You guys really know how to how to host the CAS president. You get your past premiers and commissioners of healthcare reports to come and meet me. This is really great." That was a fun one.

The non-fun one occurred during a trip to Manitoba. Saturday morning was when the news hit that our colleague in Windsor Ontario had murdered his recovery room paramour and then had committed suicide with an infusion of propofol. I think he locked himself in his car, started an IV on himself, and just let the propofol run. I was pretty sure that that was going to generate some media activity at the CAS because it involved an anesthesiologist. There was nothing, not one single request from anybody to the CAS to comment on that. They completely ignored the fact that he was an anesthesiologist and dealt with it solely as a domestic violence issue.

I made two trips to the AAQ, the Association of Anesthetists of Québec. They have a great meeting in the spring usually. I was there twice and at least one of them coincided with the funeral for Pope John Paul II. You know, things that were happening kind of anchor you in time.

That gets me through my presidency and on to the past presidency, I handed off to Dr. Shane Sheppard from Saskatchewan. The major role for the past president is to chair the nominating committee. The typical job at that time included finding somebody new to be vice-president from the board of directors. We would take various considerations under review in deciding who you might invite to do that. It happened that I had a couple of other jobs that came up that wouldn't necessarily always fall depending on the cycle, but I needed to recruit a new honorary secretary and a new honorary treasurer for the CAS.

With some good input from other people at the CAS and from non-Board members of the nominating committee – the past president and a couple of people recruited from the divisions across the country – I was able to identify Dr. Patricia Houston at that time for secretary. I was able to contact her and convince her that it would be a good thing to do. I think it turned out to be a good thing for the CAS. She ended up serving as president a few years later. The treasurer's job was kind of an interesting one. When I joined the board of directors, the treasurer was Dr. Linda Nugent from Manitoba. Something we had shared in common was that we had both worked on our local United Way campaigns; hers in Winnipeg and mine in Peterborough. I thought it was interesting that a couple of us had been involved in our communities in that way. She completed her term as treasurer and had recruited Dr. Diane Biehl – also a Winnipeg-based

anesthesiologist – to take over the role of treasurer. Diane was the treasurer through much of the time that I was on the executive. By the time I got to the past presidency as chair of the nominating committee, Diane was ready to hand off the role. She had taken it upon herself to speak to yet another Manitoban, female anesthesiologist who initially had expressed some interest, but then had withdrawn her name from consideration.

The nominating committee and I put our heads together and we ended up recruiting Dr. Sue O'Leary, from St. John's at the time at St. Clare's Mercy Hospital. She was a great asset to the CAS and went on to be president as well.

Karim
[laughs] That's wonderful!

Another question would be, can you describe a typical anesthetic in your first year of practice compared against your most recent or last anesthetic delivered?

Ren
When I started independent practice in Peterborough in 1979, we still only had ECG and temperature monitoring. We could do invasive BP monitoring if we were willing to start an arterial line but that was it. Our circuits had a pop-off valve to protect against over-pressurizing and we used the Bain (Continuous Partial Rebreathing) circuit almost exclusively. There were still re-usable red rubber endotracheal tubes in common use. I used a pre-cordial stethoscope for kids and an esophageal stethoscope for adults to monitor heart and breath sounds. Our laryngoscopy equipment consisted of only traditional incandescent bulb handles with MacIntosh or Miller blades. Our volatile agents were halothane and enflurane, probably with keyed filling devices by then to prevent filling a vaporizer with the wrong agent. There were no back-bar lockout devices yet, so it was still possible to have both vaporizers open at once, not intentionally of course but accidentally. Our machines still had two common gas outlets and Bird ventilators which we used to pressurize a bellows chamber and gave us the capacity to provide volume-controlled ventilation.

So, most cases would have been done with just a peripheral IV, manual non-invasive blood pressure cuff with the bouncing needle on the dial, and ECG on the Tektronix monitor. I don't think we even had the circuit oxygen monitoring that I'd had at Queen's before I left. The temperature monitoring system that we had at that time was a single-use disposable cotton tip ear probe that you would slide *into* the external ear canal. There was a cable that connected it to the Tektronix monitor that would display the temperature; that was what we had for temperature monitoring. I would always lubricate that with something, but it didn't matter what you did or how hard you tried, the probe always came out of the ear with blood on it.

Bigger cases, thoracic, vascular or major general surgeries would often include arterial line invasive BP monitoring and CVP [central venous pressure] or even pulmonary artery catheter monitoring on occasion.

Our standard induction agent was thiopentone and our relaxants were succinylcholine and pancuronium.

I can't recall if we had peripheral nerve stimulators to monitor neuromuscular blockade in Peterborough initially but we did have those at Queen's before I finished my residency so we would have acquired those in Peterborough soon enough.

All I do these days and have for about the last five years or so, is private office dental general anesthesia. I haven't gone into a hospital in five years from the point of view of being an anesthesia provider. The most recent is my dental office practice in Timmins, from which I'm going to retire in another six months. I

have four more workdays in November and then our license in Ontario cycles at the end of May at which point I will retire.

I turned 71 a couple of weeks ago. I have to RRIF my RRSP [convert a registered retirement savings plan into a registered retirement income fund]. I think I'm still a pretty good anesthesiologist, but *eventually* that's going to start to erode. I don't want to be forced to quit because I've harmed somebody's child!

Over the course of my career, anesthesiology practice has evolved greatly of course with a broad range of monitoring available for virtually any procedure done in any environment. Airway adjuncts and single use disposable items are standard as is the use of circle systems and low flows. We create a lot of plastic waste but can greatly reduce the use of GHG agents as compared with the flow rates that were required by our use of the Bain circuit back in the day.

In Timmins, the dentist and I set up a formal arrangement starting in 2013. I have a Datex S5 monitor, a Datex anesthesia machine, and a Baxter InfusOR syringe pump for propofol infusion. I have a Glidescope for situations where standard laryngoscopy may not suffice. We elected to work in a non-triggering environment, so I've never used volatile agents in Timmins. I only ever had succinylcholine as an emergency drug because it was mandated by the Royal College of Dental Surgeons of Ontario (RCDSO). They tell you what you are required to have and, initially, we were mandated to keep succinylcholine available somewhere in the clinic environment for use in an emergency. Because of that you also, as far as I was concerned, needed to have dantrolene on hand! The RCDSO policy at the time was that if you only had the sux to use in an emergency, you *didn't* actually need to have dantrolene; that's not really very logical! So, we always kept dantrolene on hand. They revised their policy a few years ago and said you don't have to keep sux on hand unless you're doing inhalational inductions. We work in a non-volatile environment, so we don't do inhalational inductions, so we don't have sux anymore, so we don't have dantrolene anymore. What we do with the kids is give IM ketamine, dosed by weight. Once that's kicked in, I carry them from the interview room and the parents go next door to get coffee. I carry the child into the OR, lie them in the chair supinated, put the monitors on and start an IV. Then I give them a bit of midazolam, sometimes a little bit of fentanyl. For the smaller ones, I wait until they ask for it intraoperatively, by way of how they're reacting to the procedure (vital signs, et cetera). Then I give them an induction dose of propofol mixed with remifentanil and lidocaine, bag them with oxygen, put in a naso-tracheal tube with the standard Mac 2 blade and Magill forceps, and secure that in position. I slide a temperature probe into the other nostril and put patches over their eyes, tape them all in so that everything is secure around the head, and the dentist goes to work. I have them breathe spontaneously with nitrous and oxygen and run a continuous infusion of propofol, until the dentist is finished. I also give them a little bit of dexamethasone and a little bit of ketorolac.

We do have a mixed practice including some adults and some older kids. If the kids are big enough, old enough, cooperative enough, I skip the ketamine and bring them in the room to start their IV. For the adults, of course, that's what I do. But the ketamine is for the smaller kids that are portable. I advertise carrying up to about 60 pounds. I can handle a bit more than that but, once they get bigger than that, we either don't use the ketamine or we take them into the OR and do it in there, so at least I don't have to carry them! Then, when we're done, I turn off the propofol, extubate the kids deep, oxygenate them, and make sure that they're stable and maintaining their oxygen saturation. Once I've taken the oxygen off them for a minute or two, made sure their sats don't decline too much, I carry them out to the recovery area with our nurse, who takes the IV out. When they're awake enough to be looking for mom and dad, we get them in to sit with them, and they're out the door in about 20 or 30 minutes at most.

The adults, I basically do the same thing, except without the ketamine. I start their IV, give an induction dose of propofol after the midaz and fentanyl. Once the females are approaching puberty, I also give them a dose of metoclopramide and ondansetron as well, to help with nausea. It's a reliably good experience.

Tomorrow I will be in the GTA [Greater Toronto Area] in a multi-site pediatric practice. There, we have volatiles and I just do mask inductions on them, but my Timmins practice is still trigger-free. It's two different styles of anesthesia and I quite enjoy them both.

I generally work with the same people all the time, so you become very familiar with the routine. You know, this argument about contracting public health-funded, ministry-funded surgical services out to non-hospital-based clinics and so on – there's a lot to be said for having a narrow focus, a narrow range of procedures. There's a lot of familiarity where you do develop a considerable element of ease and familiarity and it breeds efficiency.

Karim
Right. Yeah, that's really interesting.

Ren
But along the way from 1979 to 2023, non-invasive blood pressure came along. I can remember the first case that I did in the OR in Peterborough with NIBP and that was a tumultuous GI bleed. It was an emergency, at 6:00 o'clock in the morning. I arrived in the OR with the surgeon and the patient had no discernible blood pressure. I put the one NIBP on that we had, gave about 50 mg of Pentothal – I put a tube in with some relaxant. Then I probably just ventilated the patient with oxygen. As the surgeon was gaining control of what was going on with the GI tract, I was catching up with the volume transfusing and so on. Are you old enough to have used the blue Dinamap NIBP machines? It was a separate, freestanding unit, and not part of our coordinated monitoring systems that we have now. It just kept showing these zeroes when it cycled every 3 minutes. It had only one cycle time and it was 3 minutes. Then, I started getting 25 [mmHg] and I started getting 50, and then I got 75. Next thing you know, I had 120. I remember that as my first experience with NIBP and it was really very helpful because I wouldn't even have even been able to put in an art line. Basically, there were no pulses that were palpable enough to be able to put an a-line in! It was a very useful thing.

Karim
Right.

Ren
Another quick NIBP anecdote: A classmate of mine, one of the guys that I spent the summer in Trenton with, became a general surgeon. We were at our ten-year class reunion, in 1985. Another classmate, a woman who had been with us in pre-med, trained in OBGYN, ands was now practicing in Las Vegas. She and her husband were involved through their church with a community medical clinic in West Kingston, Jamaica. West Kingston was the down-market part in Jamaica. They would make regular trips to this community clinic. There was some primary care and some nursing. There was a school for the teenage girls who had become pregnant and were therefore no longer allowed to be in the regular school system. They had a nursery for the babies, and so on. They had thought that they might be able to establish a surgical component to this clinic, to provide minor procedure including tubal ligations and vasectomies. So, Murray, Marsha and I said, "Well, let's go down and have a look!"

In January '86, off we go on a three-day junket to Kingston, Jamaica. Long story short, nothing was going to come of setting up the surgical facility. With what they had available to them; it just wasn't going to happen. There were just too many logistical challenges to overcome. But, while we were there, there were community people that helped out around the clinic. There was an older lady, a grandmotherly type, who had an incisional hernia. She had three grandsons who all needed circumcisions. And there was another guy unrelated to these, a little wiry older guy who helped out around the clinic, and he had an inguinal hernia. Somehow or other, in the three days that we were there somebody thought, "We have a surgeon.

We have Marsha, who's an OBGYN and could assist. And we've got an anesthesiologist. If we could somehow arrange a hospital facility, we might be able to do some of this stuff." So, they rented access to an operating theater at St. Josephs' General Hospital, in Kingston, Jamaica, which was a private hospital. We rented half a day's access to their operating room. We then set about arranging for licensing. Marsha worked there off and on, so she had a license, but Murray and I didn't, and we hadn't planned on any of this sort of stuff. They arranged for us to get licensed for one day in Jamaica, to provide surgical and anesthesia services for these procedures. We actually sat and had a face-to-face interview with the Minister of Health.

Karim
Oh, wow.

Ren
This would have been on Tuesday. I had my CMPA wallet card. The Minister accepted that we were legit. So now we're actually going to do this stuff the next day at St. Joseph's General Hospital, in Kingston, Jamaica.

The older man seemed to potentially be a little bit dodgy. I thought it would be nice to have a cardiogram, at least. Thank goodness – it was an extra charge, right – he had a right bundle branch block, nothing worse than that, but there was an abnormality on his ECG. We get to the hospital the next day and there's a Jamaican surgeon sitting in the lounge. He trained in Toronto. He was there doing his own list. We start off with the three little guys for circumcisions. I did halothane inhalational inductions. As I was doing that, I popped in a butterfly in the back of the hand and gave a little bit of atropine. We were still doing Demerol [meperidine] and atropine at times for kids. I think I just managed them with the mask. The only monitoring was my pre-cordial stethoscope. And Murray the general surgeon had never done a circ! I had seen lots of them. Marsha, as OBGYN, had done some urology so she had done a few circs along the way. So, we talked Murray through it. We finished up the first circ and took the child into recovery. I go back to the OR and I'm getting ready to do the second one. I get a tap on the shoulder, and I turn around. It's a guy who works there, who's a cleaner or an orderly or something. A local guy. He says, "You want to use this? What he had was a Dinamap blood pressure machine which had been brought back by the surgeon we met earlier on! So, I said, "Yes, thank you very much."

I think what happened was they had kind of sat back and said, "Are these guys really okay, or are they going to be jerks?" So, we got to the end of the first case. They had decided we were okay and that they were happy working with us. They said, "Here, we've got this non-invasive blood pressure monitor." "Gee, yes, that's very valuable. Thank you very much." So that was another Dinamap automatic blood pressure machine story. Of course, now they're all built into the monitors that we use all the time. But in those days, they were all separate.

I quite enjoyed that. It was probably a bit hairy at the time, but anyway.

So, I finished in Peterborough in 2007, spent two and a half years in Ottawa – recruited by Dr. Homer Yang, who was the professor in Ottawa at the time. He and I had done some work at CAS, and he got wind of the fact that I was looking for a change. So, he recruited me to go there. I probably could have signed on as staff, but I wasn't sure that a teaching hospital environment was going to be a good place for me. We were hosting senior residents from Queen's in Peterborough, third- and fourth-year residents spending some time with us. I hadn't experienced it as being the most rewarding, so I wasn't sure that being in a real teaching environment would suit me. I talked Homer into making it a locum, which I did for two and a half years. Then I worked the locum circuit in a number of Ontario communities, doing odd bits and pieces like that. I got into the dental practice in Timmins – that's a whole other story that I won't bore you with. That started in 2013 and has been a nice way to wind down and finish up. I've enjoyed that

and I'm happy doing just dentistry for the moment. I'll be okay doing it for another six months and then I'll hang up my laryngoscope and call it a day.

Now, Dr. Kim Turner [former committee chair] will have cycled off the [CAS Archives and Artifacts] committee by now, I think?

Karim
Yes, she has. Yeah, yeah.

Ren
Okay, I may never get a chance to cross paths with Kim, but I've worked with her at CAS. She was on the committee and part of the community at the CAS when I was still there. She wrote an article that was in the journal three or four years ago about the history of cyclopropane. If I get a chance to run into her, I'll talk to her about that. I might be the last living guy to actually have used cyclopropane in Canada. During my first year as a resident at Queen's, the then-emeritus professor, Dr. Stuart Vandewater – who was at one time CAS president [from 1967 to 1968] and now deceased for a number of years – was in his last year of doing clinical anesthesia. He came once every second Monday, did a list, took call, then we wouldn't see him for another two weeks. That was my first year of residency and his last year of clinical practice.

He liked to show the trainees some of the older techniques. One day, he and I were doing an ENT list with a bunch of kids having adenoids, tonsillectomies, BMT's [bilateral myringotomy tubes], and so on. He said, "I think we'll use some cyclopropane." So, he went off down the hall to the department office and came back with a tank of cyclopropane. We mounted it on the machine, and we gave some cyclo anesthetics. We had to have the non-static boots on because it was explosive. That was kind of fun! And the thing I remember most is – once again, this was when we were still giving Demerol and atropine, which we wouldn't however give to the kids just having BMT's [bilateral myringotomy tubes], unless they're having either tonsillectomy or adenoidectomy. Some of these kids were just having BMT's and no atropine on-board. Cyclopropane is a very potent sialagogue! I thought some of these kids were going to drown!

I was so early in my training that I really didn't have a good appreciation for what that was all about. But I suspect that may have been the last time that Stu ever did that with any of the trainees. The other senior residents weren't interested but the juniors would do that. I don't know whether any of the others ever had a chance to use cyclo or not. But I did! And that might be the last time it was ever used at Queen's, and probably any place else, for that matter.

Karim
How will how do you plan on spending your retirement?

Ren
Because I was only doing private office dentistry at the beginning of the COVID pandemic, we had what amounted to about a ten-week shutdown, while we sorted out protocols and supplies of PPE. That was a very good test run for retirement. We got to the end of that period, when we were going to go back to work. I thought to myself, "You're going to be just fine."

I have lots of other interests that don't involve me being out and about, necessarily. I like to keep physically active. I like to read. I enjoy music. I play golf in the summertime. I curl in the wintertime. I have a girlfriend in Ottawa who's a semi-retired OBGYN now just doing office gynecology and surgical assists. We travel back and forth between cities. Sometimes she's here, more often I'm there. My kids are grown. My daughter's in England with her husband and my two granddaughters. My son is completing a

computer security program at Sir Sanford [Sir Sanford Fleming College] and will probably be out into the workplace before long. My ex-wife is still in Peterborough, and he lives with her.

I've never been particularly academically inclined; I've done a lot of political stuff. Sorry, I forgot about that completely! As the CAS president, [one] is usually the representative to what then was called the Committee of National Medical Organizations at the CMA, which was a round table with all of the various specialties that provided input to the CMA. I spent some time there. That was where I first met the lady who's now my girlfriend in Ottawa, and she was chairing that committee. I ended up subsequently chairing the committee after she finished. The chair of that committee typically has a designated spot on the board of directors of the CMA, so I spent a term there. There were some governance changes that eliminated the position so, before the three years was up, the job disappeared; I only got two years on the board of directors of the CMA.

I've done, you know, local medical stuff. I was class president once during medical school. I was a PAIRO [Professional Association of Interns & Residents of Ontario] rep for a while when I was a resident. [I did some] branch society stuff here in Peterborough, committee work, and eventually board of directors at the Ontario Medical Association. Meantime, I became involved with the executive of the CAS, eventually becoming president of CAS. From there, to the CMA, committee chair, CMA board of directors. I've done all of that stuff. Before that, I did a lot of stuff in the community, I told you about the United Way campaigns and so on.

So, my conscience is clear! [laughs] I think I've paid my dues. I'm happy to just try to relax and enjoy retired life. Reading, playing golf, curling, enjoying music, visiting with my girlfriend, and occasionally being with my daughter and the two grand girls. I'll be just fine.

Karim
Ren, this is the last question that I have. Do you have any advice for the next generation of trainees and anesthesiologists?

Ren
Maybe not directly to the trainees, but to the people who are *selecting* the trainees. As I mentioned along the way, I like doing things with my hands and I was going to be a surgeon. I think that trainees in anesthesia should be selected partly based on their knowledge and understanding *of surgery*. Not physiology, not pharmacology. We can teach them all of that stuff. My observation has too often been that anesthesiologists don't seem to have much of an idea of or sometimes don't seem to care much about what's going on the other side of the ether screen. In Peterborough, for the 25 years that I worked here, we were all part of the family. In the teaching environment, it's too easy for your family to be just the anesthesia people, with the surgical people and the nursing people as separate families who don't interact very much. When I went from here to working in Ottawa and started talking to the surgeons, there were a couple of [anesthesiologists] and residents, who were like, "What are you talking to them for? Nobody ever does this." But I think it's important that we do interact with our colleagues in other disciplines. We've got a common goal to provide good care for this patient, so we need to be aware of what each other needs to help make this process go well for the patient and hopefully smoothly for everybody else.

I would be looking for trainees who have some knowledge and understanding of surgery, and we can teach them the rest of the stuff.

Karim
Yes. Yeah.

Ren
If we bring people who already know a lot of pharmacology and physiology but aren't all that interested in or aware of surgery, then I think you can sell the surgeons short, if nothing else.

Karim
That's really good advice.

Ren
That's where I would go with that: *Be interested in what's going on with your other clinical colleagues and other specialists. Be a team player with your other colleagues*. They won't necessarily always react the way you would like. But hopefully if you keep at it, the smart ones will figure it out. [laughs]

Karim
Right. [laughs] Oh my gosh, thank you so much, Ren. I really appreciate you taking this time. I think this will be a great help. Thank you so much. Best wishes with your ongoing work in Timmins and with your upcoming retirement.

Ren
Thank you. Thank you very much.