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Central Line
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VOICE OVER:

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

DR. ADAM STRIKER:

Hi, welcome back. I'm Adam Striker and this is Central Line. Today we're welcoming two guests mother daughter duo, both anesthesiologists. First, meet Dr. Susan Taylor, recently retired associate professor of anesthesiology at the Medical College of Wisconsin, and her daughter, Dr. Allison Taylor, who is a CA3 resident at the Medical College of Wisconsin, soon to start a fellowship of pain medicine. And I'm happy to welcome both of you to the show. Drs. Taylor.

DRS. TAYLOR:

Thank you for having us. Nice to be here.

DR. STRIKER:

It's the first time we've had on the show two family members as part of our panel. And so, just for clarities sake, are you okay if I call you Dr. Allie or Dr. Susan when we're involved in the conversation.

DRS. TAYLOR:

Sure, that's fine. That would make it clear.

DR. STRIKER:

Okay, great. First off, I'd like to get to know both of you just a little bit. If you could tell me just a bit about your careers and touch a little bit on how work life and family life intersect. Let's start with Dr. Susan and then Dr. Allie.

DR. TAYLOR:

I began my career in surgery, actually at the University of Virginia and then transferred into an anesthesia program after my internship. From there, I also did a pain fellowship and my first job was in Cincinnati and predominantly at the children's hospital there.

I have to say, when I started in anesthesia, it was the early eighties. I was in a class, I think the second year or first year after Title 9, equality for women in medical school admissions had come into play. And that was really a very important for me that more and more women had been introduced into medical school and could follow different career paths. But it wasn't easy. I think there were many things that were just not assumed would be easy for women, and it was true. Our family, I have four kids and the family life was a balance for me particularly, and I managed to work full time in the beginning. After I had my second child, I went to 80%. After the birth of our youngest child who has disabilities, I did actually take a leave of absence for a while. So the family work life balance has always been challenging for me and I think that's had an impact on my daughter's view of her career as well.

DR. STRIKER:

And Dr. Allie, how about you?

DR. TAYLOR:

Yeah, I think that that is true. Like you said, I'm currently a CA3 at the Medical College of Wisconsin, and we'll be starting a pain fellowship at the University of Iowa in a couple of weeks. I guess the beginning of work and family intersecting for me and my siblings was really around the dinner table. We commonly ate dinner together as a family and would listen to my parents--my father is actually also a physician--discuss cases from the day or interesting things that happened and that had sort of a funny effect. I have three brothers, all of whom chose different careers and probably provided me with a lot of insight about the job and the challenges, such that I took a winding road to medical school. I taught English abroad for a few years before going to medical school. So I think I came into this with a lot of understanding about what it would be just professionally, but also how it would affect me and my personal life and growing a family and those aspects of life.

DR. STRIKER:

Well, now, Dr Susan, you started practice in a world where as a woman, you were certainly in the minority in medicine and almost certainly in anesthesiology. Tell us just a little bit about your path and experiences from that perspective.

DR. TAYLOR:

Well, actually, I went to the University of Virginia as an undergrad, and I was in the second class of women there. So I really have a long history of being a woman where men were not expecting you to be as a colleague and an equal. And that probably helped me to some extent, although I have to say when I was in training that there were people still sort of assumed you didn't belong. And so a lot of us, I think, took the position that we were grateful to be there and did our best to overlook many things that would be now regarded as unacceptable. And since I accepted this participating in this podcast, I realized that terms like microaggression, sexual harassment, sexual discrimination in the workplace, were really not common terms. And it makes it much more difficult to feel and articulate those things that happen to you in the present when you didn't have the words to describe them or even to really comprehend how unacceptable some behavior was. So I think that we've come a long way. I think there still are challenges for women, but they're vastly different from the work environment that I began in.

DR. STRIKER:

What's your opinion then on how the current state of affairs is regarding work life balance? Specifically, as it comes to trying to have a life with your family versus professionally?

DR. TAYLOR:

You know, it's obviously better. I don't think anybody in my residency program at the entire institution challenged the notion that if you had a baby during your residency, your job wouldn't be there when you returned. And clearly, the world has come to accommodate reproductive issues for both parents, men and women, in the workplace. That's tremendously different. But I think there's two sides to it that I find a little bit interesting. One is tremendous strides have been made in terms of workplace equality. And as a baby boomer, I look at some of my very recent colleagues who are my daughter's age, and I felt that their demands of what was acceptable in the workplace, sometimes we're a little bit overboard. And that I wished I could say to some of them, Look, just take a deep breath. It's going to be okay. You know, you don't really have to get X, Y, Z. You're one of the team and play like you're on the team. So I think there's

been a little bit of the pendulum swinging too far in terms of what maybe both men and women think are their rights in a workplace.

DR. STRIKER:

And did you hope your daughter would follow you in your footsteps?

DR. TAYLOR:

You know, I think we try to be very open minded about the career paths of our children. And Allie can testify to that. I was a little bit surprised. She has some brothers whose ability to think in a scientific way are really rather exceptional, and they had no interest in that. And Allie is much more of a creative, emotionally sophisticated person. And so the science part of being a physician was not her strong suit, really. I think her ability to deal with patients and really make good relationships with people is her strong suit. So it did surprise me because I thought maybe, well, she was accepted to the Peace Corps and chose not to go and she had some opportunities for business in Europe. And I actually thought that's the direction she would head.

DR. STRIKER:

Well, Dr. Allie, why don't you tell us a little bit about your path, because you do have an interesting pathway to get to anesthesia. And given the trajectory, I am curious how you ended up where you are currently right now?

DR. TAYLOR:

Yeah, it's not a linear path. It is true that my parents promoted a variety of interests in their kids and themselves have broad interests outside of medicine. And so my siblings and I all benefited from being encouraged to pursue all manner of interests. In college I majored in geography and communication arts and sort of in the geography department is where I began to rethink and entertain the idea of going to medical school. I was very interested in health disparities as they're distributed geographically and the implications of that. So sort of a public health framework, I guess. But you know, then I thought to myself, well, I know a lot about what this career looks like. I know it can be challenging. I know it can be a burden on families of physicians. And so I thought I just needed to take more time and do some other things and grow some other skills. So I taught English abroad for two years in France and Spain, and then I went back and I completed the prerequisites for medical school, which I hadn't done, and then enrolled at the Medical College of Wisconsin. And really with the intention of going into primary care, sort of to address my initial interest in medicine, which was health disparities.

During medical school, had some great relationships with primary care providers. The person I was the closest with actually sort of shared with me his concerns about practicing primary care and the constraints that the system was starting to place on internists or family practice doctors, which was system wide metrics that you were supposed to meet and really feeling like that was compromising his practice. He went back to fellowship for critical care and I think this really impacted me and got me thinking about how different specialties and subspecialties were changing at the time. And so I really then had an open mind and one of my mom's colleagues at the Children's Hospital sort of rightly -- accused is maybe the wrong word -- but rightly suggested that I was ignoring anesthesia intentionally because of my. Mom's practice and career. And I think he was really right. I think I really wanted to do something different. But I, like I said, had an open mind and I did a month in anesthesia at the Children's Hospital, and I had a wonderful time. It's an incredible specialty with ... you know you have the breadth of medicine and the challenges of the procedural aspect, and it's a different work environment than the outpatient clinic. And so I really felt like actually that was a good fit and I'm really glad that I was in the end open to pursuing anesthesia, even if that's I was doing what my mom was doing.

DR. STRIKER:

Did that play a role in your selection of Pain Fellowship?

DR. TAYLOR:

I continue to be concerned about health disparities and the way people are affected disproportionately. And like my mom said, I do really value establishing effective and meaningful relationships with people. And the pain clinic is an environment, one, where you do interface health disparity for sure. And it also is an environment to continue to grow relationships over time, which undoubtedly meeting a person in distress and building a quick relationship that's trusting and meaningful before they're having arguably the biggest day of their life is important. But I did I do value longitudinal relationships, and so I'm sort of going a little bit full circle in my intentions to pursue medicine.

DR. STRIKER:

That's excellent. And while it's not uncommon to meet physicians whose parents or children are also physician, I think it's fair to say that mother daughter duos are less common. And bearing that in mind, coming from both of your unique perspectives, I'm wondering if both of you, how both of you view the question of gender parity in the

specialty and how it's changed over the years? And Doctor Susan, you touched on it already, but I think it's a really interesting topic to delve into a little more in depth. And so if you both could give me your perspectives on that, that'd be great. And let's start with Doctor Susan.

DR. TAYLOR:

The concept of microaggression is something that's really pretty new. And so events that occurred to me over the course of decades, there were many micro and macro aggressions, but not to be described that way. Well, I left my position about a year and a half ago, but what I see is there are opportunities often times that are accessible to usually to men. And the lack of the opportunity being offered is a way of an occult way of discrimination. And I think that persists. I actually left a department where the chair was a woman. And I think there are people in the department who sort of had a perspective that a flipside was occurring once she took over, because it looked like if you were in your early forties and you were a woman, you were more likely to be offered opportunities than men. Now that's my perspective. It was discussed, but I think it's maybe natural if like things attract on like magnets, people are attracted to things that make them comfortable and make them feel part of a group. And so historically it was always men and now that's not the case. So I think you can get gender disparity going both ways.

DR. STRIKER:

And Dr. Alley, how about you?

DR. TAYLOR:

The environment in which I worked is so different than my mom that thankfully I don't think I suffer the same discrimination that she did. Being a woman in anesthesia specifically, thankfully, and I could be ignorant to that. But I do think that I've faced some challenges being a woman in the workplace that have largely been related to reproductive issues and pregnancy, which is true across workplace environments, not specific to anesthesia. But the thing that I can relate to is the struggle of not having words to describe a problem. Once I found language for those issues, it was much easier to ask for help and address some problems that I was having.

So just to share, although it's personal, I think it's just worth talking about a taboo subject. About a year ago I had a miscarriage while I was working in the emergency department for a rotation just for a month, and it was relatively straightforward. But five days later I had a hemorrhage, again while I'm working in the emergency department.

And throughout those intervening days, every day I would go to work and sort of I chose the path of trying to describe my personal medical issue because I wanted to be able to elicit help if I needed it. But that was challenging because I had to carve out a little bit of time to talk to my attending about myself in a busy emergency room that was focused on taking care of other people and had to figure out a way to frame everything so that it was going to be a short but productive conversation. So over the course of five days, I became much better at saying to staff who weren't my staff because I'm not an ED resident. "Hi, I'm Allie. I recently had this problem. Everything is okay. But I want you to know in case. In case it's not okay." Like I said, progressively got better. I cried sometimes, but I developed a stronger voice. I was able to quickly carve out some time to talk about myself and recruit help if I needed it. And five days later, after the initial D&C, I start to bleed and I'm bleeding and I'm bleeding and I'm in the ED. And on day five, I didn't tell anybody that I might need help because I didn't think I would need help anymore. But thankfully I was pretty comfortable now with saying, "Hi, I'm Allie. And do you have a quick second? I need to tell you what's going on with me?" And he said, Well, what are you going to do? And I said, Well, I'm going to step away and I'm going to call the nurse. And he said, okay, you go call the nurse. And I came back, you know, 10 minutes later and he said, Well, what did they say to do? And again, remember, I'm in the ED and I said, go to the ED, which was lucky because I was already there. So we kind of laughed about that, thankfully. And because I was already in the ED got an ED bed from within the ED.

So this story I think is I look on it now and I see a lot of humor in that scenario. I see a lot of growth in myself. I see a burden that was borne by me because I'm a woman. And I also see that even though that's the case, people around me were so gracious and so willing and eager to help me, but only when I was able to find language for it and ask for it. And I think that, well, it may seem like a burden that you would have have a miscarriage at work or have a complication network. There's a real opportunity to expose and to benefit from the graciousness and the real compassion. I mean, these are doctors after all, right? And I think we take for granted some of those traits. But when when they're able to also take care of their colleagues, I think that's a really nice moment. And for that, I'm really grateful.

To circle back, I think that part of the struggle in the workplace in general is having language for our problems. Women, this certainly affects women specifically in specific ways, but I think that's the shared struggle across all of us. And the more and more we can try to see the limits of the language that we have and work through it and learn how to talk about our struggles. And I think we'll be better and better suited to coming up with solutions and improving our gender parity and improve the workplace environment in general, because we're all humans, after all, with unique lives and experiences. So I'm hopeful that we'll continue to improve over time.

DR. STRIKER:

Well before we move on I just want to say thank you for sharing that story. It's a moving story and I appreciate you sharing it. Number one, because it's encouraging to know that a lot of your colleagues were supportive. I find it very heartening to learn that. But secondly I think it's important that we all hear these kinds of stories because, you realize that everybody has a different set of experiences and backgrounds and problems and issues that they have to deal with. I think it just helps all of us to know that we're all grappling with our own challenges and I think it'll just help make our overall working environment better when we all can relate to each other.

Through other vehicles we talked about in other, these same issues on this podcast, whether it's race, gender, or what have you. And Doctor Susan, I think you touched on it. It seems like a lot of the undercurrent of bias or lack of opportunity for certain genders or races is an occult phenomenon. It's covert. It's very subtle. And so it probably does take some years of experience to pick up on to that or to understand how that really manifests. And do you think that's continuing to get better, or do you think that younger generations are going to pick up onto those same kinds of signals?

DR. TAYLOR:

You know, that's a complex and interesting issue to address. I think that my attitude about my career over the course of time was that I was not going to bring gender issues up, that I was going to do my best in terms of how I interacted with my colleagues, how I took care of my patients, and that I was not going to play the gender card. I think the comment Allie just made are reassuring to me that that's the model that she grew up with and she also doesn't see glaring issues with gender and her experience to date. However, I work with a number of women that are her age, and they see tremendous gender issues that are challenging and difficult for them to face. And I lived in the same world they did. So I think that, and I'll say one more thing, on reflection, after I decided to leave my career, I saw some of the gender issues that I didn't like watching other people complain about as reasons why I actually left my position. And so I denied it for many, many years. And now I go, Oh, well, some of this had to do with the fact that I was the woman I chose not to work full time. Opportunities were not provided where somebody else would have had them. And after almost 40 years of saying those things didn't matter, I have a little bit of disappointment over the things that I chose to ignore over time.

DR. TAYLOR.

I guess I want to sort of chime in] and add a little bit more to the challenges that I think I have faced, have been more personal with respect to my gender. I think learning skills that my mom and I maybe are weaker in as women, things like figuring out how to ask for what you want and advocate for yourself and to make your needs known. I think that is something that I struggle with and perhaps, while, I think my mom is right, I choose not to frame struggles as gender related, probably because of what I have as she is modeled, and perhaps also because I think there's other effective ways to work through a problem. I think there are skills that I continue to need to develop to be even more effective professionally. And that's been exposed to me that I don't necessarily address some problems in the same ways that my male colleagues do and that that is perhaps sometimes a problem for me.

DR. TAYLOR:

I think that was really a compelling point to make because when you talk about gender issues in general, people describe the assertive man as maybe a leader and the assertive woman who's a little more aggressive as an unfavorable term very frequently. So I think it's a global problem for women to figure out how to be a gracious human being and emphatically work toward the things that you want in the same way that a man does. I think that's a real problem that persists today.

DR. STRIKER:

That's not surprising at all, based on my own experience working with many colleagues over the years. But this brings me to, I think, the real big question, which is in your perspective, how do you tackle that? What do we need to do to perhaps alter the environment such that regardless of whether it's a male or female, the physician can advocate in the way they see most appropriate. They don't have to worry about considering that difference or bias when they do approach a problem. And Doctor Susan, with your unique perspective, since you've left that position, I guess I'm particularly interested in how you would survey that and offer some kind of, shall we say, global advice, if you will.

DR. TAYLOR:

I didn't figure it out for myself, so I'm maybe not the best person to give advice. However, I think that one of the things that probably held me back in may not be a gender issue, but a personality issue because I got through my career tremendous reward from the intimate experiences I had with patients, from knowing that I saved somebody's life, from knowing that I taught somebody the right thing to do. And for the most part, I actually it really didn't matter to me how high the career path I climbed until I

went to Zimbabwe on a mission trip and got involved with the University of the medical school there. And I went back as a visiting professor and they asked me if I would be the International Board Examiners for their senior residents who were required to have do a thesis, a project, and a written board, an oral board and the oral board and written board had to be evaluated by an external examiner. And they asked me to do that. And there was a lot of hemming and hawing. And over the course of about 9 to 12 months, they withdrew the invitation because I wasn't a full professor. And that's when I started thinking - I published, I've spoken, I've done presentations, I've done research, and it wasn't enough in that environment because I wasn't a full professor. Which I honestly never really cared about until it started holding me back. And then I realized how many obstacles were in place for me. Partly, I think, gender related, and also because I was primarily a clinician and the path to professional advancement required things that oftentimes clinicians didn't have the time to do. So I think a woman who wants to have work life balance will often not admit to herself or admit early that she has professional ambitions, that she's going to have to rethink how she has her career path evolve.

DR. STRIKER:

And Dr. Allie, I know you don't have quite the same level of experience yet. If you had to guess now, do you think it's just time? Do you think that the newer generation already has made greater strides in understanding the diversity in the workforce? Just want to hear what your perspective is for the future, if you will.

DR. TAYLOR:

I don't know that I'm really in a position to give advice, but I think more and more I have pushed my own comfort level when I've had some issues that involve asking for something that you need or issues related to pregnancy and motherhood. The more and more I've had to face navigating those issues, the more insight I've gotten into myself and my own weaknesses to me and I think have been opportunities to grow. Just continuing to examine the areas that are challenging for you as opportunities. And I think talking about that is probably pretty helpful. Without saying too much about it, I think I've learned how to give language to problems that, like my mom was saying, it's much easier to talk about a problem if you have language for it. And I think finding language for some of these issues has been challenging for me, too. And I think once I've come to be able to describe a problem, then coming up with a solution or even eliciting help from people who definitely do want to help you once they know what's going on is much easier. So I think continuing to figure out navigating that is a good thing.

The other thing, I think that workplace culture is making efforts to promote diverse experiences and the strengths that different people and individuals bring to the workplace. You know, I've worked with my mom and I've seen her clinically. I mean, she is brilliant and she's she's everything an anesthesiologist should be, in my opinion. But I think when she really shines is, for example, getting to know the parents and the children before going back to the operating room. And I think the reason why she shines in that moment is because she is a woman and because she is a mom. And I see her colleagues who are men who don't shine in that moment. So there certainly are strengths that everybody brings. And I think being a woman in the field of anesthesiology and being a mom, it brings a unique set of skills to really make a difference in people's lives.

DR. STRIKER:

Well, I've got some more questions for the two of you, and we'll delve just a little bit into the interplay of your relationship and the generational relationship, specifically as it pertains to anesthesiology when we come back. So please stick with us through a short patient safety break.

(MUSIC SOUNDBITE)

DR. SCOTT WATKINS:

Hi, this is Dr. Scott Watkins with the ASA Patient Safety Editorial Board. Nothing strikes fear in the hearts of anesthesiologists more than the difficult airway, except perhaps the pediatric difficult airway. The physiological difference in oxygen consumption between adults and children are well known to all anesthesiologists. So it will come as no surprise that the most common complication involving pediatric airway management is desaturation or hypoxemia the use of passive oxygenation by nasal cannula with flows as low as 0.2 liters per kilogram per minute significantly increases the time to day saturation during airway management. This benefit is found with little to no discernible downside, suggesting that passive oxygenation via nasal cannula should be considered any time a potentially difficult pediatric airway is encountered. This is one way to improve the overall safety and success of airway management.

VOICE OVER:

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DR. STRIKER:

Well, we're back. Dr. Susan, I'm sure you've given your daughter advice over the years. If you don't mind, talk to us a little bit about what that looked like, specifically relating to professionalism or just clinical advice or just about being an anesthesiologist and maybe other professional aspects, whether it's business related or what have you. How has that looked and how have you felt that's gone?

DR. TAYLOR:

Well, I think we are blessed with having a pretty good relationship with each other. And I try as a parent, both professionally and in the family sense, to give space to my children. And my daughter will attest to the fact that not always successful at that. But I think I was really touched by how often she asked my advice about patient care and strategies for coming up with a treatment plan for patients. And even since I've retired, you know, she would call me up and she goes, Well, you know, this just isn't making sense to me. And I could you just go over this with me before I call my attending? Or she would say, Well, my attending said this like, what do you think? And so we really have been very lucky to have such a comfortable relationship with each other professionally. In terms of the business side of it, Allie's world is a little bit different than mine. My husband was a radiation oncologist. I sort of in his design, whether we actually spoke about it clearly or not, his career came first and the financial advantages I brought to the family were not as important as the primary breadwinner, let us say. And Allie is going to be defined the financial structure of her family, because her career path is much more lucratively reimbursed than her husband's. And so she has a different way of looking at this that I can't help her with. And it'll be interesting for me to see how that plays out for her. The flip side of it is she has a partner who's very accommodating to the needs of her career. Although she tries to make sure there's a balance and decisions being made, she doesn't have to conform to the man's career path, which actually for me was how I lived my professional life. So professionally, that's a complex answer to the question because I think I can't I'm not going to model for her what her future's going to look like.

DR. STRIKER:

Well, Dr. Allie, there's got to have been some pros and cons maybe to having a mother who was an anesthesiologist working same exact field. Talk a little bit, if you will, about some of the good and maybe some of the frustrations, if you will, of having a parent who knew exactly what you were doing on, on a daily basis.

DR. TAYLOR:

This is a unique position to be in, for sure. It's easier to speak to the pros. I think it is a unique position to be in, to be a physician in general, to be a resident. It is very helpful to have two family members who are sympathetic to the cause and can just relate to the day to day grind and the hours or the painful learning that occurs sometimes as a resident, the mistakes, the sickness that's around you, the suffering that's around you. I think that just having people who actually know and can relate to that is extremely helpful for me over the past four years. And I also did, like she said, I really valued having someone who was a phone call away who had I know that she has a lot of intellectual curiosity and so was willing to, I think, listen to me and my medical questions and my clinical reasoning and help me sort of walk through some ideas about how to take care of patients. And I think that was helpful, even though it's in the abstract sense, whether it occurred before a case or after a case probably enriched my learning in ways I can't really understand because I had the benefit of doing it. But I, I certainly think that was really helpful for me. And] just working with her in general, I think modeled a lot of positive behaviors in the operating room, which I don't think other people really necessarily had access to.

As far as the cons, you know, it was surprisingly many people had the same line when they found out that I was Dr. Susan Taylor's daughter, which was this notion that, oh, you must have learned anesthesia in utero. And the answer is no. But I think the con that really comes to mind is probably wrongly thinking that I was held to a different standard because I had this exposure to anesthesia. So I think I felt a lot of pressure to perform in the setting of working in the same department as my mother, which I think mostly was positive. I mean, there's a positive spin to that, too, which is that you feel pressure to perform well. But sometimes there's maybe something that I would have sometimes been okay avoiding.

DR. STRIKER:

Well, was there any specific advice that your mother passed on to you that sticks out to you?

DR. TAYLOR:

I don't think it's something that she said, but I she mentioned this, and I think it's worth highlighting. You go to medical school, you go to residency, and you kind of envision this linear, professional path for yourself. And it turns out the more you talk to people, the more you realize nobody's path is straight and different things happen. Your interests change, your personal life changes. And it certainly was true for my mom that she stepped away from practice for ten years to take care of one of my siblings and then went back into practice and continued to excel. And I think the fact that I know so

intimately what happened and why it happened and how it played out for her, including leading her back into medicine and anesthesia specifically is, I think, good advice for everybody. This trajectory is not going to be straight and narrow. It's going to take all kinds of turns. And that's normal. And that's probably for the best for you and for your career. And I'm grateful to know that.

DR. STRIKER:

Well, I'd like to hear both of your perspectives on the specialty in general. First, let's start with Dr. Susan. I'm sure you've seen anesthesiology change over the years. And then I'd like to get, Dr. Allie, your perspective as a new anesthesiologist and how you expect it to change or how you see it going or how you'd like to see it going if you feel like you have a thought on that. But Dr. Susan, let's start with you. How have you seen the specialty change over the years?

DR. TAYLOR:

I've always been in an academic practice, and I started out at the University of Virginia, which I think was they wanted to be difficult. They wanted the demands to be high. Your performance was expected to be very high quality and you were expected to come up with a plan and decide how you're going to take care of the patient, discuss it with the attending, and they would let you execute. And of course, you know as well as we do how much medical education has changed in the last 40 years. But what I always wanted to do was be the kind of instructor that I had, which was to expect that the trainee was going to think and question and come up with alternatives. And some of them didn't like it, I guess. But in point of fact, the evolution of anesthesia education and medical education in general is to learn a bunch of algorithms, read a whole bunch of guidelines and recommendations, and for heaven's sakes, don't think. And I find that really disappointing. And my daughter had to think she was going to talk to me. And I think that we've adopted the model of the airline industry as a way to improve patient safety. And I would just say to residents on multiple occasions, look, you know, it is a great model, but we're not. 747s. We're all different. So what are you going to do when the patient shows up and they're different? You've got to think through this. That's not a common part of medical education anymore. And I regret that. And I also think that the evolution of medicine in general and anesthesia specifically toward increasing the number of mid-level providers and turning the physician anesthesiologist into more of a position where you're an administrator rather than an on hands patient care provider, is something that appeals less to me professionally. And I know that there's many people who opt for that model and who like it. But as I was getting toward the end of my clinical career, the idea that I was going to either be supervising nurse anesthetist or

anesthesia assistants and only occasionally be teaching residents or working by myself, was an evolution that I really didn't really want to continue forward with.

DR. STRIKER:

Well, in Dr. Allie, what do you think? How do you foresee the specialty changing or would you like to see it change?

DR. TAYLOR:

I think there's two parts, I guess, to the change I see. One is the continued sub specialization of providers and the idea of the rise of the mid-level provider as the second thing. You know, I think that. If you want to continue with direct patient care in anesthesia, sub specializing is a great way to do it. It's a great way to perhaps not do supervision. And then the second part being the continued rise of mid-level providers in the operating room. That's something that is obviously not something new that I'm saying. But what I think is worth mentioning is that even in my residency training, there is an element of supervision that is unintentionally added to our residency training because there's an AA program at the medical college and the residents, we participate heavily in their education because of shared time in the operating room. And so even embedded in my residency program is an element of supervision and how to do it and how to establish relationships with your counterparts and figure out how to watch their choices and navigate their choices, and on the flip side, elicit their help when we need help, an extra set of hands and things like that. So that's definitely different than when my mom was training and is a reflection of that evolution, for better or for worse.

DR. STRIKER:

Yeah, you know, these topics we've touched on the future of anesthesiology before in previous podcast episodes. These are topics that, I mean, we could spend hours talking about and they're fascinating. And I think both brought up some not only some very interesting points, some significant concerns and some significant observations about the specialty. And those will be debated for for for much more time. And I would love to get into those even more, but I don't want to keep you guys too much longer. And I do have one last question before I let you both go. And that is, what personality characteristics or characteristic specifically have you found to be most important in your career? And let's start with Doctor Susan.

DR. TAYLOR:

Calm in the midst of disaster is the thing I found most valuable in being able to do my job. And I remember even from when I was a resident, you know it's chaos at 3 a.m. that I wouldn't really sort of unravel until I got home. And I think that we have much of our job, which becomes rather routine and rather straightforward. But when you find yourself in the middle of a disaster, you cannot execute well. If you let your emotions interfere with your ability to think rationally and productively to benefit the patient. I think I just am lucky to have that, and I've been grateful for that throughout my career.

DR. STRIKER:

And Dr. Allie.

DR. TAYLOR:

My biggest strength is, in my opinion, like my mom said, I think my ability to communicate effectively with the people around me from connecting with patients to building relationships with OR staff like circulator nurses, pacu nurses, my colleagues, my fellow residents. I think that that's allowed me to navigate crisis effectively or as best as I could by having trusting relationships with the people that I needed to help me.

DR. STRIKER:

It's always communication always comes down to communication, it seems like.

DR. TAYLOR:

For me?

DR. STRIKER:

For everyone. Oh, for everybody. Communication. It's always seems like that is always what ends up being something that's easy to list but so hard to achieve for so many in many situations, but yet is so valuable. So it's a good way to end that.

Well, I want to thank you both for joining us on Central Line. It's been a fascinating conversation. You bring such an interesting perspective. And I love hearing you talk about your relationship and seeing the different generational perspective about our specialty. And so I just really want to thank you both for joining us today.

DR. TAYLOR:

It was a pleasure to be here.

DR. TAYLOR:

Yeah, thanks for having us. It's been interesting to reflect on those issues as well.

DR. STRIKER:

Well, it's great having you and we'll have to have you back again soon and see how perspectives have changed and talk about more anesthesiology topics. Thanks again and thank you to our listeners for joining us again on Central Line. Please leave us a review. Tell your friends about it, tell your colleagues about the podcast that really helps and tune in again next time. Take care.

(SOUNDBIT OF MUSIC)

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