Central Line
Episode Number: 113
Episode Title: Generations of Anesthesiologists Live from ANESTHESIOLOGY 2023
Recorded: October, 2023

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VOICE OVER:

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

DR. ADAM STRIKER:

We are here for the Live ANESTHESIOLOGY 2023 Central Line Podcast here at Center Stage at the Exhibit Hall in San Francisco. And today, honored to be joined by several colleagues of various experience levels to talk about the specialty of anesthesiology, how it's changed, and how priorities have evolved over time as it pertains to the specialty. And so let's introduce everybody, and I'm hoping for an interesting conversation. Thanks for joining us.

DR. ABIGAIL SCHIRMER:

Hi. My name is Abigail Schirmer. I am a CA1 at the University of Florida, and I am representing the younger generation of anesthesiologists, and I'm very excited to be here. As of this morning, I am the newly elected president elect of the Resident Component, so I am excited for the next two years of that term.

DR. STRIKER:

Congratulations. That's fantastic.

DR. MARK SINGLETON:

I'm Mark Singleton. I'm a pediatric anesthesiologist. I trained right here in town at UC San Francisco. I spent 30 years in private practice in the South Bay in San Jose, and I'm currently working part time both at UCSF and at Stanford. And I do pretty much exclusively pediatric anesthesia now, although for most of my career I did everything including OB and cardiac and everything.

DR. RICHARD HIMES:

My name is Rick Himes. I'm from Austin, Texas. Have some connection with Abigail than that I did my fellowship at Gainesville at the University of Florida many, many years ago. Been in academic practice there for a couple of years, but then since then, private practice for 40 plus years, sort of done it all, have been chairman of our department a couple of different times. And just this past April went to my 50th medical school reunion, where I was the only person who was still working part time. And I took that as a sign and have basically fully retired now.

DR. STRIKER:

Well, thanks, you guys, for joining us. There's a few specifics that maybe during the conversation I'd like to get into, but let's start off generally talking about the specialty. And from each of your perspective, how has the specialty evolved since you've been in practice, and what are things that you have noticed that maybe you are more or less concerned with as that evolution has proceeded? Dr. Himes, let's start with you.

DR. HIMES:

Yeah, it's it has been such a enormous change. I joined a small practice in Austin, Texas, in 1979. There were 11 of us, all physician anesthesia practice. And over the course of the next 40 years, partially because of the location in Austin and the dynamic growth of the city, it has been an explosion of population and our practice and the nature of the practice. Just in terms of the dynamics of it, I was -- I'm going to express a bias in that I was pleased to have the majority of my practice years be as physician only practice. We transitioned then at one point to anesthesia care team model, and that was an adjustment for us. But it became clear just the value that that brought to the table and allowed us to continue to provide the kind of service that we needed to. That was one of the biggest sort of demographic changes. Clinical changes, I mean, I can sort of go on and on from training with copper kettles and cyclopropane and halothane to what we do now. And it's I mean, it's just enormous change that has occurred.

DR. STRIKER:

You basically laid out, I think, maybe the agenda for this discussion succinctly. So we'll circle back to a couple of those issues. Dr. Singleton, how about you?

DR. SINGLETON:

Well, the changes have been enormous. I was a resident in the early 80s. Pulse oximetry was a brand new invention. People didn't use very much. We took manual

blood pressures and looked at the color of our patients lips, entitled or even expired carbon dioxide, I hesitate to call it end title, because the machines that we had were so inaccurate that it was often difficult to measure. So we're able to take care of sicker patients in a safer way now than we ever could before. The practice of anesthesia has become just tremendously safer. On the other side of things. You know, this was in a day when we were all independent practitioners. Groups hadn't really formed as business entities in terms of anesthesia groups. So certainly the business model of anesthesiology has changed with consolidation and changes in the marketplace. And the other big change is in subspecialty training and practice. I introduced myself as a pediatric anesthesiologist. When I was trained, we did everything, took care of little kids. We took care of obstetrical patients. Some of us did cardiac. But when you joined an anesthesia department, both in private practice to a lesser extent in academics, you really were expected to be a fully trained anesthesiologist capable of continuum of anesthesia care. Nowadays, I think for the good of patients, we have subspecialization and we have concentrated tertiary care and centers that are capable of taking care of patients better. So all in all, you asked me what I'm less worried about. I'm pretty much less worried about a lot of that stuff. The actual business of medical practice, especially in anesthesiology, is a dynamic that I think is in tremendous flux right now. We're going to see where that all sorts out. But financing of health care is still an enormous problem.

DR. STRIKER:

Sure. Dr. Schirmer?

DR. SCHIRMER:

My experience here in the field of anesthesiology is much more limited. My first ASA annual meeting was in 2016, and since that, I would say that I think some of the biggest change are some of the smaller components of day to day practice. So a couple of weeks ago was my first time ever using Neostigmine, because I have the honor and the privilege of training with Sugammadex. And my attending and I had a full discussion about the use and the dosing. And she said, you know, ten years ago, Sugammadex wasn't readily available for use, and just small technological and pharmacological changes in day-to-day practice. And, you know, those things will continue to change and evolve and affect day to day life in the operating room.

DR. STRIKER:

I was wondering about, from your perspective, the pace of change Do you feel the pace is rapid?

DR. SCHIRMER:

I think that the change in education and in training has changed dramatically with Covid 19. So just in the past couple of years, the way that things have changed and the clinical practice has changed because of the impact of Covid, not only on our education in the classroom, but then it translated into the operating room delayed cases, lack of cases. And now I think we've we've kind of regained those that caseload.

DR. STRIKER:

Excellent. Well, thanks. Thanks for the perspective. But let's start talking about the skill sets. The later career anesthesiologists, how do you feel skill sets of current trainees, younger physicians have evolved? Do you feel like that is a problem? Do you feel like it's they're better now as technology has advanced? You mentioned Dr. Singleton doing cases with patients and watching the color of their skin. And we still watch those things, but we have so many monitoring capability now. Do you feel like that technology has caused skill sets to not …

DR. SINGLETON:

You know, it's really interesting to see where those skill sets are because they're not a homogeneous thing. I know that my younger colleagues, even even the woman sitting to my right here, is a better regional anesthesiologist with ultrasound guidance than I am, and that I will ever be. But also, you know, I've had an opportunity to, at this meeting, work with our global scholars who practice in low resource environments. They are really tuned in to the very basics of anesthesia. They have their hand on the reservoir bag. They have a different skill set because of the environment of practice that they work in. And I'm often asking my residents, you know, feel this bag here, feel what it feels like to ventilate this patient. We're focused on electronics. We're focused on technology. We're focused on the ventilator settings. And I think that if anything, it's important for me, my presence in the operating room and educating my residents, is to learn techniques that I practice when I go to other countries and practice in that environment. So anesthesia is a big world, and I see it from a global perspective. There's real value to learning about the techniques of the past. So that's my take on it.

DR. HIMES:

I agree with Mark in that more newly trained practitioners certainly have skill sets that I don't. But when I was at the University of Florida teaching, one of one of the things I found myself often doing in the operating room was taking a resident by the shoulders and turning them from looking at the monitor to looking at the patient and having a hand

on the patient. When I trained, you almost always had a hand on a temporary pulse and a hand on the bag. You were watching people. Those kinds of clinical observational skills are ones that I hope are being developed and nourished in more newly trained clinicians. They come out with hugely good skill sets and other things, but just paying close attention to patients pre enter and post operatively I think is the skill that needs to be nourished.

DR. SCHIRMER:

Well, I will ease your concern there because I have an attending that he would ask, how do you know that the tube's in the right place? And I told him, oh, well, I'll auscultate, and you know, the capnography, he's like, no, no, look at your patient. Look at the chest rise. And that's it's totally true. You know this, the younger generation does have the technological advances, but I do believe that the physical exam and the focus on the patient is still being taught. I do think that there's some more advanced skills that are being developed in a simulation setting. And the technological advances in simulation have greatly advanced the more technical skills, and just residents are able to now utilize those simulations to further advance their skills for when they do get the opportunity to learn those skills on patients, they're familiar with the technology.

DR. STRIKER:

You mentioned how the practice format has evolved, the care team model. And, Dr. Himes, let's start with you on this. How do you perceive the care team model evolution positively or negatively over time?

DR. HIMES:

It was an adjustment for me and our practice because we had been in all physician practice for many years. And it took time to develop an understanding of the skill set that CRNAs brought to the operating room and to develop trust in those individuals. But over time, that happened, and I will wholeheartedly endorse those that are really well trained, really dedicated, and look at their job as a profession, not just a job. And they're part of the group practice and the culture of our practice. And that's been a really developmental process that has gone very positively. The sort of derivative negative is that as the care team model has grown, the practice has gotten busier and the demands have gotten greater and greater. And to to try to meet those demands, it proven to be more of a struggle and stress on everyone in the system.

DR. STRIKER:

Dr. Singleton, how do you feel?

DR. SINGLETON:

Well, I've always practiced in California. It's a state that, by and large doesn't have a lot of experience with a care team model. We we have a predominantly a state that has predominantly physician only practice. Having said that, though, we work more with nurse anesthetists here at UCSF and even in a pediatric environment, which most people think of as a fairly high acuity specialized care. I work with a number of CRNAs who are expert pediatric anesthetists. And I think it's like everything, you know, you have people who are dedicated and diligent and you learn to trust each other, and that comes with collegiality and interaction.

And when I work overseas and I work in other environments of care, we work with all levels of providers of anesthesia care from medical officers and parts of Africa. It's a very similar kind of thing where there's a delineation of care between people of different levels of experience.

I think it's also valuable for our trainees to work as much in those kind of environments as they can, both to learn the kind of clinical care that is hands on and technology independent. Every time I go on a trip with a resident somewhere, they always come back and say, wow, I can't believe how much I learned on this. Not about doing ultrasound guided nerve blocks, but about real, really being a doctor.

DR. STRIKER:

In general, medicine has evolved to delegate a lot of responsibilities that physicians used to undertake. And from a 10,000 foot perspective on that, and not necessarily even specific to anesthesiology, do you feel that that is overall, from a public health perspective, a good thing, as opposed to physicians being maybe involved in all the detailed management.

DR. SINGLETON:

Bigger practices, especially academic practices, but also at Kaiser, where I occasionally work, here is a big hospital system. Nurse practitioners have been super helpful to us in perioperative care. You know, I really rely on the workups that nurse practitioners do for me so that I can quickly become acquainted with a patient and then focus on the things that are most important to me in planning my anesthetic. So yeah, I think it's great that we have people that are helping us do our job.

DR. HIMES:

From a global perspective, public health perspective, physician extenders have been an enormous value and will continue to be.

DR. SCHIRMER:

Particularly in the primary care setting, especially in underserved areas where they may not have a town doctor. They may not have a physician that is in town. Having that reach with a team model may be more beneficial in expanding the access of care.

DR. STRIKER:

So on the whole, a good thing maybe trying to strike the balance between access and quality of care delivery. Well, Dr. Schirmer, what do you foresee as a concern for the future coming newly to anesthesiology, from your perspective?

DR. SCHIRMER:

I think there's a lot of interesting things happening, not only at the state level, but in Washington as well, just with the scope of practice and discussions that are being had. I mean, we touched on it briefly at the resident component meeting this morning, just about some of the things that are happening at the federal level and trying to protect the physician anesthesiologists role in the VA, and ensuring that our veterans are going to be receiving the best anesthetic care from physician anesthesiologists and the safest care. And I think that in the next few years, there's going to kind of become a turning point in where the legislation will go.

DR. STRIKER:

On that issue. You think you're concerned, perhaps maybe this is maybe the pendulum swinging.

DR. SCHIRMER:

It could be. It could be.

DR. STRIKER:

It's a concern.

DR. SCHIRMER:

Yeah, it's a concern.

DR. STRIKER:

The statement I often hear as it pertains to anesthesiology is we are often victims of our own success. In other words, we have made anesthesiology as a specialty, a very safe one over the years. It didn't used to be like that. And as I throw that statement out there, does it resonate with all of you? I want to hear your thoughts about it?

DR. SINGLETON:

It for sure resonates. We are you know, we have clearly made anesthesia safer, but our patients always will challenge us in the environment that I work with. You know, I'll be doing an MRI. I mean, what can be easier than that? But, you know, my patient has so many comorbidities and airway management issues and all kinds of problems that even the simplest case becomes complex. So as we have extended the boundaries of safety and care for our patients, we're taking care of older, sicker, younger, sicker, and just plain sicker patients. And and I think that we're always going to be challenged by that. So when I hear that we're going to be replaced by nurse anesthetist, robots, AI, whatever, it is not going to happen because it's always going to depend on our judgment, our medical training. And, you know, the buck always stops with us.

DR. HIMES:

I couldn't agree more. And, you know, the fact that we're victims of our own success, I mean, this society has been the example of pushing forward with patient safety issues, with the anesthesia patient safety care initiatives that began a couple of decades ago. We have pushed the boundaries. We're no longer just providing care for younger, sicker, older, sicker and sicker people in the operating room. But it's the NORA cases, the ones outside of the operating room where you're on your own, you don't have the support and you really need the kind of judgment and skills that you hopefully have developed to maintain that degree of safe care, safe clinical care in those settings.

DR. SCHIRMER:

I would absolutely agree. I do think that the patients we take care of have more comorbidities. They are sicker. They are undergoing more technologically advanced procedures that may pose other risks. There's more sicker patients that are coming to surgery centers where the resources may not be as robust. And I think that the trainees

nowadays are taking care of these sicker patients, and they will rise to the occasion of being able to take care of them in the future as well.

DR. STRIKER:

So I work a lot on the communication side, ASA. Do you feel that we need to somehow message that better to our colleagues or the public? The idea that, you know, we're still dealing with some pretty acute issues and the necessity of anesthesiology involvement in these these arenas is is present, that the necessity is there?

DR. HIMES:

Yeah, absolutely. I think it's always been there and we've gotten better at it. But it's still a we still are sort of the person behind the mask and the the reality of our presence and the reality of what we do is not appreciated to the degree that I think any of us wish it were. So the more the ASA and we individually can do, the better. And one of the things that I, I am particularly insistent upon, or try to encourage people to do is, you know, be the patient advocate from with the patient and the family from the time you see them pre-operatively, post-operatively. And after you finish an anesthetic, don't just go on and do the next one. Go out and talk to the family. Because unless there is some enormous time crunch, I think that is vital to do to reinforce our presence in the role that we provide for these patients and families.

DR. SINGLETON:

As a pediatric anesthesiologist, my perspective is a little bit different, but I always, unless there's something that prevents me from doing so, I always go out into the lobby of the hospital, find Mom and Dad or whoever's there, the family, and sit down just like the surgeons do, and talk to them about their kid, what happened, how things went, and and if I can, I'm the one that brings them back into the recovery room. So I think that personal connection of, you know, being a doctor, not just a technician, is so important, but it it depends on us as individuals to do that. Right? No PR campaign. No. You know, whatever it is out there that we're trying to create is as effective as our interactions with each of the patients that we take care of. And we're all the ambassadors for this.

DR. HIMES:

And that's right. And when I started in private practice in Austin, I trained at the University of Virginia. Fritz Berry was my my mentor, and I did all of the pediatric cases in in Austin for years before there was specialty training in pediatric anesthesia. And I

totally agree with exactly the approach that you described. And it's just vital that we be our best representatives.

DR. STRIKER:

So, Dr. Schirmer, you're okay, early in your training, you may not have even gotten to this yet. Then is this an aspect of training that has been emphasized?

DR. SCHIRMER:

It absolutely is. Prior to my CA1 year, I did an intern year in surgery in Detroit. And you know, as as a former surgical resident, you get a list of patients and you round on them in the morning. And it's one thing to stand at the doorway, ask them, you know, how are you doing? It's another thing to go and sit at their bedside and actually talk to them. How did their night go? Did they eat a meal? And I've really tried my best to do that with my patients in the pre-op area. I'll pull up a chair and I'll sit at their bedside and talk to them. I'm not going to stand at the foot with the consent forms and just, you know, I'm going to talk to you about your anesthetic today. I really do try to get to know them so that they do feel comfortable with me as I'm rolling them back to the operating room, as I hook them up to monitors. And I think that the level of anxiety that patients have surrounding their anesthetic and their surgery is somewhat elevated from that.

DR. STRIKER:

That's what you do, is that you're the your teachers, is that something they stress?

DR. SCHIRMER:

I would say that there is a large stress on not only doing that with your patients in the pre-op area, but checking on your patients post-op. Obviously, there's a tight turnaround, especially as the resident who has to go waste the medications, who has to go set up the next room. But I had an attending that that told me, hey, if you can, if you're able to, it's a great idea to go check on your patient's post-op, because then you can kind of develop a sense of what works and what doesn't.

DR. SINGLETON:

When I'm working with a resident, I frequently will say, listen, I'll stay here in the OR, go over, go to the recovery room, you know, see the patient, say goodbye to the family. You do that.

DR. SCHIRMER:

Right. Well, I actually just finished up a two-week dedicated PACU rotation where I was solely in the PACU, and I, you know, I received handoff from every case that came in, and I took care of the patients that were in the PACU, whether they had some ponv, whether they had extra pain that wasn't already covered by the set PACU list. And you really developed a sense of what concerns they had before and how alleviated they were after, and especially with the pediatric population, when the parents come back and they're just so happy to see that they made it through safely.

DR. HIMES:

There's a real difference, I think, here, between academic and private practice, where the academic setting lends itself a little more easily with the kind of coverage from faculty to residents who can perhaps make the effort, see families. In a private practice setting, the pressures for performance are significantly increased to a certain degree, but I think that's where it's really vital that members of our specialty cultivate being good hospital citizens, being really tuned into and connecting with all of the other medical specialties in the hospital, the administration, so that they understand to a better degree than they would otherwise, what we do and why what we do is important. And so that if you need to take an extra 2 or 3 minutes to go out and talk to a patient post-operatively that isn't viewed as dereliction of duty. And that I think is is really an important part of how we maximize our benefit.

DR. STRIKER:

Well, you know, I, I practiced in a variety of settings. I do pediatric anesthesiology and it, there there are times it is very challenging, especially when you're out of training and you're tasked with some pretty high turnover.

DR. HIMES:

And you've got a little ones.

DR. STRIKER:

In an academic setting too, because you're, you know, you're spending a lot of time with the trainees and the operating room. And then it's like, I've got to do pre pre-op for the next one. I got to be ready. I got to go wake up the next kid. And I you know, and you want to do those things and you end up even when you have that on your mind of wanting to accomplish it, it ends up getting lost,

DR. HIMES:

Sometimes it does.

DR. SINGLETON:

I wonder also, though, if we don't impose that on ourselves to some degree, we feel like, you know, we've got to get things going. And maybe that's something that we take on, that we should question ourselves about, you know, and take that time, that two extra minutes or whatever small bit it is to make that human connection, to be that doctor that you want to be..

DR. HIMES:

That's happened within my group practice. We had a meeting some years ago when I was still working, mostly part time. And as we were in the care team model and a lot of people were expressing some discontent about satisfaction in their jobs. And, and I tried to point outm one of the things I think will contribute to your feeling better about what you do is making the effort to make more of a connection preoperatively and Post-operatively.

DR. STRIKER:

Yeah, stole my next point. That's exactly. I was actually say that next. I was going to say that I have to think that that is a significant factor in curbing a lot of burnout, for lack of a better term, or enhancing well being at work for a lot of us.

DR. HIMES:

I think it enhances your own sense of self accomplishment and and value of what you do. And that's certainly I think does translate into not having perhaps as much burnout.

DR. STRIKER:

Dr. Schirmer, what do you enjoy most about the job so far? Is it that? Like, does that when you get to interact with the patients and see how well the anesthetic went, and talk to them both before and after? How do you look at it that way?

DR. SCHIRMER:

My favorite part of my job is the people, and not just the people I work with, but the patients I take care of. I love waking up and going to work every day, because I know that I'm going to take care of patients that come to the University of Florida in are usually Florida residents, which I have a passion for. And I also get to work with wonderful people. So first and foremost, I love taking care of the patients I take care of and easing their fears, answering their questions. And if I can't answer them, I'm going to figure out a way to get those questions answered, whether that be my attending or a fellow or somebody more experienced than myself.

DR. STRIKER:

I've already accelerated your … Along those lines. What do your colleagues think in training? Burnout has got to be a big topic amongst residents because it's all we talk about it a lot in all sorts of avenues. Is that the consensus?

DR. SCHIRMER:

So I think that burnout is something that everybody, you know, everybody approaches differently. I think that everybody has some degree of it. But it's how, what's, what's stemming that burnout. For some people it's, you know, long hours. For some people it's maybe you're not located near your family. For some people, it's well, I feel like I'm struggling to keep up with my studying and just that constant nature. But I think that when you enjoy the work that you do, that degree of burnout is is definitely lessened. And if you have some sort of outlet to enhance your wellness, you can also diminish the impact that the burnout may have on you.

DR. SINGLETON:

You know what, what you said a minute ago about burnout being contributed to by that, that constant pressure. I think that the antidote for a lot of the feelings that we have about our production pressure is to feel gratitude. And if we don't allow ourselves to experience the gratitude of our patients for the care that we provide them, we're really cheating ourselves out of something important. And and we're we're missing a professional therapy. And I think that I think a lot of people get caught up in that. And and that may be the reason why, you know, at the end of the day, you're just so exhausted. And so you feel demoralized. And because you've been trying to follow a different paradigm of production and, and efficiency and all these other things and that human connection that's so important that makes us understand, you know, why we became doctors. I don't think we should miss that opportunity. And sometimes I think I don't think we give value to it the way that we should.

DR. STRIKER:

Dr. Himes?

DR. HIMES:

Yeah. I want to sort of circle back a little bit. And you asked Abigail what what she enjoyed the most. And good answer. And I think we all would identify with that. And the challenges. I did a lot of pediatrics, but I did everything else too. And I looked forward to those clinical challenges every day. That was why one of the reasons I switched from internal medicine to anesthesia, because I wanted a broader spectrum of kinds of patients I was dealing with. But I want to move this toward the difference of the things that are important to you now, and the things that became important or become important, I think, to people as they get later in their years. And I think it's vital for people as they're making decisions about what kind of practice environment they're going to be in to, to ask and have answered questions about what are the values that this practice has or this academic department has that allows someone to not practice till they drop, to give them a glide path to reducing their workload as they get older. And I'm not talking 40 or 50, I'm talking when people are in their 60s. I practice until I was I mean, I'm 76 and just stopped working part time a few months ago. But without the ability to work part time, it really makes it much harder. And I went through a phase with our practice. It was not willing to come to terms with how we provide people with alternative ways of practicing. That's changed now, and it has been to the benefit of everyone in the practice and the practice itself.

DR. STRIKER:

When you were practicing some years ago, burnout wasn't a term probably.

DR. HIMES:

It wasn't.

DR. STRIKER:

But did you do you think, oh yeah, I dealt with the same issues?

DR. HIMES:

I mean, I went through a period where I was when I was trying to get people in the practice just to understand the concept of less than full time work, job sharing, partial

whatever. It went nowhere for several years, and I almost threw my hands up. You know, I got clinically depressed. I didn't know what to do. But with the change of attitude and a help from a real good friend who was a psychologist, I sort of got over that. Finally, the practice saw the benefit and it allowed for not just me, but many others who followed to pursue a different kind of trajectory as they get further and further into their careers.

DR. STRIKER:

And Dr. Singleton, do you think that then overall this is a service or it's a good thing that we're highlighting this now as opposed… it's not this was occurring before, but we didn't do a good job of recognizing it and treating it.

DR. SINGLETON:

Absolutely.

DR. STRIKER:

The attention we are or is appropriate now and is beneficial.

DR. SINGLETON:

Absolutely. I mean, it was always when we trained, ingrained in us that you didn't complain. You worked long hours. I mean, the word intern and resident imply that you live there. That's your life. You are literally, like, entombed. You're interned in the hospital, you know, that's that's why they call it that. And we were expected to just accept that, you know, I live at the hospital because I'm a resident there. And that really got into everybody's mindset, at least in my generation. I think it's healthy that we're recognizing that that's not a reasonable way to train human doctors, doctors with humanity. What we did resulted in divorces, addiction, all sorts of other behaviors that were maladaptive and harmful to both us and our patients. And I think that, you know, we're recognizing that there's a different way to to do what we do as well as we have ever done it, but better.

DR. SCHIRMER:

What you said just reminded me of one of the most recent anesthesiology articles that showed that risk factors for burnout actually are working over 70 hours a week and working more than seven overnight calls per month. And that's very much so what I did last year as a surgical resident, and I definitely don't do that now. And I think that

programs, residency programs and residency leadership is trying to make an effort in very conscious effort to reduce any of those risk factors in the development of resident burnout, which still very much so exists, and very much so still is a problem. But I do think that efforts are being made to not only collect evidence-based data that can help future initiatives to reduce that burnout.

DR. STRIKER:

The current training. Do you feel like it's a good amount? Do you feel it's not enough?

DR. SCHIRMER:

No, I think I think it's the great amount. I have no complaints. It's a very different setup and layout of training than what I had in my internship year, and I'm just very grateful to have this structure that I do now. I will say, I think that being a CA1, some of those bigger cases, those more advanced cases, still kind of give me that chest pain of, and that anxiety, which I will one day have a lot more comfort and knowledge base with. But um…

DR. STRIKER:

Is that is that true? Is that going to ever go away?

DR. SCHIRMER:

Does it go away? Does it? Break that break that news.

DR. SINGLETON:

You know it gets better. And just when you think it's all just right, a patient will come and tell you and convince you that you don't know everything. And you better be nervous again.

DR. STRIKER:

Don't want to run out of time. And I want to ask a couple other questions because burnout. We could talk about this for for a long, long time. And it's very important. But I do want to get each of your perspective on what you think, the opposite generational anesthesiologists doesn't realize you had to deal with that you wish they did. And is there an aspect of care you provided during your career that you think that Dr. Hines

and Singleton and the younger physicians case and Dr. Shurmur, is there something you think that older physicians do not get about the current generation of.

DR. SCHIRMER:

I'm not sure it's so much in the care aspect, but more so in the education aspect. I have attendings say, oh, well, you should read on this or read on this topic, or read on that topic or read that chapter. And I think that the way that medical education, especially in medical schools now is moving. It's not a textbook based education system. Especially with Covid, there's a lot of resources out there in medical education that students are utilizing, and they're developing very efficient and very reliable study habits. But those study habits don't always confer with reading a textbook chapter. And I think that there's a lot of really good resources out there--question banks and different YouTube sites that have educational videos and keyword videos that help residents learn nowadays. But it's very difficult with the background of the study habits that we developed in medical school, to translate that into simply sitting down with the textbook at the end of a day long of cases, and researching your cases for the next day to absorb that textbook information when you don't have the study habits to back it. So I would say that that's that's the educational piece I think that I wish that the older generation understood about residents now.

DR. SINGLETON:

Yeah, I would agree with that. And that really presented itself dramatically to me when, you know, I think both of us were probably board certified with a lifetime board certification and never had to do, you know, recurring, recurring re certification. But a few years ago I took, it's been almost ten years ago now, I took the boards in pediatric anesthesia and it was like, oh my God, I got to actually study for this. And instead of going to the library and doing what I did when I was in med school or residency, I did the whole thing from my my laptop because there were hyperlinks and I could study. I used a syllabus, but I could study everything from just sitting in one chair with one device and find all the information and more than I could ever want on any given topic. So that's that was like, wow, this is different.

DR. HIMES:

I don't have really much to add to sort of the difference in the educational style piece, but one of the things that I think is important generationally to highlight is that what you feel you are as a physician, a clinician, when you finish your training, is not going to be who you are in a few years. And if you're joining a private practice or an academic practice, what you see of that organization when you join is not going to be what you

get, because it is going to evolve over time, and it's vitally important to commit yourself to being part of that change. If, if you want to continue to be part of that practice in some way.

DR. SINGLETON:

Carrying on with that same idea. When I trained our department chair, Bill Hamilton at UCSF, insisted that every operating room had a different anesthesia machine, an old forager, a this and that, and we never knew what we were going to get. So we were trained to kind of like, not expect things. I can remember my attendings asking me, have you ever done a case like this? And I'd say, yeah, I did one a few weeks ago with Dr. So-and-so. And how did you do that? And I described it and he said, well, we're not doing that. We're not doing it that way today. Doesn't matter what I said, but we weren't going to do it that way today. The whole idea of being able to adapt and do things differently, I find that residents, at least my residents at Stanford and UCSF, get very comfortable in doing the things that they know how to do well and sort of miss out on, I think, some adaptability that we as teachers could impose on them better. And the other day, one of my colleagues who was making out the schedule said, oh, I sent the I put this resident in your room because I wanted them to… she said, you go with Dr. Singleton, you'll do something different. I was like, what does that mean? I'm just going to be different.

DR. HIMES:

Yeah, I've been accused of that many times. Oh, yeah. I had the same kind of experience in the operating rooms. Not knowing what you're going to find and having the attendings say, you know, we're going to do this was the era when we did modified radical mastectomies. And and you you do it without putting a patient on a ventilator. You are ventilating them by hand the entire case, which went on for hours. I remember asking my chairman and one year of the on the anniversary of anesthesia, the ether anesthesia. I said could we, could we use ether one time? Bob Epstein was the chairman of our department. And, you know, he listened very patiently to me and and smiled and said, no, because one, it takes you 8 or 9 months to learn how to use the drug at all, all safely and effectively. And you'll make a lot of patients really unhappy.

DR. STRIKER:

The current slate of teachers, do they try to keep you off balance, or is it more, you know, what you're going to have to do when you work with a certain attending?

DR. SCHIRMER:

For the most part, no, actually, if I have a whole docket of cases with a particular attending and they're all going to be general anesthetics, they'll tell me, okay, I want you to choose a different, we're going to do a different induction, we're going to do a different method of airway, whether that be an elective video, laryngoscopy with a bougie, you know, just trying to change it up, trying to focus on different skills and different ways of providing anesthesia from induction to emergence.

DR. STRIKER:

This is the time to teach the adaptability and try to be, everybody's going to develop their own preferences. They have plenty of time to do that over time. So well, in the short few minutes we have, let's leave it with what each one of you is most optimistic for for the future and most and think maybe not concerned, but is something that you think we need to really focus on as a specialty in the future.

DR. SCHIRMER:

I'm most optimistic because of the people, the people here, the discussions that are being had at the meeting, the discussions that are being had even at the medical student level. I think in the past 3 or 4 years, there's been like a 64% increase in medical student membership. And I think that that is super promising for our specialty. Just having that young interest and having the pretty advanced discussions about advocacy at that level, both at medical students and residents, and just knowing that there's a promising future with the people that are coming into our specialty.

DR. STRIKER:

The future is bright.

DR. SCHIRMER:

The future is bright.

DR. STRIKER:

What is it that concerns you most about?

DR. SCHIRMER:

I think relating to that, not the presence of individuals in the realm of advocacy or the attention that's being brought to it, but just the topics at hand being discussed. I think that the ASA and the specialty is doing everything they can to put their best foot forward on the advocacy side. I just think that the topics being discussed in Washington and at the state level are just concerning to me personally.

DR. STRIKER:

Dr. Singleton, how about you?

DR. SINGLETON:

I would agree that I have no worries at all about our profession as a as a medical specialty. because it's fun. I mean, all of us went into anesthesiology because it's really a fun thing to do. We get to take care of patients and make them feel better about a scary event in their life. So the science is on great footing. What I worry about is our health care financing system in this country, in *this* country. And anesthesiology is probably the most out of balance, precarious part of that health care financing imbalance. And I'm convinced that it's going to take a major crisis for us to figure out how to develop a financing system that resembles any other part of the modern world. We need some kind of a system that provides good care. I mean, we're spending enough money on it, and it's just not being used in a sensible way. And I think that we spend a lot of our advocacy trying to fix a broken system that is irreparable. And I really think that your generation, I'm counting on it, can fix this.

DR. HIMES:

I couldn't agree more with what marks. You know, the sort of the question that circulated, are you optimistic or pessimistic about the future? And Madeleine Albright, when asked that, you know, had this famous quote where she said, I'm an optimist, but I worry a lot. The things that help to reduce my worry is Abigail and and the quality of the people who are entering our specialty, I think, is going to stand us in good stead. The concern is the corporatization and the financing that Mark outlined. That's the major worry.

DR. STRIKER:

I think it's a great spot to leave it. And I'm also very encouraged when I come to this meeting and I see all the younger physicians, their involvement, their passion, it's it's very encouraging and it gives me hope for all these issues that we have to tackle.

DR. HIMES:

Well, let's each of us tell a story of one of your most interesting events in your short clinical career, your longer and my longest clinical career.

DR. SINGLETON:

Oh my goodness, why don't you start?

DR. HIMES:

When I mentioned that I'd asked my chairman if we could use ether and he said no. Well, I actually did get to use ether once with Fritz Berry. And we were going down out of the operating room to do a bronchoscopy, and we used to do that intravenous ether to do that bronchoscopy, which worked amazingly well. But I don't think I know of anyone else that I know of who's ever done that.

DR. STRIKER:

I don't. Do you have a story, Dr. Singleton?

DR. SINGLETON:

Well, what I would just say is that throughout my career, there have been two aspects of my professional life that have sustained me more than anything else. I mean, I enjoy going to work every day. I enjoy taking care of patients. I enjoy the job part of it. But these two things that I never get any money for and and yet they're the most important part of my professional life. One is my involvement in in organized medicine, in the ASA and the California Society of Anesthesiologists. I you know, I was pushed into that by people more experienced than me that knew that that was an important thing to do. And it's been really the most important part of my professional career. The people that I know here at this meeting are closer to me than my partners that I worked with for 35 years. The other thing is, you know, I started early in my career, and for the same reason, because somebody told me I should do it to, I do volunteer work. And mostly that's been abroad and, you know, under-resourced environments, but also right here at home, you know, there's there are volunteer opportunities for everybody in their own backyard.

DR. SCHIRMER:

I would have to echo just the quality of the people in anesthesia, especially through the ASA. I actually, one of my best friends is an intern at Stanford, and she's here at the meeting today, and I asked her to be my bridesmaid. And I met her through the ASA a couple of years ago. And we've become the best of friends and just the field as a whole. It's built and created with the highest quality of individuals that not only become your colleagues, but your lifelong friends.

DR. HIMES:

And Mark and I are both on, I mean, we're all on this ad hoc committee of retired member engagement, which is developing into, I think, a full committee now. But it's the sort of thing that you highlighted. What can we do to continue that involvement in this society?

DR. STRIKER:

Well, I just want to thank everybody again. I would love to continue this conversation for ever. This is it's been quite a highlight of the meeting. But thank you again for all of you for joining me on this episode. Wonderful conversation and a pleasure to to meet all of you.

DR. SINGLETON:

Thank you.

DR. HIMES:

Thank you.

DR. SCHIRMER:

Thank you so much.

DR. STRIKER:

Thanks to our listeners for joining us on this episode of Central Line. If you're at the meeting, I hope you enjoy the rest of the meeting. By the time this is published, the meeting will be over. We're hoping to do this again next year, but please tune in again to our next episode. Thanks again.

(SOUNDBITE OF MUSIC)

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