Welcome to ASA Central Line, the official podcast series of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. ZACH DEUTCH:

Hello, everyone. Welcome back to our Central Line podcast. I'm Zach Deutch. I'm your guest host. And today we'll be talking about the subject of rural anesthesia with two guests, Dr. Suzanne Karan and William Roberts, both of whom are from the University of Rochester and were key contributors to the Monitor's issue on this important subject. So I'm looking forward to talking with them and learning a lot about this topic, which is something that isn't well known to many of us who may not practice in such settings. Welcome, both of you. Thanks so much.

So before we get started into kind of the meat of this topic, feel free to kind of just give a little bit of a biographical background kind of a life story about yourselves and your experiences with rural anesthesia. And. Dr. Roberts, if you don't mind starting.

DR. WILLIAM ROBERTS:

I came to medicine sideways, having entered a PhD program in neurobiology after having finished my master's in nurse anesthesia, and then was fortunate enough to be funded for a PhD, which then of course led me to be a physician. My intention had been to be a nurse anesthesia educator, but instead I've become a physician anesthesia educator. Along the way, I spent 16 years in rural Vermont practicing medicine in a setting with four operating rooms and six anesthesiologists providing care to one community and then providing support through relationships to four other hospitals, essentially eliminating the need for any locums in that interval of time. Return to the University of Rochester in 2019, just before the pandemic, to take on the role of director of strategy for the rural affiliates that were coming on board to the university at that time.
Okay, Dr. Karan, I'd love to hear from you on the subject.

DR. SUZANNE KARAN:

Yeah. So I come from a very different space. I'm actually from the Bronx and then Brooklyn. So compared to that, where I am now, which is Rochester, New York, is rural. And that said, my training and practice to date in Rochester, New York, is not at all what I would consider the practice of rural anesthesia. At some point a bunch of years ago, we started to acquire practices in in the more rural locations. And in order to lend a hand while we were staffing up in those locations, I did do some shifts out there and was surprised by what I didn't know about the practice, how we train our residents to practice in these settings. And now and for the last 15 years, being a residency program director, I think it's really important to develop a training program that allows our residents to be able to practice in these under-resourced settings to provide the best service that we can in that area.

DR. DEUTCH:

Okay. And just for my understanding and for our listeners, understanding, you all are both at University of Rochester, which is a large level one tertiary care center, correct?

DR. KARAN:

Correct.

DR. ROBERTS:

Yes.

DR. DEUTCH:

And of those rural facilities that are under the umbrella of Rochester, can you kind of describe what they are? For example, you know, the type of language that I understand is like, okay, it's a 30 bed hospital or that type of thing.

DR. ROBERTS:

Well, we have a corridor that's nestled in between the limits of the Finger Lakes region. So it's about 60 miles wide, runs from Lake Ontario in Rochester proper to the Pennsylvania border. And within that, the smallest of the facilities is a three operating
room hospital close to Pennsylvania. Then there's an adjacent, even smaller facility that has no obstetric services and three operating rooms. As you come farther north, there's Noise Health system, which has four operating rooms in the hospital and then a three operating room outpatient surgery center. And then a bit to the east. Canandaigua, New York has F.F. Thompson, which is slightly larger and actually fairly recently grown and now fully mature affiliate with quite a good intensive care unit. And in fact, the helicopters that now take off from the southernmost of the rural affiliates frequently land at one of the rural affiliates in Canandaigua because they have the ICU capacity beds available. So we're integrating and growing a system that's increasing the acuity in the affiliates as we develop the relationships.

DR. DEUTCH:

And are both of you all working in these facilities in addition to the main hospital?

DR. ROBERTS:

I recognize Susie as really being integral to the program, regardless of her physical presence in any of the hospitals. But I'll let her field her own answer to that.

DR. KARAN:

So I would say I don't regularly work there, but I'm getting myself credentialed to work anywhere so that I can be in any location where my residents are training, even if it's uncomfortable to do that.

DR. DEUTCH:

Okay. And just again, I'm kind of fixated on logistics because one of my … my prior job before I was in academics was a large multi-site practice. And we had a spread of hospitals, not necessarily in a rural area, but across a large area. So if I was standing in the perioperative area at the University of Rochester, what would be the furthest distance to one of these facilities you talked about within that Finger Lake corridor?

DR. ROBERTS:

82 miles.

DR. DEUTCH:
Okay. That's helpful. So going back, I guess, a little bit to the beginning or at least the philosophical beginning. Dr. Roberts, you wrote a memorial to Dr. Jacobs, who was obviously a big influence in your life and in the field of rural anesthesiology in his particular geographical area. And I guess he was also your neighbor. Can you talk a little bit more about him and how he influenced you and the field of anesthesiology in these rural settings?

DR. ROBERTS:

I’m incredibly satisfied to have the opportunity to reflect on his career and his influence. He graduated from the University of Vermont School of Medicine in 1946. So it’s mid-world war two. And fortunately for him, his graduation from medical school and transition into a training program in Pennsylvania, the war got over before he entered the war, but he was destined to participate had it not ended. But fortunately the timing allowed him to meet his wife, move back to Vermont, and as a one year intern, he entered rural medicine as a general practitioner and only through personal relationships and with the encouragement of the surgeons in our town, in Saint Albans, Vermont, he developed an interest in anesthesia to support the hospitals. He then trained, if you will, on the job under the guidance of Dr. Mazuzan and prior to that, Dr. Abbasian John Abbasian, whose two sons are noteworthy anesthesiologists in Vermont also. Dr. Jacobs was an incredible example of fortitude and commitment and service, and it’s impossible to overstate the contribution of his care to the wellbeing of our community.

DR. DEUTCH:

So I’m assuming that he was one of these type of individuals that could do absolutely anything and had been exposed to just about everything and worked in an environment with different types of equipment and resources than what we have now.

DR. ROBERTS:

Oh, I can recall from direct observation, having been invited by him to start going to the operating room in my mid teen years, watching him hold his finger on a pulse and the oscilloscope was a single channel EKG that involved strap on metal leads. There were no automated blood pressure cuffs, oximetry had not been invented, and carbon dioxide monitoring was about 25 years later.

DR. DEUTCH:

So obviously a life spent in conditions and with priorities quite different than many of us face today, even in the rural setting.
DR. ROBERTS:
Yes.

DR. DEUTCH:
Let's move on a little bit and get a little more into the meat of the topic. Talking about rural, suburban, urban, not all small towns are necessarily rural. Not all rural communities are necessarily small. Dr. Karan, can you comment on your definition, how you see -- in air quotes -- what is rural, either in life itself or in also health care?

DR. KARAN:
Yeah, it's a pretty complex answer, actually, and it depends who you're speaking to on any day. It depends who's who's paying. It depends who your stakeholders are. It depends who you're serving, which agency you've decided to log under to get funding for residency positions. It's almost so complex that it's easier to just think of who right now just doesn't have the same access to care as in a setting that's far away from an urban setting in the same way. Because if you're beholden to any specific definition, it's almost suffocating to being able to practice or be able to deliver the care. So the definition itself is confusing. I think it's more we know what it isn't as opposed to what it is.

DR. ROBERTS:
You have a very difficult time settling the differences between the definitions, but if you find yourself in a setting that has no competition, it almost is certain to be rural.

DR. DEUTCH:
That's helpful. So talking about health care delivery or capacities and the perioperative environment, we could venture to say, I think without too much argument that having a healthy, functional rural hospital is important for those communities and the people that it serves. But what type of surgeries should we really be doing? What's considered routine, not what's not routine. Obviously, you know, markers of quality and safety are usually -- number of times a procedure is performed, especially going along with more complexities, and these are issues that we we follow in the regulatory environment. So what are the barriers to providing surgeries, whether they be routine or not so routine or complex in these settings rather than doing them in the traditional suburban or urban facility?
DR. ROBERTS:

Unfortunately, the general surgery aging and the retirement rate for rural general surgeons is diminishing the demands on and the opportunities for rural hospitals to provide care for even adult general surgery patients. And it's almost never possible to have pediatric general surgery in a rural hospital today because the trainees from the general surgery programs are not arriving with the willingness to do that work in those settings if they can be recruited at all. So you have many settings that won't have a general surgeon after their current general surgeon retires. ENT, however, is a practice that it is possible to move the surgeon to the setting and for non-body cavity surgeries. The challenge of doing bilateral or myringotomy and adenoids, tonsils - these are things that many people in rural settings would like to have delivered near their home and are reasonable to deliver as long as the arrangements for the post-operative care are sufficient to make sure that the care for the patient who has a rebleed or other issue can be addressed, which creates then a very, very interesting constellation of training needs. A rural anesthesiologist who has a relationship with a facility that can solicit input from an ENT surgeon would almost definitely be required to do pediatric work. But as you mentioned in the question itself, maintenance of competency has to be part of what we look to when we design and implement training programs to put people into those settings. So I would say the relationship between urban and rural settings where trainees meet the rural setting through their training program, it would be ideal if the relationship was maintained with the training program so that periodically the opportunity to do a larger volume in succession of pediatric cases where possible.

DR. KARAN:

What I'll add to that is we've had practice now for over ten years in developing triaging for ambulatory surgery centers that are not as quite as rural, but disconnected for sure from the resources of a larger tertiary care center and developing guidelines for appropriating the right staff and resources and patients to that environment. A lot of those guidelines can be applied in the rural setting as well. So if we appropriately used our pre-op clinics in order to optimize health or to triage these patients appropriately, we can do the same kind of cases that we do in ambulatory centers with that volume in the rural settings.

DR. DEUTCH:

Understood. That makes that makes good sense. And also the commentary about kind of the aging of a certain generation of people that were willing to do certain things. And I think that's relevant in all settings. But obviously in these settings, certain people were
kind of relied upon to do more or to do everything. And so when they're gone, who will be the next? You know, I think that's a very pertinent statement. And it's true even in the big city at this point. Our patients in general, though, also talking about a similarity between any health care environment and any perioperative environment in the country, is increasingly aging, our perioperative patients. And in rural communities, we do tend to get concentration of older adults and a higher rate. You know the 65 plus population is growing in that setting and is more likely to need surgery. What are some of the barriers to providing perioperative care for this population and what solutions have been implemented? And Dr. Karan, you can start off with answering this one.

DR. KARAN:

Similar to the answer that we gave before, but just kind of expanding on it. We need to come up with the right screening and the right way to be able to communicate with patients who, because they're aging, might not be as mobile, might not have access to computers and to telehealth, or just cars and can drive long distances. And so we need to be innovative in the space, which perhaps Covid has allowed us to do a little bit more, to make centers or to allow that access of telehealth either in patients homes or close to where they live so that they can access the nurses or the doctors who are going to be able to ask them the right questions, to screen them for cases, to optimize their health in a way that's closer to their home and to be able to set them up with the resources to be able to care for them after surgery as well.

DR. DEUTCH:

Dr. Roberts, do you have anything to add to that?

DR. ROBERTS:

I attribute a great deal of credit in our case to our chairman and to the leadership in our Center for Perioperative Medicine. The department is called Anesthesiology and Perioperative Medicine for exactly this reason. And the appointment of faculty who have specific interest in gerontology to the Center for Perioperative Medicine has been an incredibly insightful move to take us into this with just exactly the right kind of people. I can see this becoming a very vibrant perioperative feature, the planning and care for the elderly patient, both to make sure that the care delivered in the operating room is safe, but also to coordinate the care so that the post-operative care is idealized. I think we're going to be modeled in the future, the approach to this that we're taking will be something that other people replicate.

DR. DEUTCH:
Yeah. And to that point and what both of y'all were talking about, I was thinking, having today just on anesthesia for two elderly patients that were receiving total joints, I wonder about the challenge of the other ancillary services that are so critical to providing good outcomes for people that are elderly and/or frail. And I'm thinking about things like physical therapy, occupational therapy and home health, you know, home nursing care. And I'm thinking that also must be a challenge in this setting.

DR. KARAN:

Actually, I teach a course to fourth year medical students called Health System Science, and there's a practical component to the course where they're supposed to develop a solution to a problem and make it kind of cool. And for years now, solutions have entailed embracing technology to serve people kind of outside the box, outside of the hospital, being able to do it at home with an iPad and getting family members involved and using wearable technology in order to gauge responses and vital signs. I think that's going to be a great application in the rural settings. And personally, in my experience with dealing with patients in the rural areas is that they're sturdy and they will get back to their activities sooner than people in urban settings, maybe by necessity or just by lifestyle. They tend to be a pretty sturdy bunch of people who would like to be as independent as possible sooner and with some facilitation in that area I think there's some optimization in all of that.

DR. DEUTCH:

And to relate a geographically anecdote, having grown up in New England, I don't have a lot of familiarity with Vermont, but certainly from Maine, I don't want to offend anybody from Maine, but Maine, people are known to to be, shall we say, steadfast. And I can think of no easier way to get somebody to ambulate than by saying, well, you won't be able to walk in four weeks. You'll still be on crutches. And and so what you're saying definitely resonates with me, but that's, of course, kind of a geographical joke.

Um, we'll move on to a topic that's going to be relevant to every person, whether in anesthesia or not, whether you're a surgical tech, parking valet, circulating nurse … We're going to talk about staffing and health care and the pre-op environment. So this is a problem for everybody. And I'm just going to kind of leave it open ended. I'd like to hear from both of you, starting with Dr. Karan. Talk to me about your staffing situation at your main hospital and then how it trickles down through that 82 mile corridor. What challenges do you see how you're dealing with it and how you see the future in that regard?
DR. KARAN:

Like most people in this country right now, our staffing situation is at crisis level. We have a huge demand for people who can provide anesthesiology and perioperative care. I don’t know how much that affects, you know, makes it worse in the rural area compared to just the entire spectrum of care that we give. In our particular practice, most of the people who I work with would like to not be in one location. They like the idea of being in a different place, maybe on different days. There’s something a little bit too routine about being in the same location. Taking into account not wanting to drive a long distance. But there’s something refreshing in our work to be able to change it up a little bit and be in different practice environments. There’s also the crisis of just travel across the United States and Covid and and terrorism, which has inspired a desire to latch on to idealism of of trainees who want these cool experiences elsewhere, feeling like they're giving back to the community in some way. And so in that sense, we've been able to sell the idea of going outside of the urban area, outside of like where our academic practice is into the frontier and understand where needs are need to be met in a way that you don't need a visa to go overseas, you don't have to take vaccines and you're not limited by Covid and being home. And so maybe what has happened to to us as a world and then the crisis in our specialty is inspiring us to both get outside of our skin when we can and find locations that that make lives more interesting for us. So, yes, it's a crisis, but also, finding in our particular practice, an opportunity.

DR. ROBERTS:

I'll tack to that and suggest that we already have evidence that our ability to staff the smaller settings is less difficult than the larger setting. And I can see an interval of time in the future, which I think we're already dipping our toe into, where the smaller setting offers ancillary staffing to the urban center. For instance, I got a call today saying that next week a surgeon hadn't told a particular hospital where I was supposed to be working that he was going to be on vacation. And so I got a phone call saying, Hey, do you mind going to the university on Monday instead of coming here? So I simply called our leadership and said, hey, I've got Monday, Tuesday, Wednesday, Thursday, next week I'm in New York and I'm not needed where I was supposed to be. How are you guys staffed now? As it turned out, there wasn't the ability to cancel the contracted staff that would have been the ideal people to not use on those dates. But I think that this is an example of a future where if we slightly over staff our rural affiliates with people who are in shared positions or non-traditional non full-time positions that will end up with a cadre of staff that can help reduce our dependence in the urban settings on our contracted staffs to meet peak demands. And the beauty of that is moving people from one place to another 40 miles for one day is a lot easier than getting rid of people that you committed to for three weeks at twice the cost per day. So I can see us
building into our rural affiliate staffing a little bit of padding and offer all new positions the 
obligation to spend some time at the big house, both for maintenance of competency 
and to reduce the dependence of the larger setting on contracted staff.

DR. DEUTCH:

This is a very interesting point and one that is very kind of near and dear to me because 
as I mentioned before, my first ten years in practice were in a large multi-site practice. 
And so I was involved in a great deal of scheduling and we were moving people at 6 
am. every day. And so that type of thing isn't for everybody. But when it's in use, of 
course, the system benefits tremendously as just in the way you described. You know, 
the issue I think is is getting the type of people Dr. Karen talked about that have that 
adventurous spirit or like to do different things. I mean, I was always like that. So it was 
easy for me. I had privileges at ten facilities. And telling them when they sign up, Hey, 
we may need you in Rochester, we may need you so and so we made you, need you so 
and so and having a core group of people that can respond to those type of calls really, 
really helps a system's ability to deal with the situation that we have now.

DR. KARAN:

At least in our practice. It is nice to have a balance, but it's also really important to 
everybody in our practice to have some predictability to that. So if I know we have our 
schedule out, let's say three months ahead of time, it's really important to everybody to 
know they're going to be these amount of days, especially if they're out in an area that's 
more than a half hour to an hour away from where we live, and especially in the winter 
time. They're happy to go to those areas. They just want to know to plan ahead of time 
when they're going to go to those areas. It can't be something like 6:00 in the morning. 
It's got to be with some planning and and some idea, Oh, when I go to that day, it's 
going to be far away, but it's going to be a different type of day. And I'm not going to be 
on call overnight there. And the case mix is going to be different. And then it's enjoyable 
and predictable.

DR. ROBERTS:

The operating principles of military medical management translate very easily into these 
settings. So I have a group of staff that I call the strike force because they're 
credentialed everywhere and they all go to more than one place regularly. And those 
are my go-to people. Today, there was a desire on the part of one of the rural affiliates 
to have the ability to honor a request from one of the CRNAs to have a day off to be 
with his family. And I watched a text stream in evolution -- the request and the answers 
and the filling of the shift took seven minutes and there were 11 responses. So having a
strike force attribute and then having other people who are willing to go occasionally when asked, and then having other people who primarily stay in one place, but it's only 40 miles to the other place and they'll go there if there's a need. It's essentially building an internal support network. You know, frankly, all rural hospitals will die in the absence of collaboration among them. So these shared anesthesia staffing pools, I can see that then translating into a model that includes shared nursing staffing pools. And we're already having conversations about rotating the weekend call service so that the only surgery done in a particular hospital would be absolute emergencies, and the sort of soft urgencies would go to one place each weekend to reduce the wear and tear on the nursing staff who are on call. All of these things are lifestyle enhancing. And really the conversations that I have with the residents when they do get a look inside one of these settings is almost always positive.

DR. DEUTCH:

You all have shared some excellent insight to this point, especially this last bit of conversation, which is really speaks to my own personal interest. Um, but right now, we're going to take a short break. We'll be back and we'll be talking a little bit about the academic angle to rural anesthesiology and possible exposure to trainees in that setting.

(SOUNDBITE OF MUSIC)

DR. DEBORAH SCHWENGEL:

Hi, this is Dr. Deborah Schwengel, chair of the Patient Safety Editorial Board. Mass casualty incidents exert extreme stress on Health Care Institutions. Hospital incident command systems and crisis Standard of care protocols exist in most hospitals, but gaps in knowledge of protocols can leave clinicians feeling unprepared. Anesthesiology departments can and must prepare by educating staff and allocating proper time and resources for training and rehearsals. These range from classroom based teaching, such as lectures, workshops, game based learning and tabletop simulations to small and large scale hospital simulations. Pay extra attention to vulnerable populations such as pediatric, pregnant, geriatric and mental health patients. And don't forget to address mental health care for patients and staff. The time to prepare is now.

VOICE OVER:

For more information on patient safety, visit asahq.org/patientsafety22.

DR. DEUTCH:
Okay, For Dr. Karan, I have a question for you as an educator and, you know, working in a variety of settings, what can you tell us about the ACGME's role in rural anesthesiology training and preparation of future anesthesiologists for this work settings? Does ACGME itself attempt to address inequities and to increase access? And if so, how are those efforts something you can tap into at a large academic center?

DR. KARAN:

So the ACGME is interested in establishing rural training programs and to help us develop guidelines in order to train future anesthesiologists, future clinicians really in any specialty in rural areas. I was actually a part of a focus group of health care practitioners in multiple specialties to sit around and chat about what are the challenges and the opportunities to practice in the rural settings, which was great. I think what the ACGME does really well sometimes is they crowdsource, they have an idea for something and they say, You know what, we're not the experts, but we're going to put it out to you guys to come up with some ideas and and just tread into those waters and develop some best practices and then allow us to help you spread some of that practice to everybody else so we can see how we can grow into this area. And I feel like that's where we are right now in developing rural training programs with ACGME. They've developed, I'd say, a virtual location for us to convene and ask questions and then an in-person thing to meet at national meetings. And they put it out there to say, you know, whatever it is that you call it, at least try to do it. Try to stick to some of the milestones and the competencies we've put out together that address health system science, which is, you know, what the American Medical Association describes as the third pillar of medical education. It's beyond clinical practice. It's beyond basic science. It's population health. It's how do we deliver the most equitable type of care to every type of patient. And let's think about how that looks in different settings, whether it's in underserved areas, in cities or in rural locations. And so that's exciting. It's exciting to be able to try things out and to innovate in this space with with the blessing of the ACGME and to be able to collaborate with them.

DR. DEUTCH:

And outside of the ACGME formal structure, the ASA itself runs a rural scholarship program. Dr. Roberts, can you fill myself and the listeners in about that?

DR. ROBERTS:

Yeah, this is a great opportunity. For anyone practicing in a setting that they perceive to be rural, they can request the opportunity to be a mentor and be listed among the
locations where either medical students or residents could apply for rotation. The medical students, of course, are critically important to identify them and bring them closer to anesthesia as a potential choice of career for their training, but also to bring them closer to recognizing that anesthesia occurs in all size communities. The opportunity for offsetting the travel and lodging expenses is really what the scholarship is for. And the application process is really quite simple and can be followed. But I think that by expanding the number of mentors, the impact of that program would be fostered. So I'd encourage anybody who's interested in being a mentor. It's been an incredibly satisfying experience for me. I can't actually tell you what year I began being an ASA rural scholarship mentor, but I know that it was at least 25 years ago and. Occasionally run into students that I meet in meetings or when I go to educational events. And it's always fascinating and satisfying to hear where it took them. Where are they now? It also is a way for young people to find a potential job. Nothing better than going somewhere, having a rotation, getting to know the quality and features of not only the clinical environment but the community itself. So if there are residents who end up listening to this, I would encourage them to consider applying for rural scholarship funding to do a couple of weeks in some rural place if they think that they may be destined for a rural track career. A fantastic and satisfying experience to have these young people and their curiosity adding to the satisfaction that you get delivering care in smaller settings.

DR. DEUTCH:

For listeners who might be very intrigued or attracted by that idea, what would be their first point of entry into this process? Where would they go?

DR. ROBERTS:

The society website has rural scholarship. They can just keyword it in. The mentors and the students or residents have to be members of the either resident or student members. And the application is quite simple, both for becoming a mentor and for applying for a scholarship. So they just go to American Society of Anesthesiologists and Keyword in rural Scholarships, and you'll go directly to that page.

DR. DEUTCH:

Very good. In these practice settings that you've that you've all been in, can you share a story about something particularly funny, crazy unusual that happened to you? And I'm thinking about, for example, your mentor, Dr. Jacobs, maybe being paid for his services with chickens or something like that. Any of those type of stories that might be entertaining for our listeners. And Dr. Karan, I'll start with you.
DR. KARAN:

So coming from the Bronx, for me, it's always about a patient who, you know, is just going to get up and go. In a way that it never would have dawned on me that I have to make you ready for this particular activity after your surgery. But it was a teenage woman and she had just had an orthopedic surgery and she seemed to be distressed afterwards. And I thought maybe it was nausea or it was pain. And I was worried she was never going to leave the center. But it was she was thinking about literally how she was going to milk her cows when she got home, which I couldn't wrap my brain around. And I had to get some nurse to come and help me have that conversation with her. So it's important to know who you're taking care of and and and who are your stakeholders when you're having your perioperative conversation about expectations.

DR. ROBERTS:

I was at Dansville, New York, and ran into a patient who I knew from the diner of Wellsville, New York. Literally, I seek out the greasy spoon watering holes to learn more about what's in a community. I get up in the morning and go and see who it is that has coffee with who. And I just happened to run into a patient in one hospital that I knew from the diner of a hospital 40 miles away. And those are the kinds of lattices of interaction that you could never predict occurring. But the opportunity to meet people and impact them and have them remember who you are, even if you're going to multiple rural communities, is a tremendous positive reinforcer for myself anyway. And I would encourage any student that is looking for a rural scholarship from the ASA to consider reviewing the diner quality as a major component of the experience.

DR. KARAN:

Not just the patients, but the people you work with in those situations. I haven't even practiced very long in one setting, but it was small. It was just three operating rooms and usually only 1 or 2 were open on any one day and we didn't have a huge volume and it allowed for opportunity to just talk and get to know people without a lot of production pressure. And time to actually sit and eat together, which I do not have a lot of opportunity to do in the big academic center. And sharing of food was a really big deal in this small setting. And a lot of the foods that were shared were not common to to what I ate. And I'm Jewish and and nobody knew about what a matzo ball was. And that was surprising to me. And so I brought in matzo ball soup one day and they had never had it. And I've tried some things that I've never had before, too, and I don't see a lot of the people in this particular setting very often. But sometimes I bounce over there and
they bounce over to the big hospital and we greet each other with big hugs and I feel like we've had some wonderful shared experiences.

DR. DEUTCH:

Well, you all have provided a lot of very interesting insight. Again, a reminder, anybody who's interested in mentorship, definitely seek out the ASA website and pursue that opportunity. Something that I think if I had been cognizant of that when I was a trainee, I definitely would have availed myself. And I'm sorry I kind of missed that. Dr. Karen, Doctor Roberts, thank you so much for your insight and just very eloquent presentation of your guys practice situation and adaptations to urban and rural environments. And my hats off to the work that you all are doing at University of Rochester. Sounds very, very progressive and very adaptive and I think could be a model for many of us in this country.

DR. ROBERTS:

Thank you so much for having us.

DR. KARAN:

Yeah, thank you.

DR. DEUTCH:

For listeners, thank you for tuning in. To learn more you can always visit monitor org and we look forward to seeing you back for our next Central Line podcast.

(SOUNDBITE OF MUSIC)

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