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. ADAM STRIKER:

Welcome back to Center Line. I'm your host, Dr. Adam Striker. Today we're going to talk about medical humanities and anesthesiology with Dr. Audrey Schafer. Dr. Schafer is the guest editor of the March Monitor, which shines a spotlight on the discipline of medical humanities and the many ways humanities and anesthesiology intersect and interact. Dr. Schafer, welcome to the show.

DR. AUDREY SHAFER:

Thank you. My pleasure to be here.

DR. STRIKER:

If you don't mind telling our listeners a little bit about yourself, your early training, and how you got into medical humanities. And just give us a little bit of background.

DR. SHAFER:

Okay. Sure. So I went to Stanford Medical School and then went to University of Pennsylvania for my anesthesia training. I'm originally from Philadelphia, and it was kind of a coming back home experience and then returned to Stanford for a research fellowship year in pharmacology of anesthetics. And really, one of the major goals at Stanford School of Medicine is to develop and encourage the physician scientist. And that is how I had viewed my career. However, my childhood was very immersed in the arts. My mother was a costume designer. My sister and I pretty much grew up backstage at the theater she worked at in Philadelphia. And I think sometimes your childhood comes back and informs the rest of your life. And as I was starting in on an academic anesthesiology career, I began to feel that perhaps I had more to offer in a

field outside of pharmacology. So I decided to explore an area that is at the intersection of the arts, humanities and medicine. An area I had not realized was a true academic discipline. So once I discovered that, started meeting people, joined the professional society for that, began publishing, I was so excited by this field that I decided to devote all of my scholarly work to this area.

DR. STRIKER:

Well, some of our listeners might not be familiar with the term medical humanities. Do you mind just explaining a little bit about what that is, how it relates to anesthesiology?

DR. SHAFER:

Absolutely. I do think that when I first started with this area in the early 1990s, extremely few people had heard of medical humanities, including myself. But now it is a growing field and it's an academic field that's interdisciplinary and explores the context of medicine by placing all that it is that contributes to us being human beings, our experiences of health, of health care, of illness, of mortality, of caregiving in a much larger context, in a social context. And by doing so, these tools that we gain from the arts and humanities enable us to really think critically about what it is we do in medicine and vice versa. The world of medicine is complex. It engages so many people, it engages everyone at some point in their life. And to enable artists and people who are scholars in the humanities and qualitative social sciences to enter into the world of medicine and to explore it using the refined tools of their disciplines, I think helps both those in medicine and those outside of medicine to better understand what it is that we do in medicine and what what it means to be a human being.

DR. STRIKER:

This episode of The Monitor is is rather unique. Articles include painting inspired by pediatric anesthesiology, reflections of an anesthesiologists and photographer, even a poem about mouth-to-mouth resuscitation. So for clinicians who create art, does the artistic process lead to enhanced mindfulness in their clinical practices? And can you talk a little bit about the value of the creative process for clinicians?

DR. SHAFER:

Sure. Thank you for that question. I do think there are a number of clinicians who create art or who care deeply about art and feel immersed in the arts in some way, whether it's attending theatre, loving film or going to art museums. But there are many who actually view themselves as as creators.

I think you'll find in some of the artists statements that accompany these creative works in this March issue of ASA Monitor that these anesthesiologists find multiple benefits to to doing their art, and in some ways it enhances their abilities as clinicians. There's some mention about the flow, the feeling of flow that can happen both in creating art and also in what we do as anesthesiologists as we enter into that dynamic that happens in the operating room. It also leads to skills of listening, of observing, and additionally leads to communication in ways that strengthen our human-human contacts, whether it's with a patient, or with a colleague, or even, as you'll read in one of the articles between two colleagues who had never physically met but bonded over their shared love of music. So I do think that there are a number of listeners out there who have this interest, and I'm hoping this issue highlights that that can really be part of our lives as anesthesiologists as well. It doesn't have to be a completely separate compartment in our lives.

So for me, personally, as a poet, I have found that my efforts to write poetry have encouraged me to continue to deeply listen to my patients. As we all know, we have this very tiny window to get to know a patient. And likewise the patient has a very small window to get to know their anesthesiologists in general. And for me, as a poet, I know that pauses, things unsaid, can be extremely important. So I believe it helps me pay attention to my patient as he or she is speaking, and to observe all the nonverbal aspects of communication as well.

DR. STRIKER:

Talk a little bit more about that. How long have you been writing poetry and how long have you been writing poetry regarding the specialty of anesthesiology?

DR. SHAFER:

I took my first poetry writing workshop when I was a medical student, and I very much enjoyed it. The flexibility at Stanford School of Medicine in terms of their curriculum and also the physical location of the medical school on the campus of a major university facilitates that kind of experience. But to be honest, I really was so immersed in my clinical work as a clinical student and then as a trainee that I wrote very little. And it wasn't until after my return to Stanford and we had a year that we called attend a fellow back then, which was like a transition year from your fellowship to your faculty appointment, that enabled you to have some protected time to work on writing up all the work that you had done as a as a research fellow. And it was in that year that I took my second writing workshop that was with a poet, Denise Levertoff. And I would say at that moment that I realized that how I am processing the world around me is through poetry,

that I think metaphorically, I wonder about words that are said, I--and this got reflected later on when I was young faculty member. For some reason, the phrase “under anesthesia” really sort of struck a chord with me. It's a phrase that I use in communicating with a patient about what they will undergo, saying you'll be under anesthesia or under general anesthesia, thinking that that phrase is fairly benign and neutral. But in reading more and more about metaphor and about words, phrases, metanims, then I became more familiar with sort of the embedded history within the words that we use and how those can trigger some reactions in others that we hadn't necessarily predicted. And this sense of being down and under is frequently associated in our language with things that are worse, things that are scary, being unhealthy, being ill, laying down and even dying. And so I really just became fascinated by the words that we use. And there are obviously some phrases that I think are more pronounced than that. You know when somebody says you're going under the knife or some other phrase that can be used in jest but really can have a sting to it. And I also became fascinated about how we use metaphors for sleep in terms of describing anesthesia when we as anesthesiologists know that the anesthetized state is not sleep. But there is something for adults that is reassuring about sleep. You wake up and you get through it. And so how we use our language in the operating room with the patient or with our colleagues I think is just a fascinating aspect of communication and anesthesiology.

DR. STRIKER:

No, absolutely. And you know, you highlight such an important facet of what we do, which is trying to take advantage of the very limited time many of us have with our patients to establish a significant relationship and a bond of trust and figuring out how best to do that, which is, of course, patient dependent, but is certainly a challenging part of our practice that I think is underappreciated when it comes to anesthesiology. Let's talk about storytelling a little bit. It's another discipline from the humanities that clinicians can use in the day-to-day work to improve communication. Can you talk a little bit about how that might be useful?

DR. SHAFER:

Sure. I think that storytelling is a helpful term for describing what it is that we do as anesthesiologists when we're talking with our patients, when we're describing a case we're about to do and want some feedback from a colleague or some advice, when we are talking with our surgical colleagues and then more formally, when we are writing things up for publication or writing a grant proposal. All of this is storytelling in a way. And the more one can practice in it, whether it's written or oral or both, I think the better. And acknowledging that storytelling is part of who we are as humans. It is something that is key. And that stories can be passed down through generations, can be very

differently interpreted in different cultures, and sort of an acknowledgement of the diversity of storytelling and storytellers, I think is part of an appreciation of how deeply storytelling plays into the practice of medicine. And there are a number of academic books in medical humanities that speak to the importance of story. Although the science of medicine requires data and requires numbers and statistical significance and things like that, there is still a story behind it. There's still a reason why we're interested in that particular area and why we want to study it. And communicating that interest, why it's important, is part of storytelling. So it really infuses all that we do in anesthesiology, in research and in the practices that we have in all the parts of the of the hospital and clinic.

DR. STRIKER:

You've mentioned a historical perspective a couple of times. Let's just talk about history for a minute. We've done several episodes on history of anesthesiology coming from different angles, and they've always been some of the more popular episodes. I wanted to get your take on why you think many of us are drawn to history, why you think it's so popular, and from your perspective, what does history tell us regarding our specialty and what is the significance of it all?

DR. SHAFER:

Yeah, well, history of medicine is an extremely well-developed academic discipline that gives advanced degrees at different universities and is an area in and of itself. But it's also part of this large Venn diagram of overlapping disciplines with the practice of medicine that is medical humanities.

I think people are interested in the history of of medicine and of anesthesiology because we know we are not coming de novo into an operating room with no historical background to it, that there is a long line of patients, of physicians, of nurses, of researchers, educators who are enabling us to be in the moment that we are in. So I think an acknowledgement of that is important and I think also leads to this interest.

So we have had some residents in our anesthesiology department who have submitted essays to history of anesthesiology contests. And I would encourage anyone, including our our trainees, to look into this as a way to think about what it is that they are embarking on as an anesthesiologist. Or, if you're practicing for a while, to reflect back on what it is that you have been doing. So all the history of of anesthesiology is packed with stories and characters and plot twists. And I think that that has also contributed to an interest in in the history of anesthesiology.

DR. STRIKER:

Earlier, you mentioned flow, and I want to elaborate a little bit on that concept. The concept was described by the author of the 1990 book, Flow, as, “the state in which people are so involved in an activity that nothing else seems to matter. The experience is so enjoyable that people will do it even at great cost for the sheer sake of doing it.” I know whether you're an artist humanitarian, pretty much anybody probably experience this to some degree. But how do you think anesthesiologists do specifically?

DR. SHAFER:

I do think that there are moments in the delivery of anesthesia care that are associated with experiencing flow, whether it's doing something physically, a procedure, getting ready for a case in the operating room, that you do enter into this sense of flow, this sense of timelessness, of being there in the moment and experiencing it and being sort of aware of yourself in that moment. And some other things can drop away. But we all know as anesthesiologists that we cannot stay in that moment. We have to be able to dually pay attention to very focused things and also to anything that might be happening in the room that could affect our patient and our anesthetic care. So unlike a surgeon who I do feel has more opportunity for extended periods of flow in the operating room as they are focused in on one area of the patient's body, the anesthesiologist has to develop this sense of being in the moment, but also being aware of what has just happened, anticipating what is to come, and have an understanding of all the things that might be happening in an operating room that could impact what you need to do for your patient as their anesthesiologist, as their guide, as their protector.

So I, I think it's a bit different than my experiences as a writer in terms of experiencing flow where you don't have somebody's life at stake. And I think where these sort of differences become apparent can be extremely interesting, just as like where a metaphor might break down that those moments and sort of the edges of things can be extremely interesting, particularly as someone who's been involved in the education of anesthesia residents for a long time. I think that is one of the things that simulation is so good at in terms of being part of trainee education and continuing education. Is that examining how people approach an issue that develops and whether that focus on one thing prevents them from being aware of other things going on. Or vice versa, being too distracted and unable to see what's really important that's happening. So I think there's some overlap in terms of those experiences of flow, but also important differences.

DR. STRIKER:

Well, it brings up kind of this age-old question about medicine and specifically in our context, anesthesiology being an art or a science, I would imagine most would answer that it's both. Most would probably feel that it's both. How do you perceive the specialty when it comes to that question?

DR. SHAFER:

Yeah, I absolutely think it's both. I think it's like improv. It's it's *and* you know, you're always going for the inclusion. There just are some things about anesthesiology, about the practice of it, that are not predictable. There's some ambiguity. Even though we as anesthesiologists like precision and like, say, to have our patient's blood pressure within a very limited band, which we feel is best compatible with their health at that moment, it doesn't always happen that way. And why we're not able to control things so precisely, how to deal with that particular patient's physiology and anatomy, I think, is part of this range of skills that the anesthesiologist brings to the table. So, yeah, we we just do have to accept that there is an art to the practice of anesthesiology. Every patient that we meet is different, has different background connections, experiences. And if we rely on one way to approach every patient that's going to fail us and fail our patients. On the other hand, we can't be reinventing the wheel every single time. We know what certain drugs are useful for. We know what we need to accomplish in terms of placing a patient into the anesthetized state such that they can have surgery performed on them. So the science of anesthesiology is extremely important. And learning the science of anesthesiology, and keeping abreast of all the changes and updates to that, is extremely important. I think it's is definitely an *and.* And one complements the other. And there is also some overlap because in science there's ambiguity as well. And the arts can help us deal with our discomfort with ambiguity can enable us to, to see it and enable us to deal with it in a way that doesn't lead to pure frustration.

DR. STRIKER:

Can one exist without the other?

DR. SHAFER:

You know, I don't think so. Maybe we can't all be the Renaissance man like Da Vinci. But I do think within each of us, there is an interest in both the arts and the sciences. That's part of how we live in this world, how we're social beings, how we are intellectual beings, and growing in our emotional lives as well. I feel it's a bit artificial to separate them out. There is, as we've said before, there is storytelling in science and there's just incredible works of art that are based on science itself. As we look at microscopic

images of our tissues and things, it's just stunning. So I think there's there's many ways they overlap.

DR. STRIKER:

Well, want to continue talking about this. But before we go any further, let's take a quick patient safety break and we'll be right back.

(SOUNDBITE OF MUSIC)

DR. DEBORAH SCHWENGEL:

Hi. This is Dr. Deborah Swingle, chair of the ASA Patient Safety Editorial Board.

Perioperative hypothermia continues to be a common occurrence despite extensive knowledge of its ill effects and the common practice of warming patients during surgery. The amount of time a patient experiences hypothermia matters. Work to prevent heat loss, reducing the percentage of time patients experience hypothermia and ensure the patient is normal thermic upon arrival to the PACU. It's essential that all team members understand the importance of pre warming patients prior to entering the operating room and then actively warming during surgery. A team-based approach with the anesthesiologist who is responsible for ensuring patients remain normal. Thermic as the team leader improves perioperative temperature management.

VOICE OVER: For more information on patient safety, visit asahq.org/patientsafet22.

DR. STRIKER:

Welcome back. Well, Dr. Shafer, do you think that as a medical field, that not in training, but in looking for people that are interested in medicine, that we place too little emphasis on the arts, too much emphasis on the arts in terms of what people study, what people's aptitudes are--arts versus like the natural sciences, if you will, when we are looking for students of medicine.

DR. SHAFER:

Mm hmm. Yeah, that's a really complicated question. And I do think that there, you know, there are certain courses that are expected for a student who's going to be entering medical school, and there are certain tests that are required. And even though there may be writing components or components about the context of medicine, such as ethics questions or anthropology related questions, the bulk really, I believe, is still in

the domain of the sciences. Having said that, I think that medical schools are interested in a diverse student body, and diversity comes in all kinds of ways, including having students who have had different educational journeys to get to medical school, and that I believe medical schools feel that this enhances the life of the medical school. I do think that, in this age where there is so much bashing of science by some members of the lay public, it is critically important to note that science is foundational to medicine and that we really do need people who are able to move that needle further in terms of our our scientific understanding of how the body works and how medicines work and how illness affects us. But we also, having said that, need to have a very human understanding of the experience of all of those things. And that comes from having educations which include not only basic sciences, but also include a much broader range of courses in the arts, humanities, and social sciences.

DR. STRIKER:

I know you know how much physicians grapple with intense work schedules, increasing demands, whether it's clinical, regulatory, administrative, what have you. And we've talked about wellness and burnout. And I wonder if you might talk a little bit about how the humanities can help in that regard and perhaps maybe keep us as physicians from becoming too dehumanized from all the stressors or demands of the job or the rote routine, if you will.

DR. SHAFER:

I mean, the issues of wellness and burnout are critical to our specialty and to medicine at large. The impact of the pandemic, I think, has echoing repercussions, and that will continue for a long time.

I would say it's just a really complex, complicated area, and I don't want to promote medical humanities as some panacea or some slap on add on experience that can cure these really deep and important aspects of our experience of being health care workers and being anesthesiologists. But having said that, I will say that including the arts and humanities in programs that are designed to help the clinician appreciate what it is that they've gone through, to help them reflect on who they are now, I think is extremely helpful.

So, for example, in our department, we are fortunate to have a professional writer, Dr. Laurel Brightman, who has given TED talks. So she's both an oral storyteller and a writer, and she leads some of the groups in our department, because you don't want to do it en masse, in intense writing workshops, even people who feel they're not writers,

this experience of writing together, of sharing, of having permission to be vulnerable, of feeling protected in that group, I think can really be beneficial.

So there are areas where the arts and humanities can offer us ways of connecting. And I think connection is critically important for our wellness as human beings and certainly for our wellness as physicians. So I do think that it can be helpful. It's also the fact that we just hsbr our own experience to learn by. But if you if you share with others your own experience, your own storytelling of that experience, or visual response to that experience, and by drawing that those can also help us understand how others have experienced their working life, their attempts to find balance in their lives, their passions and their struggles. So I do think that there are places for the arts and humanities in programs to promote wellness, but it shouldn't be like a slapped on, added on extending the workday kind of experience. It needs to be more integrated and supported by the program that you're that you're already in.

DR. STRIKER:

Well, speaking of the program and departments, we've talked a little bit about the individual, but how can supporting the arts and humanities A. benefited department and or organization? And then along with that, what, if anything, should departments or organizations be doing if they're not in support of this?

DR. SHAFER:

Well, there is a wonderful article in the March issue of the Monitor that I would direct people to by Dr. Ron Perl, who was chair of the department at Stanford for 22 years and was an incredible supporter for developing arts and humanities in our department and hence also at the School of Medicine and the university. And I think what he says is that this connection to the arts and humanities connects our department to other departments, to the school as a whole, to the university as a whole. And because anesthesiology can be a hidden profession, even within a school of medicine. This, this, this different layer of connection through building a program in the arts and humanities can then help make our department of anesthesiology more visible. And indeed, because I love being an anesthesiologist and through growing a program in arts and humanities at the School of Medicine, I would meet many medical students. I always encourage them to take the elective clerkship because you just never know until you take that clerkship whether you're going to fall in love with the field of anesthesiology and become an anesthesiologist yourself. So I think there's some benefit in terms as he terms it being an ambassador for the department, and that comes from the very interdisciplinary nature of medical humanities.

But I think there's other aspects to it. And one of them that I feel passionate about is diversity. And the way that arts and humanities improves diversity in a department is that for those people who have an interest in the arts and humanities or social sciences, it provides a way for them to flourish within the department as well. And the arts and humanities, as I've mentioned before, opens our eyes, widens our world, deepens our understanding of what it means to be in this world, in this very diverse world. And our country is a country of diversity, and that needs to be celebrated, welcomed and also examined as to what are the struggles that have resulted from imbalance, from prejudice and bias. So the arts and humanities enables us to critically think about what it is we do in medicine. And I think that benefits a department. It strengthens the department by encouraging diversity, by encouraging opinions to be expressed and and encouraging people to feel comfortable that they may have different backgrounds and different views on things and that those will be respected. So it provides for more of a sense of inclusion within the department. So I think that's a really major aspect of how arts and humanities can perhaps more indirectly but foundationally improve diversity in a department. And it's something that I feel is extremely important.

I think the other thing about an arts and humanities program within a department is that now that the academic field of medical humanities has gained so much traction, there are a couple hundred undergraduate colleges with majors in medical humanities, similarly with minors in medical humanities. So more and more students are being exposed to this area. And as those students go up through the system, there should be, and there will be, a way for those intellectual passions to be supported. And so in our department, for example, medical humanities is now recognized as a potential pathway for success, for development as a faculty member, for reappointment promotion and so forth. And there are a number of faculty in our department who are pursuing medical humanities. So I think you'll find some of them in this issue of the ASA Monitor. And I think that's also true across the country as well, that it's it's just an exciting area to explore. And I encourage other departments across the country to consider really being supportive of this growing, exciting, dynamic area.

DR. STRIKER:

Well, for our listeners who want to learn more about medical humanities in general, do you mind pointing them to a starting place or a resource that they might first engage?

DR. SHAFER:

Well, I think that our medical journals are a good place, and for a long time, medical journals have included what has become very popular columns such as JAMA, New England Journal, British medical Journal, Lancet. All of these journals have areas in

them that focus on medical humanities, on reflections, on perspectives, on art. And in our specialty, Mind to Mind in Anesthesiology is a great place to start. It also includes poetry as well as prose. reflections on the experience of being an anesthesiologist. There are multiple areas. The Human Experience in Anesthesia and Analgesia is another major journal that has that promotes this concept that we as anesthesiologists have something to say that is of importance and should be out there in in a major publication about some aspect of being an anesthesiologist.

DR. STRIKER:

Well, let's wrap up the conversation. Circling back to the March ASA Monitor issue, as the guest editor of this issue, what do you hope the readers will experience or take away from reading it?

DR. SHAFER:

Thanks. Yes, I do hope that readers will understand that there are many entryways into this area and many moments in your career where you could start to become involved. For those already involved, I'm hoping that this issue encourages you to share that involvement with those around you and to support others who are exploring this area. I have tried to include a range of contributors from people who have just finished residency all the way through to established and senior anesthesiologists. I hope that the issue sparks some interest. Is also fun to read and provocative as well in terms of enabling our readers to think about aspects of anesthesiology that touch all of our lives.

DR. STRIKER:

Well, Dr. Shafer, thank you for joining us today to discuss this underappreciated topic and aspect of our specialty, but more importantly, for sharing your insights. And I can't wait to read the issue, and I certainly hope everybody else does as well.

DR. SHAFER:

Thank you so much, Dr. Striker.

DR. STRIKER:

And to our listeners, thank you so much for joining us on another episode of Central Line A please check out the March ASA Monitor at asamonitor.org. Tell your friends about our podcast. If you find it interesting, we review and tune in again next time. Take care.

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VOICE OVER:

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