Central Line
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VOICEOVER:

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

DR. ADAM STRIKER (HOST):

Welcome to Central Line. I'm Adam Striker your host and editor. Today, we're going to do something a little different. I'm going to share highlights from this year's Annual Meeting, Anesthesiology 2021. The team from Top Med Talk, trusted partners of the ASA, interviewed leaders from the specialty throughout the week. These included past and current Presidents like Drs. Beverly Philip, Randy Clark and Mary Dale Peterson, and they've kindly let us share some of our favorite moments with you, our Central Line listeners. So if you didn't make it to the meeting, or if you're just longing to relive the experience, this episode is for you.

First, let me start with the confession, I was actually one of the interviewees getting the opportunity to talk about my work with ASA's Committee on Communications. Being in the other seat was certainly quite an adventure, as answering the questions is, is a lot harder than asking them.

DR. STRIKER (AT THE ANNUAL MEETING):

Well, the Committee on Communications is tasked in general with making sure, not only taking care of the messaging to the public about what it is anesthesiologists do and the value we bring to patient care, but also shaping that message and creating messages, evaluating ideas, figuring out how best to affect that messaging. And it's a robust Committee made up of a number of individuals around the country. Different backgrounds, both culturally as well as backgrounds from practices, academic, private practice and so we've got a diversity of opinion and thought, and it really makes for a successful forum to come up with what we think is the optimum way to get the message out to everybody that needs to know about who anesthesiologists are.

DR. STRIKER:

They asked me about the pandemic and how COVID 19 has changed the public's perception of anesthesiologists.

DR. STRIKER (AT THE ANNUAL MEETING):

It's, it's afforded us an opportunity to try to take advantage because anesthesiologists, you know, across the world have stepped up out of need, but out of the desire to be at the forefront of taking care of patients during this pandemic. And all of a sudden, people do now know who we are, and it's specifically afforded our committee the opportunity to try to alter how we're going to shape that message because we're doing it, we're doing that work. We're out there helping people. We need people to know about it, though, because this is a specialty that hasn't always been at the forefront of everyone's mind.

DR. STRIKER:

And I got to talk about one of my favorite subjects, ASA'S Made for This Moment campaign.

DR. STRIKER (AT THE ANNUAL MEETING):

This is a campaign we have embarked upon with the American Society of Anesthesiologists and specifically coming out of the Committee on Communications as an, a broad strategic campaign to accomplish just that, to get the message out to the public. Now the public is a broad category that includes, more specifically, policymakers, health care executives, patients and everyone, so that they know who it is, what it is we do and who, and who we are.

Fundamentally, the campaign is about getting the message out to everyone who it is, or who we are, and what it is we do that's fundamentally. More specifically it tackles or highlights our education, our expertise, the skills we bring and why is it called Made for this Moment? Because we believe that, not only the campaign is to is going to show how we're made for this moment, these moments, we believe anesthesiologists are made for the moments that matter to patients. Whether that's delivering quality of care, whether that's advocating on a public health scale for the benefit of our patients, whether it's driving innovation in health care, which we do constantly. And more specifically and of recent note, how we step up to lead during the global, unprecedented, global pandemic.

DR. STRIKER:

Well, I wasn't the only interviewee, and I certainly wasn't the most prominent. ASA's immediate past President, Dr. Beverly Philip shared her thoughts on the challenges we face and the possibilities of ASA's leaders and our members.

DR. BEVERLY PHILIP:

I think the challenges actually have remained the same with, with the 2021 version, but the same, and our challenge has always been as an organization is define our own future, to ignore the chatter of the universe and that we decide who we want to be as a specialty. I, I went into organizational leadership because I really like helping other people reach their goals, and this, this is what we, I've been, this is the big accomplishment that ASA's leadership can do. All the members with all their breadth of interests, we as leaders can give them the opportunity to succeed at what they do. And you look at the membership of, of ASA. It's, it's all these interests, whether it's academic, whether it's science, whether you have a subspecialty interest, whether you like history. We, as leaders, can enable everybody's best vision of the future for the specialty.

DR. STRIKER:

Dr. Phillips sat down for her interview, along with ASA's President Elect, now President, Dr. Randy Clark. Dr. Clark talked about where the specialty is heading.

DR. RANDY CLARK:

I think the future is bright, as I said this morning. And it's bright because anesthesiologists are such an essential component to most parts of a hospital. We think about operating room anesthesia, but it's much more than that. And our mission and the reason for ASA and the reason for a lot of the people you see around you here, is driving the improvements in the care we provide to our patients.

DR. STRIKER:
Dr. Clark spoke to how ASA is enabling the adaption of new tools and technologies to expand the breadth of the specialty to touchpoints beyond the hospital.

DR. CLARK:

We really began seriously discussing transforming the specialty into this broader arena, five, six, seven years ago. It's going to take a process and it's going to take

time. We have to change many parts of our system. We have to change the training programs, we have to change attitudes and we have to change the receptiveness of others in other specialties to the types of services that we're talking about in perioperative medicine. All of that's going to take time, but I think it's absolutely essential. And ASA hopes to be one of the partners. We need multiple other partners with academic Chairs, hospital leadership, other medical specialists to be able to accomplish this. But I'm very confident and optimistic that we can do that.

DR. STRIKER:

They both shared their passion for the specialty, with med students, explaining why anesthesia is such a great choice for young physicians and what drew them to the specialty.

DR. PHILIP:

What I loved about anesthesiology from the beginning is the intellectual challenge of it, that you need to have enough physiology, pharmacology, all this knowledge that you get to implement right here, right now. So, it's a great intellectual challenge every day, all the time, every patient. And then of course, there's the fact that, that you get to do things. You know, this was not just sitting around and going on rounds or just talking. It's you actually get to get it done, now. So there's a really wonderful combination of real intellectual, on-going challenge and the fun of actually doing things physically.

DR. CLARK:

Yeah. Couldn't agree more. We're both in training programs. I tell the medical students that we see, and the residents that have chosen anesthesiology, it's the best specialty in medicine for all the reasons we've talked about already. But the, every day you go in the intellectual challenge of what you're approaching is what really keeps us going. And I, I can't imagine too many other specialties that would have the equivalent of what we're able to do.

DR. STRIKER:

It was great to hear from the Presidents just as the baton was changing hands, and they weren't the only Presidents in the hot seat. Dr. Mary Dale Peterson, who was ASA’s immediate past President at that time, also spoke about the qualities found in leaders.

DR. MARY DALE PETERSON:

You know, I think one of the biggest qualities is humility. I think humility is what really makes a great physician. Knowing when you don't know something, knowing when to ask for help, when there's a crisis. And it's also, you know, not being a know-it-all or think you know everything, even though you may be a very smart and well-educated person. But I think we learned that as leaders in health care systems during the pandemic, you know, you know, we have about 3,000 in our organization and it's like, here are the rules right now based on this evidence. And then, you know, then, then the rules change.

INTERVIEWER:

Two days, two days later, they change.

DR. PETERSON:

And so I, I started like preempting, you know, the guidance is by saying, this is what we know today and this is what we're doing today based on what we know. And that really could change tomorrow. But, but what you have to learn as a leader and this gets into my next point is about 80% of people are concrete thinkers. And 20% are, are a little bit more abstract and they can deal with this change. It's very hard for people dealing with continuous change. And so that's where I think another quality of, if being a good leader is, is communication. I'm still learning that. I think that's where our failure is, whether it's in patient care and doing handoffs or as a system and, and communicating.

DR. STRIKER:

She shared her thoughts on how to improve organizational culture, stay adaptive and value empathy.

DR. PETERSON:

It really does go back to the mission of the organization where, whether it's the ASA mission, you know, advancing the practice, securing the future or, you know, the mission or the vision of our facility and, and our whole system, until all children are well. And it's really, you know, I would hope that the people that are attracted to work in our health care system are married to that mission. And so, I think it's always about the why. When you're trying to get people to go that extra mile and, and put in that extra bit or deal with change, that may be hard. And it's, it's why are we doing

this? And because we want to get from here to here, and, and really and these are the steps we need to go to along the way. So I think it's the why.

I also think that if you can show empathy with what they are going through and how hard it is, and sometimes you may not even have the answer for them. I had so many ASA members writing to me, you know, during my Presidency, during COVID and I, it was hard. You know, I had women writing in saying, I have two young children at home. I have, you know, an elderly parent living with me and I go to work. This is of course, before vaccines, I go to work and I just live in fear that I'm going to bring this home to my family. And of course, I, I'm living with two 87 year old women as well. And then I'm a college student. It's multigenerational. I don't, you know, should I be living in the basement? Or is it OK if I shower and then go into my house? I can't tell them that, at all, but I can be a good listener. I can be empathetic. I can thank them for what they are trying to do in saving patients' lives and still protecting their family.

DR. STRIKER:

And she spoke to the core issues she expects to shape anesthesiology in the next decade.

DR. PETERSON:

We have a lot of core issues and it's really, unfortunately, around economics. It's, you know, ensuring that we get appropriate payment for services. All your anesthesiologists are looking at this know that we're in a different, different payment system than the rest of medicine. And we, we have to continue to work on that. You know, that was my number one thing coming into the ASA presidency that I wanted to concentrate on. We got a little bit sidetracked with COVID. I mean, we were still working on it, but not to the degree that we need to. And really, it is our number one priority, whether it's you know, the No Surprises Act. But, you know, we obviously don't want patients to have surprise medical bills, and we worked very hard to get appropriate language in the legislation. And unfortunately, we now have the Interim Final Rule that completely ignored what was written in legislation. So now we're working on how, how do we figure that out?

I think it's about workforce. I think people are feeling the pinch. To your point, Monty, a lot of people are retiring and, you know, people are not wanting to, to work the 80 hours that, that maybe we did initially, you know, we're not in that place anymore, and that's fine. I think that's good, actually. But, but we've got to figure out how, how to get more folks in the pipeline, even though anesthesiologists have been so

blessed because we, we actually have more demand to become an anesthesiologist and we have positions open. So it's really encouraging. Urging everybody to open up more anesthesiology residency positions so we can increase that pipeline to take care of patients, and so I think those are really two really big issues that are facing the specialty.

But there's so much other positive, exciting things, just the science, the silver linings that we've learned about the pandemic, the science, the mRNA technology, learning how to, to utilize technology better to our advantage and communication and outreach our tele-town halls, you know, so I, I'm so, you know, I, I think there's a very bright future.

DR. STRIKER:

Dr. Jonathan Gal from ASA's Committee on Economics addressed Alternative Payment Models. He touched on what anesthesiologists know about APMs and how he hopes to educate more members.

DR. JONATHAN GAL:

Much of the audience is probably very green when it comes to Alternative Payment Models. They don't really know much about them yet. It hasn't, wasn't on their boards. They didn't study it when in their residency. It's not part of their continuing medical education. It's, it's some new stuff out there. And so, I try to approach, you know, the different presentations, different resources we're putting on the ASA website thinking that most of the audience is still rather green. There are some people that know quite a bit about it, but we're going to dive into a little bit more, you know, details on certain things as we move along with the different educational research that we're going with, so…

DR. STRIKER:

Dr. Gal shed light on who's embracing APMs and why, and encouraged anesthesiologists to lean into value based care.

DR. GAL:

Probably the one community that's probably been embracing it the most is, is the surgeons. So, an orthopedic total joint surgeon, basically all that they do all day, every day. Yeah, they're going to embrace it because every one of their patients that comes into the operating room, there's a potential for them to get some gain out of

that. If they, you know, hit better metrics, they get some more of the, the gain sharing or the shade, save-sharings with the payer on it, then they're going to win out.

For an anesthesia practice, that's just one OR right now. Maybe it's two. Maybe it's three, maybe it's four or whatever, but it's not 100% of your ORs. And so that's why it's important to realize that, you know, total joints was basically the first surgical bundle that was out there. Now there's bariatric surgery, now there's lumbar spine fusion, cardiac surgery ones, there's maternity bundles coming out there. So, pretty soon this amount of your, you know, daily case count that's going to be part of a bundled arrangement might be up to 50% before you know it, within a few years. And so now it's like, wow, half my cases, I could get some sort of gain on this, and that's where you need to start positioning yourselves now. Because if you wait until half of them are in there but you haven't been at the table yet, then you're on the menu.

DR. STRIKER:

I especially enjoyed his tips on how anesthesiologists can demonstrate our value.

DR. GAL:

Lean on the data. If you have your, you know, your Anesthesia Information Management System, your AIMS, that helps you, you know, know the data sometimes before the other people at the table and the surgeons have a general idea of like, this is what's going on, but they don't realize like, wow, I'm one of 10 total joint surgeons here. I don't know what the other nine people are doing. So you have all 10 of them, you know what they're like, you know, what their operating times are. You can tap into what their costs are. You can, you know, realize like how they their patients perform in the post-op area. How accurate are they? What are there, sort of complications are they having? If you can tap into that sort of stuff and, and show it with data, it's another way of you, you know, demonstrating that a little bit better.

DR. STRIKER:

We heard more about Value Based Payment Models, specifically the perioperative surgical home. Dr. Chris Steel, who has extensive experience with the perioperative surgical home, spoke about this.

DR. CHRIS STEEL:

Perioperative surgical home is a patient-centered, physician-led model of coordinated care that spans the continuum from the decision to have a procedure to after, the person, the patient recovers from the procedure. The perioperative surgical home is a model in which you could reproducibly lay different protocols, enhanced recovery protocols, as well as other protocols which may be more efficiency or financially based protocols at an institution. And the PSH really works on how to set up this model reproducibly at an institution, regardless if it's an academic center, a private practice or a rural hospital.

DR. STRIKER:

He talked about what PSH looks like in practice.

DR. STEEL:

Different institutions have done it different ways. I think that what you have to do is understand how to, where you are as an institution, from a sophistication standpoint. A lot of times institutions just starting need to, the very first step is to identify the stakeholders where you're trying to set this up in an institution. This is not a one man show, nor one specialty show in setting up a perioperative surgical home. So I think first step is really step out, figure out who is at the institution, are the stakeholders in perioperative care like we're talking about and bring them to the table and figure out what are the needs that are, what is salient to each and every stakeholder? And how do you create this program to be a win for each and every one of them?

And so I think once you do that, you figure out what are the goals for the institution? Again, some of the principles and components or things that we've been fleshing out and, and coming up very soon, we'll be able to, to reveal those. But what we can do through conversations with the stakeholders is start with creating this patient-centric physician-led program and find that usually one service line and an energetic sponsor of that service line and achieve reproducible care through standardization of the pre-op process and intra-op process and post-discharge.

Usually after that occurs, that's when you start scaling it up, usually other service, other procedures in the same service line, and then other service lines as you scale it up. So that's usually the process where organizations do it. Some are remarkably sophisticated and already have reproducible systems like ERAS or other things in place where they really just need to get the stakeholders together and figure out how to organize their current system. So it really depends on where you are as to how to set this up.

DR. STRIKER:

Dr. Steel also talked about ASA's new PSH implementation guide and how it came about.

DR. STEEL:

The ASA actually brought members from the American College, the American Academy of Orthopedic Surgery, along with several representatives from different size institutions, academic, private practice, rural, urban, all types of different practice together along with nurse representatives, representatives from the National Health Council, which is a, a, a, a patient advocacy group as well as the American Hospital Association, all came together in the Implementation Guide Workgroup to come together to create it.

And a similarly diversified PSH Steering Committee was actually leading that process. And so they, they came out with this very recently, and it's a, available now for pre to, to preorder, and it should be coming out in the next couple of months, which will shed a lot of light on some of these processes. What it is, is a, a way that the all the things that have been learned over the last decade of implement, PSH 1.0, 2.0 and PSH 2020, all the lessons learned can be kind of put together into one guide. They can really help an institution implement this at their own hospital, which is what we're really excited about. But we actually have a section in the guide that specifically talks about how this guide is to be used. And that's it. You can use it in a modular type model. Some people just want to worry about pre-op or just want to worry about intraoperative standardization or just post-operative care. And so you can look at it in different ways.

And also, we've tried to look at it from different stakeholder standpoints because we think that this information is not only salient for anesthesia providers, for hospitalists, other clinicians, as well as for the C-suite champions, nursing. A lot of different areas could benefit from this and really take a, a big role in implementing this at their health system. So we, we're really excited about it. It's going to be a really fun tool that I think a lot of people are going to benefit from.

DR. STRIKER:

Dr. Steel stressed the value of engagement. Protocols only work if people engage with them, after all. The subject of engagement was addressed from other perspectives by other leaders in the specialty, including Dr. Kraig de Lanzac,

Assistant Secretary of the ASA, who sat for an interview on the importance of young member engagement.

DR. KRAIG DE LANZAC:

You don't have to go further than the ASA's mission, which is advancing the practice and securing the future. The only way we're going to secure the future is if we get folks, no matter how long us mid-career, I guess I'll consider myself maybe nearing end, how hard and long we want to work. At some point, somebody else is going to have to take over the legacy of this field and the legacy of this organization. And I passionately believe, as the American Society of Anesthesiologists goes, so does the field of anesthesiology in the United States. So, we have to train up, mentor up, engage our young members in any way possible. We're talking from medical students, residents and the early career members. So to me, I just see it as the lifeblood. I mean, it's cliché to say that children are the future, but our young members are the future of this field, and my hope is to leave the legacy of the specialty that I've loved to them.

DR. STRIKER:

He shared information about ASA's efforts to attract young med students to the specialty, which I'm happy to hear are paying off.

DR. DE LANZAC:

The nice thing I see is we are engaging younger and younger members. We now have more medical student members in the ASA than we have ever had, over 3,000. We have more resident members, we have approximately 8,000, so we let them sample what it is, being a member of the American Society of Anesthesiologists is, trying to get them engaged early and to get a feel for what it is that we want to do with this field and what we want them to help us bring. You know, bringing in the younger members gives us strength and vibrancy, and it gives us a new perspective.

DR. STRIKER:

Dr. de Lanzac passed on some specifics about what the society is doing to try and attract young members.

DR. DE LANZAC:

We've started a new Residency Engagement Department. That's only come about in February 2020, and that is a direct focus towards resident members and our medical student members. We're also transitioning to what we're calling Early Career Members that first 10 years. And one of the things that we've seen is if we can have a member of our American Society of Anesthesiologists for the first 10 years, they're probably going to be career-long members. Those are the folks that we need to help to engage. The nice thing about ASA membership, it is what you put into it, and you can actually make the organization better by being involved.

Right now, we're trying to give the resources, and we did it in a smart way. We talked to them. We actually talked, to…

INTERVIEWER:

What do you need?

DR. DE LANZAC:

What is it we can do for you as ASA? And we took that research and we continue. We call it our Life Cycle and Ecosystem Research. What do you need right now as a third-year resident? What do you need right now as you're finishing your fellowship? And what can we do to, to, to provide that? And a lot of the talk goes around mentorship and near peer mentorship. You know, it's, it's nice we're hearing from our retiring members that they want to be mentors, but apparently the, the young doctors don't want to hear from us, old guys. So we're going to get the near peers. We're still going to use those, those, senior physicians, but we got to get the near peers to them.

So what we're trying to do is come up with this network of mentorship and we have virtual mentorship right now. You know, COVID has done interesting things, but the one thing it has done is taught us to use the technology to the fullest. Our resident website is nothing like it used to be. You can go on and get financial advice, wellness advice. There's some information there, I probably should go spend some time with about my finances, too. But it is impressive what is there. And then we're developing, based on what they wanted, resident a curriculum. We're putting up some interesting talks and lectures and using the expertise nationwide. Grand rounds on demand, basically, is something we're going to be looking at, too.

DR. STRIKER:

Dr. Stephanie Byerly, Chair of the Committee on Women Anesthesiologists, talked about the challenge and importance of engaging women in the specialty.

DR. STEPHANIE BYERLY:

Currently, there's decreasing numbers of women going into anesthesia, and we know that women add so much with diversity and not just, you know, women who look the same. We need women of all different colors to be a part of it because we know in the business world that women save companies when they come in because of the diversity they bring, and it's the same in medicine.

DR. STRIKER:

I found her explanation of the difference between mentorship and sponsorship and how those categories intersect with gender, particularly interesting.

DR. BYERLY:

One of the things that's really a problem for women is they get over-mentored and under-sponsored. So, mentorship is when someone who usually reminds the mentor of themselves sort of advises you about your career. But for women, it's usually about your personal life. Men get sponsored more often, and sponsorship is when someone that's above you who can get opportunities for you will say, hey, I know this person, they're great, give them an interview, or, they would be great for this role. Women barely are sponsored, so they're over mentored about their personal life, and men are sponsored and men are promoted on potential. So, oh, he has the potential to do well when women have to prove themselves over and over and over again.

DR. STRIKER:

Dr. Byerly educated listeners about the gender pay gap and other challenges women anesthesiologists face.

DR. BYERLY:

There was a paper that just came out in Anesthesia and Analgesia a couple of months ago that I will say Dr. Hertzberg and a whole team of people we're working on for three years. And it actually showed that, and after being correcting for years of experience, hours worked, where you live, there's a $32,000 pay gap on average between male and female anesthesiologists. So if we talk about promotion, women

get promoted less. Women are less Deans. Women have less papers published, less grants that are accepted. I mean, there's just so many things that happen. And so I think it has to be the responsibility of where you are to want to address those issues.

DR. STRIKER:

She explained that COVID exacerbated these existing problems.

DR. BYERLY:

They actually were fired more than men. They were furloughed more than men, they also got bigger pay cuts than men, and they also got asked to take on new clinical responsibilities more than men that they were put in situations they had not been in before, clinically. Women's' academic productivity in academics has drastically dropped where for men it's actually gone up, during COVID.

DR. STRIKER:

Dr. Byerly's committee is working hard to address these issues, and solutions are out there.

DR. BYERLY:

If you look at people of color applying to medical school, so we have someone that was hired at our university, Dr. Quinn Capers. And he explained all this to me, and it was fascinating that in Ohio, when he got there, they had a very uniform group of medical students that looked pretty much the same. When he introduced implicit black/white bias testing, and the admissions committee took the tests and they realized how biased they were. The next year, they had the most diverse group of medical students that they've ever had. And here's the thing we need people to look like the patients…

INTERVIEWER:

Absolutely.

DR. BYERLY:

…because certain populations are discriminated against in medicine and they need to be taken care of by doctors who look like them.

INTERVIEWER:

Yeah.

DR. BYERLY:

And so if we don't get a diverse, a diverse workforce, where our patients are suffering.

DR. STRIKER:

Another prominent anesthesiologist, Dr. Bonnie Milas, talked about a project she's passionate about, Revive Me, an initiative designed to address the opioid crisis.

DR. BONNIE MILAS:

The Revive Me Campaign is really an initiative to get our anesthesiologists really inspired to not only carry a naloxone product, but also to educate the public on how to recognize and to revive an overdose victim.

DR. STRIKER:

She discussed some of the steps anesthesiologists are taking to address the crisis and shared her thoughts on what we should do more of.

DR. MILAS:

We are decreasing the number of prescriptions that we're putting in people's hands, so we want them to not have an extra supply of drugs at home, you know, hoping that we decrease the rate of opioid addiction, but also that those drugs aren't in the hands of someone who is not prescribed them. So, we don't want people to divert their drug supply should they have additional pills available at home, so we certainly as anesthesiologists, we don't want to be handing out prescriptions needlessly.

You know, I would say probably now we're giving people prescriptions for opioids if necessary for no more than, say, a five-day period of time, whereby they would have to come back to the hospital or to their physician to have an additional prescription written. You know, intraoperatively, we're also using opioids for less or we're we are keeping those doses to a minimum. We're using multimodal analgesia and offering patients other means of handling pain in the operating room.

DR. STRIKER:

Dr. Milas shared her own personal, painful story, which inspired her to become an advocate for other families.

DR. MILAS:

I have lost, tragically, both of my adult sons to accidental opioid overdoses, and really, from that experience, I've been in the home where I've had to do full on CPR, rescue breathing, calling 9-1-1, giving the, the naloxone dose, and I'm a trained anesthesiologist. I have a skill set and I'm good at what I do. I was able to revive my son on multiple occasions, but I thought to myself, what would that be like if I didn't have that experience, if I didn't have all of that immediately right at my fingertips? And that's really what led me on this mission, really to educate others. And I thought, you know, anesthesiologists, we're all skilled. We know how to recognize an opioid overdose. We know how to rescue breathe. We know how to give naloxone. What other group has more experience giving a, a naloxone product? It's us.

So that is an opportunity for us to do more. And I contacted Mary Dale Peterson, our immediate Past President, and I explained my experiences. She was inspired. I'm inspired, and we are working with the ASA to inspire others to take this on as again, a, an opportunity to represent our profession as individuals who are lifesavers. That is what we do. And we have signed a Position Paper from the American Heart Association and the ASA. We are going to work together, and we will save lives.

DR. STRIKER:

While Dr. Milas' powerful personal story is a hard one to follow, I do have one final interview to share with you from Dr. Evan Kharasch, Editor-in-Chief of Anesthesiology, who was interviewed about ASA’s peer-reviewed Journal in his goals for the publication. Dr. Kharasch shared specifics about the Journal's audience and reach the information he shared speaks to the influence ASA has, not just in the states, but around the world.

DR. EVAN KHARASCH:

It is by a number of, of metrics and measurements, the premier Journal of anesthesiology in the specialty and our target is, is not just anesthesia practitioners, but we really want to bring science and evidence-based medicine beyond the realm of anesthesia, critical care, pain, and even to, to scientists and practitioners outside

of those core specialties because so much of the information that gets published in our Journal can be usable by individuals who are other than anesthesiologists. I talked to, to my editorial board and our authors and our readers and, and the ASA, and I said I wanted to. We want to do two things. We want to increase our richness and increase our reach. It's the quality and the value of our content and the size of the audience that we connect with.

DR. STRIKER:

I was particularly interested in Dr. Kharasch's thoughts about science and communications and the remarkable challenges and accomplishments of the past year.

DR. KHARASCH:

Not only have we learned a massive amount about this virus and this disease, we've learned a lot about science. We've learned a lot about how the public reacts to scientific information, things like scientific literacy, for example.

INTERVIEWER:

For sure.

DR. KHARASCH:

And, and the fact that people are trying to consume information, science doesn't work on a linear path. It follows a serpentine path and, and it's not a inexorable unraveling of truth, if you will. But it's hard for the public sometimes to understand that it is the accumulated, built upon evidence which leads towards the truth. But each individual kernel isn't necessarily the absolute truth. The average member of the public doesn't understand that. So, one of the roles I think of, of people like Dr. Fauci and like the head of the CDC, is the challenge of, of taking this di, very dynamic scientific milieu and trying to communicate it in a way that the public can both understand and trust. And what we've learned is that that's a very, very difficult task.

But the other part of the answer is, is that the pace of what we've learned in COVID is unheralded in my career. I know no other endeavor in which science has advanced so fast and so far. I mean, literally within days of, of discovering the virus, it was sequenced. Hundreds of labs changed what they were doing overnight to investigate it. We were able to develop a vaccine in a year. There are diseases on

which we've worked for decades to try and develop a vaccine and still haven't succeeded. So, the pace of discovery and accomplishment with COVID has been like nothing else that I've seen in my career.

DR. STRIKER:

And finally, I'm going to leave you with Dr. Kharasch's celebration and warning about the state of anesthesiology today.

DR. KHARASCH:

We look back over decades and see the improvements in perioperative care. But those advancements just didn't materialize. They came as a result of concerted investigation and curiosity and the creation of that new knowledge. The information that we use today in practice was created before. But if we don't continue to innovate and create and develop new knowledge, the specialty risks becoming static.

DR. STRIKER:

With that nod to what the specialty has accomplished and reminder that we, as physicians, scientists, caregivers must keep innovating. That's it for this episode of Central Line.

I hope you enjoyed the trip back to Anesthesiology 2021. More information about topics guests' talked about can be found on the ASA website at asahq.org. Thanks for listening to this special episode. And don't forget to subscribe wherever you get your podcasts.

(SOUNDBITE OF MUSIC)

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