

Canadian Anesthesiologists' Society Gold Medalist Interviews

Dr. Brendan Finucane, interviewed by Archives & Artifacts Committee Chair Dr. Mike Wong

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Dr. Brendan Finucane was awarded the CAS Gold Medal in 2005. He is Professor Emeritus in the Department of Anesthesiology and Pain Medicine at the University of Alberta. He has contributed to numerous facets of anesthesiology throughout his career, as an administrator, educator, researcher, and as a skilled clinician. A prolific researcher, Dr. Finucane worked tirelessly on advancing the practice of regional anesthesia. He is a recipient of the Gaston Labat Award from the American Society of Regional Anesthesia (ASRA). Among his many leadership roles, he served as President of ASRA from 1998 to 1999 and also headed the Association of Canadian University Departments of Anesthesia (ACUDA), the Academy of Anesthesiology, and Canadian Anesthesiologists' Society International Education Foundation (CASIEF). He also served as Chair of the CAS Archives and Artifacts Committee. His contributions to scholarship in anesthesia history are reflected by his receipt of the Paul Wood Fellowship from the Wood Library-Museum and the David M. Little Award from the Anesthesia History Association.



**Archives &
Artifacts
Committee**



Mike

Welcome, Dr. Finucane!

Brendan

Thank you very much.

Mike

You have lived in Alberta for many years now, but I believe your story begins in Ireland.

Brendan

Yes. I was born in Ireland during World War 2, 1942. My father was a veterinarian. He was one of the first to graduate from the Royal College Veterinary School in Dublin in the 1930s. I think there were only 13 graduates.

During the war there was very little gasoline available and food was rationed. The practice of veterinary medicine was in its infancy then, and the farmers didn't have any money – Ireland was a new country! My father had to do something else to make a living. We lived on a 15-acre farm, so my father started a dairy. I was brought up in the dairy farming business in my early life and participated in all those chores!

I went to the Christian Brothers School in Wexford, Ireland. The [eponymous] Christian Brothers are no longer there, of course, but the school is still there. After that, I went to boarding school [Presentation College, Bray] just outside Dublin and I was there for 8 years. That was quite a long spell. I really got into rugby there.

Mike

What got you interested in medicine?

Brendan

That's a kind of an interesting story. From early childhood, I went with my father almost everywhere when he was doing his veterinary calls. He very much wanted me to be a veterinarian [at first]. I was on the right track to do that, but times were very hard. There was very little money in the game. There came a point when he said to me – I remember this very clearly – “Don't ever do Veterinary. It was a huge mistake.” I guess I took that to heart. However, things changed. I would say the first 20 years or so it was very hard to make a living in veterinary medicine! One was paid mostly in kind. Then, the government

introduced the Tuberculosis Eradication Scheme in Ireland. Every animal of the bovine species was tested for tuberculosis at least twice and there was a fee for every injection you gave. Suddenly, veterinarians were being more than adequately rewarded for their work. After that monumental change, Veterinary Medicine became a very popular career choice in Ireland and entry to veterinary medicine was very competitive, but I had already lost interest in it by then and my father's earlier advice prevailed.

Actually, I had decided I was going to be an engineer. A couple of my classmates decided to do Medicine and convinced me that I should do likewise. So, I went home and told my parents, but they weren't totally happy with my decision!

I started Medicine in University College Dublin (UCD) in the fall of 1960 and did my 7 years – it almost sounds like a jail sentence! Medicine was a 7-year program in Western Europe then! I graduated in July 1967. My life was before me. I remember the Social and Preventive Medicine professor, who happened to be the Dean of Medicine at the time, addressed the class in our final year. He looked at our class numbers, estimated to be around one hundred students, and said, “75% of you will be leaving the country.” And, true to his word, that happened! This was quite a shocking revelation to most of us. That meant that three out of four of us were destined to emigrate!!

Upon graduation I did an internship in Ardkeen Hospital in Waterford City, which is where they made the famous glass [Waterford Crystal]. Ardkeen was a big regional hospital in Ireland. In the process of doing my internship, I began to think about what I really wanted to do as a career in medicine if not Family Medicine.

A pivotal moment came during my internship year, when I got a phone call at 2 o'clock in the morning, from the Head Nurse in the operating room, who happened to be a nun. She said, “Dr. Finucane, your presence is badly needed in the operating room to give the anesthetic.” Boy, was I ever jolted out of my bed! I got down to the O.R. terrified!

She said, “Here's the machine. Just get on with it.”

And, I said, “I'm sorry, Sister, I can't do that.”

And, she said, “Why not?”

I said, “I don't know the first thing about it.”

She said, “You went to medical school, didn't they train you?”

I said, “They told us very little about anesthesia. I saw the machine once.”

That was a very rude awakening. The surgeon said, “well if you can't do the anesthetic, you're going to have to do the appendix.” Well, that was less of a challenge, but I obviously needed a lot of help to do that, too. Anyway, the County Anaesthetist, Dr Shanahan [arrived] and he said, “Why didn't you give the anesthetic Finucane?” And, I said, “Sir, I didn't know how to.” That was Dr. John Shanahan, one of my very first mentors. He said to me, “Well, would you like to learn?”

I said, “Yes, sir. I would like to learn.” So that's how my career in anesthesia began! Instead of holding retractors for surgeons all day, and doing other menial tasks, I gave anesthetics. I would say, during my internship, I administered, under supervision, approximately 300 anesthetics. To me, this was the most wonderful internship I could ever have imagined.

Mike

That really speaks to just how broad and varied your experience could be in the rotating internship.

Brendan

Absolutely. It was an amazing year. During medical school students had very little hands-on experience clinically but the moment you were awarded your degree, the sky was the limit. We just did so many things during internship.

Finally, Dr. Shanahan said to me, "Well, do you want to pursue this further?" I said, "Yes sir, I would like to do that." So, he sent me to see the Dean of Medicine in Dublin, who said, "I can't help you much. I don't know very much about anesthesia, but I know somebody who can advise you." He introduced me to Dr. Billy Wren, a very well-connected anesthesiologist in Dublin who was a very astute man and a very accomplished pediatric anesthesiologist. He said, "Look, you've got two choices. You go to the Dublin training program, or you apply to the University of Liverpool. I will tell you from the start that it is very difficult to get into the Liverpool Program but put your name in there, you'll never know what might happen."

Well, time went by, and one day I got a phone call from afar. This would be in the spring of 1968. It was Professor Cecil Gray, who was a very prominent professor of Anesthesiology and Dean of Medicine at the University of Liverpool. He had a premium anesthesia program in Liverpool. He said, "Be at Broadgreen Hospital on September first," and so I was in the program! That was a dramatic call. So, I packed my bags and set out for Liverpool. That was September 1968!

When I finished my internship, I had a little time off for the summer and started my training at the University of Liverpool. There are several hospitals in the system. I was on Merseyside, and the Beatles had just been there and were now traveling the world. Merseyside was an amazing place to be in the fall of 1968!

Mike

Was it common or not for trainees from Ireland to be going over to that side [Liverpool or England in general]?

Brendan

We would if we could. Obviously, there was a lot of political tension between Ireland and England at that time, but their training programs were the best in Western Europe. Most of us would welcome the challenge if offered. In fact, Liverpool was considered to be the [unofficial] capital of Ireland. There are so many Irish people there that it was just like going home. So, no concerns that way at all. In fact, I was absolutely thrilled to be in that program. There were doctors from all over the world there.

It was just a phenomenal program. It wasn't like the standard residency training program anywhere I knew. Every morning for two or three hours, we had basic science training. In the afternoons, we did clinical [work]. It was just an amazing place. Professor Gray was very heavily involved with the Royal College of Anesthetists in the U.K. He was also the Dean of Medicine in Liverpool at that time.

I spent four years administering anesthesia under supervision in Liverpool and finally completed the requirements to sit the FFARCS [Fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons] exam in Queen's Square, London. I did the exam and passed. However, there were some deficiencies in the training program, especially pediatric anesthesia. I expressed this concern to my mentors. They said, "Well, there is a three year wait for Alder Hey Hospital," which was the prime pediatric training hospital in Liverpool. "Why don't you apply to Toronto's Hospital for Sick Children? You'll never know what might happen."

Well, to my great surprise, I got a letter from Dr. David Stewart, Chief of Anesthesia at the Hospital for Sick Children, in Toronto, in the spring of 1972, offering me a fellowship position. So began my second emigration, this time across the Atlantic to Canada!

That was on the 29th of May, 1972. My vehicle was in the airport parking lot unsold. I had one suitcase and I was headed for Toronto from Manchester Airport at twelve noon! Fortunately, my colleague and friend, at the last minute [bought my car]. That was one of my lasting memories of how I left the UK as I headed for Toronto to start my training in pediatric anesthesia at the Hospital for Sick Children.

Mike

I can't resist a chance to touch on the topic of Cecil Gray since you've mentioned him. Very influential figure in anesthesia. He had a technique, the Liverpool technique, of balanced anesthesia. Perhaps it's a little ironic looking back at it [given your later focus on regional anesthesia] that, because of the widespread use of the Liverpool technique, perhaps that area was slow in picking up on regional anesthesia techniques?

Brendan

Tell me about it. Now, I told you I thought that there was a deficiency in pediatric anesthesia in Liverpool so I needed to do some extra training. But regional anesthesia was non-existent, except for epidural anesthesia for obstetrics! I was keen to try some regional techniques during my residency in Liverpool, especially the Bier block, which I had read extensively about. I just thought this was a fantastic technique and I really wanted to learn how to do it. I was really taken aback when the consultant said to me, "That's highly risky, very, very dangerous. Don't ever even try it." That was the end of that. However, I did one spinal anesthetic when I was in Liverpool. I was a senior registrar and there was nobody to guide me. I got the appropriate needles, and I gave my first spinal guided by reading MacIntosh's book entitled: Lumbar Puncture and Spinal Anaesthesia! I used bupivacaine and it worked. It seemed like pure magic to me! Spinal anesthesia became obsolete in the UK for about 30 years following a highly publicised case when two patients in adjoining operating rooms were paralyzed following spinal anesthesia [Wooley and Roe] in the late 1940s.

Epidurals were widely used in obstetric anesthesia in the U.K. I became a great fan of Dr. Philip Bromage and his book. I got to know Phil Bromage quite well when I became involved with ASRA in the 1970s. I previously mentioned that I brought one suitcase [to Canada] and two books – Goodman and Gilman [The Pharmacological Basis of Therapeutics] and Bromage's book [Epidural Analgesia] – with me. My suitcase was quite heavy.

Mike

It's a good start to your library. As one more aside, do you remember using the Liverpool technique?

Brendan

Of course! The Liverpool technique was Professor Gray's brainchild. Briefly, patients received generous doses of atropine and an opioid preoperatively. Then they were preoxygenated and induced with thiopental followed by a large dose of d-tubocurarine (45 mg) and then were maintained with 30% oxygen and 70% nitrous oxide and then hyperventilated vigorously. Volatile agents were strictly prohibited. Large doses of neostigmine and atropine were used to reverse the effects of the curare at the end of the procedure. The procedure was not without its flaws. There was a concern about awareness especially in obstetric patients because it was common practise to administer 100 % oxygen just before delivery of the baby, during a cesarian section. As we gained experience with the technique most of us added in fractional doses of volatile agents to offset the potential of awareness, which was a realistic concern.

Mike

That was a Cecil Grey's motto, wasn't it? No smelly gases.

Brendan

Yes. If you were caught sneaking in some inhalation agent, you would be rebuked quite severely. But there's a great story about Cecil Grey, who needed a procedure himself. It was a minor operative procedure, and a senior registrar was selected to give the anesthetic. There was a bottle of halothane on the anesthetic machine before the case, and that bottle was pretty empty at the end of the procedure. [laughs] I think Professor Gray got a lot of halothane that day!

I'll tell you one more story about Professor Gray. There was a patient in one of the regional hospitals, who would not wake up, following an anesthetic. The problem continued for hours. The professor was called and when he came into the room, he clapped his hands and said, "Wake up!" and the patient sat bolt upright in the bed. That's one of the fables still circulating in the operating theatres in Merseyside to this very day! It was probably a [pseudocholinesterase deficiency].

!

Mike

Or he had mythical powers. Returning to your move to Canada, had you imagined yourself to be one of those 75 out of 100, who would leave the shores of Ireland never to return?

Brendan

I didn't really. I thought I'd be coming back at some point, but I never did, except to visit family.

While I was at Toronto Sick Children's Hospital, I met a resident from Atlanta. Dr. Jim Bland was his name. In fact, he was a pediatric cardiologist who made a career change and decided to become a pediatric anesthesiologist. He was a highly accomplished doctor and we got to know each other during the training year. He said, "Look, I'm returning to Atlanta, and my boss wants me to start a pediatric anesthesia program in Atlanta. Would you like to come and join me in this endeavor? I'll put you in touch with my chairman."

And, that he did. I met [the Chairman] Dr. John Steinhaus, who was a very well-known anesthesiologist in the United States. He was a Past President of the ASA [American Society of Anesthesiologists] and a very accomplished medical scientist and anesthesiologist. He was one of the first to describe the cardiac effects of lidocaine. He was a very charming man. [When I met him] he put his arm on my shoulder and said, "You can start with us next September." They were very short staffed at the time.

I started at Emory in January of 1974 and what a dramatic change that was!

Mike

Had you been to Emory before?

Brendan

No. I'd never heard of Emory before I met Jim Bland. Of course, I quickly learned that Emory was a very prestigious, private university. It was known as the Coca-Cola University, because of the huge endowment contributed by Woodruff [Robert W. Woodruff, former President of the Coca-Cola Company] in 1979. It was a very, special place and I was delighted to find myself there.

Mike

Who were your most important early influences?

Brendan

In addition to my parents, I give enormous credit to John Shanahan the County Anaesthetist who introduced me to anesthesia. Cecil Grey, not so much a mentor but one that I definitely looked up to, and who gave me an opportunity of a lifetime. I would be remiss if I did not mention a very good mentor whom you know and that is Dr. Des Writer, whom I met in St. Catherine's Hospital in Birkenhead in 1968, when I started my career in anesthesia. I did a lot of obstetric anesthesia when I was in Liverpool, and there were a couple of great role models there: Dr. John Beddard, and Dr. Tom Bryson. I also remember a very good mentor named Dr. Ray Ahern when I was at the David Lewis Northern Hospital in Liverpool. Then, David Stewart, the Chief at Sick Children's Hospital and his staff were excellent mentors when I was a fellow in Toronto.

Then, I met John Steinhaus, who had a huge influence on my career. There was another colleague of his who was the Vice Chair, and his name was Dr. Evan Frederickson. They were excellent mentors and terrific academic advisors.

Mike

[Steinhaus] was Chair at Emory for a *very* long time!

Brendan

Yes, for about 30 years. I had the honor of being Steinhaus' Acting Chair when he retired. That was just a wonderful accolade for 6 months, until the new Chair was appointed.

Mike

A lot of things happened at Emory, academically and professionally. I think it was there that your passion for regional anesthesia really blossomed, right?

Brendan

Yes, it was at Grady Memorial Hospital [Atlanta's public hospital] where I started. GMH was a Level IV Trauma Center. I came in on a special visa, I didn't yet have a license to practice so I had to get a license from Illinois, and I was confined to Grady for a year while I got the [American] exam and obtained a Georgia license. Grady Memorial Hospital was run by residents predominantly in all specialties. Recruitment of anesthesia residents to training programs in the South was a major challenge for Emory at that time. There were very few staff people.

John Steinhaus had initiated a program for anesthesiology assistants to deal with this shortage of anesthesia trainees. They [had a] Master's degree in anesthesia and were very well trained. I had never been exposed to non-MD Anesthesia before. We never had that in Canada nor in the UK or Ireland. I complained so much about it, they eventually appointed me Chief of Anesthesia at Grady Memorial Hospital! By the time I left Emory in 1989 we had a full complement of Board-Certified Anesthesiologists at Grady Memorial Hospital. We were the first department to do so at Emory. When I was first appointed at Emory in 1974 there were about 10 residents and 12 staff covering four hospitals in the Atlanta region and when I left in 1989 there were about 80 residents and fellows and about 60 Board-Certified anesthesiologists covering at least six hospitals.

I had the perfect environment to do regional anesthesia at Grady Memorial Hospital. I preached it and practiced it as much as I could. We did a lot of orthopedic cases, and the residents had not been exposed to regional before. I trained a number of residents there, and when they completed their residency training many of them did fellowships or joined the staff and they stayed with me for two or three years. I became friendly with Drs. Danny Moore and Pritvi Raj and invited them as visiting professors to teach at Grady Hospital. We ran a very successful regional anesthesia course in Atlanta for a number of years.

In the midst of all that, I joined ASRA [American Society of Regional Anesthesia]. That was 50 years ago this year [2026]. I presented a paper at every ASRA meeting I could. They got to know me quite well and eventually Raj said to me, "I'm going to get you on the ASRA Board."

The years went by and I went back to Canada, and I thought that's the end of that. Well, it wasn't. They appointed me to the Board, and I was the first Canadian representative on the ASRA Board. Canada had one of the largest numbers of ASRA members outside the USA! So that's my regional anesthesia story.

Mike

When you first started, what did things look like? What did your practice look like in general?

Brendan

When I started formal training in Liverpool in 1968, trainees would typically administer 5000 anesthetics in a four-year period. Patients were seen the night before surgery and a premedication consisting of an opioid and atropine was the standard premed and NPO [nil per os; fasting] orders were written.

We used the Boyles machine with the Magill circuit and we used replaceable gas tanks. We did not have piped oxygen, so our gas tanks had to be replaced frequently. There was an alarm system on the anesthesia machine which activated when the nitrous tank was empty. Monitoring was very rudimentary at that time. ECG [electrocardiogram] monitoring was not available for routine cases. So, we monitored blood pressures every fifteen minutes along with the pulse rate.

We did not routinely start IV infusions. Thiopental was the standard induction agent, but it was only available as a 5% solution at that time. We did intravenous inductions with thiopental and succinylcholine if we were planning to intubate. For abdominal or chest surgery we used neuromuscular blocking drugs. Curare was the most widely used neuromuscular blocking drug used in the Liverpool region at the time. Halothane was a major breakthrough in inhalation anesthesia and was introduced in the late 1950s and following that came the introduction of proper calibrated vaporisers, which allowed us to deliver specific concentrations of volatile agent.

I should point out that ether was still being used in Liverpool during my training period. Trichlorethylene was also still being used in obstetric anesthesia, as was cyclopropane. Methoxyflurane was introduced in the early 1970s. Although chloroform was obsolete when I started my training, I found canisters of chloroform in the drawers of some of the anesthesia machines! I witnessed my mentor Dr. Shanahan anesthetise a three-month-old baby with ethyl chloride! [As an aside], I also witnessed my father anesthetise a horse with chloroform when I was about 10 years old! The introduction of the fluorinated hydrocarbons in the late 1950s was a major advance in anesthesia and it was just preceded by the introduction of thiopental for induction and the neuromuscular blocking drugs by Dr. Harold Griffith which were quantum leaps in the development of our specialty. The rag 'n bottle days were over and new medical graduates were attracted to this new specialty. In my training period, between 1968 and 1972, we were excited about the advances that were being made but never thought they would be affordable for another generation! Well, I was wrong about that. Patient safety pushed that agenda forward rapidly.

Other major advances we have seen have been the replacement of thiopental with propofol. The introduction of ketamine is also worth mentioning. The vast array of new opioids and neuromuscular blocking drugs added to our choice of anesthesia cocktails.

Then a major paradigm shift was made, when anesthesiologists became more involved in preoperative and postoperative care, postoperative pain management, and the treatment of chronic pain.

Invasive monitoring became mainstream in the 1970s. We started measuring blood gases on a routine basis. The introduction of oxygen saturation monitoring was a huge breakthrough, followed quickly by end-tidal CO₂ monitoring. These were pivotal advances in anesthesia.

One of the major advances in airway management in the mid-70s was the introduction of the fiber-optic bronchoscope. It was an invaluable tool for difficult intubations. The LMA [Laryngeal Mask Airway] was a major breakthrough in airway management in the 1980s and the introduction of the light wand and Glidescope and various pieces of equipment to improve visualisation of the airway were a big advance.

The introduction of nerve stimulation to monitor neuromuscular blockade was a big advance in the 1960s and neurostimulation was also used to facilitate regional anesthesia and the introduction of ultrasound has greatly improved our ability to accurately locate peripheral nerves. I just missed out on the use of ultrasound for regional anesthesia. I started out just with a needle and some knowledge of anatomy and hope and a prayer to find the target. We have come a long way in the forty years or so that I was involved in regional anesthesia.

Mike

There really has been a sea change in terms of how the practice of regional anesthesia has evolved over the years.

Brendan

Initially, the ASRA program had three elements to it. There was the Regional section, the Obstetric section, and there was a Pain section. I told you that I did a lot of obstetric anesthesia. So, I joined the other organization initially [Society for Obstetric Anesthesia and Perinatology (SOAP)]. I did a fair bit of obstetrics when I went to Grady Hospital. Then, when I was appointed Chief, I was in the main operating room, and that's where my interest in regional anesthesia flourished.

We did lots of brachial plexus blocks, spinals, epidurals, Bier blocks, femoral nerve blocks, and other peripheral nerve blocks. Nothing like what's involved today, but it was a beginning. We went to our meetings. We preached, essentially, that it may not be ideal for the operating room every time but you're going to get the benefit post-operatively. We really started promoting that creed and that did stick. Of course, we knew that the brachial plexus blocks only worked 75% of the time – I openly admitted that. But talking to Dr. Alon Winnie and Dr. Gale Thompson, they never had those failures that I experienced! We used to have a lot of banter about that. We were all good friends, and we teased each other.

I challenged Dr. Ban Tsui to find a way to improve our success rates with regional blocks. He resoundingly addressed that challenge using a combination of neurostimulation and ultrasound resulting in a vast improvement in success rates in regional anesthesia!

I recently met one of my former residents from Atlanta, Dr. Mike Ferrante, and asked him what programs promote regional anesthesia in America today. Surprisingly he said the best work in Regional Anesthesia is being done in Canada! That really surprised me! Incidentally Mike Ferrante is a Professor of Pain Medicine in UCLA [University of California, Los Angeles]. Centers of excellence in regional anesthesia in the past were: the Mayo Clinic, the Mason Clinic in Seattle, the Brigham and Women's Hospital, Cook County Hospital in Chicago, University of Virginia, and of course, Emory!

Mike

You started off with a needle and a knowledge of anatomy. It's much more than that now. Can you walk through some of the contributions that you had made in evolving regional anesthesia practice? Like, neurostimulation?

Brendan

Quite frankly, Mike, my main role was to establish a credible research program at the University of Alberta and that was a huge challenge. I also wanted to establish a Pain Center at the University. That was equally challenging. It was a very slow process. We eventually had a credible research program at the University, long after my tenure as Chair. Drs. Barry Finegan and Ban Tsui were an important part of that success. And we did eventually establish a multi-disciplinary Pain Center at the University of Alberta.

Ban was an amazing contributor to research. He published papers during his residency. He was the hardest working resident I had ever met and his research output was prodigious. My main success was to convince Ban to dedicate his research to the discipline of pain and regional anesthesia. Without a doubt Ban has been one of the most successful researchers in regional anesthesia of all time. He recently received the Gaston Labat Award from ASRA [2026].

Mike

You've trained so many people who have gone on to become highly accomplished in their own right! I'm also thinking Dr. Rick Rosenquist

Brendan

Oh yes. He became president of ASRA. He's the Enterprise Chair and a major pain doctor at the Neurologic Institute of the Cleveland Clinic and he's been there for 14 years. I recruited Rick when I was a Visiting Professor, at Northwestern [University]. He was just thinking about going into practice. I gave a talk on regional anesthesia. I remember, I went out to breakfast with him and had a long chat with him. I said, "Why don't you come to Georgia? We'll give you a good fellowship there." He came, as did his colleagues, Dr. Diane Lefebvre and Dr. Mary Clemency. Rick went to the University of Iowa with Dr. David Brown after I left Emory and eventually, they both joined the Cleveland Clinic.

[Rick] has been a phenomenal character in medicine, in anesthesia, in America. He is a very positive man and there was nothing he could not do. He has good hands and a good brain, and a terrific attitude. He does it all with a smile on his face and has been a great mentor for many medical students and young doctors.

There is one other person I would like to mention and that is Dr. Al Santora. He was one of my residents at Grady Hospital. He co-authored a book we wrote, entitled Principles of Airway Management, now in its fourth edition. Al was a very good writer and an excellent anesthesiologist.

Mike

Eventually, I believe in 1989, you were recruited to Alberta. What led you to that? Did you have ties to the institution?

Brendan

That was kind of an interesting change. Well, I met Donna, my wife, at St. Michael's Hospital [Toronto] in 1973 and she worked in the Emergency Room. Basically, I convinced her that Georgia was a good place to check out. It took a bit of convincing for her to come to Georgia, but she did, and I married her in '76. Donna worked as a research nurse for Dr. Carl Hug at Emory, who did much of original pharmacologic research work on the synthetic opioids such as fentanyl and derivatives.

After about ten years in Georgia, Donna developed very severe allergies to various pollens. It became a major health risk for her. Eventually her allergist said, "You need to get out of here and go north or go west." She'd had all the testing imaginable, and nothing worked.

I started looking at the journals and the University of Alberta Chair position was open. I put my name in, and they invited me to visit the University and shortly thereafter I was appointed.

It was the year Wayne Gretzky was traded. Everybody was leaving Alberta. The economy had tanked and it seemed not to be the best place to go.

We moved to Edmonton in the fall of 1989. It was a long drive from Atlanta, Georgia!

Mike

It is a long drive! Well, this time you did not have to sell your car before flying over. Then, you entered as Chief in a new institution, with new challenges. What sorts of things did you have to tackle?

Brendan

It was a huge challenge. My main goal was to try and get research going at the University of Alberta. The majority of the anesthesiologists were just interested in practice. They were a very, very good group of practitioners, with very little interest in research. Research was not in the culture of the Department. With the help of some colleagues, and a tincture of time, we actually did get something going.

Mike

I guess we should also mention the leadership you provided on a national and international organizational standpoint, too – things you did with CAS, CASIEF, ACUDA, ASRA, AOA [Academy of Anesthesiology]. You've done a lot!

Brendan

When a new Chair is appointed in Canada, they get a flood of invitations to come visit! And, if I didn't realize how big Canada was before, I found out very quickly afterwards! Edmonton is not the easiest place to get to and from!

I have some advice for new Anesthesia Chairs: Your priority is your own department first!

CASIEF was very interesting, very challenging, and it's just a phenomenal organization. I really enjoyed my trips to Rwanda and Palestine. The program we started in Palestine generated a lot of controversy. We were not political, but it was perceived by some to be. We weren't at all into that. Fortunately, the WFSA [World Federation of Societies of Anesthesiologists] took it over from us after about three years. I think that was about 2014. I'm not sure of the dates, but WFSA always approved it. In fact, the Israel Society of Anesthesiologists approved it from the start, but at home and by our own organization [CAS] it was not perceived to be a good thing to do. We were very disappointed by that. I'm not sure if the Palestine program continues today. In the process of going there you learned a lot about what's going on in East Jerusalem and the West Bank. We did not go to Gaza.

Mike

In terms of your overseas work, that was towards the end of [your career]. You had had numerous trips elsewhere too?

Brendan

Yes, those service trips were an offshoot from my contacts with the Hospital for Sick Children and the Interplast group. I remember my first [trip] was to La Cieba in Honduras. We went there for three weeks, and we did multiple cases of cleft lip and cleft palate repair in children. We worked maybe 12-hour days. At the end of the trip, we had some time off to explore our surroundings. We did a mission to Cuzco, Peru. We went there for a 3- or 4-week trip, and we went to Machu Picchu, and Lake Titicaca during our time there. It was hard work but it was a nice change of pace from conventional practice and the volunteer

aspect was gratifying. We were encouraged to learn Spanish, which I enjoyed doing. We got a chance to test our knowledge of Spanish during pre-op examinations.

Mike

Did your overseas work inform much of your practice back in Canada and the United States? Things are different in an austere environment.

Brendan

Yes, absolutely. You just realize that fee-for-service medicine is not everything. You can get a great charge out of doing volunteer work. It's something I would encourage people to do. It opens your eyes to see how tough it is in other parts of the world, compared to what we have here.

Mike

That's a really valuable perspective. At what point did you start winding down your clinical practice?

Brendan

I started winding down my University assignments in 2008. I took retirement from the University in three phases over three a three-year period , from 2008 to 2011. In the meantime, I did some of the Rwanda assignments for a few years and then I took the lead role in the Palestine Program in 2010 and in the meantime, I had some light clinical duties at home until about 2013.

I'm glad I'm healthy enough to enjoy my retirement, I feel very lucky.

Mike

What are your plans now for the future?

Brendan

My plans are not to make any long-term plans anymore! I read quite a bit. I'm still trying to learn French. I play tennis and pickleball three days a week, and I play golf twice a week.

Mike

It's a very busy itinerary

Brendan

In my day and in my father's day, work was number one. Very late in life I learned that that's not the way it should be! Family is number one. Now I devote a lot of time to my family.

Mike

Looking back, is there anything you would do differently?

Brendan

Many things! We all have regrets. A lot happens in 83 years, you know...when you fall off the horse it's very important to get back in the saddle, really quickly!

Mike

Thank you very much for speaking with us!