



American Society of
Anesthesiologists[™]

Central Line
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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. BROOKE TRAINER:

Welcome to Central Line. I'm your guest host for today's episode. My name is Dr. Brooke Trainer, and today we're flipping the script, putting Dr. Striker on the hot seat. We've heard him ask all the questions and get real down and deep with all of our guests. And now it's time to hear from him. Welcome to your own show, Dr. Striker.

DR. ADAM STRIKER:

Thanks, Dr. Trainer. Certainly already a little more nervous being on this end of things.

DR. TRAINER:

It's a little more nerve wracking being on the other side of the curtain, huh?

DR. STRIKER:

Yep.

DR. TRAINER:

So listeners will know you as the host of Central Line. This will be the show's 73rd episode. But many probably don't know that you are a pediatric cardiac anesthesiologist trained in my hometown and alma mater of Indiana University, I might add. Go Hoosier. So you often ask your guest to introduce themselves. So it seems only fair that we start there and ask you to tell us a bit about yourself, your clinical work, etc. So I'll hand it over to you. Tell us a little bit about yourself.

DR. STRIKER:

Well, you mentioned the Hoosiers. Now, funny enough, I actually am a boilermaker. I started off at Purdue as a – I know, I just just disappointed you. So I was an engineer, a chemical engineer by training. And but that's how I wound up at IU for medical school. I met a lot of people, both through college and and medical school. So I have a lot of great friends from Indiana, but loved, loved IU when I visited it and decided to pursue medicine there.

But really, you know, everybody's got their own story about how they got into medicine. I, I really plan on being an engineer, but I found myself really thinking about the aspects of being a chemical engineer within a health care framework and looking for opportunities there. And ultimately, with a little bit of encouragement from my parents, I found myself looking into medical school being that I felt like what I really wanted to do was be involved in medicine and taking care of people. And that's kind of what I liked. And then saw how I could bridge from engineering to medicine, how I could integrate what I learned in engineering school and in a medical school. Would it work? And so that took a little bit of doing actually. This was some some years ago where, you know, the resources were not as probably readily available for people like us who had maybe a little more unconventional pathways. And I don't regret at all going to an engineering school. It was a great experience and it was a really a great training ground for medical school. Ultimately, you think differently. And so it really helped with a lot of concepts when I finally did get to to med school.

And then ultimately when when I got there, I really I thought for sure I was going to do something like emergency medicine. I just I love the idea of it. I was in college when E.R. and Chicago Hope started, and those were exciting shows and seemed like that's where all the action was. And funny enough, I did, there were we were looking for jobs in between first and second year med school, me and my classmates, something that had to do with medicine and all these great externships were already taken and the anesthesia department was looking for students to do a few weeks, basically learning about anesthesia and helping them out in the ORs. And I knew nothing about it, but they said they would teach us clinical skills and it would be interesting. And we got a free textbook and it sounded kind of cool and nobody else I knew was doing it. So I decided to do it. And then, you know, long story short, I ended up choosing that as my specialty. Ultimately, I fell in love with it. I loved what anesthesiologists did. I didn't know anything about really what they did other than they put people to sleep, which is kind of a microcosm for our role on communications. Now, as we stand today and dealing with the public and the lack of knowledge about what we do. So it's it's interesting, but that's that's how I got started in anesthesia and I haven't looked back since.

DR. TRAINER:

Yeah, I could definitely see the connection between being a chemical engineer major and going into anesthesiology. I could also understand going into cardiology, you know, anesthesia and cardiology. But I haven't been able to figure out the pediatric part of your fellowship. So can you give us some explanation or what really drew you to specifically pediatric cardiology and anesthesia? I mean, this is very specialized. And any advice that you have for rising anesthesiology residents or even medical students who are contemplating going into a fellowship or debating between specialties, whether or not it's even worth it to pursue a fellowship and one that's so specialized, for example.

DR. STRIKER:

Yeah, certainly. So, you know, once I got into anesthesia and I really enjoyed it, but one thing I would never, never have guessed if I had to pick a specialty or subspecialty when I went into it was pediatrics. I was fortunate that I was at a program at Indiana University at the time, and they still have a heavy pediatric load for the residents. But at the time it was even more so. And you started off doing pediatrics your very first year, and that was at Riley Children's. And the experience there was very immersive, plenty of staff. There were wonderful staff that were great teachers, great role models, and you ended up learning quite a bit there, but also functioning fairly independently under appropriate supervision. And so you got, as a resident, you got to do quite a bit of pediatrics and do it in a way that was very engaging and where you learned a lot about physiology and surgical problems within the pediatric population. So I spent a number of months in that environment, but really some of the role models I had as staff were very encouraging about pediatrics. And over time I started thinking more and more because every time I rotated through there, they'd say, Hey, Adam, why have you thought about pediatrics? We think you'd really be good at it. Now, for all I knew, that was a recruiting tactic. I don't know. But, but I started thinking about it, and I found that I really enjoyed my days there. And they were oftentimes longer days because of busy service. But I enjoyed the work during the day and I enjoyed my time there and I think I found I enjoyed it even more than some of the other locations.

And so when it came time to looking into subspecialties--and I considered ICU, I'd consider just going out and getting a job. And a lot of my colleagues did that. But ultimately when I was thinking about plans afterward, again, took my time, looked more into it and decided, you know what, I think I would like to do this. And I wasn't 100% sure. I was maybe 90% sure. But I felt at the time, pediatric anesthesia fellowship is a year. There's even more subspecialty sub subspecialty training. If I said that right, you can do advanced cardiac pediatric fellowships and paying fellowships in pediatrics and whatnot. But the general pedes fellowship is a year and I thought, this is not a huge investment of time, it's only an extra year. I'm never going to go back and do it again if I

don't do it. But the worst case scenario, I've spent an extra year getting pediatric experience, and if I don't want to do pediatrics as my primary practice, then I'm not very far out. I can just go back and do kind of adult anesthesia, regular anesthesia, go through it, pursue something else. That's why I decided to do it. I felt like it was a good use of a year. It was a very high yield, low cost, if you will, year both financially and time wise. And so then I did it and I really enjoyed it more than so I ended up just working in the field in tertiary care pediatrics since then. And part of that fellowship experience was cardiac. And I really enjoyed the cardiac physiology, when it comes to pediatrics and congenital cardiac physiology and problems and dealing with the anesthetics and figuring out how best to proceed with an anesthetic, what are pitfalls when you are dealing with congenital physiology? And it just I just really enjoyed the thought processes and the challenges of each and every patient and every specialty and every facet of anesthesiology has those.

And when you talk about what advice to give to other residents thinking about furthering training, I think one piece is to have an open mind. You never know what you're going to like and everybody is a little different. Everybody has different aptitudes, everybody has different interests. And try to just let it come to you and feel it out as to what do you enjoy doing on a daily basis because you're going to be doing it for a long time. But I will say that I personally I'm biased because I went on to do a fellowship. If you're thinking about a fellowship, I highly recommend it, whatever the subspecialty is, because right after residency is the time to do it. You're still in the mode of learning, you're still in the mode of training, and I imagine it's a lot harder to go back. It's not that you can't do it, but I would take advantage of the time you have and the ability to get into these programs. You know, worst case scenario, you can always revert back to kind of what your original plan was. But I do think it's worth it if you're thinking about doing a fellowship. I think a lot of people might miss out if they if they don't pursue it. And a lot of the fellowships after anesthesiology are not that long relative to your whole career.

DR. TRAINER:

Yeah, that's right. I mean, I can't agree more. I'm biased as well, but I'm one of those late comers to fellowship. I pursued a critical care fellowship about ten years into my practice. There's been a lot of debate in the anesthesiology community on whether pursuing a fellowship is really necessary or worth it. And are we sacrificing lifestyle and money and time away from family by doing this? And I agree with you wholeheartedly that it was worth it. And yeah, I think the more knowledge is power, right?

DR. STRIKER:

Yeah. Well, and what you did is we took the other tack, which is great. You know, if you're willing to do that, that's that's a great way to do it as well. But I think a lot of people getting out into into the workforce, if you will, and getting into the routine of what they're doing now for the foreseeable future after training. I think it's a lot. I bet you for most people it's not easy to do that. And it is a sacrifice of time and money, but everybody has to make that decision for themselves. But I will say, I just think when it comes to your well being, what you want to do for a whole career, I personally just don't think it's that much of an investment in time and money. When you think about your entire career and your daily work life balance, if you will, and something that you really want to you really like to enjoy for for some time.

DR. TRAINER:

Right? Yeah. So you also serve as I mean, as if you don't have enough on your plate, but you also serve as chair of ASA's Communications Committee, which is the committee that I'm on with you. And it's how we met. And I've really admired your your leadership. You've had a lot of involvement in a lot of the different campaigns and avenues that we've pursued in that committee. But can you talk with us a bit about your pathway to that leadership role, and particularly even more broadly in organized medicine and the ASA? And talk a little bit about how your career evolved to include the role as committee chair and even hosting this podcast, for example.

DR. STRIKER:

Yeah, this is a ... that's a great question. Well, let me start off. We were always encouraged in residency to be involved in professional societies. But, you know, when everybody gets out to work, you're just worrying about keeping your head afloat, figuring out your job, just trying to make sure you're doing a good job. Really, I got involved in more professionally as a staff when I got to my first job out of fellowship in Kansas City and I had a role model, Doctor Cathy Perryman, who was the chief of anesthesia at Children's Mercy in Kansas City at the time, was very encouraging of me to get involved with the Missouri Society of Anesthesiologists. We were talking about anesthesia issues in general, and she was heavily involved. And she said, you know, we really are looking for people to be involved in the state society. I think you seem to really be engaged in in these issues. And and if you want to do something active that would help contribute to the optimization of solving problems or contributing to making our lives better, as anesthesiologists, you should get involved.

So I started getting involved at the state level society there and kind of in parallel, I was also tasked in that group to start making checklists for the anesthesia machines. Nobody had done that yet for the group. There was like the manufacturer's checklist, but

nobody had actually made it a department checklist that we would all use every day for the machines. And I started doing research as to what the assay recommended, and I knew there was more to it than just what the manufacturers recommended. So as I was looking into that, I called up people on the Equipment and Facilities Committee as I got referred to them by people I knew to try to get answers on how best to make these checklists and got a little more involved with that committee simply because I got to know them a little better. And I thought, Hey, this sounds really interesting. They told me they had just worked on revising ASA guidelines, on checking anesthesia workstations out, and they were in the process of implementing that, but they were still doing more work. And I thought, Hey, this sounds really interesting. And so I asked them, you know, do you need help with that? I'm happy to help. I think this was really fascinating. And they said, yeah, absolutely, we could use help with cataloging these hecklist. We're trying to maybe get different examples from different institutions. And so I started to get to know them.

And then at the same time, I was getting involved with the Missouri Society of Anesthesiologists. And then when it came time to to recommend people for committees, you know, my name came up and I told them I was involved just with working with the equipment facility committee. And I said, that would be great to get on that because I really liked working with them. And sure enough, I got on that this was a number of years ago and so I started my work with the ASA and then I really enjoyed working on that committee. And then the more I got involved, the more I realized what other opportunities were available at the ASA with other committees and other work products, and so started getting involved in other committees.

And then after some years I got on the Communications Committee and really enjoyed that and then took over that a few years ago as chair of the ASA Committee on Communications. But it was really a stepwise approach of involvement both at the state level and the national level at the ASA that that got me to where I am today.

There's a lot of different ways to get involved. But I, I tell new staff and residents it starts small, but there's plenty of opportunities to get involved, even if you don't have a formal role. And that's that's how I started. And I'm sure it's all a lot of people started. I looked for I a task in my group and then I ended up just getting to know people, the ASA because of that task. But there's there's a lot of ways to get involved, both your state, national levels, societies where it just may be an interest you have within the field that causes you to start doing more and more.

DR. TRAINER:

Yeah. And that was actually going to be my follow up question was what advice for young ASA members or new anesthesiologist or even just members who have question now, how is it that I get involved in this committee or that committee? And they're eager, they're motivated, they want to be more engaged, but they're just not sure where to start or who to talk to or what what to do to position themselves as candidates to be even considered for these committees. Any advice?

DR. STRIKER:

Well, nowadays it's very difficult to get on committees because there's a lot of interest from a lot of a lot of anesthesiologists around around the country. And so it's not it's not easy just because the interest has gone up over the years. So it starts small. But to get on a committee doesn't necessarily happen right away. It can for some people, and it depends on the committee. They're certainly going to be more popular committees than others. There's over 100 committees or review committees to get that you could possibly get on.

But the advice I would give is, number one, if you have an interest, you don't have to have an official role to be involved if you have an interest in anything -- blood management, pediatrics, obstetrics, finances, governmental affairs, whatever it is, find the committee. And they're there on the website for members. And find who's on the committee, who chairs the committee. And usually you can find someone that you might know or you know, someone that knows. And if not, that doesn't mean you can't get in touch with. I would get in touch with one of the committee members and say, How can I help? I'm really interested in this. What advice do you have for me with regard to this special interest that this committee works on? And what can I do and they'll get to know you? And that that is very helpful. And then in addition, as I told the residents where I work with currently, you know, you try to get involved with your state society because that's the state societies tend to have a lot of influence with the powers that be that choose the committee members. But also they have a lot of say from their region with who they'd like to represent their areas on these committees. And a lot of times the committees are chosen based on a number of factors, but in general, they try to make the committees diverse in terms of background, diverse in terms of practice, diverse in terms of geographic region. So you have a wide variety of thought and expertise and experience to draw upon for the betterment of the society and the specialty. So that's a good, easy way to start getting involved and get known.

You don't have to wait to get on a committee to be involved. There's plenty of opportunities to help out. I'll give you a great example. When I was on the Equipment and Facilities Committee a number of years ago, we started up a environmental task force. It was borne out of the Equipment and Facilities Committee. It was a few

individuals that felt strongly about environmental issues as it related to anesthesia. And for years it was a subcommittee of that committee. So you had members from the Committee on Equipment and Facilities that were a member of this subcommittee, this task force. But the subcommittee was open to anybody that wanted to join. And so anybody that had an interest in environmental sustainability or in environmental issues was welcome on it. And there was a lot of opportunity to be involved in and do subcommittee work products and help out. And so even though you didn't have an official role, and that's still the case today, and it's grown quite a bit as environmental issues have become even more popular with the membership, and certainly the importance has grown as well. Obviously, that's a that's one example of how you could be involved and not necessarily have an official role. But you're intimately involved with with committee work product.

DR. TRAINER:

Yeah, absolutely. And I will say the communication that's come out of the communications committee, including ASA's branding and just branding anesthesiology broadly, how it's expanded and grown to the point where now they've even developed a product that is helping anesthesiologists brand themselves with patients. It's helping communicate our value and what we have to offer with our C-suite administrators and even our surgical colleagues. How would you say that the responsibilities and objectives of that committee have evolved since you've stepped into your role as chair, especially when you consider what's happened with the pandemic and even the movement for us to be a more diverse and inclusive organization.

DR. STRIKER:

A great question. When I joined the Communications Committee a number of years ago, the task of the ASA Committee on Communications, I think this actually is probably misunderstood by a lot of the membership. The real primary purpose is that this committee is dedicated to increasing public awareness of anesthesiologists, as well as the specialty of anesthesiology, and in addition, improving resources and making them available to all physician anesthesiologists so that they can communicate the critical role that anesthesiologists play. And misunderstandings, I think, people probably assume that communication is involved in anything the ASA puts out, but which isn't necessarily true. We're a more strategic committee that offers input, advice to the larger body and how best to accomplish this. But we're not intimately involved as a committee in every message or every statement the ASA puts out. That stuff comes from ASA leadership, and we felt if ASA leadership asks us, we will specifically weigh in on certain issues. Like our most recent made for this moment campaign, the ASA Committee on Communications does a lot of vetting of images. And when I say campaign material, it's

not campaign in the political sense, but campaign in like the the made for this moment campaign of getting the message out about who anesthesiologists are. The Committee on Communications does a lot of work in that regard, but that's the primary role of the of this committee.

And when I joined a number of years ago, it was about making sure our we had interviews in different media outlets. It was about making sure people would come to our website. It was about making sure that we had social media hits, you know, those kinds of things. How much play are we getting in the press? And that seemed to be where the focus was. Then the committee had worked on a campaign called When Seconds Count, which was to help educate the public on what anesthesiologists did and provide information to the public about the specialty of anesthesiology and drive try to drive traffic to that site so that people could learn more about it.

Over the years, though, it's become apparent that the public simply just doesn't know as much as we would like them to about who anesthesiologists are. And a lot of times they don't even know what we do. And we felt like at this point, especially over the last few years, it's imperative that we take a more aggressive approach into trying to rectify that. I think all of us would agree that anesthesiologists are critical in health care, and for each patient, they're critical. And how do we make sure that our patients know that? How do we make sure the public knows that? Because if they don't, the patients don't know it. If the public doesn't know it, then anesthesiologists will be further devalued in any number of senses to the point where they won't be available to patients or the health care system. We all believe that it's critical that we're involved.

And so we felt as a committee and as an organization, that we had to be a little more proactive. And so hence the Made for This Moment campaign was created and invested in. And it's an ongoing, large, proactive project that is attempting to target various audiences in different ways so that that message can resonate about who anesthesiologists are and what we do. And so it's remembered. I think most if you ask a layperson anywhere out on the street, they're going to know what a surgeon is. But I don't know that a lot of them are going to know what nesthesiologists are. In fact, research has borne that out. A majority of people actually this was a few years back, did not know that anesthesiologists were physicians. And so there's a lot of work to do and it's going to be an ongoing task. But I think that's probably the biggest evolution, if you will, of the Committee on Communications over the last the last few years.

DR. TRAINER:

Yeah, that's right. I think even my experience on the committee has sort of taught me a thing or two about communicating with patients. I mean, I used to introduce myself, hi,

I'm Brooke Trainer, one of your anesthesiologists going to help you go back to surgery, make sure you're comfy and safe for your procedure, never saying or introducing myself as doctor. And then I was quickly called, Hey, nurse, can you get me that or this? You know? And so that has to do with a lot of the stereotypes of females in the workforce, and it's changing. And we are a more diverse workforce, but patients don't always know that. And you're right, like a lot of times they think that we're ancillary staff or maybe not a physician. And so I think what we're what the communications committee is doing is very meaningful to helping patients understand our value.

So I want to talk more about the show and and you and get to know you a little more and get our listeners some more information to to share with you. But let's take a quick break, a patient safety break first, so stay with me.

DR. DEBORAH SWINGLE:

Hi, this is Dr. Deborah Swingle, chair of the ASA Patient Safety Editorial Board. Mass casualty incidents exert extreme stress on health care institutions. Hospital incident command systems and crisis standard of care protocols exist in most hospitals, but gaps in knowledge of protocols can leave clinicians feeling unprepared.

Anesthesiology departments can and must prepare by educating staff and allocating proper time and resources for training and rehearsals. These range from classroom based teaching, such as lectures, workshops, game based learning and tabletop simulations to small and large scale hospital simulations. Pay extra attention to vulnerable populations such as pediatric, pregnant, geriatric and mental health patients. And don't forget to address mental health care for patients and staff. The time to prepare is now.

VOICE OVER:

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

DR. TRAINER:

All right. Welcome back to the show. One thing I do want to talk about the podcast and how things started with Central Line. But before we do just want to close the loop on your role and your work with the Communications Committee. I know there's a lot of work products that have come out of that committee. One being the enhanced patients toolkit. And I know this gives us their members, gives members a lot of good information on communicating effectively with colleagues. But can you give us some of your best

tips and sort of talk a little bit more about that, that work product and how it's benefiting and how members can benefit from it?

DR. STRIKER:

Yes, thank you for asking. The this is a good example of some tangible resources that the committee has provided the membership. You know, it's easy to just talk about how we should be better communicators, but we wanted to go a step further and actually make some real, tangible resources available, as is charged by the ASA for the Committee on Communications. And so when we started the Made for this Moment campaign, we targeted different audiences: policymakers, C-suite executives and and our patients. And as a committee, we decided patients was probably the most important piece, because as time goes on, if our patients remember us and know who we are and know how valuable we were to the care they received, they're going to want to continue to have anesthesiologists involved in that care.

And so the toolkit you mentioned, the Enhancing Patient Communications Program, was put together by a subgroup of the Committee on Communications, and it's an actual work product that we've produced that you can access online. It's very easy. If you go on to the ASA website and the member page, you can easily find it or it's on the made for this moment campaign web page or access to it is links to it, but you can easily find it. Download the toolkit and it's got a lot of tips on how how to improve your communications with patients. It is by no means an instruction manual of how to proceed.

The goal was not to start from a position that nobody knows how to communicate with patients. It was quite the opposite. We understand that there's a lot of great communicators within the ASA and the anesthesiology community. We wanted to provide a pamphlet of helpful tips, hints, suggestions that could help any anesthesiologist, whether they're a trainee or a practicing staff or seasoned staff, optimize or improve their communications. So there's there's a lot of great tips, things like simple things that I think make sense when you read them, but may not be thought of in a vacuum. Things like avoiding jargon. So often we talk about what we're going to do. We're going to put a put a central line in and then put an arterial line in and then we're going to we're going to put an epidural in. And we take for granted that these terms are so easy for us to understand. And we forget that the level of understanding of our patients is is different. And everybody may have a wide gap of understanding between patients on medical terms. And so the avoiding the use of jargon, tailoring your message to each patient and situation is so valuable. That's just that's just an example. And that seems I'm sure that seems obvious to a lot of people and I'm sure a lot of people have thought about it.

But when you look at this toolkit and it's presented in an organized manner, it really helps, I think, crystallize how to tailor your own communications, try to adapt to each situation. And you can't go in with a script for every patient because every situation is different. It sounds subjective. It is subjective. But you've got to feel out the room a little bit. You know, I can go into one room and joke around with a family of a patient and the patient themselves, and it eases the tension and everybody's relaxed and they remember me. But you go into the next patient and it's a very stoic patient, or maybe they're very anxious or the family is very worried, or maybe they've had some bad experiences. They're not in any mood to joke around, and I think most people would understand that. But I think it's important to recognize that each situation is a little different. And what you're there for is to reassure the patients. It's to explain to them what to expect. It's to make sure that they know that you're there for them throughout the entire perioperative process. And there's a whole pamphlet of different suggestions, different situations, what what might work, some examples. Having it written down and having it in this format really I think, emphasizes the importance of it and helps. I really think it makes a big difference with helping individuals improve their communications.

DR. TRAINER:

Yeah. Our relationships with patients is not only good to show them the value of how we contribute meaningful to their care, but also relationship building, mitigating litigation, improving patient safety scores and outcomes, and building trust and rapport. I mean, so that's all soft reminders and gentle ways of giving examples to them on how to do so.

DR. STRIKER:

So absolutely. I'm glad you brought that up. Patient satisfaction scores. I mean, research has shown that they are directly correlated to how well health care workers, specifically physicians, communicate with them. So right, there's there's tangible value in that. Aside from us making sure that we're conveying who anesthesiologists are, there's value to the institution, value to the health care system. Readmission rates are shown to drop with proper communication with patients. Complication rates will therefore drop. You're right, there's a lot of tentacles to this. It's important. Communication is so vital. And it's one of those things that I think everybody just assumes they're good at. And it's not it's not scientific in a book sense. I mean, it is if you study communications, but, you know, it's not learning math. It's not learning equations on how to describe blood flow. So I think for a lot of us that are science based, you know, we just assume that this is no big deal or that we're all good at it or

this is easy, this is the easy stuff, when in reality it's actually not that easy, but it's so important, right?

DR. TRAINER:

This is the art of medicine. You're right. Not the science necessarily. You're right.

So fast forward and pivot a bit. I wanted to get back to talking about the podcast. It's true. I believe that ASA did not have an official podcast when you help start up Central Line. And I know you've been very humble about your involvement and your your initiative in this endeavor, but you have helped expand the reach of the society with this podcast. And so I wanted to ask and I'm sure many others are curious, did you have any specific goals in mind for the series when you help start it up? And and is this how you hoped the podcast would play out and is it stacking up to what you sort of intended for it to be?

DR. STRIKER:

The short answer is yes. It's actually it's grown to a point that has exceeded my initial expectations. Initially, the podcast series was developed to provide ASA with an additional channel to share stories and information of interest and importance to anesthesiologists. We wanted it to be a series that would be of interest to all practicing anesthesiologists, trainees and non trainees. But that would cover a wide variety of topics. Not necessarily. We didn't want to focus on the science part. We wanted to focus on current events or events of interest, things of that nature, and we want it to be accessible to everyone. But we felt, we had talked about a podcast idea in communications some years ago, you know, amongst other brainstorming ideas and how to get information out to the membership. But it did come to fruition finally a number of years later, and goal was to make it a series that was wide variety, had a wide variety of topics and wide variety of guests. We wanted to showcase ASA members and their work they're doing. We wanted to get, they don't have to be ASA members, but we have a lot of great expertise in the society and we wanted to have a different avenue for our members to have access to that.

It's been quite a fascinating ride because we started off small and it's expanded progressively over the last couple of years. And over time we've expanded our topics, we've expanded our footprint, if you will. We originally were producing episodes once a month and now we're producing them semi-monthly because we decided to add the Inside to Monitor themed episodes. So every month we have an episode dedicated to focusing on a feature in the ASA Monitor, which has ASA members contribute to it, and those have been some of the most informative episodes we've had. But it's also helped

expand the footprint of this podcast in that we're a little more frequent and reliably produced, if you will, so that people can depend on getting this a little more regularly. And then we have about a handful of bonus episodes each year, on all sorts of topics.

One thing I wanted to see with this podcast is I wanted it to be something that the ASA could be proud of, that it could be something that could be referred to, that was informative, that any ASA member would feel comfortable listening to and feel like it was valuable and something we look back on and are proud of. We certainly never had any other ideas about making this more entertaining. This we hope it's entertaining, but we wanted it to be informative and engaging. And you know, the goal of it is not for shock value. The goal is not to garner suspense or make it a series or anything like that. I'm sure a lot of podcasts out there are very, very interesting in that regard and I'm and get a lot of listeners. But we wanted it to be a product that our members were proud of, that they could always rely on, that they could count on being not only a solid reference of information, but but interesting and and thoughtful and hopefully make them think about issues that they weren't they weren't abreast of before.

DR. TRAINER:

So any interesting interviews with the anesthesiologist that stick out to you? Any topics that stick out to you? Any favorite guests or surprising moments that are you'd like to share?

DR. STRIKER:

Well, we've had a lot of interesting guests. The ones that have been the most impactful have been the ones that we've had that have shared their personal stories and struggles with not only specialty of anesthesiology, but the field of medicine because of their race, because of their sexual orientation, because of their background. We've had some very, very moving episodes that have I felt privileged to be a part of, but have caused myself to really think about medicine in general and look at it through a different lens. And so those are the ones that I didn't really anticipate when we started, but have been the most impactful for me, the ones that when I hear how some very respected individuals in the anesthesiology community have struggled to get to that point, more so than I could have ever imagined, it leaves quite a quite an impression, and those are the ones that I think I'm most impacted by. In that respect, I'm always going to feel very privileged to to be a part of it, to be able to share in those stories, but also try to play a small role in trying to bring those stories to more people because they're so important. But those are the ones that I think leave the leave the largest mark.

DR. TRAINER:

And any tips or pearls that you have for folks following in your footsteps. Podcasts are pretty popular and effective communication tools, and I know our society has even considered launching one, but has been really hindered by all of the logistics of getting one started. But if there are any listeners out there that are considering starting up a podcast or just somehow getting even involved, any advice that you have for them?

DR. STRIKER:

Well, it starts with a great production team. We have, the ASA has a great production team and the production team is committed to making this work. They keep us on point. They make sure the production value is good. And so you have to have some point people, at least one point person, but hopefully more than that that are willing to commit to making the podcast work, commit to making the production really top notch, and to make sure we stay on schedule. And I think you have to have that champion.

If you want to start up your own podcast and you're dedicated, you can do it yourself. But it really starts with that commitment, the commitment to regular episodic activity, that you're releasing things not necessarily frequently, but constantly. But it really helps to have a team of individuals that can help keep that on track.

I would say that assuming that's in place, another piece of advice, assuming you're going to have guests on be prepared. This is from my experience, if you're going to just get on and start talking with someone off the cuff, if you're an entertainer or somebody who's in show business, that that may be easier to do. But if you're trying to get listeners to listen about a specific topic or a certain guest, I can't emphasize the importance of having some preparation on what you're going to talk about and how to articulate that.

You know, the whole point of each episode is to showcase the guest and the topic that the guest is covering. I try to facilitate that information. I try to highlight the topic and the guest and not get into too much conversation because I think it's more important that that person or persons and their information gets out to the membership and our listeners and I, so I try not to make it about just a off the cuff conversation, if you will, which may be engaging for the people participating. But I have to think that the listeners would rather hear the guests on there and the people or the information that the guest is trying to convey.

DR. TRAINER:

Yes. And you have also been an amazing guest on your own show. And this was really fun [for me. Dr. Striker. You've been really such an amazing mentor, dedicated leader,

someone who leads by example and you're genuinely passionate about advancing our profession and improving the image of our organization and truly inspiration to me. And I've certainly learned a lot about you today and through your leadership over the years on the committee. I'm sure your listeners have enjoyed this peek behind the curtain of your life as well. So thanks for letting me join the show, really.

DR. STRIKER:

Oh, my pleasure. Dr. Trainer, you've done a fantastic job, but I just thank you for those extraordinarily nice words. That's very generous of you. I don't know that I deserve that. Thank you. That means a lot to me.

DR. TRAINER:

And this goes back to your humbleness, you know, so that's one of the things that you are most admired for. So we do thank all of our listeners for listening today and we hope you join us again for the next Central Line. I'm going to pass the mic back to Dr. Striker for hosting next time. But please remember to follow and review. We appreciate you.

DR. STRIKER:

Thanks, Dr. Trainer.

(SOUNDBITE OF MUSIC)

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