

Canadian Anesthesiologists' Society – Oral Histories

Dr. Homer Yang, interviewed by Archives & Artifacts Committee Chair Dr. Mike Wong

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Dr. Homer Yang received the Canadian Anesthesiologists' Society Gold Medal in 2018. Throughout his career, Dr. Yang made many contributions to medical education, perioperative medicine, and physician leadership, while his work with the Anesthesia Care Teams model continues to be salient in the current era of health human resource challenges. He has been Residency Program Director at McMaster University (1989 to 1996), Chair of the Education Committee on the Association of Canadian University Departments of Anesthesia (ACUDA; 1992 to 1994), Chief Examiner for Anesthesia at the Royal College of Physicians and Surgeons of Canada (1996 to 2001), President of ACUDA (2007 to 2008), Principle Investigator for the Perioperative Ischemia Evaluation Study (POISE), founder of the CAS Perioperative Medicine Section and founding member of the Perioperative Anesthesia Clinical Trials Group (PACT), and Chair of the Departments of Anesthesia at McMaster University (1998 to 2002), at University of Ottawa (2003 to 2013), and at Western University (2018 to 2021).



**Archives
& Artifacts
Committee**



Mike

Welcome, Dr. Yang. We have a lot to talk about! I am very excited to chat today.

Homer

Thank you.

Mike

Before we move on to your professional life, would you set the scene for us in terms of your early years and family background?

Homer

I think many individuals like myself – of Chinese ethnicity – came out of a period of immense instability and chaos in China as well as in Hong Kong. I certainly was fortunate that my parents left China when they did, just as the governments changed over from the Nationalists to Communists. I was born in Hong Kong. As such, I was a British subject. Nevertheless, the chaos in China during that period affected many of us who are of Chinese ethnic descent, even those who have left China subsequently.

Mike

How old were you when you came over?

Homer

I was 14, a teenager. I was educated in [one of the Catholic] church schools in Hong Kong. My primary school was run by nuns. I didn't know it at the time [but] subsequently, in revisiting Hong Kong, I embarrassingly discovered that they were actually the Canadian Grey Nuns [of Montréal]. Because of the shrinking number of nuns, they have retreated from [teaching at] that school nowadays.

I benefited a lot from those nuns who educated us. I bring that up because one of them was a music teacher, Sister Denise. A lot of my music education and inherent values came from her. I have no idea where Sister Denise is [now]. I bring it up because as educators [their] impact goes much further and for much longer than we actually realize. I certainly appreciate what Sister Denise did, as well as many other teachers.

When I was in middle school in Hong Kong, I was taught by the Jesuits. There were a number of Jesuit Fathers who made an indelible impact in my psyche as well as my values and life philosophy. And I think, in some ways we undervalue the people who have taught us over the years. Subsequently, because of changes and world events, we may or may not even know where they are. They have made a huge impact, at least for me, and I believe for many of my classmates.

Mike

Such a formative time.

Homer

Absolutely.

Mike

When you came to Ontario, was there much of a culture shock?

Homer

I was fortunate. For the Jesuits and the Grey Nuns, the teaching language was English. Hong Kong, because it was then a British colony, was very much Anglified. Nevertheless, the English was more UK [United Kingdom] English than North American English, so some of the expressions were completely different.

For example, “Can you pass the torch?” versus “Can you pass the flashlight?” In high school after arriving in Canada, when I asked that, my classmates thought, “What are you talking about?”

We initially went to Vancouver and then we moved to Ontario. Then, I stayed in Ontario ever since.

Mike

As a young person, did you know that you were interested in medicine? Did you explore other things?

Homer

In fact, I had wanted to go into music. I was also interested in architecture. I was taking architecture drafting and developing a portfolio in preparation to apply for architecture school. I also was taking violin lessons ever since primary school organized by Sister Denise. Instead, I went into university, not knowing exactly what I wanted to do. That's when I sort of started thinking about medicine, very late. It literally was in my second year of university. [I thought] maybe I could apply and see what happens.

Mike

You did not have any family members who were in health professions before.

Homer

One of my maternal uncles was a dentist but he was in China. I hadn't met him until the mid-2000s. That was the only sort of connection, and he wasn't a physician.

Mike

So, you played violin. You still play today at a pretty high level, correct?

Homer

Amateur, but I definitely have always enjoyed music. When I was in the first year of university at McMaster University, I was appointed the Assistant Concertmaster. What was more scary, at that time, I was sitting beside the Concertmaster who was the professor in calculus. I really had to behave sitting beside him!

When it comes to music I have to say it has helped me to keep my sanity. For those who need some calming time, it's a very, very good form of meditation. Maybe the left hemisphere and the right hemisphere speak to each other much more with music and it helps to calm oneself. As we all know, the left hemisphere is very mathematical and you can count very accurately [with it], but if your right hemisphere doesn't speak to the left hemisphere the music would be very metrical. It would be very boring! On the other hand, you can play very emotionally but, if you can't keep count, nobody can play with you. You would sound funny. The two hemispheres need to speak to each other constantly in order to make good music. I think that music is one thing that I was fortunate [to have learned]. It certainly helps me to keep my sanity.

Mike

Do you have a favorite piece or type of composition that you enjoy playing?

Homer

Oh, there are so many! Mostly, it's classical music. I definitely love Mozart, Brahms, Beethoven, and also Prokofiev. When I was in my last year of medical school, I did an elective in Newfoundland. At that time, computers or TV [television] was very much in the background, not the foreground. A lot of the entertainment was [made] amongst ourselves – sort of by the people, for the people. I actually ended up learning some fiddle music from Newfoundland and it was great! I'm not good at fiddle music, but at least I know I can play some of that stuff. It opened my eyes to another world of music. It's [still] violin, but played very differently.

Mike

It's wonderful to move through life with open eyes and see different opportunities for growth and development.

Homer

Never stop learning.

Mike

So, you went to the University of Toronto to study medicine. You started in family practice and then came around a few years afterwards to pursue Royal College certification in anesthesia. What were those early years of your career and postgraduate training like?

Homer

I think I was, again, fortunate. [It] wasn't termed FPA or family practice anesthesia [then], but it was essentially family practice anesthesia, and it was only six months' training at that time. I did that and my interest at that time was doing a small-town practice. After the FPA training, I did locums up north, places like Kapuskasing, Manitouwadge, and White River. During my FPA training I was also encouraged by quite a few of the specialist anaesthetists – or anesthesiologists – including the program director in McMaster University at the time. [He was] certainly a very influential and great individual, Dr. Fred Wright. He's passed away. There were a number of individuals, Dr. Ken Tse, Dr. Larry Chiu, Dr. Peter Chan, Dr. Harry Andry; they all encouraged me to go into specialty anesthesia.

[After] I did the locums up north, I came back to do specialty anesthesia but, in the back of my mind I really enjoyed doing the locums up north. It's a completely different world, certainly. I would encourage either junior faculty members or residents to not forget rural Canada in either their learning experience or their practice. It is in many ways actually more of the real world out there, especially in rural Canada. I was very much by myself. You had to think constantly on your feet!

For me, for a number of personal reasons, [I was not able to stay in the north indefinitely]. At the time, my wife was finishing her PhD in chemistry, doing archaeological chemistry. We both knew that she was not going to get a job in White River, for example! That's one of the reasons I came back. So, I came back and then ended up doing the Royal College stream. I've enjoyed it very much. I appreciated all the encouragement and help.

Mike

It must have been challenging coming back into training [after practicing independently], though I suppose it was more of a common thing that people did at the time.

Homer

Yeah. Obviously, circumstances have changed tremendously since the 1980s. I believe anyone who has gained experience outside of teaching centers or gained experience outside of a specialty or subspecialty – [the experience] enriches that person's medical training and medical perspectives. [I mean] both in helping patients and maybe keeping their own sanity, their own well-being in mind. It's obvious we can't go back [to that way of practising and training] anymore.

I was program director when things were changed in 1990, to a two-year pre-licensure. That's another discussion, another story. Certainly, from my perspective, in some ways, it's taken away from physicians' rich training tradition that we had prior to 1990.

Mike

You mention your time as Residency Program Director at McMaster. It looks like medical education has been a really important part of your professional life, even from very early on in your career. How did you come to enter that role?

Homer

I remember very clearly another of my mentors at the time was Dr. Jay Forrest. He was the Chair of the department at McMaster. I was actually writing computer codes to do a study on feedback control infusion of muscle relaxants. I was using the train-of-four with the EMG [electromyography] machine with an RS232 cable feeding the data back into a laptop, then from the laptop controlling the IVAC 560 infusion pump on the atracurium as a [closed loop system]. I was in the department writing all this code and testing it. Then, Jay came in [saying], "You're still here?" "Oh, yeah. Just, you know, working on this research." [He says], "Well, I have a favour to ask you..." All of a sudden, I went from doing research to [doing] education. The crux of that was, there were a few things going on in the residency program and I had already been nominated and given the teaching award for the best clinical teacher a number of times.

Mike

Six times in total?

Homer

By that time, I think I got it maybe four times – or something like that – by the residents at McMaster. That's why he wanted me to help to take over the residency program.

I did finish the project on the feedback infusion. We presented the preliminary data at the CAS as an abstract, but then the project stopped because I had to deal with the Program Director responsibilities. After an initial meet and greet with the residents, it became clear that there were a lot of issues I had to deal with. It actually became very busy.

I have to boast [about resident satisfaction]. I took over first as Assistant Program Director, then as Program Director in 1989. Then, in 1990, if I remember correctly, the Royal College came for review.

CAIR [Canadian Association of Internes and Residents] would accompany the Royal College. CAIR also did a survey of the residency programs in McMaster. At that time, despite some of the challenges initially, the representative from CAIR, told us that our program was the second happiest or content [or] whatever the word was in their survey. I said, "Oh, that's very nice, thank you. Who was the first?" They said, "Hematology. They have one resident and they have a hundred percent happiness or satisfaction!" Anyhow, the program basically had to navigate through a few challenges.

Mike

Right. What was the biggest change at that time, at Mac?

Homer

I think one of the one of the biggest changes was to make sure that the residents got the education that...I was gonna say, that they should get.

Mike

Like, the structured teaching?

Homer

There was structured teaching. We made sure the residents' [academic] half day had a very formalized curriculum. Also, at the end of the day, these are adult learners. These are not primary school students. So, a lot of the adult learners, they know what they want! The biggest change I would say, was to make sure that – within the framework of what we need to teach the residents – we let the adult learners help decide how they want to learn this material. As opposed to someone just writing a prescription where residents have no input. I have to admit at that time I was also fortunate that several of the residents [were exceptional]. One was subsequently both an examiner and she was actually Program Director, Dr. Karen Raymer. She was a resident and Chief Resident. Then, there was Dr. Liz Ling. There were others and they were all very, very instrumental in helping and giving me the right feedback. Of course, I always met with the residents as a group. It was very much like, "Okay, this is what we need to teach you. How do you want us to provide that to you? Just slacking off and taking the half day off and disappearing is not [an option]!" I think most programs now have it, but at that time it was different. Some of the 4th year residents – at that time it was like PGY5, because they still had internship – they would actually have their half days off on for self-study. That was actually unheard of at that time, but a lot of that really is, "Okay, what is it that we can do to help you to learn the material? You are an adult learner. We're not, you know, public school!"

Mike

Not spoon feeding at that point.

Homer

Exactly.

Mike

At another side of the residency experience, you became involved in exam development at the Royal College. It sounds like you were instrumental, shall I say, in standardizing how the oral exams were delivered and graded?

Homer

Yeah. I was very fortunate. I was very honoured to be appointed to the exam board. I met many of the examiners. There were too many for me to mention. Dr. Doug Duval, for example, he was the President of CAS many years later. He works in Edmonton. He was very kind, a mentor helping people to settle in.

It was an honor to meet some of these examiners. The challenge, however, was figuring out how to ask the questions, and to deal with the reliability and validity of exams.

[It took] the help of many, many people along the way. Dr. Chris Eagle was the Chief Examiner before me. He subsequently led Alberta Health Services [AHS]. We called him the Czar of the AHS. That was, gosh, easily 10 or 15 years ago. [Anyway], he was Chief Examiner before I took over. Prior to [him] there was another Chief Examiner by the name of Dr. Frank King. Prior to that [was] Dr. Bill Pope, who was subsequently the Manitoba College registrar and also did a law degree. Among these Chief Examiners, [we had] talked along the way, “We need to think about how we are doing the Royal College examination.” It's not just me coming out with an idea *de novo*. [I had] the help of many people: Dr. Steve Puchalski, Dr. Ramona Kearney, Dr. Bill Sischek, Dr. Ruth Covert, Dr. Larry Byford, and others. We started to work together to restructure the Royal College oral exam. There were a lot of discussions. First, I presented the literature and a sort of a straw dog model of what we might do. [We sought] lots of input and discussion on the Exam Board and from there we actually made the proposal. The Royal College at the time had people to help us. [We were able] to change the exam so that we would have standardized questions, proper review, and we also recognized at the time the exam had very much a hidden curriculum. If we ask the questions, the residents will be studying those questions or those areas. Some residents have obviously very good memory, and then they can transmit even the entire bank of questions. Rather than having some residents having access to those questions and others not, we even said, “Take the exam question booklet home and just use it for practice orals!” I understand subsequently, after I stepped down – after another Chief Examiner or two – that's been stopped by the Royal College. But, from our perspective, from 1996 to 2001, it was very much, “Take the book home. Learn the stuff because we want you to learn it. We are not trying to sink you just because we can sneak a question on you. We want you to know how to answer those questions *and manage those patients*.” We did all of that with the help of the entire board. Lots of people, too numerous for me to name, we worked together. We worked through every single detail when we changed the exam format. Literally [down to details like], “Where do we put the chair outside the room?” It was very rigorous and there was good consensus amongst examiners.

Mike

You still played an important role in tying it all together to make it happen. I understand, at the end of your tenure as Chief Examiner, there was a poem that was composed to commemorate that.

Do you mind if I share it?

Homer

How did you get hold of it!?

Mike

Homer's Iliad, Royal College version, of which there's just a couple of lines that I have:

There once was a time when the exams were cruel:
Each question was unique,
Marking had no rule,
But Homer changed that using principal sound.
Now, there is reason,
Less chaos all around.

It's very touching!

Homer

I really appreciated the Examination Board!

It was important for us that both the French Board and the English Board worked together. I certainly went out of my way to make sure of it. The French Chief Examiner at the time was Dr. Michel Clairoux. It was always an honor to serve on the Exam Board. We were not well remunerated, I can tell you that.

[One time] we had we all agreed to go out for dinner. As human nature would be, the French board sat on one side of the room and then the English sat on the other. I made sure I sat the French examiners and the English examiners together. I mean, we were all colleagues, so I don't want to give the wrong impression. But, somebody needed to break the ice, as it were. And, we had people who were bilingual and appointed to both boards. For example, Dr. Karen Raymer, who I mentioned earlier. She was the Chief Resident when I was a Program Director. She is bilingual, and she actually was able to examine in French as well as in English.

I don't know what [happens with the oral examination] nowadays. Once you're past that stage, the process within the exam board keeps going and generally is confidential, and I respect that.

Mike

It does look like it's very important to foster a sense of collaboration and camaraderie amongst the examiners.

Speaking of collaboration, can we talk about your research? You've been busy, more than 70 peer-reviewed articles. You've had numerous contributions to the study of perioperative ischemic events. Most notably, or notoriously perhaps, you led the POISE trial. I'm really curious, what led you along those lines of inquiry?

Homer

One of my respected colleagues and friends – one of his family members was undergoing surgery. Everything went well intraoperatively, even in the immediate post-op period. Yet, subsequently – I think it was somewhere around 24 h to 36 h – that family member ended up with a post-op MI [myocardial infarction]. From a relatively active and healthy status, that individual became a cardiac cripple.

If you go back through our literature, you'll know that has been a problem [going] way back. Even Tarhan and Steen [[Steen, Tinker, Tarhan, 1978](#)] refer to it in their earlier studies back in the 1970s. Dr. Lee Goldman of the Goldman Index [talked about it] in the 1970s. We knew that this was a problem. About 20 years later, Dr. Dennis Mangano also started to work on it, but there were some challenges in his studies. People, including myself, saw some challenges in the conclusions they drew. It was also around that time the Cardiac Risk Index came out, 20 years after the Goldman Index. Despite the RCRI [Revised Cardiac Risk Index], Mangano's work, we still [hadn't] solved it. We were still seeing perioperative MI and there was a lot of misunderstanding – especially from our cardiology colleagues – thinking it was all because of management issues intraoperatively, that people ended up with a post-op MI. So, that's when I started to look into it.

Our initial trial was the MaVS trial [Metoprolol After Vascular Surgery]. That was actually funded by the CAS. This is why CAS is so important. They gave me the Dr. R.A. Gordon Award. [It was] not a lot of money, but it was excellent seed money for us to start looking at the Metoprolol After Vascular Surgery trial. That was published back in the early 2000s or late 1990s. [We had collaborators] at Queens, in London, and at McMaster. Using that data, I was able to collaborate with Dr. Salim Yusuf in McMaster. He was a cardiologist looking at perioperative MI and beta blockers in the ISIS [International Study of

Infarct Survival] studies in the UK [before] he was subsequently recruited to McMaster. So, we talked, and then we brought in Dr. P.J. Devereaux and we started to do the POISE trial.

It was also timely, I suppose. At that point many of the American institutions were bringing in [perioperative prophylactic beta blockers as] standards of practice. “You must do this, else we don't pay you or we will reduce your payment.” One of those standards, in quotation marks was, “You *must* give prophylactic beta blockers.”

When we actually [started] the POISE trial, I was receiving much correspondence from [American] colleagues asking whether we have any data to try and stave that off, [but] we were right in the middle of the study. The MaVS trial showed no difference, but we only had 496 patients, and so we could be committing a type 2 error (i.e., the sample size was not large enough). So, we couldn't use that to stave off what was going on. Subsequently, when the POISE trial results were published, yes, we could prove that: one, we could reduce post-op MI; two, most of the post-op MIs occur 24 to 72 h post-op. So, it wasn't because of intraoperative management that patients had MIs. We have reasonable pathophysiology to explain that, but not completely. And, thirdly, prophylactic beta blockers also increased mortality and stroke rate! That became a bit of a pivotal change for a lot of the [American] institutions to back off on the compulsory mandatory prophylactic beta blockers perioperatively.

There was a study in the European Heart Journal, published electronically, for about maybe 2 weeks – then it disappeared, which was surprising! They calculated, based on POISE data, how many additional patients in Europe might have succumbed because of compulsory beta blockers. It was not a small number. I think that might have been too provocative or whatever. I just remember reading it. I said, “Oh, wow!” and the next thing, it disappeared. To my knowledge, never appeared again. At least, I never saw it again.

Mike

That's surprising.

Homer

Yeah, it was. I was surprised, because if it was an error, then there should be a notice that it's been withdrawn, but it just sort of disappeared. I don't know what happened.

The crux of it is, one of the things I have to say I learned, is we as human beings have the ignorance and the arrogance to think that we can give one pill and change the course of human evolution over tens of thousands of years. I think a Higher Power has conferred on us a very robust biological system, and it's probably not so simple as a single pill that's gonna change everything.

[And] somewhat unrelated, one of my junior faculty members was doing stem cell research. He was showing one day what the mRNA panel would show when a stem cell was injected into a population of cells. The mRNA was almost like a light show, being activated and deactivated, in green and red on the panel! They were just popping up all over the place. That's when I had an epiphany that for every complex problem, there's always a simple solution that is *wrong*. So, for us to think that a beta blocker affecting beta receptors would all of a sudden change the course of history is really ignorant and arrogant on our part. Just look at the stem cells, where something you inject makes the cells change. The mRNA is much more complex than just one or two things that will completely change the entire course [of the cell]. No, the cells are much more complex than that. Obviously, stem cell research is not the same as giving beta blocker as prophylaxis against a perioperative MI, but we might be able to learn from what nature does.

It is one thing that gave me an epiphany that, no, we are thinking too simply about this.

It's very complex, a lot of moving parts, and a lot of interactions between different things. When talking about the clinical setting, all sorts of external factors can also influence how things turn out in the end.

Mike

I think that does tie into the role that you've had with championing perioperative medicine both through the PACT group and with establishing the section of Perioperative Medicine at the CAS.

Can you speak a little bit about organizing on a national scale to really advance that cause?

Homer

It wasn't just me. A lot of colleagues felt likewise. Just speaking for myself, doing the MaVS trial, the POISE trial, seeing that mRNA panel, plus other things, certainly pointed me to the direction that we need to understand much more before a patient comes to surgery. Physiologically, we've known for decades, if not centuries, that *surgery is trauma*. There are two things that happen – that go back to when we were living in caves. If we were injured, we would go back into a cave trying to recover. During the recovery process, we might or might not be able to find food. So, what do we do? We eat up our muscles. We go into a catabolic state. That's well known. The second thing that we also know is, in recovery from trauma, our coagulation system increases its functions so that we don't bleed as much. We will form clots much easier, and then we don't die of exsanguination. A side effect may well be, after surgery, deep vein thrombosis, and possibly, arterial thrombosis as in MI or strokes.

Around the same time, there were already a lot of discussions about neuroinflammation in the post-op period, with delirium and all that stuff. I didn't know it at the time – because some of the studies had not been done – but subsequently, [some] animal studies were done where rats were subjected to having just general anesthesia versus general anesthesia [with] femoral fracture and repair. Then, the mice were sacrificed over a period of time and in the former (i.e., just under general anesthesia), the brain looked fine. No problem. In the latter, there was evidence of neuroinflammation. That was very astounding because the neuroinflammation was remote from the femoral fracture, and because [the trial] was controlled between general anesthesia [and] general anesthesia plus fracture [groups], we could see that there was something else going on affecting the inflammatory process after surgery.

There were already some talks when I was looking at establishing the Perioperative Medicine section [with] people at Toronto Western, Dr. David Wong plus a number of others – again, too numerous for me to mention! We were saying, we should be looking at a Perioperative Medicine section [and] we can also start to help with research in those areas. A proposal was made to the CAS and they were very receptive. We got enough signatures and then we submitted to the CAS Board. It was at the Halifax CAS Annual meeting, and then the next subsequent meeting was in Victoria, which Dr. Angela Enright was instrumental in bringing there. I think that was the first time the CAS went to Victoria [for the annual meeting]. I was fortunate, because of the POISE collaboration and all that, we were able to get Lee Goldman to come and speak about perioperative MI, risk stratification, and possible risk modification of perioperative MI. [Goldman] was an excellent speaker, needless to say. We were all at the Victoria Convention Centre for that meeting. We actually had a very strong start [to the Perioperative Medicine section]. From our perspective, it also helps to put some focus on anesthesia [in the operating room], absolutely crucial and important. I enjoy doing it. But we also have to be perioperative physicians so that we can actually help the patients more.

Again, at the time we didn't have that information yet, but subsequently, a lot of data started to come out on frailty. Halifax did a lot of work and Edmonton did a lot of work, as had one of my prodigies – I don't know what's a better term – Dr. Dan McIsaac. Unbeknownst to each other, we had both started to approach geriatricians and others to look at the frailty scale and how to document it. I was fortunate we

were in Ottawa at the time because our health record and anesthesia record were electronic. We could actually track how many patients [we had] and their frailty score. Then, I discovered [he was looking at the same things]. I was so pleased and told Dan that I fully supported him in whatever he would need. This was also when the Perioperative Anesthesia Clinical Trials Group [developed]. It's not one person. [We had] Dr. Rick Hall from Halifax – haven't seen him forever now, but he's a great guy – and Dr. Hilary Grocott, Dr. Alex Turgeon-Fournier, who actually did his fellowship in Ottawa. We had already gotten to know each other. [There were others], again too numerous to name. We got together and said, “Yeah, we need to establish a Perioperative Anesthesia Clinical Trials group.” That's how the PACT group came into being. It really is giving a forum for people to start talking and thinking about research issues. If you look at the PACT Group, one of the strongest projects that we supported, helped, and encouraged was intraoperative transfusion during cardiac surgery. [It's about] pre-op, post-op. It's peri-op. All through the anesthesia period, not just focusing on the intra-op [period].

Right now, [we are thinking about] frailty and pre-habilitation. Many people have worked on it. That's Dr. Franco Carli and Dr. Thomas Schricker – both in Montreal [McGill University] – who did a lot of work on this. Everybody's slowly building on each other's work. I think that's the crucial point when we try to understand something. It's not one person who just comes along and [has] an immaculate birth of an idea. No, we build on each other's ideas. We are inspired by other people's successes.

Mike

I think that is a really eloquent way to really conceptualize team-working and the synergy that comes from it, and the role that senior investigators or team members can have in terms of elevating up-and-coming people as well.

It's about an hour [into the interview], and I have not even discussed any of your contributions leading and helping guide three of the major academic anesthesia departments in the country. Those are also very, very challenging roles. What led you to jump into that?

Homer

My personal philosophy is that I don't seek out leadership roles! But, if I can contribute, I'm happy to step forward.

[There was] a Roman general, Lucius Quinctius Cincinnati. He had retired. He was a farmer and Rome was besieged at one point. The Roman Council basically went to him and asked him to defend Rome. At that time the Roman democracy – which subsequently was destroyed by Julius Caesar – had bylaws or provisions that they could actually confer upon one individual to have kind of a dictatorship status for the defence of Rome. Cincinnati did that. He defended Rome, settled things down, defeated the enemy, and then he *went back to farming*.

That always has resonated very strongly with me. In many ways, people who seek power, maybe they shouldn't have power.

Mike

For future readers of this transcript, we are talking now in the middle of a Canadian federal election, and after a transition of power south of the border as well. We're in a period of some historical importance!

Homer

I believe it was George Santayana who said those who don't learn from history, repeat it – the same thing that Winston Churchill said. If we look back in history, many of the events currently [happening] are not exactly the same, but they definitely rhyme with what happened in the past.

It's unfortunate that we, as a human race, haven't learned from those lessons in history.

Anyhow, I did not seek to be Chair in McMaster. As we discussed earlier, I was Program Director. I had asked to step down as Program Director because I served – oh, gosh – from 1989 to 1995. Something like that. Somewhere around there, I was asked to be Interim Chair. Then, in 1996 I believe, I was appointed the Chair. I was very happy, if anyone had stepped forward, to just step back! But I ended up being the Chair, until [about] 2002. I had actually asked the Dean – Dr. John Kelton, great hematologist, great guy – [I said,] “Yep, I've served my term, and I'm happy to step back. Go find someone else.”

I guess some folks in Ottawa, including Dr. Earl Wynands, heard about that. They actually approached me and asked me to apply to Ottawa as Chair and Chief. I have to admit, I wasn't going to [do so] but another good friend and colleague talked to me and on their advice I applied. I became the Chair and Chief, so the responsibilities doubled. Actually, more than doubled! I was overseeing the academic as well as the clinical services.

It was also around that time in the early 2000s when the surgical wait list [got very long]. There was a backup of a lot of cases: cardiac, cataracts, hip and knee replacements, also – if I remember correctly – oncology and radiology. There [was] a list of five [types of cases] that the federal government as well as the provincial governments agreed [to prioritize]. All of a sudden, not only did we have to catch up on the number of cases, we had *more* cases to do! We had to open up more ORs. At the same time, I had an extra challenge: over a 12-month period, something like eight maternity leaves! I absolutely protected those maternity leaves. Didn't have any problems with it. I said, “Well, we just have to figure out a way to work around that while we try to increase the number of ORs.” We navigated through that and through a number of challenges. That was just an example of the Chief's job. It's not a Chair's job. Then, I was appointed the inaugural Director of Professionalism in the deanery. Their terminology was different at that time but the position was an equivalent level of an Assistant Dean.

Mike

Were there any specific concerns about professionalism that led to you becoming the first Assistant Dean for professionalism? What was the background behind that?

Homer

I think it was happening in many medical schools. Our Dean at the time, Dr. Jacques Bradwejn, had the foresight to see things that needed to be addressed. Some other places either did not address this or did not even look into the issue. Part of the issue is, unlike the US [United States] and many other countries, in Canada, the medical school does not run a hospital in most centers. The medical school and the hospitals basically have an affiliation agreement. Because of that, the medical school may have several if not numerous hospitals as teaching hospitals.

So, we saw, for example, individuals who had professionalism issues, especially towards medical students, residents, and nursing staff. Many of the hospitals would have a policy to address it with a nondisclosure agreement [NDA]. “You don't do that again or your privileges are gone. Sign here, then.” Because we go to different hospitals and we teach in the medical school, it came to our attention that some of these individuals actually had several NDAs in several institutions and that information was never shared. That's when we started to work through it. How can we actually make sure that we are truly addressing [problematic behaviours]?

There was another issue that was rearing its head, social media. Unfortunately, individuals who had either some sort of appointments with the medical school or in the hospital would put their title down on the social media as if they were speaking with the authority of that institution. [Are their] controversial statements their own *personal* statements? We had to also work through [the question], “how can we

ensure social media as free speech?” Absolutely, you can have free speech, as long as you live with the consequences. Don't drag the institutions into it because you're not speaking for the institution. Some of these [issues], we had to address them with policies. We were certainly one of the first universities at that time to deal with those issues.

Mike

It's important in terms of our responsibilities towards learners and the community to be vigilant and responsive to these sorts of concerns. [It sounds like] that was a very challenging position in different ways.

Homer

The bad apples are not common, most of the times. It's easier to not have to deal with the bad apples with any sort of policies. Unfortunately, when it happens where the policies are not there, the bad apples can merrily carry on.

At this point, I have no idea what the University of Ottawa is doing because, again, I am an Adjunct Professor and not holding any administrative responsibilities. But definitely we helped to address [these issues] at that time. Without going into specifics, we did definitely address specific individuals on some of those issues.

Mike

As you alluded, London is currently your home base, at Western University.

Homer

Yes, I was approached again. I said no initially, but I was convinced by someone else and moved down to London. I have finished my tenure, so I'm semi-retired or whatever the right term is. I'm not working flat-out, which I appreciate. With London, there has been some turmoil so I appreciate the fact that I am actually out of the kitchen. For clarity, London is now under a supervisor and the supervisor also is calling for the police to investigate [some] accounts. The entire Board of Governors in London Health Sciences has been fired. A number of things have been going on in London. I have great sympathy and respect for those who are in leadership positions nowadays.

Mike

At this point, you say you're winding down. I'm not sure if I believe you!

It does seem things have kind of come full circle. You're doing locum work back in Northern Ontario and returning to some of the same communities that you'd had experience with before. How are you finding that, many years later?

Homer

I'll answer the question in a long way. At this point, whenever London is short, I am there. I did recruit quite a few people before I stepped down. Nevertheless, whenever they are short, I go down to help.

Up north, some of the people remembered me from before. They actually approached me and said, “Would you come and help?” They are very short of physicians, so I have been back up to Kapuskasing, Moose Factory, and Timmins. I enjoy it because it is very much for a smaller community. The healthcare workers care a lot about their community – this [patient] could be their best friend, this could be their cousin, their family member. When things were happening and they needed to do something about it, everybody sort of came together to help. That's the reason we go into medicine, to help people. So, I'm glad when I can help. I only go up there when they really need me, and whenever there's somebody else who can also go up there, I will say, “Please go. I'll just step right back!”

In the meantime, it gives me a bit of time to carry on with my [latest] research project. We're now doing an AI [artificial intelligence] research project down in London. [There have been a] few hurdles, but we're slowly navigating through them. At the same time, it allows me to rejoin an amateur orchestra to play my violin more.

Mike

How did you, through all these years, manage to balance clinical work, research, service, with your personal responsibilities as an individual and family man?

Homer

I have to admit that I owe a lot to my wife. She certainly was instrumental in supporting me. She has a PhD, as I sort of mentioned earlier. She's a great editor, so she sometimes helps edit my papers.

In my earlier days, it was so busy! I don't have any recollection of my oldest child as a baby. There were periods when we were very stressed. But, I have the perspective that life is a journey. We just have to make sure that we carry on the journey with resiliency. If we have the compass bearing, we know where we are going. When we're going out for a walk in the woods and, say, if a bear jumps out onto my path, I'm not going to ignore the bear, keep following my compass bearing, and go towards the bear. No, I will get out of the bear's way. Once the bear is out of the way, I can start walking again, following my path. I think life is like that. It is not a straight line but we just carry on.

Mike

What's next? What are you looking forward to?

Homer

I definitely hope we can get the AI research to fruition. CAS supported that as well.

Mike

This is your latest grant, using artificial intelligence to remotely look at perioperative ECG [electrocardiogram] and monitor it?

Homer

In the MaVS study and POISE study we found that one simple pill does not do the trick. We published [as have others] over the years that we can see perioperative ischemia, ST depressions. Mangano actually had done that work a long time ago, in the mid-90s, [showing] when you have ST depressions you had five times the likelihood of an MI. Right now, we don't know what the odds are [exactly]. We know the overall rate is somewhere between 1% and 5%, depending on your risk stratification group. But, when you actually have some indicator [and some continuous monitor] to say that this is five times the odds [that would be very powerful]. We tried to do that after the POISE trial. The trouble was artifacts causing false positives. I had a great collaborator from the biomedical engineering faculty. We tried to reduce the artifacts, unsuccessfully. I mean, we did reduce it by 50% but, at the same time, with remote ECG in one patient we actually saw something like 2,000 false alarms in 24 h. Even if you reduce it by 50%, it's untenable!

So that's why we're trying to see if the AI could actually improve that. We thought by now that others would have done it. But, to our surprise, people haven't done it yet. Only with 12-lead ECG in patients lying flat and still. Obviously, when you are post-op, the last thing we want the patient to do is to lie still and not move a muscle. We want to ambulate them!

Can we use AI to improve that? I don't know. We'll see.

Mike

That sounds very exciting. Being mindful of time, I will end with something I ask everybody: looking back, do you have any advice to confer on the next generation of anesthesiologists, physician-leaders?

Homer

If I may say two things – one, it is a great privilege to be a physician, to be able to help people, to be trusted by people who want you to help them. It's a great privilege for me. Times can be very rough, very turbulent, but I think it's important to keep that in mind.

The second thing is more towards the physician leaders. I did not get here as an immaculate conception. We want to provide leadership but with principles, and with people believing in the principles to do the right thing. Maybe we should think more about being a “servant leader”? The West Coast Indigenous nations have a tradition of “potlatches” where leaders would share their “wealth”, material or otherwise, in front of everyone, in a transparent fashion. If we abuse that power [that comes with leadership], then we may win short term [but] lose in the long term.

Mike

Use it responsibly.

Homer

Yeah.

Mike

It is always a pleasure to talk to you, Dr. Yang. I really appreciate your time today. There's a lot to digest [here]. You have really made a lot of contributions.

Homer

You're being kind. But thank you very much.