

Canadian Anesthesiologists' Society – Oral Histories

Dr. Pat Morley-Forster, interviewed by Archives & Artifacts Committee Member Dr. Anne Wong

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Dr. Pat Morley-Forster is a Professor Emerita at Western University. She conducted clinical research and served as Resident Research Coordinator and as Director of Obstetric Anesthesia. She was honoured with the inaugural Earl Russell Chair in Pain Management, and she oversaw the St. Joseph's Hospital Pain Clinic. She spearheaded the development of a Royal College Pain Medicine subspecialty Residency. She received the CAS Gold Medal in 2013 in recognition of her outstanding contributions to anesthesiology and her leadership in advancing chronic pain management.



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Committee**



Anne

I am looking forward [to delving] into your important contributions and career highlights in this conversation. Welcome, Dr. Morley-Forster, and thank you very much for taking the time to speak with us.

Pat

My pleasure.

Anne

I wonder if we could start by talking a little bit about your background, where you grew up, and how you got interested in medicine?

Pat

I grew up in a small town just outside of Ottawa called Manotick, which is actually on an island called Long Island. When I tell people this, they usually imagine a long ferry ride to this island. But, in fact, you wouldn't even know you were on an island most of the time. It was on the Rideau Canal, and we had the Rideau River in our backyard. I spent a lot of time with friends and family canoeing on the river.

My mother and father were both professionals. My mother, at first, was a housewife. Then she went back to university and got her PhD in English Literature over about six years and became a writer and a Professor at Concordia University in Montreal. My father worked in the civil service as a geophysicist-scientist. My mother was the one that really put it in my mind to become a doctor. Her father – my grandfather – had been a doctor in Toronto. He died early, so I never met him.

Anne

I find it quite interesting that your mom was a housewife and then had a huge trajectory to get her PhD and become a professor.

Pat

It wasn't until I myself changed my career [that I understood] – a little bit later than she did. She started doing that at about 40 or 41 [years old], and I started at about 47.

Anne

Where did you do your medical degree?

Pat

I did my undergrad at the University of Western Ontario, and I did not get in to medical school after second year. At that time, if applying in second year, you could only apply to the university which you were attending, so that would have been Western, and no other options. I switched to getting a three-year

degree and, that gave me the freedom to apply to all the medical schools across Canada, which I did in third year.

I received a letter around June that I was accepted to the University of Toronto waiting list. I didn't hear anything until about August the 20th, then received a late acceptance letter. By that time, I really had given up all hope! I had no other plan. I was going to travel to Australia. That was my dream and I'd been saving money for that. That was not my mother's dream, so of course she was delighted. I was somewhat familiar with Toronto because of frequent visits there and had gone to school there for a couple of years. So, within two weeks I had found a place in Toronto, settled in, and started classes.

Anne

That must have been an amazing time in your life. Everything going all at once.

Pat

You think back and you're just more accepting of stress when you are that age. I was really looking forward to the adventure, which helped me handle it.

Anne

So, what experiences, circumstances, or people influenced you then to train in anesthesia?

Pat

As I had mentioned in my talk, *Striving and Thriving in Anesthesia* [Canadian Anesthesiologists' Society 2026 Annual Meeting opening plenary session]. I really became convinced from an elective in the Ottawa Valley in my fourth year of medicine that I wanted to be a small-town family doctor. I applied to the Ottawa Civic for rotating and mixed internship.

There was a secondary motive in that my fiancé was doing research at the Ottawa Archives for that year. So, we could be in the same city. He was working on his PhD in History. I did another elective up in Arnprior and still was convinced family practice was my thing. I went through the rotating internship, then I thought, "Well, it would be good to have good to have anesthesia as an added skill and I can certify as a GP anesthetist."

We decided to get married in between internship in Ottawa and starting the GP anesthesia training in Toronto. At that point, he was much keener on staying in a large city where he could teach in a major university, and I was still thinking I preferred a small town.

Moving forward, about three to four months into the anesthesia residency – which I started at Wellesley Hospital in Toronto – I discovered I really liked anesthesia. This was not something I had anticipated! I thought it was going to be somewhat boring, and I would just have to deal with the boredom. There was so much more to it! I had great clinical teachers who really interested me in respiratory physiology, cardiac physiology. And the Intensive Care Unit.

Also, I found I liked obstetric anesthesia. We're talking 1974, so things like epidural anesthesia for labour pain were not that common. I would say it was about 20%, at that time. Until then, I had not seen how an epidural could sort of transform things into a much more pleasant experience for the mother, if you knew how to do them quickly and skillfully.

My next rotation was the Hospital for Sick Children because, doing GP [general practice] anesthesia, you had six months of adult anesthesia and six months of pediatric. Again, I really loved pediatric anesthesia and had some great teachers then.

In about March of my year, I went to the then-chair, who was Dr. Arthur Scott. I must have gone to the Program Director too, but I just remember going to Arthur Scott and him sitting there smiling and saying, “Well, we kind of expected this – that you would do this – so we saved a spot for you!” I was really surprised. So, it was all set. We were going to stay in Toronto. My husband was happy because that's where he wanted to be.

The other thing that happened during my early training that confirmed that I perhaps had some talent in anesthesia is that I got an award, the Thomas Donald Hammell Memorial Award. I think some other Gold Medal winners have won that award. It was an unfortunate and tragic accident that a first-year anesthesia resident – on his way home to visit his parents in, I think, Thunder Bay – was killed. [1977 was] the first year.

It certainly encouraged me. I think there's nothing like some validation when you're insecure about your own career trajectory. To have something like that confirmed that this was a good path.

Anne

That's quite an honor. And, to clarify, did you receive that after that first year of anesthesia?

Pat

There's a book that Dr. [Robert] Bob Byrick edited about the history of anesthesia at the University of Toronto [*A Commemorative History of the Department of Anaesthesia, University of Toronto*]. You can see the Thomas Donald Hammell Memorial Award and the list of all of the recipients. I think I actually received it in my second year of residency, but for the year's work before that.

Anne

That's quite an acknowledgement. I'm sure it gave you a little added boost to what you were getting already.

Pat

Obviously, any sort of encouragement [is welcome] when you're quite junior.

Anne

Absolutely.

Maybe you could give us an overview of your career trajectory in anesthesia and your main areas of interest that have developed over the years?

Pat

As I went through the program, I became more interested in cardiovascular anesthesia, abdominal aortic aneurysms and aortobifemoral surgery, where you had to be on your toes, you had to evaluate the patient properly, you had to run a lot of different medications and monitors. I did that in my fellowship year, after residency. It was at The Toronto Hospital – that was the name of it then, a merger of Toronto General Hospital and Toronto Western Hospital – under Dr. Sally Teasdale and Dr. Richard Weisel, a cardiovascular surgeon. I undertook a [research] project there. It was my first research project. I won't go into it, but at any rate, I presented it at the American Society of Anesthesiology meeting the next year. I must say was a very stressful event: one, because I had to leave my just recently born baby at home; and two, because I was not used to public speaking at a conference. It was a big hurdle for me to suddenly get up and speak to 100 people about my research!

After that, I was accepted on staff at The Toronto Hospital and things were going well. I started into some other research questions. I realized that I was curious about a lot of things! I did a review article on hypothermia in the OR [operating room]. From that, other projects followed.

The residents were always looking for supervisors, even if my credentials were rather thin at that point! It was fun to work on projects together, especially when the residents were close in age to me. [One project] I was doing with a resident in obstetric anesthesia meant led to me being booked at least two days a week on the obstetric floor. This was in order to recruit patients for a study on shivering after epidural anesthesia for cesarean sections. I found I was really enjoying obstetric anesthesia, the team approach, and I appreciated that the nurses, the obstetricians, and the anesthesiologists all had to be working together as a team in order for the mother to have the best experience and the baby to have the best outcome. They all had to be focused together and communicate.

Then, my husband was offered a teaching job at the University of Western Ontario in 1984. He was quite keen to take it. I had been at the University of Western Ontario in my undergrad, so I liked the city. And the thing was, the Chair of Anesthesia, Dr. Arnold Tweed, and he was a very well-known obstetric anesthesiologist from Winnipeg, who had come to London to be the Chair. He wanted a stronger obstetric anesthesia presence in the Anesthesia Department, and he wanted to improve the system for covering the Labour floor. Whenever an epidural was needed, the on-call anesthetist – who would also be covering an operating room with a resident – would go up and do the epidural quickly. It was a bit of *catch as catch can*. He thought it should be – as I had appreciated at Toronto – a team approach, more supervised with a staff anesthesiologist available. So, Dr Tweed hired me as an obstetric anesthesiologist, though my postgrad training and interest had been in vascular anesthesia!

Our family moved down the 401 to London. By that point, we had two young sons. We bought a house in London. I started on staff at University of Western Ontario at St. Joseph's Hospital in 1987.

Anne

It sounds like you had a very interesting start to your career at Western, in an area that you hadn't anticipated! I suspect that you really took it on, really enjoyed, and made it your own.

Pat

Yes. I had to! At that point, I started learning to be a little more politically adept. I knew that you had to be accepted and have allies. In Toronto there were lots of women anesthesiologists, but in London we were few and far between. The surgeons would actually make some comments that you'd be surprised [to hear] in 1987. They would be teasing or questioning your technique or choice of anesthesia. Nowadays the comments would be called micro-aggressions.

So, I tried to persuade people in our department [about] the benefits of having a dedicated obstetric anesthetist, at least during the daytime hours from eight to six. Quite a few colleagues were supportive and so we were all working towards that goal.

The other hospital in London that had an obstetric service was Victoria Hospital. They did a lot of deliveries, but our unit was the high-risk maternal-fetal unit. The obstetricians at St Joseph's were involved in more research. Gradually it became the norm that there would be a resident doing an obstetric anesthesia elective who would be sure of getting an obstetric anesthesia assignment every day, and there would be rotating anesthesiologists assigned to the floor every day. Definitely, the nurses appreciated that there was always somebody they could go to if they saw a problem coming up. The obstetricians appreciated it as well.

Anne

It sounded like you really brought in a lot of leadership in changing the culture of obstetric anesthesia by making a dedicated anesthesiologist separate from the on call [anesthesiologist].

Pat

I discovered there were quite a few people who not only believed in that model, but appreciated the lack of stress on their day, of not having to cover possibly two inexperienced residents, in both the operating room and obstetrics. There were a few that still objected but they became a minority

That happened over several years and I learned some lessons being a part of that. We were also able to offer an obstetric anesthesia fellowship.

Anne

They always say cultural change is so difficult. It is remarkable that you were able to lead it.

Pat

I can't take all the credit. As older anesthesiologists were retiring, new ones were coming on who wanted to practice that way.

Anne

You talked about allyship and really having a team approach as well. You were heading obstetric anesthesia for a number of years. Maybe you could reflect on the highlights of that time and what happened after that?

Pat

I became interested in alternatives to epidural analgesia, including PCA [patient-controlled analgesia], [using] fentanyl, remifentanyl. [For instance] with low platelets, women in labour cannot have an epidural, but they need something [for analgesia]. The other alternative I was interested in was nitrous oxide. I did some studies on the levels of nitrous oxide in the room that the nurses were being exposed to, if the patient was breathing it for several hours. Spinal anesthesia for elective C-section became very accepted.

One thing that really struck me about obstetric pain is the huge variation. I mean, some women were completely unable to cope with low level contractions, Others just seemed to be very focused and would get through it. Support was very important and anxiety, but I also realized there were obstetric factors, and other contributors that I didn't understand.

During that time, I was the Resident Research Director and not just for obstetric anesthesia. There were a number of other projects that I was supervising. One development around 1993 to 94, was the Post-Operative Pain Service. Patient-controlled analgesia, called a "pain pump" [patient-controlled analgesia pump] came to be widely use, and was supervised by anesthesiology. It was a steep learning curve for the anesthesiologists, the surgeons, the patients, and the nurses. There was an opportunity to talk to patients a little bit more and, again to see the wide variability in how they could control their pain. Some were still complaining while others thought [PCA] was just wonderful. Most of the surgeons really liked it too. I did some research projects with residents on acute post-operative pain. One of them got the first prize in a resident research competition! I started to think acute postoperative pain could be an area of research as well.

Then, things changed in 1998. There had been news that the Ontario provincial government wanted to restructure the London hospitals. They'd been meeting for a couple of years, but when they made the final decision, it was sudden.

I can remember exactly where I was at the time- in the PACU [post-anesthesia care unit] around three in the afternoon. One of the nurses said, “Oh, there's an announcement [about] St. Joseph's. They're going to close the maternal-fetal unit. They're going to focus on surgical daycare procedures , Hand and Upper Limb surgery, which means not admitting patients for more than a couple of days post-op. The Emergency Dept will be closed.”

This decision had huge implications for the nurses, surgeons, and for the anesthesiologists, who they didn't seem to have consulted at all!

The reasons were financial. I still am not sure that it was the best decision, but we're certainly accustomed to it now. I mean, that was 28 years ago.

I realized that within a few years I would either have to relocate to Victoria Hospital or I would need to give up on obstetric anesthesia. Again, the culture there with regards to obstetric anesthesia was different. They were still using the system of double-covering during the day. I don't want to be unfair to them; they certainly appreciated that they would have to reorganize their care, as the case load would be over 4,000 deliveries per year. But, I thought, well it's not a group of anesthesiologists that I know well. Why don't I leave it to somebody younger? Leave the conflicts to someone who knows them better.

I decided to make a change.

Anne

When you decided to look, it sounds like the seeds of pain management were already sown during your time in obstetric anesthesia. I wonder if that simmering came to a more formalized realization?

Pat

You know, there was little really known about acute pain other than, “Here, take this Percocet [oxycodone-acetaminophen tablet] for post-op pain.” Obstetric anesthesia had taught me the variability of acute pain responses.

The other event that was happening at that time, is my youngest brother had been diagnosed with a squamous cell cancer of his tongue. He was 32 when he was first diagnosed and had no risk factors. As it turned out, he had a nine-year fight with it. Sadly, he did die of it. The last year or two of his life was very painful due to nerve pain in his neck. He had radiation treatment, so he had post-radiation pain, which I didn't really know anything about.

I felt cancer pain might be something I could do. . I had discovered that there were not enough people working in that area. Perhaps two days a week I could work out of the cancer clinic,

So, for that personal reason, I decided I would explore [pain medicine]. I connected with a neurologist, Dr. Dwight Moulin, a cancer pain specialist at Victoria Hospital. I connected with him and spent one day a week training at the cancer pain clinic. I realized there was a heck of a lot to learn and decided I would take a six-month sabbatical at the Wasser Pain Clinic in Mount Sinai Hospital, the Wasser Pain Clinic.

Anne

That must have been quite transformative for you. After that, when you returned to London, I understand that you received an endowed chair, the inaugural Earl Russell Chair in Pain Management.

Pat

Yeah, it was totally out of the blue! I came back and I started working two days a week in the chronic pain clinic and three days in the OR plus call. I was just getting my feet wet and building up a practice in chronic pain, trying to figure out how I could also work in the cancer pain clinic at Victoria Hospital.

Then Dr. Earl Russell entered the scene and contributed a very major, multimillion dollar donation to endow a chair in pain management at the University of Western Ontario. He was at that time in his late 80s but still working very busily in several rural pain clinics. He had been the [Chief of Anesthesia] in the '60s and '70s at Victoria Hospital, which I mentioned before was a big, busy hospital. He certainly knew a lot about anesthesia, but he had moved to a busy pain practice.[He was a farmer from Saskatchewan. He got his degree and got into university by working nights, late, after he'd done a full day's work on the farm! He told me stories about how he had become interested in treatment of pain including that he had spent time in Korea and had seen soldiers with frostbite. He taught himself to do stellate blocks which gave dramatic relief to the young soldiers.

He taught himself many other techniques and was extraordinarily dedicated to his patients.

He said, "Chronic pain management and it's mostly non-cancer chronic pain is so prevalent and there's not enough people in it. What I would really like in this chair is that more people enter this, so that people aren't waiting for a long time or simply not getting any treatment for it." He expressed himself very forthrightly to the university administrators that that's what he wanted.

At the urging of Dr Davy Cheng, I agreed to apply for Earl Russell Chair in Pain Management. In my interview, there was a nurse who was the chair of the committee. I had known her from her days as an obstetric nurse, but she had gone back to school, done some administrative training and now was in a top administrative position. I'm sure she put in a good word for me. Dr. Cheng did as well.

To my surprise, I was appointed the inaugural Earl Russell Endowed Chair.

Anne

That was a major turning point, I would think, in your career in chronic pain management. Would you characterize it as that?

Pat

I was completely overwhelmed. I did think there were other pain clinicians in the city more suitable, who knew a lot more than I did. But really none of them wanted to take on this brand-new role and give up the other roles they were in. They were already quite busy in multiple administrative and directorship roles whereas, I was brand-new to the field.

They placed an awful lot of confidence in me! In my first few months, I was given an office and a secretary. I would sit there and think, "Well, I'm really not too sure what I'm supposed to be doing here!" The dean was helpful. She was a woman, the first woman at Western to serve in this role. She said, "You need to establish a governance model. You need to bring people together because they're all over the city working at three different hospitals and in different faculties, in neurology, physical medicine, basic science. You need to somehow bring them together."

So how to do that? It was [about] making connections, setting up a board. Some of these people actually didn't like each other! Not only were they not used to working together – they were used to working in silos – they had developed animosities because they didn't like the theory of one person. One mentor that I should mention as well as Dr. Dwight Moulin, was a psychiatrist, Dr. Harold Merskey who was a very

renowned international expert in pain and chronic pain. He took me under his wing, and we would meet for lunch once a week. He was very wise, and his patients loved him. Most of what he had to teach me was very, very useful.

Anne

I think you're being very modest about your suitability for the role, because there must have been something in what you said to the interview committee that obviously showed that you had certain visions, goals, and objectives that aligned with Dr. Russell's vision. Can you expand on your [vision] for chronic pain management and how that later manifested in all the accomplishments that you've made since that point, including expanding the pain clinic into [an interdisciplinary model]. You talked about bringing a lot of people together and then, of course, bringing in a dedicated Royal College training program [for Pain Medicine].

Pat

To do all that, I needed connections. I still was not thinking of the training program [yet]. As well as the Earl Russell Chair, I was now the Director of a Multidisciplinary clinic based at St. Joe's. I was meeting with administrators. We were building a whole new clinic space with a Radiology suite. I felt I need to learn from other Pain Clinic Directors.

I started going to the Canadian Pain Society meetings at the recommendation of one of my mentors, Dr. Allan Gordon, a neurologist [at Mount Sinai Hospital]. I found the lack of hierarchy refreshing! You could find yourself sitting in a lecture with researchers, PhDs, patient advocates, psychiatrist, psychologists and physiatrist. I liked the breadth.

I'm abbreviating this, but within a few years, I realized we needed an association of pain clinic directors across the country. We started meeting annually, addressing topics like, how do you deal with your wait list? How do you get funds from your hospital? We had meetings by phone, between the annual meetings. We talked about the patchwork training of residents, the need for standardization. That's how the Pain Medicine Residency was born. It came out of the Canadian Pain Society exposure and also the frustration of trying to get our fellowship positions funded by provincial government.

Then, a small group of us just decided we would write to the Royal College and state we would like to create a new specialty. We learned there were three phases to creating a new subspecialty. We needed a parent medical specialty which all agreed would be the Canadian Anesthesiologists' Society with shared support from the Canadian Pain Society. Back at that time, in 2007, the opioid crisis was going on. The hope was that this crisis would be addressed with better training of the physicians.

Anne

Yes, it's really an incredible amount of effort. It's not easy to bring in a completely new specialty.

Pat

It took eight years of work of following a process, before Western opened their first applications to a Pain Medicine Residency. The Royal College had a well-thought-out plan. If you didn't pass Phase 1 approval, then you couldn't go on to the second. We had to prove there were appropriate supervisors in each centre who were capable of being clinical teachers.

Anne

You've had such a long and really remarkable career in chronic pain. What are you most proud of in terms of your contributions to this field?

Pat

I did train a number of fellows and still keep in touch with many of them. That is a big positive contribution. Several of them are running clinics and doing great work in Canada or in other countries. I made connections with a lot of people, not just physicians, also psychologists. I contributed research and my own understanding of pain became more comprehensive. Also, I had quite a number of patients who I had very personal connections with, and it was hard to break those when I retired.

Anne

I think that sounds like that was very important to you: patient connection, clinical work, advocacy, administrative leadership, teaching.

Pat

I would joke sometimes that I had started thinking I would be a family doctor, and then sometimes I was just acting like a family doctor. Some [patients] didn't have family doctors and would bring medical concerns to me. I would spend 30 minutes with each patient. A family doctor can't do that. Just having a bit more time to listen helped.

Anne

That's very interesting, to draw that circle back to your initial interest in family medicine. One thing I want to speak about is that you've been described by many sources as, and I'll read this as a quote, "...a remarkable coach and mentor and have distinguished yourself as an educator among her peers." I think you're very highly respected as an educator. Can you expand upon what it means to you to be an educator, a coach, a mentor, and how this has translated to when you teach your trainees?

Pat

Those kinds of comments are probably the highest praise for anything. [It's one thing to say], "Oh, you were a good organizer, you made connections." Well, that's great. [But this is] very personal praise and it takes me back to how important when I was a junior resident my mentors were – to giving confidence, to stimulating my curiosity, and to telling me if I'd done a good job or pointing out if there was something else that should have been done. Also, it was the personal connection. I was just so pleased that they would take an interest in chronic pain. Even if they weren't going to make it their career, I hoped that they would go out from even their one-month rotation with a different attitude to it. I guess I just liked connecting with younger people too at that point in my career.

Anne

I think that's kind of obvious in all that you've described [about] your curiosity, openness, and willingness to take on resident [research] projects right from the start of your career. Publication has been a big part of your career, and it shows a wide range of diversity.

Pat

I've been criticized for that. I was told "You need to focus."

Anne

Isn't that a positive trait to have? Your intense curiosity, willingness, openness to exploring different perspectives and [mentoring] younger generations to pursue these different questions.

Pat

Yes, I did take a course in research design at McMaster while I was working with Dr. Teasdale. That stood me in good stead. The other thing is, I really genuinely like to write. So, I was always fussing over the

introductions and the conclusions and how clear was the presentation. I am still writing now, but not medical research.

Anne

I'd like to just shift the focus a little bit and just look back at your career. You talked about having a young family early in your career, having to change locations, disciplines, a lot of things! Could you talk about how you manage to balance – some people don't like the word balance because they think that that's an oxymoron – your clinical work, research, teaching and leadership responsibilities with your personal life and personal responsibilities? Can you give any advice when you look back on how you managed to keep all the balls in the air?

Pat

[First is childcare.] I had a daytime nanny in Toronto who was excellent; four days a week, and I took one day off per week for the first two years. When I came to London, I requested shorter days. Shorter days turned out to be 3:30 or 4:00 instead of 6:00 p.m. so not so short. I had an excellent daytime caregiver in the first nine or ten years here in London. Without her, we couldn't have done it. We're still in touch with her. Also, my husband was not on call, always knew his schedule. Often, he would have office days so he could take over or be home at a regular time. That was very helpful.

I guess I just had a lot of energy as well. Sometimes I would have been up all night, and I'd come home and have two or three hours sleep and then carry on through the day when the kids came home from school. My husband did complain I would fall asleep a lot at unusual times, but now I don't do that.

Anne

That's very instructive, having really excellent support. Did you have any career setbacks? How did you deal with them, if you could characterize them as setbacks?

Pat

The main setbacks were the changes [career pivots]. But I had a medical diagnosis when I was about 43 of interstitial cystitis, which at that time was had not good management pathway. I couldn't stay in an OR for more than an hour and a half without a bathroom break. I thought for while that I would have to give up anesthesia entirely, but I found my own way to manage. I gave up coffee completely, changed my diet and found a medication that worked for me. That contributed to my decision to work in chronic pain. Fortunately, it's a minimal problem now.

Anne

Perseverance and really courage is an important factor that I think played in your being able to find some sort of solution.

Pat

I am an optimistic person. I think that's just my biology. I would just wake up in the morning and feel positive!

Anne

Is that an important trait, do you think, for longevity in an anesthesia career?

Pat

I think [it is important] in any career. There were people in my family or in my husband's family who were troubled with depression. I came to understand that for some genetic reason, I could regain my equilibrium quickly. That is a beneficial trait that I think I inherited from both parents.

Anne

That's a very fortunate part of your physiology, it seems. It's seen you in good stead.

Okay, I'm going to go into more of the big picture now as we're starting to wrap up this fascinating conversation with you. If you could just sit back and look back on your amazing, remarkable career in anesthesia, can you reflect on what were the things that gave you the most fulfillment or joy in your career? [What were] the lessons learned or advice that you might be able to pass on for the next generation of anesthesiologists, or those who are early in their career, or for those who may be struggling?

Pat

Lifelong learning. There was always something to learn. I think that the only way to have a fulfilling career in anything – especially anesthesiology – is to say, “Today I'm going to go in and learn something. Then I'm going to pass on what I've learned to somebody else “ So, you're challenging your own mind, but then challenging and teaching somebody else as well.

Anne

The main lessons learned, or advice you can give for the next generation of anesthesiologists?

Pat

No matter what you know and are doing in one part of your career, it can be taken away or can suddenly change. Look at that as a challenge that will make you stronger. One other piece of advice for the next generation... about 10-15% of anesthesiologists become involved in department or hospital administration. For those who think they have this talent, administrative courses could be undertaken at an earlier stage.

So, accept change is going to happen. Enjoy the learning that will be required. You will be a more confident leader if you've had basic instruction, and good mentor supports.

Anne

That's a really great advice. I think you role model that throughout the trajectory of your career.

Pat

Thank you.

Anne

I really do appreciate this conversation, and I just wondered if there were any other things that you'd like to add or speak about before we conclude?

Pat

I was thinking about pain management and the future of chronic pain in particular. There have been two Earl Russell Chairs since I left the position. One of them was a neurologist, Dr. Dwight Moulin, who focused on neuropathic pain and trying to develop a database across the country. The other one who's currently the chair [Dr. Eldon Loh], he's a Physical Medicine specialist and focused on using technology to enhance placement for fluoroscopically guided blocks.

I would just say that as long as you remain open to different possibilities and you do not think that learning stops at a certain stage, there's a great variety of research and clinical activities you could undertake still using basic anesthesiology training.

So don't ever let yourself feel bored because a bored anesthesiologist is a dangerous anesthesiologist.