Canadian Anesthesiologists' Society Presidential Interviews
Dr. Rick Chisholm, interviewed by Archives & Artifacts Committee Chair Dr. Mike Wong
June 24, 2022

Mike
I am joined today by Dr. Rick Chisholm, who served as president of the Canadian Anesthesiologists' Society from 2010 to 2012. He practices at the Dr. Everett Chalmers Regional Hospital in Fredericton, New Brunswick, where he has been based for the past three decades.

Thank you for joining us, Dr. Chisholm, and welcome!

Rick
Thank you.

Mike
Let's start from the beginning. Can you tell us a little bit about your early life and education in Halifax?

Rick
I was born as the oldest of five boys. I grew up in Halifax and was educated there. My dad worked in health insurance and eventually for the company that ran MSI for Nova Scotia [Medical Services Insurance; provincial medical insurance]. We heard stories about doctors in our family. My mom was a nurse, so doctors were [placed] on pedestals as far as we were concerned which is a little different than today. Being a physician was something that was put out there as for us to do.

As a kid, I liked science. I had a little lab in the basement. I used to make do experiments and things, and it was a little weird! Everybody else read Hardy Boys [series of mystery novels]; I read Tom Swift [series of adventure novels]. [It] was all about going into space. Science interested me.

So, when I was deciding what I'd like to do, being a physician was something that came to mind. In grade 8, I was 13, [and it was around 1969] the time of the first heart transplant in South Africa. I found this very intriguing. There was a lot of coverage back then, in print media (Time, Life magazines), local newspapers a little bit less so. I found it very interesting. [Out of all the] courses I took in in grade 8, my English teacher assigned a multimedia project. There were three or four of my friends who were interested in medicine as well, [and] we decided to do [our project on] the heart.

We did some research [beforehand]. We paid off [with a bunch of Lifesavers candies] one of our classmates whose father was a psychiatrist, to give us the [Dr. Frank Netter] drawings of the heart. Then, I called up the Victoria General Hospital's Department of Cardiovascular Surgery and asked if I could interview one of their surgeons. I was pretty brazen for a 13-year-old, but they said yes! Two of us went down [to the hospital] and there were two surgeons there who let us interview them about heart surgery. They took us to their dog lab, and they took us to the OR, showed us a heart-lung machine and a pacemaker that was bigger than a hockey puck – that's how long ago it was, compared to today! I was quite impressed with the melding of science and technique. [The experience] just furthered my desire to be a physician.

When I was resident almost 20 years later, one of these heart surgeons was operating and I said to him, "You know, you are one of the reasons I'm in medicine." I told him the story and then he remembered me. It was one of the things that led me on this path.

So, I went through high school and went to [Dalhousie University]. In those days, you were kinda told to go to your "home" medical school. [Not many peers were] going elsewhere. I did try to apply to McGill [University], and they said you had to have a degree. [But] I was in such a hurry, and I just wanted to get in after two years, which was possible in those days. So, I managed to get into Dal after two years of science. In hindsight, I'm not so sure that was a great idea. A little more maturity would've been better. I probably would have had a better time in medical school.

Med school was a good experience, like it is with everybody else, it was a lot of work and some fun. I found, with each year, you were thinking about just getting through the year. Some [of my classmates] had very definitive ideas about what they were going to do. I thought about surgery, and I liked pediatrics, but I didn't really have [my mind made up]. In fourth year, you had to figure out what you're going to do in the rotating internship. There were a few "straight internships" [direct entry], like internal medicine, but I did the rotating internship because I still didn't know what I was going to do.

As part of fourth year, [I did] a family practice rotation, with two weeks in the city [Halifax] and two weeks in the town of Lunenburg. The two weeks in the city didn't impress me much at all; the guys sat in the office, and family docs weren't involved in the hospital very much. [It was] an office job, which I absolutely hated, because I had done [some other desk jobs] in the summer. It wasn't my idea of a fun time.

When I went to Lunenburg, it was with Dr. Murray McQuigg, who [went on to be] the public health doctor who dealt with [the Walkerton *E. coli* outbreak in 2000]. He was in Lunenburg at the time, and he was an "everything" GP [general practitioner]. He did everything, and I was quite impressed by that. That's where I got the idea to be a family doc in a smaller place.

During that time, I got married. My wife was pregnant, so I got really desperate [for] a job. We had a kid coming. I needed money to put food on the table, get diapers, etc. I started looking around in Nova Scotia. Antigonish appealed to me, but they didn't need anybody. One day, I got a call from a GP around Miramichi. He asked if I wanted a job [there]. He was from Antigonish originally. I thought it couldn't be too bad, so I went up in the middle of a snowstorm in January. They had a hospital that had a McDonald's [restaurant] and, for a 24-year-old, that was ideal. [laughs] So, that's how I ended up in the Miramichi.

When I was [in Miramichi], we did everything. The bottom line was that *you had to know what you didn't know*, so you didn't screw up. You had to always think an hour and a half ahead, like, [whether your] patient needed to go to Moncton or Fredericton for services that were not available in this smaller community. [There] I got pretty good at thinking ahead, assessing the situation, taking care of very ill patients, and I grew to like critical care. The problem was that what you could do in a small place was somewhat limited.

After about two years, I was doing everything including obstetrics, assisting in the OR, working in the ER [emergency room], running the office. I was getting pretty tired, and I was never home. My daughter was two years old, and she was saying, "Don't worry Grammy and Grampy, Dad is only grumpy when he's working – which is all the time." I started wondering about what I was going to do. This is pre-ATLS/ACLS [Advanced Trauma Life Support and Advanced Cardiovascular Life Support courses], and I felt I wasn't well prepared to deal with that. When you were an intern in those days, you were the low man in the totem pole. The surgical residents were running the arrest, the trauma resuscitation. Some of the surgical residents were quite organized, doing what is now ATLS protocol, but back then it had didn't exist. When these courses became available, I took them, and it gave me a protocol to hang my hat on. I got a few of the other guys to do it, then we're all talking the same language and our patient care improved.

When I was taking the ATLS course, there were two anesthesia fellows who be eventually became staff in Halifax. I was talking to them, telling what my interests were, and that I was thinking about either moving or going into residency. I became quite impressed with what they told me about anesthesia, and that lit the spark. [Previously], my exposure [to anesthesia] was a two-week rotation as a fourth-year med student and it didn't turn me on. Anesthesia didn't turn me off either, but it was just something you had to do as a fourth year.

Later, I came home and told my wife about it. The next thing you know – obviously, this is the pre-digital age – the applications for Dal [Dalhousie University anesthesia residency program] were on my desk. She [had requested them] and she filled them out! I applied and was accepted. I decided to go back to do a residency, starting in '85 and finishing in '89. I enjoyed my residency. I found I was more afraid of the academic side of things than I was with the actual [clinical] work because I had been so busy as a family doc. The call wasn't difficult, because I had been used to doing it when I was the only one [around in Miramichi]. [As a resident], you had a staff man to look over your shoulders, guide you, and teach you. I didn't mind that!

[However,] I remember being terrified to be so old [in residency]. I was 28. I started running…I gotta get in shape with those young guys! Then, I showed up the first day, July 1st, 1985, and I walked in and four of the residents were classmates [from medical school]! [laughs] So, the age thing wasn't a problem [in the end]. [As a resident], I liked everything we did. I liked thoracic, I liked vascular, I loved pediatrics. And, having gone away from Halifax, I said, "Well, maybe I'd like to stay [in Halifax]. [It was like coming home]. Unfortunately, as you know, jobs come and go; sometimes there are a lot of jobs, sometimes there's none.

Back then you only had do to a six-month fellowship to get an academic job in Halifax. I was willing to do [one], but I wanted a job commitment because I wasn't taking my kids – by this time, we had two kids – to a larger center to do peds in Toronto or UBC [University of British Columbia], or maybe one of the larger centers in the US, and not have a job [at the other end of it]. There was no commitment [from the department]. So, then, I started looking around [elsewhere]. Antigonish [was hiring]. I had done locums there as a resident, but the biggest case they did was a bowel resection. I figured I that may be fine with that in my 60s [but not as a newly minted anesthesiologist]! And even though I'm now in my 60s, I would still like to be doing the bigger cases!

I also got calls from Moncton and Fredericton. I went up to both places. Moncton was doing neuro, and the only thing they weren't doing was cardiac surgery. In fact, there was no cardiac at all in New Brunswick at that time. Fredericton, I thought, was just a nicer place to live, and a better place to raise a family. My mother was raised there so I knew it from visiting quite a bit. There were a couple of senior guys there – one guy in particular, Dr. John Price, had been president of CAS in 1983-1984. So, I committed to go to Fredericton. Funny enough, after I was there six months, I got job offers at the IWK [Izaak Walton Killam Hospital for Children]. I [also] got a job offer in Kentville [Nova Scotia], and I had to turn them down. I [had purchased] a house and I couldn't move anymore; it would not have been fair to my family.

I actually did a locum at the IWK in the summer of '89 because they were [short-staffed at the time], but they couldn't commit to a job offer. I loved pediatrics. I mean, sometimes you took it home with you, especially when the kids are the same age [as your own], but they also bounce back pretty good [after treatment]. I just enjoyed [that practice], and I still do.

Anyways, I went to Fredericton and, back then, we were doing everything instead of hearts and heads [cardiac surgery and neurosurgery]. I never had a desire to do cardiac. The neuro I liked, because [of the challenge]. Sometimes, what was successful in neuro wasn't always what I'd [personally] call success.

I've often wondered or marveled at the neurosurgeons and how they could deal with patients that were waking up with significant morbidity afterward. [In the end], I didn't miss it.

I liked it [in Fredericton]. I found that the older guys were progressive. The monitoring was better than what I had experienced at the main teaching hospital [during residency] at the Victoria General Hospital, now QEII Health Sciences Center. The monitoring was better [in Fredericton], and newer drugs were available. One of the things I found interesting at the VG was that I thought, as a resident you would be exposed to the newer, modern monitoring modalities and newer drugs – and we weren't! Imagine four months of thoracic anesthesia and never using a pulse oximeter as a resident. But I went to the IWK, the Grace [Maternity Hospital], the old [Halifax] Infirmary, and they had all those monitors. It didn't make a lot of sense, because I thought you should be exposed to those in your training, if they're available. But that wasn't what was happening [at the VG].

[After some time in practice, Dr. Price], the chief of the department – he was in his 60s – was stepping down. Nobody wanted the job. I [thought], "I don't want anything to do with bureaucracy. I don't want to get involved." Then, I was approached by Dr. John Price, who I had a lot of respect for. He asked me to do it and I said, "Well, I have no experience." He said, "Neither did I!" Around the same time, Dr. John Scovil, who was in Saint John, was the [incoming] vice president of Canadian Anesthesiologists' Society. [Scovil] started talking to me about how he was going to become vice president. He had been the [representative] to the board – [previously known as] Council, then they restructured, and Council became the board. I remember going to [regional division] meetings and John [Scovil] would talk about how he loved the CAS. [At the time, I didn't] know what the Hell he was talking about. It's something I sent money to every year and got a journal [in return]. He started talking about his love of the CAS and what it meant [to him]. Then, when he became vice president, they were looking for someone to get involved in the New Brunswick section, and then you would also be on the board representing New Brunswick for a two- or three-year term; I actually can't remember [how long the term really was], it went so fast. I loved it so much I forgot!

So, I was chief of [my] department and I was on the board [of CAS]. Initially, I said, "I'll do this for three years and that's it; I'm done, not doing anything else!"

Mike
That's how they get you.

Rick
Yeah, so I was chief of my department for six years, which nobody else has done – well, actually, the current chief Dr. James Norris has – but I was the first one to do that in 20 years. And I did the CAS [board position] and I said that I wanted to do it again. When the second term was up, I was hoping that Dr. David Hughes wasn't going to take [the position], so I could do it again. I loved it so much.

At that point, John Scovil was president. He asked me if I'd take over chairing the physician resources committee. I agreed, not knowing what the heck I was getting into. I hadn't heard of it before I took it over, having not been involved in manpower or human resource planning.

One thing I learned, don't call it manpower, call it human resources, because the [demographic] makeup of physicians especially has changed quite a bit. I actually get a little irritated sometimes when I hear people call it manpower. But anyway I thought they [health authorities, government, etc.] had some grand plan where they looked at the population, the demographics, the number of [operations], the number of hospitals, the number of anesthesiologists, and they came up with how many people had to train every year. [Then,] we talked to some program directors and the response I got was, "We go to whoever the postgraduate dean is, and we beg for another [residency] position." That's 20 years ago.

When I see the issues we're having now, I'm not surprised! Unfortunately, in hindsight, I think maybe we should have pushed more, too. [It's a challenge] to come up with some sort of plan – we're seeing this in all aspects of health care in Canada – because, we don't have [the necessary] data. So how do we make decisions if we don't have data?

[For example], I can't even tell you what the post-op nausea and vomiting rate is in our center. If we introduce some new drugs, some new technique, how do we know if it's made a difference or not? "Oh yeah, I think it works." All anecdotal, it's all you get. It's a bit of a problem, [and only worse for more complex issues].

Around the time I took over the physician resources position, there was a guy from Edmonton, Dr. Barry Finnegan. I think he was the secretary of the society then. We went to dinner [with the CAS Board], and he said, looking around, "Maybe the future president of CAS is sitting here." And he looks *right at me*! I said, "Not in your life." Anyways, by the time I had chaired this committee and sat at the board for six years, [eventually] I thought it was something I'd like to do. I can't remember if I told anyone. John Scovil knew I liked it, so did John Price. They were my mentors. They both had been there, done that. Sometime in '08, Dr. Renwick Mann, who was then the past president and chair of the nominations committee, called me and he asked me if I'd be interested [in working toward becoming CAS president]. I said, yeah, I talked to my department, talked to my wife, she already knew I was interested. I said yes. It wasn't a voting-type thing. The committee puts some names forward and I think most of the time they only have one candidate. I don't think there are people pounding the doors down to [become CAS president]. Maybe it's changed, I don't know.

So, I [first] became vice president and, I gotta say, I don't regret it at all, [though] there were times when you felt like you were banging your head against the wall. I had a BlackBerry [smartphone], and I remember Dr. Shane Sheppard, who preceded, me saying he noticed I was fast with responding [to emails] on the BlackBerry. He said, "You're gonna regret that." And he was right. I remember being in Florida once with my wife near the end of my term [as president], and I got 24 phone calls in a one-hour period while trying to sit on the beach. She said, "Would you throw that in the water already?"

That's pretty well how I ended up as the president of CAS.

Mike
During your term, were there any unexpected controversies or problems?

Rick
There are two that come to mind.

So, I read a lot, and I love electronics. I was getting a lot of electronic publications even back 20 years ago. And I started to notice reports from the United States, from the Anesthesia Patient Safety Foundation, on drug shortages. I think [I was also reading this from] the Institute for Safe Medical Practices (ISMP) in the US. They were also talking about drug shortages. Locally, we had had some experience with drugs that you know we never thought were going to be in short supply, like succinylcholine. I started looking around and talking to colleagues. One of the things I loved about being president of CAS was [getting a broad perspective]. When you're in Fredericton, you think, "Oh my God, we're the only people with [such and such] problems!" But you start talking [with others] when you get involved in CAS. You talk and you find out what's going on going on nationally. You find out actually what's common, what's not common. You get information, which helps you guide you in terms of decision making. When you're president of CAS, you get a worldwide view because you go to a lot of meetings.

There's something called the Common Interest Group, which involves the Americans, the Brits, the Aussies, the Kiwis and I think currently South Africans. You sit down and you talk about [issues impacting anesthesia]. Every year [our meeting] is held in a different locale – actually, it's in Halifax this year [2022] – and you meet and find commonalities and differences. We started talking to these various groups. The Americans were kind of ahead on it [the drug shortages]. The Aussies didn't have a problem at the time. The Brits weren't saying anything. Eventually, it came to me that there were drug shortages everywhere, then it started to be drugs that we needed every day.

A couple things happened; there was a fire at a company plant in Boucherville, Quebec. We lost a lot of our drugs [due to the shutdown of the plant]. It was one of the generic companies – I can't remember which it was – but suddenly it was in the media, and we had been talking about it. Then, I was in the Globe and Mail, I was on CBC Power and Politics, I gave a testimony to the House of Commons Subcommittee on Health. We had a motion at the World Congress [of Anaesthesiologists] at Buenos Aires in 2012 about drug shortages. It was interesting at the World Congress; drug shortages, as we define them, were a little different than when you talk to people in Southeast Asia and Africa with drugs shortages. They just did not have the drugs [to begin with]. It gave us some perspective. Yeah, it's bad, but it could be worse!

We started advocating with government. I remember presenting to the House of Commons and saying, "You know, we need a strategic plan. We need a secure supply for an emergency, like a pandemic." Surprise, surprise! Like, they say they have this supply of ventilators and things, so I thought we should have drugs [available in an emergency supply] like that. The World Health Organization has a list of essential drugs, so I thought we should have that. I don't think it went anywhere. People listened to it and politicians get involved, but they wanted to score points. I learned to be nonpartisan. You know, the NDP invites you to a press thing and you'd realize, when you go there, you're seen to be supporting them. What are the Harper conservatives going to say [in such an instance]? Or whoever the Liberal leader is? So, we try to stay neutral and just advocate for our society.

After I finished as president, the advocacy worked in terms of legislation being passed in terms of drug shortages though, in 2022, we still have drug shortages. Remifentanil is in shortage right now, as an example. So, I don't think people listen. Unfortunately for us in anesthesia, with the exception of sugammadex, everything is generic! It doesn't make money. As you know, the name of the game is making money. But our patients don't really care about that, and neither do I! I want to take care of my patients the best way possible.

Another issue with drugs was pentothal. Even though propofol is a wonderful drug and I love it, I grew up using pentothal in anesthesia. In the early 2000s, because the Americans were getting into lethal injection, people were not that keen in Europe on supplying pentothal to the US. Then, because we were just north of the US, the European Union would ban the export of pentothal to Canada. They said that we could take it across the border. I remember writing to whoever and saying that it was a controlled drug and can't just be taken across the border. So, why are they denying us this drug? Which is an alternative? I mean, I haven't seen this yet, but say someone comes in and is allergic to propofol [and now you are missing this alternative agent]. We used to use [pentothal] a lot for ECT [electroconvulsive therapy] and things like that. [Our advocacy] got nowhere, and we lost pentothal as an alternative drug. Such an old drug, it's been around since the '40s, but we ran into bureaucracy with that.

The second thing I remember was that there was a request from FMRAC [Federation of Medical Regulatory Authorities of Canada], which is [a group of] all the provincial colleges across Canada that license physicians. They were getting an increasing number of requests for licensure of non-Canadian trained specialists. They wanted some way to award them [Royal College fellowship] without doing

[residency at a Canadian institution] and the usual examination process. [To clarify], The Royal College was involved with this, [CAS wasn't directly] involved. As I recall, they came up with what's called Practice Eligibility Routes (PEB). There were two of them, called A and B. With A, they were assessed – now, some of these people have in practice [for years] – and, if [their practice] were felt to be acceptable, they were approved to go forward and do the exam as we all did [as Canadian trained specialists]. In B, they had to be in practice for 20 years, and they'd be awarded the FRCPC based on practice assessment. When I first saw [the news], I didn't think much of it, but we shared it across the country through the [CAS] board reps, they went took it back to their various [divisions], and there was a groundswell of opposition to this! It took up a lot of time. I spent a lot of time writing letters. I remember going to Ontario and BC, and that was the number one question, what's happening with PEB? We wrote letters to the Royal College and met with [them]. The Royal College doesn't [tend to] back down very much and basically, it's our way or the highway; but they did rescind for anesthesia the PEB pathway. They did also reconsider, starting with psychiatry…I don't know if it's still going, I kind of stopped reading about it. But that was a big controversy.

What I learned about that was, even though we [CAS leadership] sit at a board, we are only as good or strong as our members. If we don't talk to our members, if we don't know what they think or what they think is important, then what we might think is not very important [may actually be important] to the members. That was a lesson learned there.

As far as I know, the Royal College hasn't backed off very much. They probably threw darts at my picture at some point, but we were successful with that [advocacy]. I don't know what they did to solve the problem, because there are specialists who get the FRCPC and are mobile. It's a little easier from an assessment of training and everything if you have the FRCPC. I guess today all we hear about is how we're going to bring in physicians from elsewhere and nobody yet has come up with a way of how to handle them fairly but look out for patient safety as well.

The other things I [remember fondly are all the] people I met, realizing that there are a lot of people all over the world who do what we do. We have a lot in common and we have a lot of things that are different. I'll never forget it.

[Being president of CAS] was one of the highlights in my career and it was an honor to be able to do it.

Mike
Was it difficult for you to step away from that role once your term ended?

Rick
Yeah, it was. You know, it was interesting because I was talking to some people just recently – when you grow up in Canada, train in Canada, we look very often south to our American colleagues. I've been a member of the ASA as long as I have been a member of CAS and I've gone to their meetings. I mean I went [to ASA] three times as a resident, which was almost unheard of [in Halifax]. Somehow, I managed to be in the right place at the right time. So, I got to know the guy [who went to be become] president of the ASA. [I'll get back to this in a moment.]

One of the things I noticed was, when I finished my term as past president [of CAS], [I was] done and just walked away. I was in my mid-50s then. I thought, maybe there were some things I could do at a hospital or whatever, [for instance] we have our surgical program and there's a medical director. In most places – I remember talking to Dr. Patricia Houston about it – they have no problems getting the medical director of their surgical program. At our place, it's written up so only the chief of surgery can do it! I don't understand [that], because we have a vested interest in the OR and surgical program working right.

I thought that would be something I can walk into. If I could do what I was doing as president of CAS, I'd be able to facilitate our surgical program, [but] that went nowhere. The line I remember from the chief of the department when I put my name forward is that I wouldn't have the respect to the surgeons. [laughs] I said, I really don't care if I had the respect or not! That's just the way it's going to be!

So, yeah, when I was done [as president and past-president of CAS] and walked away, there was a…I wouldn't call it a hole [in my life], but you kind of missed the busy-ness, the connections you make.

Now, I guess I alluded to the Americans. When they finish their presidency [at ASA], and usually it's just a one-year term, whereas ours is 2 years – that started in 2000. Their presidents usually stay around and are involved in a lot of other committees and things like that. Dr. Alex Hannenberg [ASA president in 2010] was one guy that comes to mind. He's an exceptional guy from Newton, Massachusetts that I got to know quite well. He's still involved. Dr. Mark Warner [ASA president in 2011] is involved with the Anesthesia Patient Safety Foundation.

We don't tend to do that in Canada and with CAS. Maybe that's just me. Maybe there are other people who have been president, and they're glad when it's done, but I enjoyed it. As I say, when you [are in that role] you find out what's going on in the rest of the country and the rest of the world. I think that's important.

Mike
Perhaps that's something we can think about in the future: what we want to do with our past presidents who still have plenty of vim and vigor left within them.

Along the lines of what you've been talking about, where do you see anesthesia heading as a specialty in the future?

Rick
Well, I guess I have two comments.

One, I think anesthesia is a very important, especially if you go back [in history]. Before I had decided to do anesthesia, I read the history of surgery. I had this big, thick book somebody gave me once upon a time. It became obvious to me that, without anesthesia, there would be no advances in surgery. That includes the research, the science. You can sit in the community and say that research is BS but, really, research is important. Just what I've seen over 37 years as a resident and a staff guy, the things we do were shown by research. We can't just go with anecdotal evidence. So, I think anesthesia is very important specialty.

Two, I'm very concerned [about] rumours of alternative providers, possibly in BC [where there is discussion of introducing certified registered nurse anesthetists (CRNAS)]. I cannot figure how you can get a four-year degree in nursing and your masters [degree] and be the equivalent of somebody who's done a four-year [bachelor's degree], four years of medical school, and five years of residency. What worries me is [that the introduction of CRNAs is sold as] working in a team [i.e., led by a physician]. But what we see happening in the US [is that they're] constantly putting out fires where independent practice is wanted by the nurse anesthetists. This is because, "I can do your job," and that's what happens. Somebody thinks they can do your job. They want your job. They want your money, your income. They want your status. Et cetera. The people on the other side of planning: the bureaucrats, the politicians – I guess I'm a little cynical after so many years – but they don't get it. They just want a warm body there to give the drugs.

I'm a little concerned that there's increasing pressure to provide services. We've got an aging population, my generation! The Baby Boomers are going to make demands like you've never seen on the [healthcare] system. The system isn't ready to deliver.

I also hear stories – and I've seen nothing written down on this one – about GPA's [general practice anesthetists, or family practice anesthetists]. You do a two-year family practice residency, then you do one year after that [for added competency in anesthesia]. And they want to start team-based anesthesia too. We had [general practice anesthetists] in New Brunswick and most northern parts of Canada. We have the CAS guidelines, up until recently, say that ideally there would be a specialist in every in every hospital, but reality doesn't allow that. What I'm hearing now is that there's pressure to bring GPs in larger urban centers and use them in a team approach. Well, that might work [for a while], but look what's happening in the US. They have team anesthesia as well, and the nurses want independent practice. Again, if somebody thinks they can do your job, they'll do it if they can. The people who run the system will see it [and allow it].

I'm a little worried about it. If we do this, if this is allowed to happen, what happens to our specialty? If the people who pay for the education and pay for services concede this, and we're not measuring quality and outcomes because we have a dearth of data, how will we justify our anesthesia training programs? How do we justify our anesthesia research? Effectively, we're going back to the 1900s where there was no specialty of anesthesia and the lowest guy on the totem pole gave the chloroform or whatever. That's going backwards, as far as I'm concerned.

I think it's a very important specialty. I think we have to advocate for our specialty and make sure that specialists continue to deliver anesthesia care. I don't know what's going to happen because it's really hard to know. There are a lot of rumours, but I don't see much written down.

Mike
For the next generation of younger anesthesiologists and trainees starting out, how might they be best able to position themselves to succeed in such a challenging environment now?

Rick
Oh boy, that's a hard one. I think, frankly, we're indispensable so they don't have to [think that they need to] make themselves indispensable, because they [already are]. The problem is going back what I said before. When you show up with a set of greens on, the patient has no idea who you are. In the US, they have had to pass a law that says if you're [calling yourself a doctor], you have to say doctor of what, because some nurse anesthetists have gone and got a PhD and they call themselves Dr. Nurse.

We tried this [raising public awareness around anesthesiology] before. I remember 20 years ago we had Canadian Anesthesia Day. I remember two years in a row being in the lobby of hospital trying to raise awareness of what we do, so people know we're not just some sleepy-doctor. [laughs] The funny part is, I remember everybody just wanted me to put the automated blood pressure cuff on their arm to take their blood pressure. What I notice is that some patients will say to me, "The surgeon will take care of me!" As I get older little, I get a thicker skin. I'll say to them, "Now, who do you think may change your bodily functions and keeps you alive when you're having your surgery?" They'll say, "The surgeon." [laughs] I say, "No, the surgeon is looking in whatever incision they make for your surgery. I'm the one taking care of your heart, your lungs, your kidneys, your brain. That's how it works, and I'm the one who will resuscitate you if anything untoward were to come on." Most people like that, and don't get too upset by that information. Some people are more anxious than others, so I have to play it by ear. I don't know how we can educate the public of the importance of what it is we do. Our surgeons are like everybody else, with a whole spectrum of personalities. Some of them are very honest and will admit what our role is with

their patients. Others, we're there to blame for anything that goes wrong and all the glory goes to them. I guess that's what some [people] feel you need, to be able to make it. Anyway…

I'm a little worried about how we're going to do with this. The other thing that's happening is that the demands for time and commitment are greater. At the same time, people want to spend more time on some of the things that are as important or more important [personally], like family, spouse, etc.

How are we going to balance this in a world where we don't have enough people? I'm not sure. I think it's important [to consider work-life balance nonetheless]. I don't think when I take my last breath, I'm going to be remembering my last case. I think that's something the younger generation is aware of.

We may have thought about it [family, work-life balance]. [But when I was a trainee] you wouldn't dare say it. I mean, you weren't allowed to talk about that. I remember, as a resident being told that the fact I had kids would not be of any [importance]. There was no special treatment. I took two weeks of vacation [when we were expecting our child]. My wife hadn't gone into labor after one week, and I said, "Oh God, we've got to have this baby. I gotta go back to work next week!" [laughs] You know, just stuff like that. [The culture] has changed and it hopefully continues to change. *If you're a healthy person, both mentally and physically, I think it's better for you, better for your family, better for your patients*.

I don't know if I have the answers. Again, I'm a little afraid for our specialty. Unfortunately, once they go even down a road, it's hard to go back and reverse things. I wasn't involved in the development of the AA [anesthesia assistant] concept, but I sat on [the allied health committee on CAS]. When the document was tabled that defined what an AA did, I remember going to Dr. Pierre Fiset. He was probably most involved in that. Pierre is a really good guy and they have had AAs in Québec for a long time. I remember going to a meeting where there were representatives of the respiratory therapists, and one guy in particular seemed to feel that they could do our job in independent practice. I thought there was going to be a physical fight in the meeting. This is 20 years ago, so it's there. We say, "No, it'll never happen" but, yes, it can if we allow it to. The problem is, how do you guide this discussion and guide this process without appearing to do turf protection. This is what people will accuse you of. It's not turf protection, I think it's a safety issue.

At some point, if we get all these alternative providers who only need two years or one year [of additional training], young [anesthesiology residency] grads are going to start asking themselves, "Why did I do a five year residency?" How are we going to justify our residency programs? How can we justify our teaching or research?

We have to think of this specialty's survival. Again, I don't have the answers for that, but I'm very concerned.

I think it's too easy to say that you can have a nurse anesthetist. Why don't we have the data [on anesthesia needs in Canada]? Why don't we know how many we need and why are we not training them? Those questions were never answered when I asked them, and I still don't think they have been answered.

Mike
I think they're going to continue to be a big challenge ahead and will be an even greater challenge in the years to come.

Do you have any final thoughts on how practice has changed since your early years?

Rick
I remember a couple of things. First, the monitoring. They used to call me Batman when I first started in Fredericton. I love technology. So, in our place [Dr. Isaac Miao, an early career anesthesiologist] and I use the train-of-four monitor the most, the old guy and the young guy. I remember Dr. David Bevan – who used to be in Montreal, Toronto, and then BC – and Dr. François Donati, they would always talk about train-of-four ratios. That was always in the scientific literature but there was nothing clinical [yet], and I'd read the paper not getting what were they were talking about. Then, we got the train-of-four and it made a lot of sense. I think the literature has shown that what we thought was okay in terms of clinical assessment [of residual neuromuscular blockade] or qualitative assessment didn't work, so [quantitative] monitoring is so much better.

I know BIS [bispectral index] monitoring is somewhat controversial. I use it but I don't call it an awareness monitor. I think we overdose a lot of our senior patients [and it has raised awareness about that]. One big change I've seen is that our patients are older, they're sicker, and they're coming for procedures they never came for when I first started. I like being able to give them a safe anesthetic, but not overdo it. I can do that using that particular monitor as part of my armamentarium.

For medications, I can remember as a resident all you had was Inderal [propranolol] and you'd give it in a case and have bradycardia for an hour. Then esmolol came along, and it was wonderful. Similarly, with sugammadex. I don't know how it is in your place but, for us, some of our laparoscopic surgeons don't want any diaphragmatic motion whatsoever. You know, it would be 10 minutes before the end of the case – but you don't know that since it's laparoscopic surgery – and they want more muscle relaxation. You look at the train-of-four and there's nothing you see. There's just the odd blip on the end-tidal CO_2. Well, nowadays, you can give them what they want then use sugammadex and not pay the price [of prolonged neuromuscular blockade at the end of the case]. Well, somebody pays for it [the price of the medication], but you and the patient don't pay the price [clinically].

Those sorts of things have made my professional life better and more interesting, and who knows what the future holds.

I guess, another big thing is – I don't know how it is where you're working – but we're getting a lot of talk about the environmental effects of our anesthetics. I just read a paper yesterday about desflurane and nitrous oxide, and the amount of time they spend in the atmosphere. We're probably going to have significant implications for what we use and don't use. I've hardly used nitrous oxide in probably 15 or 20 years, except for pediatric inductions, and I probably don't need it there. I used to use desflurane a lot because we have a significant number of morbidly obese patients in my practice; I might do two or three people a day with a BMI over 40. [With desflurane], they do tend to wake up quicker. But, after discussion at journal club and reading a few papers, I basically don't turn des on anymore. I use sevoflurane. Do I notice a difference in terms of [emergence]? I don't measure it, but I don't know clinically if it's a big [difference]. So, that's something else we're going to have to think about. That's just in terms of our drugs.

If you look at the OR itself, the garbage you throw out with disposable drapes and everything else, that's another big issue. I don't know how we're going to deal with it, but we contribute a lot to waste as well. Those are things that I think are going to be a big deal going forward.

You know, it's funny, you don't see a lot of stuff written about industrial medicine and safety in the OR. When I look at the floor, I see cords [everywhere]. I assume if you went to a Ford factory, you would not see this mess of cords on the floor.

Mike
Some days, there are braids of cords all over the place.

Rick
Yeah, the [industrial] unions would just go crazy over this. So, there's an aspect of physical safety [that has been neglected]. Like, all the times I hit my head on lights and the monitors that are hanging on booms. I saw a paper recently looking at OR nurses who worked over 30 years, and their incidence of COPD was higher than it was in the general population. Maybe it's due to surgical smoke, laser plume, methylmethacrylate cement, etc.

I have hearing aids. Nobody in my family has a hearing deficit. When I polled [our own OR staff], it seems like an awful lot of people have a hearing problem. Why is that? The orthopedic equipment and our Greenlight laser are loud. You can barely have a conversation [in the OR, sometimes]. Has anybody studied this? I haven't seen a lot, but that's something else going forward [that we need to consider]. I call it industrial medicine, there's probably another term for it. Are our ORs safe for the people who work there: the nurses, the docs, and the ancillary staff?

If I were younger, it would probably be a sort of a niche [area of research and quality improvement]. You probably wouldn't get much support starting off and, probably, administration wouldn't like it.

Mike
There are a lot of questions to be addressed there, particularly when we need people to be practicing for a long time, given our human resource issues.

One more question, what's in your future in the years to come?

Rick
I'm 65, and I stopped taking call last year. My plan was to work about 0.6 [FTE, full time equivalent]. I'm a little hyper. I have to go ride my bike 30 kilometers to relax. My wife doesn't want me around that much but, of course, with COVID you can have all these plans – you want to travel and do things – though I still don't think that the time is right for doing those sorts of things. So, I would like to continue working.

It's funny. From January 'till April I think I worked 10 days, because we have so many issues with human resources [shortages with other perioperative staff]. I told the scheduler I'm not going to take any vacation in the summer, I think I'm working almost the entire week, all summer. We'll see how that goes.

When I stopped doing call, I missed the cases you do on call. They are definitely different from what you do during the day. But it was getting scary at two or three in the morning when you'd think, "If the patient knew how I felt right now, I doubt they'd want me doing something for them!" The fatigue factor becomes a big issue and then you worry about making a mistake. In these cases, for every action there's a reaction; you do something, then you have to do something else. [Before you know it], you're giving 30 units of blood. You can't schedule those [complex or emergent cases], they just happen. So, I don't miss that. It's scary, but that's where I am right now.

How much longer am I going to do this? I don't know, when my wife tells me to stop, I guess! I enjoy it. I don't mind. I've been working in the OR for so long now it's part of my [life]. They say when you retire, you have to have a social structure. Well, one of the things I noticed for a lot of docs of my generation is [that they lose] that social structure. You work so hard that your social structure is in fact the people at work. That's who I talk to; I know about their kids, what's going on with their pets, etc. Things like that. When you don't go to work, you don't have that social interaction.

It's interesting in my neighborhood. A lot of people my age or even younger are all retired. They see me going to work at 7:15 in the morning, I think some of them are chuckling, “What the Hell is that old fogey doing?” Anyway, I enjoy it.

[Nowadays], the way it works [with OR list as senior staff], you get the last pick of the list, and you get the list nobody else wants to do, which in our places tends to be gyne. I have great respect for our gynecologists and obstetricians; sometimes they could be a handful or whatever, but they truly have the best interest of the patient at heart. I see that every day when I work with them, and I enjoy that.

That's probably what my future is, for a little while. After that, I don't know. I'd like to do some more traveling, but the world is gonna have to change a little bit. I think, why do I want to travel? That's related to my time as [CAS] president, because I did a lot of traveling [in that position]. There's a big world out there and I like going to meetings too. That's probably another reason to keep working. I always like meetings. There's obviously the sessions you go to, but what was important to me was talking to people from other parts of Canada and other parts of the world. Learning what was going on and what they were doing. There was the formal learning and there was the informal learning.

Mike
Sounds like you've got things on the horizon. Hopefully, this pandemic will eventually wind down. It's been an interesting time, for sure.

Rick
Oh, I know, I know. We've had our share of issues [in New Brunswick during the pandemic], but when I remember seeing pictures from Toronto, Montreal, Vancouver, of nurses at the end of a 12-hour shift and they just look exhausted, going back day in and day out, I just I can't imagine. It was worse outside than we had. You know, it was bad at times but nowhere near as bad as some of the other areas of the parts of Canada and other parts of the world.

Mike
Thanks very much for your time. It was very interesting to hear about your experiences.