

Canadian Anesthesiologists' Society Presidential Interviews

Dr. Dolores McKeen, interviewed by Archives & Artifacts Committee Chair Dr. Mike Wong

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Dr. Dolores McKeen served as the president of CAS from 2020 to 2022. She practiced anesthesia in Nova Scotia for 22 years, and was Chief of the Division of Obstetric Anesthesia at the IWK Health Center from 2018 to 2021. She has since worked as Vice Dean of Education and Faculty Affairs at Memorial University, where she is a Professor of Anesthesia. Her involvement in professional service and governance extends to DoctorsNS, the Association of Faculties of Medicine of Canada, the Royal College of Physicians and Surgeons of Canada, among other endeavours.



**Archives
& Artifacts
Committee**



Mike

Thank you so much for joining us today, from beautiful St. John's, Newfoundland. Beautiful, but perhaps a bit drizzly today.

Dolores

It is indeed raining. Thank you very much for inviting me to be part of this series of interviews with the CAS presidents!

Mike

Let's start from the beginning. I understand you have roots in Newfoundland and Labrador, so would you tell us a little bit about your life growing up there?

Dolores

I grew up in rural Newfoundland until about age 12 or 13, then moved into the city with my family where I finished high school and attended university. That gave me a real sense of both rural life and later on living in a small urban city of St. John's.

My family was of modest means, with limited worldly experiences. I was the first person in my family to attend university. To be honest, that was beyond a lot of my family's experience or vision, really. Having Memorial University in my home city was one of the key enabling factors for me to attend. I don't think my family would have had the resources to support me studying and living elsewhere. Being able to stay at home while attending university made it possible for me to pursue post-secondary education and ultimately attend medical school.

Mike

As an undergraduate, you completed the Bachelor of Medical Science program at Memorial [University]. As you were going through secondary school and university, did you know early on that you were interested in medicine, or did you explore a number of other options as well?

Dolores

I didn't think about medicine or becoming a doctor until I was in second year of university, fairly late in my career planning. My original goal was veterinary school. At the time, admission to UPEI required a four-year undergraduate degree to apply, whereas medical school at Memorial only required two years of undergraduate study. And, I really wasn't sure that I could afford to move.

In my third year, I decided to apply to medical school, not really expecting to get in. I thought it would be good practice for applying to veterinary school the following year. I don't think anyone was more surprised than I was when I was accepted. I completed my MD at Memorial in 1992.

Initially, I planned to pursue internal medicine with a goal of critical care. That interest ultimately led me to anesthesia. During residency, I realized that I spent enormous emotional energy worrying about patients after work. I recognized that a critical care career could be attained through an anesthesia entry while offering me better boundaries. Once the OR day ended, I felt I could leave the patients behind rather than carrying constant worry home with me.

So, I switched to anesthesia in my third year of residency, with the hope of pursuing critical care. At first, with little undergraduate exposure, anesthesia wasn't what I expected. I loved clinical problem solving and aspired to an academic career. In the first year, I worried I had switched into the wrong specialty. As a junior resident, anesthesia can feel very technical and protocol-driven. I didn't truly develop a passion for anesthesia until my fourth and fifth years of residency, when I actually dug in and studied. Understood the why; the physiology and the pharmacology, the anesthesia considerations behind what we do...anticipating problems rather than simply reacting to them. That's when I fell in love with the profession!

Around that same time, I solidified my desire to pursue research. Although residents were expected to complete scholarly projects, there was limited capacity and infrastructure to support academic anesthesiologists. As we didn't have a clinician-scientist program at Memorial then, I enrolled in a graduate studies program – a Master of Science (Medicine - Clinical Epidemiology) during my fourth and fifth years of residency. Initially, I needed special permission to enroll in two professional programs, and I was paying tuition both as a resident and as a graduate student. I jokingly say I probably funded someone's pension with those fees.

I completed my Royal College exams in 1997 and worked at Memorial as a locum for nearly two years while finishing my MSc thesis. I then became a clinical fellow at the IWK Health Centre and Dalhousie University, where I completed a combined clinical and research fellowship in obstetric anesthesia. I moved to Halifax on what I call a "two-year plan," which became 22 years. I completed my fellowship and thesis based at Dalhousie and ultimately earned my graduate MSc degree from Memorial.

At Dalhousie, I quickly became integrated into the academic program. I served as the resident research coordinator and began working across multiple academic pillars — teaching research methodology, translating evidence into clinical practice. Over my career, I transitioned between teaching, developing my own research program in obstetric anesthesia, building a research methodology unit, later moving into leadership and administrative roles. I became Chief of the Department of Women's and Obstetric Anesthesia and expanded into broader leadership at the departmental, university, provincial, and national levels.

That has been my academic journey.

Mike

Quite the trajectory! As a 4th- and 5th-year resident, it's not for the faint of heart to embark on an additional graduate school program at that same time.

During your training and the early years of practice, who were who are some people around Memorial and Dalhousie who helped to guide you and shaped you as the clinician-researcher you became?

Dolores

One of my earliest mentors was Dr. Brendan Barrett. I first connected with him during internal medicine training, and he continued to supervise my anesthesia research thesis. He played a major role in nurturing my academic curiosity.

My thesis examined postoperative neuropsychological recovery following midazolam co-induction — specifically whether patients had impaired immediate recall in the recovery room. It emerged from simple clinical observations and basic questions about patient experience.

Later, Dr. Tom Coonan, then Chair of Anesthesia at Dalhousie, was instrumental in supporting my academic career. Resources were limited at the time, but he helped secure non-clinical time so I could pursue education and research. He strongly encouraged me to follow those passions.

One thing I reflect on is that I never had a woman mentor. There simply weren't many women academic anesthesiologists at the time. As a result, I now make a deliberate effort to support women pursuing academic careers. I was the first woman anesthesiologist at Dalhousie to become a full professor, and although others have followed, I remain very proud of that milestone.

I often say, *"you have to see her to be her."* I never imagined I would become a full professor or a vice dean, given my background. One of the things that I strive to do - I try to be visible so others - to be a public face for women in medicine, especially those from similar beginnings, so they can imagine themselves in these roles.

Mike

Breaking glass ceilings, overcoming barriers. It's very inspirational! As a mentor to others now, being a role model for others – how does that challenge [differ compared to] focusing on your own personal development early on in your career?

Dolores

I love mentoring. I've served as both a formal and informal mentor to many learners. For me, mentorship starts with personal connection. And then the mentor-mentee relationship is like a long-term partnership—it often lasts three to five years or more and requires trust, honesty, and generosity. You give time, energy, and sometimes difficult advice, without expecting anything in return. Ultimately, the goal is to support both professional and personal growth. I would say, being a good Newfoundlander, that a rising tide floats all boats. When they're successful, I'm successful!

One of the most rewarding aspects is watching mentees outgrow you. That moment, when they no longer need you, is true success. You can stand back and just be the little bit of wind beneath their wings, and eventually they're flying on their own. That is the most rewarding thing that I have personally found in this career. *That* is like the best thing ever.

After nearly 25 years in practice, training numerous undergrads and five or six residents each year – hundreds of Canadian learners – these are careers and lives that you have touched. It's incredibly meaningful when former trainees approach me at anesthesia meetings and share how they remember a single interaction that impacted their day or how that experience with me influenced their career choice. People are very generous.

The other thing that I'm apparently known for is my sayings. People will come up to me and say, "Oh, I remember you saying this or this is the funniest thing that I've ever heard anybody say." Apparently, I have quite the Newfoundese, or colloquial, sayings and odd comments.

Mike

To switch gears a little bit, you mentioned the CAS, so I suppose we should talk about it a little bit too. When and how did you come to become involved in the CAS? You've had many roles over the years!

Dolores

For me, joining the CAS was about trying to connect with a community of like-minded anesthesiologists who wanted to conduct research and leaders who continued to move the specialty forward. Historically, anesthesia was very much an academic specialty. Think about the respiratory physiology, cardiovascular physiology, Swan-Ganz catheters, mechanical ventilation, all that stuff. In the 50s and 60's a lot of that work was led by anesthesiologists.

Then we had an era in the late '90s early 2000's where, as a specialty, we became a little less academic. We started to see impact of HHR shortages, with clinical work taking priority, anesthesiologists who weren't as [engaged in research].

It was 1996 and I remember saying to my department chair, "I want to go to the CAS annual meeting this year. I'd like to meet some researchers." Ultimately we started a Residents' Section in 1997.. and this is really funny.. I still have the letter from the CAS executive, establishing a new Resident Section, explaining governance and congratulating myself (and Dr. Claudio DiQuinzio, a UBC resident) on becoming the inaugural co-chairs.

I have consistently attended the CAS since and my first research presentation where I presented my MSc thesis research was in the 2002 in the Richard Knill competition – that I won!

So, I have been embedded with the CAS in many ways and involved in many aspects of the organization. I joined the Research Advisory Committee in 2004 and where I sat as the only woman for over 10 years. I became a co-chair and then chair of that committee 2015 and 2016. I finished my term in 2018 when I became CAS Vice President and chair of the ACUDA [Association of Canadian University Departments of Anesthesia] research advisory subcommittee. In this role, I then worked with the Royal College and Dr. Peter Choi at UBC on the development of a formal research methodology curriculum for postgraduate training programs.

Mike

Can you talk about your motivation for pursuing presidency of the CAS, and the challenges facing the organization and the specialty during that time?

Dolores

I was informally approached in 2014, but at that time I was happy with my CAS research roles and local institutional leadership. And I still had a young family. At that point, I did not see myself at all in that leadership role!! People sometimes say that I'm ambitious, though I don't consider myself ambitious. I've simply always been one who wants to get things accomplished. You know, [as the saying goes] if you want something done, ask a busy person to do it.

In 2017 Dr. Susan O'Leary, in her role CAS past president more formally approached me about my interest. While I was transitioning away from academic medicine and into leadership roles – if I'm to be honest with you – I had become a little disengaged with the society. I had volunteered with the CAS for close to 20 years at that point. Yet, I still very much wanted people to see that the profession of anesthesia was more than "big syringe, little syringe." Don't get me wrong, I'm passionate about clinical care and being in the OR, it is what I love most. As I stated earlier, anesthesiologists were still struggling to be seen as leaders outside the OR or as academic physicians.

Dr. Susan O'Leary pressed me, stating "If you want to make changes in the profession, here's a good place to start."

And EDI [Equity, Diversity, and Inclusion] was becoming a big thing; a thing that I wanted to see more of within the profession. We can do lots of individually, but if you want to make big, systems and organizational changes, then [you need to be in the right position].

Recall my earlier mantra, *if you want to be her, you need to see her*.

That's how I got involved with the CAS executive! The rest as they say is history!

Mike

Absolutely.

Dolores

Health human resources has long been a challenge. I certainly think that it was able to sort of unify us, in terms of being proud of our specialty and wanting to be a voice in it and a face to our specialty.

Mike

With that sort of uncertainty about the future, what would you say to the next generation of trainees and early career anesthesiologists about how they navigate these waters?

Dolores

I think professional citizenship, advocacy, and pride in our specialty are essential. As anesthesiologists, we have often been content to be the quiet, unknown face of medicine. People sometimes say, "If they don't remember us, our job is well done." While there is truth in that, we also need to step outside our comfort zones in the operating room.

I love my day-to-day intraoperative practice and the perioperative care I provide. However, evidence clearly shows that some of the biggest impacts we can have as anesthesiologists are in perioperative medicine—preventing postoperative failure to rescue and advocating for patient safety.

This is about leadership: having a voice and a presence, rather than remaining the unknown person behind the mask or drapes.

It's important for others to see that we can lead and that we *do* lead. We are the de facto leaders in the operating room; we conduct clinical research and lead evidence-based medicine; we are deeply involved in quality improvement and patient safety; and we play key roles in health-system leadership and planning. As the saying goes in leadership, *if you're not at the table, you're on the menu*.

As a profession, particularly within inpatient care, anesthesia touches nearly everything—whether through perioperative care, critical care, acute and chronic pain, interventional practice, or obstetrics. We have a broad clinical footprint, and we need to maintain it both inside the operating room and, increasingly, outside it.

What would I say to the next generation of anesthesiologists? You can have a wonderful career in the operating room; yet expanding our footprint and value beyond it will be critical to sustaining and advancing the specialty.

Mike

To be proud of what we do and not to be afraid to share it with the world.

Dolores

People don't always appreciate what we do. We sometimes look like we are not paying attention, doing sudoku all day! That is so WRONG. In my mind this means I have anticipated everything and nothing is going wrong!! I once had a surgeon tell me they never fully appreciated the role of an anesthesiologist until they saw us in action, using our skills in an urgent, critical situation. That appreciation sadly often comes when things go wrong. Folks need to appreciate everyone's contributions, skills and roles.

Lastly, I want to talk about roles and scope of practice. I often use the analogy of an airline pilot. Pilots train to fly in hurricanes and severe weather, but they don't – and shouldn't – fly every day under those conditions. Similarly, anesthesiologists are trained to work at the very top of their scope of practice, but no one can function at that level every day without burning out. We need routine days as well. And some folks need variety, such as research and academics or working outside the OR.

We provide safe, solid intraoperative care for low-risk patients and procedures, just as much as we care for high-risk, tertiary-level patients. Anesthesiologists cannot give up the easy lists and practice continuously at the extreme upper limits of their scope -it is neither realistic nor sustainable. Training for excellence is essential—but working in the mid-range of one's capabilities is what allows a long, healthy, and effective career. It is my opinion anesthesia led care with anesthesia care teams can support workforce challenges, add to provider well being and improve patient safety.

Mike

This interview has been an inspirational journey! For all the readers out there, I did train with you as a resident at Dal. I look back very fondly on those days and nights at the IWK. I very much appreciated first hand being able to learn from you and to be a mentee under your tutelage. I think issues you spoke about today will resonate for future generations to come. Thank you!

Dolores

That's very kind, Mike. I have to say that I do miss the clinical care [being busy now with university administration]. I was on call last night with a resident. Teaching and and clinical care still makes me happy. Thanks for having me.