

SCA Past President Interview Series: Earl Wynands (May 7, 2023)		
Start Time	End Time	Text
00:00:00:00	00:00:41:06	Good afternoon. It's my very great pleasure to be interviewing my mentor, Earl Wynands, from Ottawa, Canada. I met Earl and trained with him in Montreal, 1979 to 83. And you can imagine how wonderful it is to have Earl here with us at the 45th meeting here in Portland. And this is a little unusual introduction because we have Earl's team here.
00:00:41:08	00:01:12:03	So Earl was brought down from Ottawa by Ian Slezak, who is sitting Turtle's left Ian's wife, Patricia MacDonald. Did I get that right? Yes. Patricia MacDonald worked with Earl in the operating room in 1969 to 6869 when he was doing cardiac anesthesia in at McGill University. And to Earl's right is Earl's oldest child, John, who is about my age, actually, right.
00:01:12:06	00:01:50:28	And I think we're going to start the interview with a little presentation from John about being Earl's son. And I just wanted to make a couple of comments about that. You know, I come to an event like this and hear about being a world class physician, researcher, mentor that he was. And it strikes me that my siblings and I and I have five siblings when we were growing up, we had no idea we were living with this world class physician because for us he was just dad and he was a great dad.
00:01:51:00	00:02:31:10	He always had time for us. You know, he would he would come home from the hospital at the end of the day and we would hear the door rattle and everybody would run to the door yelling, Dad's on dad's home, Dad, because it was a good thing. A great thing to have Dad back home. So I just wanted to share that that our siblings and I, you know, he taught us the values that we all hold dear today and the values that I hear people talking about for him now, about the importance of, you know, understanding your humanity and things like emotional intelligence and being true to yourself and your values and his the mentoring
00:02:31:10	00:03:00:11	that he's tackled over the years. So I just wanted to put it in a make a brief comment about that, because I know this will be viewed through into the future for his accomplishments in the field of master's theology and cardiac anesthesiology. But he was a great, great father as well. So thank you, John. My thanks. Well, now it's just the two of us talking.
00:03:00:13	00:03:27:11	We've had so many conversations. When I was your resident and your fellow and there's so much I would like to talk to you about, which I can do it another time. But this time, we're going to focus on the history of Earl and your involvement in cardiac anesthesia and then your career that SCA was a part of, but only a part of, and many of the other honors and responses abilities you had.
00:03:27:13	00:04:05:10	I think it's important for everybody to understand that Earl is 93 years old. I asked his permission to tell you that and that that Earl is 100% in his right mind and remembering things better than I do. And just for those of you who might want to put this in perspective, that would put Earl about 24 years old in medical school in 1953, which was the year that Gibbons first described the use of cardiopulmonary bypass that he had developed and used for a human operation.
00:04:05:12	00:04:30:13	And not long after that, Earl in the late 1950s was providing care for some of the earliest cardiac surgical procedures done at McGill University in Montreal. And so I want to ask you a little bit about that, Earl. Tell us about those who influenced your decision to get into medical school and cardiac anesthesia and your interest in it.
00:04:30:15	00:05:01:25	It's a real pleasure to be here, and thank you, Jamie, for being present here to go through this with me. And it's a huge, huge pleasure because the SCA, SCA is so important and my life has become so much to me over the years, even though it's only since 1979 that we came together.
00:05:01:27	00:05:32:07	I think everybody should know that I'm probably a little bit different than another cardiac anesthesiologist that we're going to be talking about. I've had a very long career going back to when I graduated from McGill and Will go into that in a moment. But during all that time, you find out that I've worked with a disability, that it's been difficult and a challenge, but nevertheless probably has been.
00:05:32:10	00:05:41:10	I can't say good for me, but it is certainly has made me have a good work ethic.
00:05:41:12	00:06:06:23	I was born in Montreal and my mother and father. My mother was born in Montreal. My father was born in Rotterdam and we lived in a little village outside of Montreal, Saint-Pierre. And the house that my grandfather built for my grandmother and his children. Unfortunately, he died with the flu in 1920. Never knew the house until Saint-Pierre, but I certainly did.
00:06:06:26	00:06:34:24	And it was a lovely place to live. My family was loving and caring, and I wasn't very far from my schools where I would go to and and e.g. the Loyola High School and Loyola College. And happily, when I was living in Saint Peter, I found the Royal Montreal Golf Club, which was in Dorval, and I went up and decided I wanted to carry.
00:06:34:24	00:07:01:14	This was about 12 years old or so, and I got run off because it was just the beginning of the war. And there were some gentlemen still working there because of the shortage of jobs at that time. And so the following year I began to caddy and I ended up pro pro one day as a kid. Do you want to come in and clean clubs?
00:07:01:16	00:07:33:27	I went into the pro shop and started cleaning clubs and that two years later ended up being in the pro shop permanently. And by the age of 18 I had a professional golfers card and thought maybe I would go into golf. But I was interested in medicine and and I ended up going to McGill. I only applied to one medical school and fortunately I was accepted.
00:07:34:00	00:07:57:19	It's one of the one of the nice things that happened to me when I went. When I went to Loyola High School and college was close. I love that school. I, I think it appealed to me and my my values and everything. And I liked the, the schoolwork, but I also like the the extracurricular work that I could do at the school.
00:07:57:19	00:08:20:19	So I was involved in a lot of things, and I always found something to keep me interested. And one of the things that did keep me interested for about 72 years was Mary Grant. Yeah, she was. She and I were 17 years old when we met. We went to. I went to a school dance. Mary School and I met her and I thought she was pretty nice.
00:08:20:19	00:08:51:10	And. And it ended up. We decided that I would would we would, we would get married. And of course, it was not. When we were 17, we decided it was probably three or four years later, but that I would finish my career in medicine first. Before that happened, I we had a wonderful life together. And as you've heard, we have six children and they have been wonderful.
00:08:51:10	00:09:23:00	And in my throughout my career and our life together, Mary and I, she passed away three years ago. But in our life together, we had a wonderful time and a wonderful family life and most rewarding. And she, as you will hear it, did an awful lot of reading for me when I was going through medical school and subsequently when I was training in the in anesthesia.
00:09:23:03	00:09:53:03	I went to went to medical school and one day while dissecting a cadaver, which we all had to do in those days as medical students, I don't think is necessary now. But we we just left with the cadaver. I was told by Mike, we all we always had partners working at tables with us. My partner said, are you getting pretty close to the cadaver?
00:09:53:03	00:10:25:27	You better go and get your eyes examined. And I said, okay. And I told my my father about it. I was living at home with my father, lived at home until I finished medical school. But anyway, I did go and see the ophthalmologist when in expecting to come up with a pair of glasses and instead came up with the diagnosis that you're you're going to be legally blind shortly that is unable to read without having a magnifying glass.
00:10:25:29	00:10:50:29	And I would also be losing peripheral vision. But it would be slower. But eventually I would lose a lot of that too. But I was not likely to go completely blind. So with that information, I went out and told Mary I was in first year medical school at the time and told my mother and father the diagnosis. And you know what you do?
00:10:51:02	00:11:27:11	You're you're you're perfectly well. You feel well, except your vision is changing a little bit. But you're going to be going blind. I saw I decided it was either that or stay and go because I had hadn't. If I didn't get into medical school, I was going to think of if I seen in golf, you know that God knows what I could do in golf with the impending blindness thing, but I suppose I could have run a driving range or something because I was thinking about the driving range as part of the golf experience.
00:11:27:13	00:11:54:07	Anyway, I was accepted into medical school. So what to do now in medical school too, I tell them at McGill I decided not to. I thought I keep a low profile and see how far I could go. Mary was happy with that, and so this trend through medical school started. The first year was okay, All right. Second year, I had to start reading things with a magnifying glass.

00:11:54:09	00:12:28:17	Third year, it got more difficult. A lot of work to do on the microscope. Strangely, as a microscope to help the magnified things that I could see things a little bit better through the magnifying glass, through the microscope than I could without it. Nevertheless, I had a decision what to do. And I. I was going to be heading into the clinical years, in the clinical years where you do a lot of clinical work and go and see patients and offer to help with surgery and get involved in statics and do suturing and do all these things.
00:12:28:17	00:12:54:11	I could not do that. I did not want to establish myself as as somebody who has a disability. And the future in medicine may be limited. And so I didn't tell anybody and I kept a very low profile. I knew that going into the clinical years you had a lot of reading to do. I couldn't do all that reading and the very high one, which was pathology.
00:12:54:13	00:13:33:08	And so I, uh, I made a decision to concentrate on the theology and, and use that as a way of reinforcing my lack of the clinical experience that I would be not able to do at medical school and probably have enough to get through my four years. And that's what happened. I, I did very well in medical school actually, but I had friends who were or one friend who read a textbook of medicine with me and on weekends and and fourth years he had to do it and he said read it aloud.
00:13:33:08	00:13:55:22	For me. It was a huge benefit, great help. And I got through medical school. But in fourth year, you have to make up your mind what you're going to do. And I said, Now what in the world can I do in medicine? I can't be a family doctor, can't drive a car. Family doctors have to do. I have to drive and see patients.
00:13:55:24	00:14:22:15	I said, I can't be a surgeon. I can't study neurology. What's interesting is, is too much work, can't do it. So I was getting pretty, pretty low down in choices when I went to the Queen Elizabeth Hospital to visit a friend. And there I met two outstanding young men. They were probably just under 31. One was David Power.
00:14:22:15	00:14:48:01	He was from Ireland, and yet he was anesthesia. He finished his specialty and then a seizure, and the other was Arthur Sheridan. And he had been in family practice for a little while. And was going to decide to come back and do anesthesia. And so both these experienced, mature people were talking sense and talking good medicine to me.
00:14:48:01	00:15:10:05	And that is what I admired when I heard them talking about it was about their appreciation and love for what they were doing. I thought, maybe I'd better find out something about this. I had a couple of lectures in medical school, but, you know, they didn't tell you anything about anesthesia, so I, uh, I told them I was interested.
00:15:10:05	00:15:40:06	I did not tell them that my vision was going to be going and how far down it might go. But they said, Well, they take me to meet Dr. Harold Griffith. Dr. Harold Griffith happened to be an anesthesiologist who was the chairman of anesthesia at McGill University and who was the chief of the Homeopathic hospital. So they introduced me to him and I was able to observe anesthesia with these two chaps.
00:15:40:06	00:16:07:27	And and it was a great learning experience. I told Dr. Griffith that I was interested in going into anesthesia as a career, and he asked me what experience I had. And Otto, I didn't have any yet, but I thought, forget it. And he said, Well, when you're when you're interned, make sure you get a year of anesthesia. So when we parted on that and he said, Contact me if you have any more questions.
00:16:08:00	00:16:36:25	And so with that, I, uh, I went off and, and we, I talked to Mary. We were going to be married at the end of medical school, which we did one day after graduation or not, two days after graduating, actually. And so off I went to Bridgeport, Connecticut, interned. There were three of three other my classmates who were going to Bridgeport, and they actually told me about it.
00:16:36:25	00:16:58:28	So it sounded good, a good place to go. So of getting paid \$25 a month at the Royal Victoria Hospital, which is what interns would play with. And I would get \$250, which would be all right because we were going to get married. And I borrowed \$500 from my father to get married and and managed to pay him back in a year.
00:16:58:28	00:17:24:15	And the money that I made in Bridgeport shows you the difference in the value of the dollar. Anyway, I went to Bridgeport wondering how I would make out with my decreasing visual acuity, having to use a magnifying glass to do any difficult reading. It would be difficult doing some of the clinical things. Maybe I didn't know what I could do or not do it really.
00:17:24:15	00:17:47:12	I just had to make sure that I fulfill the contract of an intern, which in most times is doing histories and physicals and then doing the work that is called the scut work of on the floors. When you're on the various specialties, like when you're in obstetrics, you have to do certain things where you're an emergency room, you have to do certain other things.
00:17:47:12	00:18:10:08	I have to find out what I could do. And at the end of the year, I found out that I could do the skills. All right. My problem was with the reading or the charting, and I could manage the charting. All right. You can. You can write. You can write pretty well with decreasing vision and not be able to read without a magnifying glass.
00:18:10:08	00:18:33:26	But you can get along anyway that I made out and got through. And I did have a month with Leonard Del Vecchio, who was the chief of anesthesia there in Bridgeport, and I told him I was doing a month with him because I wasn't sure what to do, and I thought I might like to go into a seizure.
00:18:33:28	00:18:59:03	And he gave me a great months of training. He he had three nurses working for him and another anesthesiologist and so forth. And so they ran two or three operating rooms a day. And I was in one of those for the whole month that I was there. And much to my intense happiness, I found out that I could do the skills of anesthesia.
00:18:59:03	00:19:26:12	I had no trouble starting IVs. Well, I well, I found out that I could I could see a lot of them were peripheral vision, but I could also seal them. And I said anyways, and I could intubate people. I could ventilate people. So I, I did all right. And then anesthesia. So I contacted Dr. Griffith and told him that I was pretty sure that I wanted to do anesthesia.
00:19:26:14	00:19:53:28	And and I told Del Vecchio, the chief in Bridgeport, and he said, well, he was he had a friend who was achieved and in New Orleans, and he he could arrange a place for me down there to do a residency. And I said, Well, I better check out with Howard Griffith, because I spoke to him, too. And I called him and he said, Earle, where do you want to live?
00:19:54:00	00:20:44:19	Uh, I said, Well, I want to live in Montreal eventually. And he said, Then you better come back and and join the McGill McGill diploma course now sees you, which is what I did. I went back to Montreal, to McGill, and so I was influenced by Doctor Power and by the Overkill. Yeah, yeah. By Arthur Sheridan into going into it anesthesia and by Dr. Delvecchio, and then, of course, by the chairman himself who said, Come back with me and so I went back to Montreal, I joined the McGill diploma course.
00:20:44:21	00:21:21:06	It's a it's a three year, three year course. You go around seven hospitals and that's what I that's what I set out to do. And I should tell you that I went to Saint Mary's for it was the first one I stayed in power who was or then was working at Saint Mary's, and he took me under his wing and taught me to do to give the Montreal technique for general anesthesia, which is it's an anesthetic technique you can use for any type of surgery that's going on and is a perfectly safe way of anesthetizing somebody.
00:21:21:06	00:21:47:21	And it's a standard of a pretty medication penicillin, nitrous oxide, oxygen and increments of Demerol. And in those days, sexual calling trip for it, for the surgery to keep people quiet and somewhat like the anesthesia, it was it was a vapor cycle, propane or ether, or we had run on that. It was a it was a Boyle's machine.
00:21:47:21	00:22:07:15	And on it there was a tank, a cycle cycle, and there was an ether ball. And both were primed. And we could use them if we wanted to, to turn it on and learn how to give the cycle with nitrous oxide or with it with or without it. And what a great. Then I say, Well, that came a little bit later.
00:22:07:17	00:22:39:28	The other thing we had to learn was how to give a general anesthetic for a delivery. And. And why? Because you were on call at night and when a baby's born, a lot of them were born at night. And when are they born? Also on weekends, when the staff want to be home. So the US had to be covering the the case rooms, and that meant going in and giving some kind of assistance to the mothers for their pain of their delivery.
00:22:40:00	00:23:04:06	And and I learned how to do that. And my, my wife Mary eventually would have all over six children born that's at St Mary's Hospital with David Power giving five of the six out of six to Mary. The other one he was going to be away in holiday, was going to give up his holiday to look after Mary.

00:23:04:06	00:23:34:02	And I said, this is a no good and we got another one of the next half to look after her. But they were I did very well at St Mary's. This would have been between 1955 and 19. That's 1955 and 1958. Yeah. Yeah. And then how did you segue into cardiac? Well, I, in one of my rotations was to the Children's Hospital and the children's hospital there.
00:23:34:05	00:24:10:29	The, the surgeon there that there was a cardiac surgeon told Dr. Tony Jo Bell he had, he trained with a, with uh, John what's his name. Who did the first. Kirkland. No, the first had given John Gibson. Yeah. And he came back and was starting the, the cardiac surgery open heart surgery program at McGill, and they were doing it with the children's and I wanted to get involved to see what I could do with was this because I knew that was brand new surgery.
00:24:11:00	00:24:48:16	They don't even they only started late in 1957 and the last the first four, I think patients and I had to go in and change their oxygenation. And so when I got there, the new system was up and going. But very early on, like less than a year of operations. And I as a as go I'm in my final year by the end of the three years and I, uh, I was booked on one of the cases because of my status there at the time.
00:24:48:18	00:25:18:08	And I loved, I loved doing it and the things that the anesthetic was simple, the mortality rates were high because of misdiagnosis of the problem and, and the, the, the operation was complicated and the and the heart lung machine was brand new and everything was brand new, But there were lots of people in there. And I thought, well, maybe I'm going to be needing help because of my disability.
00:25:18:10	00:25:40:16	That was just going to increase and maybe this is the thing for me. So I showed interest and I got booked on the life course. I did about six cases helping. I was the number two, number two or number three anesthesia person on the team on any given case that was going on. But I got to have a feel for the anesthetic, that's for sure.
00:25:40:16	00:26:03:00	And it was simple. I mean, when you think of these those children and all that that day, whether they have you that they were put to sleep, was a little pedestal, rectal pedestal for one thing, worked very well. And then they were given nitrous oxide, oxygen and ether and and ventilated down and the started and I.V. on them.
00:26:03:03	00:26:28:08	And then they had one liter of an EKG put on. That was the only thing that they monitored and that was the monitoring. And there was no ventilator. There was there was we they were ventilated by hand because you controlled their ventilation. They were given the muscle relaxant curare if they needed to be quieted down, not move, or if you were worried about it.
00:26:28:10	00:27:03:20	And and it was a simple and you look at the color of the patients and for cyanosis or not and and it was it was so simple and so that information I uh I finished my training and I went to, to the Royal Victoria Hospital, but I should tell you that one of my rotations in, in my second year, the beginning of my second year, was with Dr. Griffiths at the Queen Elizabeth Hospital.
00:27:03:22	00:27:37:27	And so he's the chief and chairman and so he's my boss, so to speak. And now I'm working in this hospital and he's he's a cycle propane person then. And Ralph Waters, who discovers psychic powers first, they use it was a friend of Griffith because Griffith was started as anesthesia practice in the twenties and and in those days mean he eastern anesthesia was only introduced in 1846.
00:27:38:00	00:28:12:08	And so now you're talking 19 and 1920. He's he's working at the Queen Elizabeth Hospital. His father was the chief of the hospital. And he's interested in seizure and he's interested in controlling the airway. He's he's made a study of of anesthesia, as it should have been in those days. And he's he's he's an expert. And you have to remember in the 1920s who gave anesthetics in the operating room, when it came time to send it to it was a person who was not employed physically.
00:28:12:13	00:28:40:29	Would you pour the ether or just give the ether and he would give it a went for you got to report ether. He learned the airway. He learned control of the airway. You learned that intubate people. He was he was a consummate anesthesia technician and then super judge within anesthesia and knowledge and everything else. So I joined him for my six months.
00:28:41:02	00:29:01:24	And he taught me how to use Psycho under all kinds of conditions. I gave lots of Psycho. I learned how to give ethylene sex. Nobody else was using ethylene because it was it was came ethylene, came on to replace it to replace nitrous oxide, but it was explosive. And so it was better than nitrous oxide.
00:29:01:24	00:29:25:28	But it could blow up. So they got rid of it. But there are still some tanks on and I use it. And I became good at Circular propane anesthesia was with Dr. Harold and he would he would he was the one who introduced curare into the practice of anesthesia. It's interesting that he was the first one to use it in 1942.
00:29:26:01	00:29:57:02	And where were others for like he had he had the the intercostal in the cure area called into caution and in his desk for a couple of years before he decided to use it to try it. And other other people to the they had who had been getting a seizure who had been given Ferrari to try out. They tried it on dogs and they didn't assist the ventilation.
00:29:57:02	00:30:20:00	And of course, the dogs died and they said was not safe to use because we gave it to dogs and dogs died, so we're not going to give it to people, Griffiths said. I am ventilating people. They're I'm just like the propane. I'll just go a little bit and see what happens. And so and in 1942 I forget them.
00:30:20:00	00:30:56:06	But anyway, he, uh, he did that and it was for an appendectomy and the surgeon fought it and he assisted ventilation. Never let them stop breathing. He or he didn't give enough to start them breathing. That was a better system because the surgeon reported that all of a sudden the muscles were relaxed. And so he, he did In the next few months, he did something like 25 cases and a complete, complete success in using curare.
00:30:56:08	00:31:19:24	And within within the year, he had published the use of curare in the practice of anesthesia. So when I got there, he's using curare and cyclo for surgery. But it's not it's not curare, actually, because as soon as looked any clinical came engagement, he switched from purely to cyclo to to sexual calling because it was more control. Would you like, take it, turn it off?
00:31:19:24	00:31:48:21	And they started breathing again. They didn't know all that. They didn't know all the problems was with sexual calling at the time. But we eventually came to know. But he controlled ventilation. He believed that safety and anesthesia was critical and that allowing respiratory problems to occur was the main problem and a seizure. If you control the airway, you're probably going to have a completely successful anesthetic.
00:31:48:24	00:32:14:19	And that's the thing that he taught me to do. The other thing that and it was a real learning experience for me because all of a sudden one day he said that when I worked with him early, you better go with Alan Noble, who was the chief of anesthesia at the Royal Victoria Hospital. Yeah, the adult hospital, Yeah.
00:32:14:22	00:32:44:24	He, he, he, he took over from the, the, the chief who was retiring actually finishes the finishes rotated as rotations assignment there and, and he was recruiting Alan was recruiting the new people. And so Dr. Griff said you should go with Alan Noble perform your final year in training. There are two ways of when you finish your career.
00:32:44:26	00:33:03:10	There are two ways of doing that. Your last year you had to do one more year, you do a year in medicine and then you do. You can write your fellowship exams. You don't do the year of medicine, then you do another year of anesthesia training and you become certainly write your exam. You get you write a certification exam.
00:33:03:12	00:33:38:28	I knew I could not do a year in medicine. It's too much paperwork. I could do the skills of anesthesia. I could never be able to do all the paperwork of being a medical resident on the floors would be impossible. So I had never discussed with with Dr. Griffiths my problem, my visual problem. But he must have picked up the way I did things differently than other people and liked what I was doing because he was telling me, don't do the your medicine, go with Alan Noble, be happy with certification.
00:33:38:28	00:34:03:04	And then he said to me, Earl, you'll never need your fellowship. I didn't know what he meant, but he told me that I wouldn't need the fellowship to maybe feel better not being able to do it because my colleagues were taking the year of medicine and that was a higher level. I was going to be a second class citizen, but I had no choice and it was my way out.

00:34:03:07	00:34:30:13	So when I finished with the with my residency in the in the form, of course, I joined Alan Noble at the Royal Victoria Hospital as a clinical fellow with a one year contract for a year with them and with the the interesting thing is that my job there as a clinical fellow, when we're still talking about clinical fellows now here.
00:34:30:18	00:34:57:03	Yeah and my job there in 1958, in July was to do clinical anesthesia for the cases that were assigned to me and they signed to the clinical fellows. There are four of us. The cases that we would be able to do without supervision. And then not only that, if there was a resident, the resident might work with us and we might be able to teach the resident.
00:34:57:08	00:35:27:03	Even though we're just brand new on the job, we're gaining experience. And we also had to get involved in doing some clinical research if we were so inclined. And and we didn't have any administrative work and it was just to, to do cases. And that's what I had to do when I went to the Royal Victoria Hospital for my first, first rotation as a as a clinical fellow.
00:35:27:06	00:36:03:02	So when did you start getting involved in adult cardiac at the Royal Vic? So I met the Royal Victoria Hospital about two weeks. I finding my way around, getting used to where everything is and where I can if I have to use a magnifying glass to go in and work quietly where nobody's going to see me. And I made I made it known that Dr. Sheridan, who influenced me into going into anesthesia, that I was interested in the cardiac cases when he's in and he is in charge of the cardiac.
00:36:03:04	00:36:37:25	And so he's he's doing the vineberg. So he asked me if I'd like to help him with the Vineberg. No, I had one done, one Vineberg operation in my rotation as a resident, and that was at the veterans hospital. And I didn't know anything about a Vineberg operation when they signed me to that case with somebody else. But I found out it was a dissection of the internal memory artery and doing a so recovery and and implanting the the artery into a tunnel as it creates an event ventricular wall muscle.
00:36:37:27	00:37:04:11	And it was pretty straightforward and it was, you know, anesthesia for for a thoracotomy and dissection the internal memory artery and 2 hours later, which is longer than I probably should have taken. But we were done and and it was done under the usual Montreal technique. And but we didn't use cyclo or anything that could explode. And this is not on bypass?
00:37:04:12	00:37:32:06	No, not with cardio and not with cardio working on the heart, calling all this stuff. And we're ventilating the patients and we don't have an EKG at that. Veterans. We didn't have it. We didn't have a ventilator. And I'm a third year resident of anesthesia helping somebody. And I know the Montreal technique for doing so economy. And I've done that.
00:37:32:09	00:37:56:24	And so that's all I have to do. And and it was fine. So I arrive at the vic and I said, hey, this is the Victoria Hospital is the only hospital in the McGill program where they do hard cases. And I say and Dr. Sheerin says, Would you like to help me out in one of the libraries? Oh, yes, I would.
00:37:56:26	00:38:23:21	And so I joined them one on one and I did two. This is in the first couple of months after I'm there. So what happens, Doctor, that it's the start of Sheridan and that I should go back a little bit. They had just before I arrived at the vic they, they had decided Vineberg that he was going to start doing open heart surgery there at the vic.
00:38:23:23	00:38:57:02	And they did two cases before I got there. This is with cardiopulmonary bypass. With cardiopulmonary bypass. And they're doing the same monitoring, the same kind of anesthesia as they did at the children's. And it's still, as I described it to you. And so I arrived there, the the anesthesia team. There were three and Dr. Shepherd and two others, including the chief, are away on holiday.
00:38:57:04	00:39:20:25	And Vineberg comes in and says he wants to do an open heart case the next two days away. And he's told by Gladys Olson, who was the acting chief, No, you can't do it. The team's away and they've only done two cases, open, heart set. And he says, I got it. I got to do it. You got to find somebody.
00:39:20:25	00:39:45:06	Get somebody from the children's. No, Can't we can't take anybody from the children's. And I'm standing there and she knows I've just come from the children's, says, Can you do that case, Earl? And I'll help you. I said, Yeah, I can. I can do it. I had a straightforward general anesthetic. There's nothing. And the pump, but I have nothing to do.
00:39:45:12	00:40:05:05	So I seen the pump work at the at the children's and but I'm just taking in information what the pump does and all this stuff. And it's up to the surgeon. And the perfusion is to decide whether the pump is doing things properly. I just to look at the general metastatic and so I said, Yeah, I can do it.
00:40:05:07	00:40:40:19	So I did it with God's help there. A resident. So there were too many people on the case, but nevertheless I did that case. There was a was a sub aortic stenosis, an 11 year old boy. And I've never seen this operation done since that day. And what he did was he he they went on bypass and Dr. Vineberg opened up the aorta and and extended a backbiting instrument down through the valve and started taking bites of the subway or not occurring.
00:40:40:22	00:41:04:19	And they said there it's done. Okay. And we couldn't we were having a hard time getting him off bypass because he had what looked like failure to me. We had nothing to monitor. We didn't have a CVP or anything, you know, it was just looking at the patient, taking the pulse and blood pressure. And we had one we had one of the BCG.
00:41:04:24	00:41:41:23	That's right. And but that's all we had. And so I had to see some give some support drug. And I think I use this idea of fraternal because we had a search party and all that and we got them off bypass eventually with great difficulty. And he died very shortly to thereafter in a recovery room. And when putting them back, putting his foot down through the aorta and taking the blind bites out, he had thought the mitral valve and tore hole.
00:41:41:25	00:42:10:02	And so we were dealing then with the medical insufficiency problem and so the patient died. Well, I had nothing to do with the problems that were wrong. I, I supported the trial and got him out of the or as best as I could. But about a week later, Dr. Vineberg comes in. He said he has another case as soon as the this is Vineberg fourth cases and fourth open heart case.
00:42:10:02	00:42:33:10	Yeah. Yeah. And so it's the same old story. It comes in and says to me, let it go grab the cells. They came to me, Can you help me? Junior is the. Yes, I can help you do honestly. And you're a fellow at this time? I'm a fellow. I'm a fellow. I'm in what may be months two and the Royal Victoria Hospital and a brand new services.
00:42:33:11	00:43:05:21	Everything is brand new. Everything's new. And I'm falling into the heart cases. I didn't have a clue what was going on with the pump and all that stuff. Anyway, but I did the second case and that went. That went really well. The chief comes back from holidays. He finds out that I've done to open hearts as a fellow and the other clinical fellows, they didn't want to have anything to do with this stuff, you know, bloody.
00:43:05:21	00:43:32:02	And you could die and you might lose somebody. No way. You know, they wouldn't do that. But to me it was a life saver because I would have people around who could help me. And so that's well, that's what happened in terms of me getting a job. And then with the passage of time that's in that summer and fall into the winter, the spring time, things were good.
00:43:32:06	00:44:00:22	I was getting more and more of the hard stuff to do and and I was quite happy with that. And I guess at one point I didn't know where I was going to be going. Partway through my internship, I needed in my residence my clinical field job, rather, I had to find a job, a permanent job. And so I did.
00:44:00:22	00:44:25:06	I got to guard. It's crazy how things happened. Two phone calls on us on a Friday night, one from Toronto asking me if I wanted to go to one of the regional hospitals in Toronto. I forget the name of it now. Anyway, it was for the person to call me who had been a senior resident when I was a junior resident, and I got to know him pretty well.
00:44:25:06	00:44:49:26	And and he was he was recruiting. And so he offered me a job there. And at the same time, the same the same day I got a phone call from somebody who I interned with in Bridgeport, Connecticut, and he wanted to know if you of I would join him and and and Troy in New York. And I said I said I'll have to talk to Mary about it.
00:44:49:28	00:45:10:15	And so I went to talk to Mary. She wasn't keen on going to the States, so it looked like it was good for Toronto. Now, in those days, we worked in the O.R. and on Saturdays, part half, half staff and I go into my Saturday morning. I had these two phone calls on the Friday. I mean, it was so weird that it stuck with me.

00:45:10:17	00:45:32:23	You know how strange it was. And Dr. Noble called me into the office. What are you doing next year? I said, I don't know. I said I wanted to go to Saint Mary's Hospital, but they don't have any position there. And they they said the general said that they were going to call me if a position opened up there, but I haven't heard from them.
00:45:32:26	00:45:53:11	I said, So I think I'm going to go to Toronto. Where are you going to go to Toronto for? I said, because that's the only job I've got offered. He said, I'm offering you a job. I said, I'll take it. I said, I'll take it kind of in the department. Okay. I'm a I'm a clinical fellow. I'm being offered a job.
00:45:53:11	00:46:17:16	I have to get my exams and certificate and I not doing the fellowship. You guys are doing the fellowship. They're going to be. If they get it, then I got my certification. They're going to be much better situated than I am. But are they? I'm going to be on the staff and I'm doing I'm doing open arts and I'm doing the Feinberg's not May very many, but I'm I'm, I'm in there.
00:46:17:16	00:46:52:24	I'm doing them. And that's what happened. So we're I'm going to I'm going to jump ahead a bit now because I do have to have some SCA content in this interview. Yeah, I don't want to jump quite that far ahead. So we're talking right now about the late 1950s and then 1967. Was your publication, your essentially seminal publication on the Vineberg Procedure, which was people at this meeting have said was really one of the first articles about cardiac anesthesia that was published and it was published in anesthesiology.
00:46:52:24	00:47:26:07	Am I correct or was it was referred to as the change? You want to tell you about that? I want you I want you to tell us about your experience with the Vineberg procedure, with Dr. Vineberg and the publication that resulted from it. So Dr. Vineberg is we have two streams. You have to take the two streams, the Vineberg one, and then Dr. Vineberg doing Open heart, open heart surgery with scissors, a doctor, double who comes up from the children's now just about the vineberg I'm doing.
00:47:26:07	00:47:49:23	The vineberg is getting more and more to do with them. Dr. Vineberg saying the mortality rate for the Vineberg operation is about 2%. It's going to be a more complex thing. I got to at first he did the left internal memory artery and then he decided to wrap up survival on sponge around the his scraped. It looked like it was a potato peeler.
00:47:49:25	00:48:27:00	He scraped the surface of the of the left ventricle and and whatever part of the heart he could wrap because his scraper on to make it bleed. And then he took one sponge and his and he put it on top of the heart like a like a bun around the heart. And then it scraped the inside of the pericardium and it would close them up and said, you hope that vessels would come from the pericardium and other and take those structures in and mediastinum and latch on and go through the Avalon's sponge and latch onto the heart.
00:48:27:02	00:48:45:26	And then he decided what if one of internal memory arteries good, we should do two and then the omentum is probably better than Ivan's sponge. And so he had to get a piece of the omentum from the thorax. So we went down through the diaphragm, pulled up, omentum and. And it up and and wrapped it around the heart.
00:48:45:28	00:49:11:19	And then he did a laparotomy and other times and it got hold of a gastro of a public artery and pulled it up through the diaphragm. So it evolved from one vessel. It became three vessels and momentum around the heart. And of course, bypass. Right. This is all of the bypass. Yes. And it's bleeding bloody cases. And so I started off on the vine.
00:49:11:19	00:49:39:11	We're going now. We're we're going 1 to 2 vessels in. Let's see the momentum. And that in that first two years, I'm I'm at the Royal Victoria Hospital and we say I said Dr. Weir, the mortality rates got to be higher than 2%. We have to study this. And and he agreed with me. So we decided we would we'd give the anesthetics and just record what happened to them.
00:49:39:13	00:50:06:21	And, and to make a long story short, the cardiologists who looked after the Vipers on the floor, some of these patients, they all they all had angina. Some had it at rest, some had it on the exercise. And some who had it at rest had failure. And so the cardiologist said these people have to be dried out before they they're fit for surgery.
00:50:06:24	00:50:30:02	Okay? If people came down, they would have to you put it to sleep. Their blood pressure fell. Dr. Reimers given is and therefore he had to have this sort of running that was what they were using before I got there. The virus had been going on since 1957 or so that there's they started than the open heart things.
00:50:30:04	00:50:57:24	And when you when you were when you were given just enough into the increase, the increase the blood pressure, I said to Arthur the reason they're they're falling is they're all getting their diaries and they're coming down Hypovolemic And what they need to do have is get some fluid into them. And we found that we could decrease the needs and therefore time.
00:50:57:25	00:51:34:20	Vineberg And run the run the I.V. solutions in the ceiling and when we got them filled up again they did much better. But anyway we we were we were dealing with ongoing problems with the complexity of this surgery increased and documenting everything. And we had our discovery by by time we had 120 patients. We had the mortality rate wasn't 2%, it was 32.3%.
00:51:34:23	00:52:03:22	And the patients who were operated on who had angina at rest and had some had a failure, was 5.8. And the patients who were who didn't who had angina, but only on exercise and we put in five people died and five patients died in the operating room, five in the ICU. Who was in ICU then? It was just the recovery room with with within four days of surgery.
00:52:03:22	00:53:09:00	And there were another six deaths beyond out on the ward. And so the mortality rates were very high and we published it. And the next thing I know is I got a letter from anesthesiology and and it's it's the yeah, the, the the editor of the of a a review that they put out every August and Keats's is is putting one out and and it's Van Dam Leroy van Dam who contacted me and he he's chairman of Peter Van Brigham and and teachers from Texas and we very comes with I read a review article for anesthesia and coronary artery disease in the August issue which was anesthesiology and cardiology symposium this was 1970 70 to
00:53:09:00	00:53:36:05	be published in 70. And I'd say who were getting over my head here? And and they said, No, we got to do it. We got to do it. I'll help you with it. So Keith and Leroy Van Dam said, But we want you to do more cases, so keep doing cases as many as you can do. Get in before and beat the publishing deadline for 1970.
00:53:36:08	00:54:20:17	So we go from 120 cases up to 377. The meantime, our technique is getting better and better and the the the death rates are going down. So but by the time we do the 377 cases, we only have one death in the last 70, 78 cases, way down in mortality rates are way down. And and so we publish it with with a detailed analysis of all the things that can go wrong and anesthetizing people people with coronary artery disease backed up by 377 cases, consecutive case it's published.
00:54:20:20	00:54:46:26	I'll never forget that manuscript coming back. Read them. My God, He had red markers all over the place. Prove it. You know, not nonsense, just nonsense. Prove it wrong, I said. I think God is going to take us a year, a half to correct this thing. But I said no. But anyway, we made it, made the deadline and it got problems.
00:54:46:27	00:55:13:10	Analysis, geology. And then the telephone rang and it was from Massachusetts General Hospital. And that's Brian Dalton, the guy I interned with, one of the one of the people I interned with who had gone to the Mass General when I went to the VA, when I went to the golf course. And he's on he's on the on the hard team at the Mass General there.
00:55:13:10	00:55:36:11	Yeah, he said, I didn't know you're at the vic. We want you to come and talk to us about what you just published. I said, not me. I'm hiding from, you know, this. This guy's going blind and he doesn't want to be any any outside attention at all. Keep a low profile. Yeah, you got to come out there.
00:55:36:11	00:56:03:20	Sure, you got to go. So I said, All right, I'll come down. So I went down with my slides. I got there and the who's who of cardiac anesthesia at that time is is at the Massachusetts General Hospital. There's no doubt about, you know, Lowenstein. Lowenstein just published an article on that or it was, was or was not.
00:56:03:22	00:56:24:26	Yeah, he just published an article on intravenous morphine instead of Demerol. And then we were using it. We were starting to use and folic acid for the for the hearts and for the even for the binders we used how they when it came along with oxy for and whatever new drug came along that might be better. We tried it.

00:56:24:28	00:56:54:26	But anyway, I got this this call and what I come down and labor was there and all the bigwigs and I gave my talk and then we, we, we talked questions and answers and it's great discussion and button down and said we should do this more often. We should form a club There's everybody rooms. Yeah. Sounds good. So push for it.
00:56:54:28	00:57:02:26	We could do it. We could do it in Boston next year. The same meetings in Boston. We could do it there. Okay.
00:57:02:29	00:57:32:05	Or would you come down and join the and be a member of the of this new club? Yeah. And so that's what happened. This was with the publishing in 1970. I in Boston 71 where we're in Boston in 72 we're for when we formed the Association of Cardiac Anesthetists and they asked me to be on the executive, I said, no way, I can't keep it.
00:57:32:05	00:58:04:00	I got to keep keep a low profile. I said, No. I said, Yeah, there I am. You know, I've come up through the clinical fellows thing in first year all the way to being in Boston, talking about the ACA, and we formed it and we, the 50 people, because we wanted it to be a discussion group. And if you get more than 50, you're not going to be discussing it very much.
00:58:04:03	00:58:31:17	And so that's what happened. Thank you for for explaining the origin of the ACA. You're and your role in Earl. And eventually there were other groups, other cardiac groups around the country that wanted to join but were not able to because it was a limited membership. And that was the basis to forming the SCA. And from some of the other past presidents, we've heard some about that.
00:58:31:19	00:59:12:24	Can you tell us about how you got engaged in the SCA in the early years? Yeah, well, I had the ACA meetings. I heard some great, great things that really turned me on that I heard was the pulmonary artery catheter and the ACA and got involved in that technology as a result of it. But I also heard that that that the people who were calling up the calling up and asking to join the ACA were really annoyed and decided to form their own their own their own society.
00:59:12:27	00:59:40:00	And I thought that sounded pretty interesting. And people were calling me friends who who heard about the ACA and heard about not being able to become members, calling me to see if I could get them and I was embarrassed, really embarrassed. I know I can't do anything, but I thought this sounded good. I said, This is the now.
00:59:40:01	01:00:10:05	And now we're talking 1970, 78 or something like somewhere. And I said 78. It sounded good to me. I said, you know, I like the ACA, but the idea of having an exhibit area and new equipment and new technology and the workshops and all the programs that the the the ACA were talking about that sounded pretty good to me.
01:00:10:07	01:00:32:20	And so I joined I joined in 81 and that's how I joined. I simple as that. And I think one of the interesting points to make here is that we we saw this morning the photographs of the founders of the founding fathers of the ACA, who are all young men who, are all probably 30 ish. They were not far out of their training.
01:00:32:22	01:00:59:03	And when you joined them, you had been doing cardiac cases for 20 years. Yeah. Because at the same time we just started I started doing the, the but the open heart surgery and we had a lot to learn. And we got I mean, when we started doing aortic valve in the Royal Victoria Hospital, you think that your cardiac surgery program was going to collapse because the mortality rates so high?
01:00:59:05	01:01:35:02	I mean, you were then we were then we were doing a group of patients, aortic valve, inferior hypertrophy, thick hearts and very complex surgery and replacing aortic valve with equipment and an artificial lung and artificial pumps and all this new technology and high risk, very high risk. People started dying like flies to the point where we had to say to the cardiologist, Don't send us any more patients.
01:01:35:02	01:02:00:20	There's a surgeon talking. Don't send us any more patients in heart failure. They're more of a you got to get us patients in better shape before we can do anything. But we started things started to improve. I mean, when you didn't get the morbid patients. Yeah, well, everything though, everything had improved. I mean, the first pump we were, we were like.
01:02:00:22	01:02:32:13	Like what I describe for the open heart surgery, the anesthetic. But we got a ventilator. And then in 1969, we did a heart transplant. In 1969, we didn't even have a pacemaker. The pacemakers weren't available. We I used to propel to get the heart rate going on the on the implanted heart. And and we were learning about the oxygenated you know, were forever changing oxygen.
01:02:32:14	01:02:58:06	There's this one is better because it just gets a better better stream and we're probably going to get better flow rates. And then we we were prime priming it with fresh, fresh blood. Why? Because it seemed better. And so we had donors come in in the morning and guided us to 5 hours blood draw, maybe even more than that, maybe a seven sometimes.
01:02:58:08	01:03:22:27	And we we we that was a prime that we put into the heart lung machine. And we used to say that the patients on on pump for more than an hour. They're not going to make it they're coming out they they're going to failure and they have to wait it out longer. Everything is what you look at the x ray and the next day everything is white and they're not doing well.
01:03:23:00	01:03:46:29	And and we didn't have blood gases at that time either. I mean, you could get a P or two if you went through a very extreme process. Go into the lab and and then that then the pumps were occlusive and they were damaging the, the, the, the, the red cells and the and you're getting hemolysis and that there were all kinds of things that were going wrong with the pump.
01:03:47:05	01:04:09:12	And we're being corrected gradually over the ensuing two, three, four years. Yeah. We didn't have an entry or recovery pulsation device. I mean, that was a godsend. When we finally got a balloon, you could put in the aorta and it would augment the perfusion of the heart during diastole. It made a big, big difference and we were getting bit better.
01:04:09:12	01:04:38:21	When we I put in, I one day and one of the Weinberg's, the patient was in recovery room not doing well and the cardiologist is there. It's Morris MacGregor. And he said, I wonder what the CVP is. Cause I was saying, I think the patients under Transfused, we used to weigh the patients before and after surgery and if if they were under we, we we infuse blood to bring them up to the weight.
01:04:38:23	01:05:05:18	And if they were overweight, we were thinking that maybe they were overloaded. It was crazy. I mean, it was absolutely crazy thinking. Morris MacGregor said if. Only we knew what the CVP is. Do you think you could get something in there, measure the CVP? I said, Well, I can try putting in one of these plastic needles into the external jugular vein, and we could hook it up to a spinal monomer.
01:05:05:21	01:05:30:05	That would be good. So we did that. Vineberg was offered that, but also the hospital checking to see if the X-rays showed overload. And by the time we came up, they said, Did you bleed them? No. We had pumped in two bottles of blood because found the CVP was very, very low. And and we also decided from now on, all the hearts are going to have a CVP put in.
01:05:30:08	01:05:52:17	And that's that's how we did. That's how we got to doing CVP. And when the pulmonary artery catheter came along, we would go to rely on that very highly. And we think it made a difference by today's standards. Maybe that doesn't compete, that there's no question about it. Does it compete? But then it was a godsend, I think.
01:05:52:19	01:06:18:28	And we did. We just improved the care of these things. But the thing that really changed that was the cardiology and cardiology became available in 1973. The case was still hard being hard to look after and and Doble came in and he said here, and he had a bottle of fluid in his hand. And he said, We're going to put this or we're going to we're going to put this into the heart.
01:06:18:28	01:06:46:01	And it's called quadriplegia. But I have to tell you this story. The rest of it, too, when you you're starting that when you're starting the aortic valve, it had to go in and they had the cross clamp, the aorta to make a decision to go down, that the valve to cut it out. So the artificial valve closed and grab it and hope that everything was well, that's the way it was in the beginning.
01:06:46:01	01:07:09:03	And early, early sixties. And when they did that, the first was they went in and took it out. And so the well then as fast as they could get and hope it was in less than an hour and maybe everything would be all right. Well, it wasn't all right. The patients were did very poorly. The next thing you know, let's let's get a coronary.
01:07:09:06	01:07:51:10	We got to know that because the next thing is we'll get them fibrillation faster. We want it to start to replenish. We're going to stimulate the heart and fibrillation before that, before the they get them on pump almost. And and the next thing is we're going to perfused the coronary arteries with perfused from the heart lung machine. So you're putting cannulas into the corner of vessels before taking out the aortic valve and so there were all these things and then the there's still is this game of camaraderie and of course it's developing.

01:07:51:12	01:08:16:27	And so we're not getting it anywhere. It's just going downhill. And then it was a cardiologist solution was like turning the lights on in the dark room. You start the heart to heart and the heart recover. And then then we But in the meantime, that was that's a that's a neat nine year process versus the 1970s, right? Yeah, That's really in the 1970s.
01:08:16:27	01:08:37:27	Yes, 1973. So it's from 19. So these people that you joined at the SCA in the 1980s. Yeah. Hadn't lived through this the way you had. Yeah. At all. And you I if I remember correctly, I think I wrote this right is that you kind of rocketed up to being invited to be a leader at the SCA very soon after you joined, correct?
01:08:37:27	01:09:04:21	Yeah, I'm walking, I'm walking, I'm walking the halls and I think I figured it had to be 1973. The meeting, 83, 83, I mean, yeah. And walking the halls and enjoying the meeting. And Fozzie has the fairness who's the chief of Cleveland comes up and the president and he's No, Joe's the president. He's the past president. Okay? Because it goes like this.
01:09:04:24	01:09:31:07	Have you seen Joe? Yeah, it just let them do the ask. You ask me, what are you going to will you be the program chairman for the for the ACA next year? I said no. They're asking that. He didn't know. So he said, we want you to be the program chairman. I said, Me, no way. I can't do that.
01:09:31:09	01:09:55:05	And make a long story short, they came to me because I had for ten years I was in the process of running over a ten year period. The the McGill review course. And as the and it was a very successful meeting. And a lot of these people who are meeting now in the halls and I invited some of them out to come and speak at the annual at the overview course.
01:09:55:07	01:10:24:07	So I knew what was going on. I had, of course, and I had 20 years of experience doing open Hearts and and the what the Divine was, and that was tremendous experience, looking after coronary artery disease for 20 years before the the carriage surgery started. Hey, we were way ahead in terms of experience with coronary artery disease. So eventually I, I said, yeah, I would do it.
01:10:24:08	01:10:45:10	I do the, uh, program, the annual program. I spoke to Mary about it and my wife and, she said, Whatever you think. I talked to a couple of the people who were at the meeting from McGill. They thought it was a great that I had been asked to run the program. I took it on. And the rest is history, though.
01:10:45:10	01:11:13:00	Earl, I want to jump ahead a little bit and I want to ask you a little bit about your your efforts, successful efforts in having the SCA engage Canada. And I know that was something that you asked about when you the executive committee. Yeah, when they asked me to run the program committee, I said to them, I'll do it, but I want to be on the board.
01:11:13:03	01:11:35:14	I want to sit at the board meetings because the annual program is the most important thing that at that time the SCA was putting on for the for the members. And the only way that the program chairman and the program committee could know what's going on and and development of education and research is to be sitting at the board.
01:11:35:16	01:12:01:19	And that's all part of you need to do to run a good program and know what the board is doing. And they agreed. And then I took it one step further because shortly after that I said and, I also think that having an international sort of reputation for being a great international society is very important. And I want Canadians on the board want should all I want to always want a Canadian.
01:12:01:20	01:12:36:05	I'd like that. Okay. Always on the board, not necessarily in an executive committee, but maybe working up to be there sometime. But at least there should be a Canadian on the board all the time. And they got it. Yeah, because it made sense. Yeah. And there been ever since it has been ever since. And one of the things that the ACA did after your presidency was they initiated the Wynands lecture and that was discussed and proposed in 2008.
01:12:36:08	01:12:59:08	And then there was a big fundraiser held at the annual meeting in Vancouver that year that raised money to help support the wine and the lecture, which was first done, I think, in 2010, correct? Yeah. And and I believe at the time and I'm not 100% sure now, but you probably know that the deal was that the Canadian Society and the SCA co-sponsored this lecture.
01:12:59:11	01:13:31:13	Yeah. And the Canadians were also involved in input in nominating appropriate people to be the lecturer. Yeah, correct. Yeah. And I know you were awarded the Distinguished Service award. I think I can't I don't have the year written down here, but you got that from the SCA as well. I did. And Then I think maybe to, to conclude our, our interview which has been so informative for people who have really no very little idea about those early years of cardiac surgery.
01:13:31:15	01:13:56:27	Let's talk a little bit about your your move to Ottawa to be chair in Ottawa. That was I don't I don't have the year written down for that 1988 1988 and the Ottawa Heart Center. I think last year at the end of last year, you were awarded there was a named chair for the Wynands Associate chair for cardiac research at the Ottawa Heart to Heart Center, right?
01:13:56:27	01:14:19:07	Yeah, that's right. You were also very involved in developing simulation and raising money for that. I founded that. You founded that at the University of Ottawa. And I get I raise the money, equip it the first year and and then, of course, the pinnacle, which is the order of Canada. Yeah. Which you received. And maybe you could tell us a little bit about that.
01:14:19:07	01:14:43:11	I know it was your Canadian colleagues that got together and nominated you for that. You never really know what goes on with that because it's supposed to be absolute secrecy that nobody ever knows that they're being nominated. But like, my cousin was a was a cardiologist and he was at the Montreal General Hospital running their emergency room and stuff like that.
01:14:43:11	01:15:05:10	And one day he came up to me. I was running the Make Me Go review course and he said, I got to nominate you for the Order of Canada. One day I said, Don't waste your time. And we laughed and laughed. This is 1970s. You said, Yeah, that was a long time ago. And so then all of a sudden in the 1990, 1997.
01:15:05:12	01:15:41:26	Yeah, because I got the award in 98. So it was sometime in 98, early 98, I got a phone call. Would you accept the Order of Canada? Officer In the Order of Canada? I said, Who is this government house Government For those who don't know what the Order of Canada is, it's the highest civilian award in Canada and as Earl said, it's a it's a very it's an unusual award to get is the highest award.
01:15:41:29	01:16:01:10	And I think it's a sort of a suitable way to kind of wind up our interview, which kind of tells everybody what kind of a person you are. Earl, we started out with your son telling us what kind of a dad you are. Well, I can tell the the anybody listening to this interview that you were exactly the same kind of mentor as you were a dad.
01:16:01:13	01:16:43:14	And my whole career was launched really by you. You drew me into cardiac anesthesia and surgery, the way you were drawn into it, except at a very different era. And you encourage coming to the SCA and joining the SCA, and you mentored my my pathway in the SCA and as I mentioned at one of our conferences this morning, or maybe it was last night at the Royal Vic Hospital in Montreal, people were aware of your visual, your visual limitations, and at the same time were aware that you were the most accomplished anesthesiologist.
01:16:43:14	01:17:21:17	There. And if anybody had a relative or they themselves needed anesthesia care, you were the one that was most frequently requested. And so not only did you overcome your disability. Yeah, but I think it it probably magnified all the incredibly positive characters that you have exemplified all these years. Well, Jamie, there's one thing when we have people that want to work with us that we can say, Boy, if I could work with this, this person, they're going to become even better than I am right now.
01:17:21:17	01:17:43:13	So that's what I looked at you. Your potential was so great we couldn't lose you. Well, thank you, Ro, but this is about you, not about me. And no, that's okay. So what a great pleasure. And thank you again for coming down. And thank you, Ian. And thank you, John, for being here to bring Earl to this society.
01:17:43:13	01:18:10:14	And you can see how Earl is viewed by all of our members. I'm just expressing it in a more intense way because Earl was my mentor this time flew by. Is there anything more you'd like to say, Earl? No, I think I said my piece. Good. Yeah, I know. We. We skipped lot of stuff that was about the ACA, but I don't think that's really the most interesting part of what you have to say.
01:18:10:14	01:18:21:24	And you said the most interesting part. So thank you. Thank you.