



American Society of
Anesthesiologists[™]

Central Line
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(SOUNDBITE OF MUSIC)

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 Central Line. I'm Dr. Adam Striker, your host and editor. And today I'm welcoming two guests to the show, Drs. Kumar Belani and Ana Maria Crawford. Both guest editors of the April ASA Monitor. Today we're going to discuss global engagement, and I'm certainly excited to learn more about this broad, complex and important topic. So Drs. Belani and Crawford, welcome to the show.

DR. KUMAR BELANI:

Thank you.

DR. ANA MARIA CRAWFORD: Thank you.

DR. STRIKER:

Let's start off with just diving right into what this topic really is. Global engagement is a broad term, and I'm sure that means different things to different people. I myself would like to know what it really encompasses. Dr. Belani, do you mind starting us off and telling us a little bit about that term?

DR. BELANI:

Yes, Dr. Striker. Global engagement is a broad term. And when we talk about global engagement, we are actually talking about engaging globally on health-related activities from educational research, knowledge exchange, clinical service so that we can understand our global and cultural diversity and see how that pertains to patient safety, particularly as it relates to our field of anesthesiology and perioperative care, including pain management.

One of the goals of global engagement in health is to learn from each other and bring up to speed efficiencies and safety principles with our global partners. We want to make sure that, you know, just like when you go from one country to another and you take a bus drive from the airport to the hotel, there are rules and regulations and safety principles in place and one feels comfortable because those are universally available and adopted. The same thing in global health. We would wish that wherever we go, wherever we are, and whenever we are there, we have the same safety and facilities available to take care of us. So this is how broad global engagement and health is. It's basically providing service to mankind and making sure that this service is safe and up to date and has equal access and good health for everybody.

DR. STRIKER:

So, Dr. Crawford, do you mind broadening that framework out, to use the term, quote, global engagement, that encompasses global health, advocacy, diversity, etcetera? Why that matters? Why is this framework more useful than what we've done before?

DR. CRAWFORD:

Yeah. First, I'd like to just second everything that Dr. Belani said, that global engagement certainly encompasses global health. The global health field has really exploded across North America and Europe. And it's really almost exclusively used in North American and European literature. And I think that that suggests that historically we have been building these programs in service to patients across the globe. But it's really important to realize that we need to have partnerships that are bidirectional, and that means that we benefit from our colleagues just as much as they benefit from us. And really recognizing that global engagement means more about building a community across the globe or a global community than it does about, you know, a high resource setting, you know, teaching and sharing with a low resource setting. Because there's a lot for us to learn from our colleagues who work with resource constraints. It's really speaks a little bit more towards building a global community and having a bidirectional impact. And I think it makes all of us a bit stronger when we when we consider the perspectives of a diverse global community.

DR. STRIKER:

So when you say bidirectional, does that mean that it's been flowing mainly in one direction from our country to to the rest of the world and not the other way?

DR. CRAWFORD:

Certainly, certainly. The advent of any sort of international health had its history in war times where people wanted to protect their troops. So it was always like thinking about the diseases in another country and either how to protect yourself or how to treat what was called in the past tropical diseases or infectious diseases. And so it was really about taking resources and expertise from highly resourced settings and then sharing them in some of these other places that didn't have the same resources or access to education and systems building, etcetera.

As global health has continued to grow, it still has a unidirectional character to it. And I feel like expanding the definition from global health to global engagement is really important in making everyone think a little bit more about what we can learn from our colleagues that are adept at navigating, for example, supply chain issues or delivering safe anesthesia and perioperative care with a less carbon footprint, for example. So there's there's a lot of things that, you know, our colleagues working with less resources are incredibly innovative in. And having that bidirectional narrative versus we're going there to help them is really a shift.

DR. STRIKER:

Okay. Well, I do want to follow up a little bit on the the personnel aspect in just a moment, but I'd like to ask Dr. Belani another question regarding the anesthesiology ratios to population that we all know is an issue in other countries as compared to our own. For instance, here in America, I think it's the number is approximately 21 anesthesiologists per 100,000 people. But if I'm not mistaken, it's less than one anesthesiologist per 100,000 people in many low-income countries. I just wanted to get your take, Dr. Belani, on how that specific problem can be addressed by this global engagement modality and specifically by anesthesiologists who want to get involved.

DR. BELANI:

I think you are so correct. We do have a larger number of anesthesiologists per 100,000. It's about 30 per 100,000 in the United States. And data from the Indian Society of Anesthesiologists, which was just recently published in the APSF (Anesthesia Patient Safety Foundation) newsletter, there are 1.27 anesthesiologists for every 100,000 people. And if you look at Uganda, the whole country has only 70 actively practicing anesthesiologists for a population of about 45 million, that's approximately one for every 650,000 people. So there's a huge difference in trained personnel being available. And this issue has come up in many meetings with our global engagement colleagues. And one of my own colleagues who's from Uganda is trying to get this problem solved by creating a system where people can be educated and trained in

working with anesthesiologists like we have anesthesia assistants here, and that program has been shown to work in some countries. And with the help of ASA, the American Society of Anesthesiologists, we should be able to assist in providing the curriculum that might be needed for these activities so that anesthesia assistants can come about and be trained rather rapidly so that they can assist anesthesiologists to provide the much-needed care in those countries.

And I know that the World Federation of the Society of Anesthesiologists has several programs with advanced countries where they can have people that are interested in anesthesia, go to these advanced countries and get educated in anesthesia. And these individuals then can go back to that country and then become the trainers for teaching anesthesiology. There is one program that we are affiliated with in Bangalore, India, that gets medical students who have just become doctors where they can learn anesthesia in this institution, and then they are supported by the World Federation for the Society of Anesthesiology. And then they get their training and they go back. And even faculty can go and rotate at those places so that this education can be continued and there can be sustained relationships between these two countries.

The goal is to have these programs available in in the country so that they can be educational facilities set up there with a with a good curriculum.

DR. CRAWFORD:

While Kumar was speaking, a few other ideas came to mind. One component of our ASA membership, which is somewhat neglected, is our members that are approaching retirement. They're incredibly valuable assets to some of these initiatives.

The ASA Committee on Global Health has several programs which are always looking for volunteers. The ASA Overseas Program in Rwanda is a very established program that's been running since it started in 2006 in conjunction with the Canadian Anesthesiologists Society. It's certainly a program I'm intimately familiar with. I've been to Rwanda now 14 times, but we're always looking for volunteers in Rwanda.

And then the ASA Global Health Committee also has a partnership in Guyana that really needs support, needs not only volunteers to travel, but volunteers to help develop lectures and curriculum as as Dr. Belani was mentioning.

It's also important for us to really reframe what we consider global health. I mean, we're talking about health care access and getting rid of disparities for patients across the entire globe. And so I really feel passionately that that global includes local and that a lot of our initiatives here in our own communities really are global health as well.

And then the last thing that came to mind was, I believe it's 57 or more Native American nations right here within the borders of the United States. So another way to actually do international health is actually within the borders of the US, and that's to address some of the health care disparities that occur within our Native American indigenous population.**

DR. STRIKER:

Well, I think you basically just highlighted an important distinction when it comes to global engagement at this point, as opposed to what we might have all come to know as global health. And the idea that it's only for people that are interested in doing mission trips or going abroad. From what you're saying, that's certainly no longer the case. There's many different ways to think about it if you do not want to leave the borders of this country.

DR. CRAWFORD:

Absolutely. Another thought around how to engage without traveling abroad goes back to this theme of bidirectionality. You know, if we're really trying to impact patient outcomes and improve patient outcomes, which is really what we're all trying to do, hosting our colleagues that are working with resource limitations, hosting them in a highly resourced environment, really teaches a lot of lessons that are almost impossible for us to convey while we're in country. For example, we have had three cohorts come through Stanford University as visiting scholars, and we surveyed what they took away from their time with us and the lessons were really remarkable. They really don't care about our echmo or our highly technical aspects of our practice. What they took away was witnessing an organized health care system, patient autonomy, patient safety, non-hierarchical feedback between, for example, faculty and trainees. So a lot of these things--good open communication, professionalism, open discussions about quality improvement, etcetera. And these things are really, really hard to teach if you go and embed yourself in a completely different culture. And when our colleagues come here, they are better able to see what works in our system that may actually be adaptable and work in their system as well.

So developing these bidirectional partnerships really is a benefit to both sides. And going back to, you know, our colleagues that are nearing retirement, engaging in these types of programs is really a good way to impact patient outcomes in another country, but not necessarily requiring travel.

DR. BELANI:

I agree with Dr. Anna Crawford. Many of our faculty that are coming from abroad and rotating here on their visits, what they like most is not only what Dr. Crawford said, but they also like to learn about how to do research, how to pursue academics, how to create clinical trials so that they can actually go back and do the same things in their own countries. And that program has worked out very well. It's not just our people going there, but having them come and learn here also.

DR. STRIKER:

I'm just curious, a lot of anesthesiologists coming from other countries where there's, as you mentioned, are resource limited, would bring a lot of insights into our own practices that are resource rich in how to manage practices, whether it's more efficiency, less waste, or in a in a manner that perhaps uses less resources. And I'm wondering, do either of you have any insight into how that is perceived in our current organizations when individuals come over from other resource limited countries, how it's perceived by them, you know, when it comes to the plethora of resources we have. And if there's anything we can actually realistically implement, whether it's methods or insights, that they have to perhaps more efficiently utilize our resource, given the large administrative structure that many of us are working under.

DR. BELANI:

You bring up a great point. One of our fellows, was rotating abroad. When she came back, she said, Wow, they hardly use any blood when they do pediatric heart surgery over there. And she thought that was actually something not correct. But then she realized that it's because it was not needed and the surgeons were quite quick. They didn't lose much blood and the patients got a caudal morphine, which gave them significant pain control without having to worry about giving them additional, you know, intravenous opioids. And seeing that was an eye opener for her. And then when she came back here, she started to talk to the surgeons and figured out that this caudal morphine approach will work quite well even here. And that became instituted pretty readily as soon as, you know, that was discussed with the groups over here. So there's a lot to learn when they go and see the efficiencies that are available in other places, the cultural differences, and the way that they manage without having to waste a lot of time and money.

DR. CRAWFORD:

Another thing that comes to mind along those lines is the health care industry's effect on climate change. So a lot of us are familiar with recent study this past year that came out

and essentially equated the health care industry to a country and said it would be the fifth largest contributor to carbon emissions. In our setting, we've really focused a lot on patient safety. And with that has come, you know, the establishment of kits and single use items, which certainly has a downside. One striking difference when you are operating in the theaters and somewhere that doesn't have as ample resources is really how they're able to do a safe anesthetic and surgery with a lot less waste. And the surgeries that we do here, I think we're all familiar. We'll see one, two, three, sometimes up to 5 or 6 or more bags of trash that are taken out of the OR for every single case. And in Rwanda, for example, I see them with just a simple kick bucket. So it's really, really remarkable the amount of reusable materials they have. And they're still able to deliver a safe anesthetic.

DR. STRIKER:

Yeah. Do you think the administrations that you have been a part of or at least heard about, when new efficiencies are identified, or new methods are implemented, are receptive and embracing of those changes?

DR. CRAWFORD:

With looking at hospital waste, I mean, I certainly think that's gaining traction. There's a there's a lot of attention to obviously climate change. And so I think people are looking for ways to improve our efficiency and waste patterns. So that's again, one area we certainly have a lot to learn.

You know, they use obviously sterile materials for every every surgery, but a lot of it is reusable. I don't know if you remember, but we used to have cloth gowns and cloth drapes and things that were processed. And so we've cut a lot of that out because of either concerns about safety or infections or the cost of processing. And the cost of climate change might actually outweigh the cost of processing. And so it's just something I think that we should really think about and look at other systems that are able to do it with a lot less waste, with the same efficiency. I mean, there's certainly differences in infection rates and safety profiles, but, you know, I think our pendulum has swung too far and the amount of single use disposable waste that we have generated.

DR. BELANI:

That's correct. And we have a relationship with a missionary hospital in Bangalore, India. And when our trainees go there, they can see how the areas next to the operating room are used to save reusable equipment that is cleaned, sterilized, and returned back

in clean packs, back for use in the operating room. And this is done diligently every day. And people realize that they are very careful in how many syringes they open and how many they toss without thinking. And what is the piece that can be saved and reused or what shouldn't be wasted. They learn all that when they are there and see what differences there are between a place where there's a lot and a place where there is, you know, not much that you can use. So there's a close eye that the attention to these things when they're working in those missionary hospitals.

DR. STRIKER:

Yeah, I can only imagine. You know, we could talk about this extensively, which is resource utilization and how we've gotten into the single use items a lot more and, you know, for a number of reasons, at least in this country. And what the true risk profile is versus environmental and monetary cost with utilizing all of these items and more disposable items now. It is a big topic and one that generates a lot of strong feelings, especially when it comes to different countries and the in the resources they're given.

DR. CRAWFORD:

Yeah, absolutely. And you know, for a while it was mandatory that we all had sleeves on and wore these paper jackets and we had to have the disposable head caps and and things that we that turned out didn't really have that much of an impact on surgical site infections. Similarly with the with the pandemic I'm an intensivist as well and was working at two different county hospitals and one of them was using paper gowns that we just kept throwing, you know, all this PPE away, which was just remarkable. And the other one had reusable cloth gowns, which I was really pleased to see. And then they did away with them and went with the paper as well. But the pandemic was horrendous for the amount of trash and waste that we generated from the health care system. So we're going to see more epidemics, pandemics. I mean, that's just the way it is. And so it's certainly something to think about moving forward.

DR. STRIKER:

Yeah, absolutely. Well, I do want to talk about global advocacy and diversity and also touch on how this impacts physician well-being. But let's do that after a short patient safety break, if you both don't mind staying with me.

(SOUNDBITE OF MUSIC)

DR. DEBORAH SCHWENGEL:

Hi, this is Doctor Deborah Schwengel, 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/patientsafet22.

DR. STRIKER:

Well, we're back. I'm talking with Dr. Kumar Belani and Ana Maria Crawford about global engagement. Wanted to discuss specifically the aspects of that related to global advocacy and diversity. But let's start with global advocacy.

You know, anesthesiologists are familiar with advocacy in a number of of realms. And anesthesiologists can play a crucial role here. Our professional societies comprise the World Federation of Societies of Anesthesiologists, or WFSA, which is a partner of the World Health Organization. And we've talked many times on this show about how essential our role in perioperative care is for patient safety. But on a global level, what role do anesthesiologists play? Dr. Belani, do you mind talking a little bit about that?

DR. BELANI:

Oh, all of us are interested in global health, and we are aware that health is a human right and we have to ensure that everyone in this world has a right to his or her health. And it will be great if the best health care can be provided to the poorest of the poor as it is to those that can afford it without difficulty. And so for this, we certainly need to have a strong advocacy and make this happen.

And I can give a good example of how this has been done at the world's largest cardiovascular centers, which is Narayana Health. They do 35 to 40 open hearts a day. And the group there figured out that the only way they can do this is to make sure that they can provide care to everybody and give the best care to everybody. And they felt

that this can only be done by developing a health scheme where individual farmers paid a little bit of money every month and created what's called the Ashwini Health Scheme. And this has been publicized a lot in the Harvard Business School. And for pennies, these farmers, along with a little bit of contribution by the government, were able to guarantee good, adequate health to these people and giving them the best health for a very inexpensive cost. So it was the advocacy that was done by the institution and getting involved with the government, getting involved with the people, and carrying this even to extensive levels by bringing in other countries to participate. And we are having this program spread to nearby countries, and they also are serving Uganda and other countries in Africa by telemedicine. And doing all this, they are able to provide the best care with all the monitoring safety principles that we as anesthesiologists would like to promote globally. And it was a great thing to learn that this can be done in a country with limited resources as compared to some of the other countries.

Nothing is possible without good advocacy, creating awareness and education.

The Indian College of Anesthesiologists has actually one of the benefits of this pandemic resulted in getting good Zoom webinars, and for the last two years, they have created about 140 webinars which are available free to anybody that can log in and get educated on anesthesia topics. And this is done every week. And the American Society of Anesthesiologists and the Society of Ambulatory Anesthesia participate in these webinars at least twice a year. And it is these types of things that, as anesthesiologists, we can bring to the community and make safety top profile when we provide care to our patients.

DR. CRAWFORD:

Adam, if I may add to that, I think anesthesiologists are really amazing. Our skill set is quite unique. You know, not only do we engage with patients from birth to death, we're in the labor and delivery, we're in the ICUs, we're often running down to the emergency department or the wards, we have a presence in the clinics. And all of that is in addition to the operating rooms or operating theaters. So we've we've really engage with patients at every every level, which makes us true physicians, in my opinion. But we're also experts at logistics and transport and throughput. And so when we take a step back and look at the amazing skill set that anesthesiologists possess, that can be applied in countless ways on advocating for patients. And and it's not just in our own institutions and not even at just our own professional societies here, but, you know, engaging with the ASA, engaging with the WFSA, really has an impact on health organizations across the globe. The WFSA has got the ear of the W.H.O. constantly, and I just think anesthesiologists sometimes work quietly in the background. But our skill set is really,

really unique and we're all physicians first, and we have this amazing skill set and perspective that really should be shared to advocate for patients.

DR. STRIKER:

Yeah, well stated. It has become of paramount importance that we as physicians demonstrate to people outside of our specific specialty just how valuable those skill sets are, whether it's executives, administrators, other physicians, other health care personnel. Yeah, I couldn't agree more.

DR. CRAWFORD:

A lot of times our patients aren't even quite sure what we do. You know, they certainly think about us in regards to epidurals and going to sleep for surgery. Our skill set is amazing, we need to use our voices as advocates and that again, global includes local. So that's at the institutional level and country and, and globe.

DR. STRIKER:

Yeah. And I think the term itself, advocacy, I think has been for a long time associated with just legislative activity. And there are so many other ways to be an advocate. And probably it's important to be an advocate in multiple ways: an advocate for the profession, an advocate for your colleagues, but more most importantly, an advocate for your patients and the public. And so I think it's a term that, you know, continues to evolve in a good way and hopefully, hopefully get that continue to get that message out.

Well, I, I do want to touch a little bit on the diversity aspect. And Dr. Crawford, we've well established in previous podcast episodes how important it is to have diverse physicians for diverse patient populations. And I wanted to touch on how this works in concert with global engagement. How important is it to grow diversity on that front and vice versa? How can global engagement serve to improve diversity as it comes to our patients? Diversity includes various aspects—its culture, background, geography, etcetera.

DR. CRAWFORD:

Yeah, it's hugely important and I think we're all working pretty diligently towards greater diversity. Sometimes you're right about the breadth of the definition and, and diversity is often thought of in our non-modifiable characteristics. But diversity comes in many forms and has many layers to it. Again, kind of stepping back to a like a broader framework of, of what global engagement means, it is defined by our community being a

global community. And so I see global engagement as an incredibly valuable tool for both diversity of our patients and of us and our colleagues. And I think that that works in a couple of ways.

Our patient population is increasing in diversity, and it's hugely important that our providers reflect that. I also think that we, for example, in my practice, we have over 300 faculty and many of them are from all over the globe. And so I think it's important to actually give a little bit of recognition to everything that they bring and they bring with them intimate knowledge of different cultures, languages, religions, perspectives. Really learning from each other even within our own practices is really going to make all of us stronger and better providers to our diverse patient population.

Also an important thing is realizing that I can't remember the percentage, but a very large percentage of the health care workforce within the United States is made up of foreign medical graduates, and that number is increasing and it's increasing not only through immigration but also through the match itself. So I think that is a plus, especially in a country where we are short doctors, we're short nurses, and our health care workforce is struggling. We're seeing more and more people suffering from burnout, etcetera. Reframing our community as global and recognizing that the diversity that brings all of us is really valuable. And I think it makes all of us stronger and better providers, better caretakers of our patients and each other.

DR. STRIKER:

Well, Dr. Belani, let's talk a little bit about wellbeing of clinicians. In the editorial you argue that global engagement improves mental health and well-being of our clinicians. Do you mind talking about a little bit about how engagement might help stem burnout tide?

DR. BELANI:

I think that's a great point that you bring out. You know, we all go to medical school to learn and practice medicine. Some of us get involved in global health. And when we do, when we go to these other places and interact with people, it's like taking a break from what you're doing at home and able to share your knowledge and see what the other people are doing. You get a sense of satisfaction and you interact with people of different backgrounds. You engage with them socially. You look at the things they do after work. You meet with them, you discuss things. And then you talk about the possibility of doing joint studies, looking at how quality can be improved in those places. You get an opportunity to invite them to your place. and you feel like you belong to the specialty So it's like taking a little vacation from your work and going and sharing what

you learned in medical school, seeing how others are practicing, and seeing what the local cultures are. And you learn a lot. You build up camaraderie, friendship and see what those local cultures mean.

You know, like Dr. Crawford said, our communities are becoming more and more multicultural. So culturally we are quite diverse and just interacting with them and going to the countries where they came from and seeing what goes on there really makes you open up your mind and you feel so comfortable. And the time for having a burnout doesn't exist.

DR. STRIKER:

Well, that's as important a reason as any to stay globally engaged. But, Dr. Crawford, do you mind talking a little bit about the importance for most of the clinicians out there to stay globally informed and engaged? How does that impact our understanding of the world we inhabit and how does it impact us locally where we're practicing?

DR. CRAWFORD:

Yeah. I would maybe push back a little bit on having lower stress levels when you're working abroad. Our colleagues that are working in resource constrained settings are certainly dealing with a lot of stressors -- higher mortality rates, heavier workloads, less staffing, less pay, you know, a completely different medical legal environment. And so it can be quite stressful not only for our colleagues abroad, but also for us that travel there. It's really difficult to watch your complications and mortality rates when, you know, it could be different.

But I think as far as wellness and physician burnout, I think global engagement certainly can play a role. And I think the evidence supports that. You know, when you feel like you're part of a community, when you volunteer or when you give to others, it's been demonstrated to improve happiness and well-being. Our burnout is, is oftentimes due to emotional exhaustion and depersonalization, loss of meanings, feelings of ineffectiveness. And all of that is driving these high rates of physician burnout that we're seeing. Providing more opportunities for community building and community engagement even at the global level is certainly an opportunity to improve physician well-being.

I absolutely love my global community. I have friends all over the world and that's just a really good feeling. And the world is a big place. But I think once you become an anesthesiologist and especially one that's working globally, the world becomes really small and it feels like you have friends everywhere. So really get a lot of joy out of

having a global community, learn a ton from, you know, my friends abroad. And it's also just a great opportunity for us to all help each other, take the best care of patients that we can.

DR. STRIKER:

Well, we're all victims of our own habitat. And I think just if nothing else, everybody has their own stressors and work environment issues they deal with. And when that's all you're dealing with, those things take on a great level of importance. And I think just being able to expose yourself to other stressors that others are dealing with in and of itself is probably helpful because it maybe resets your own perspective on what you have to deal with back at home, wherever that is.

DR. CRAWFORD:

Certainly. And it perhaps makes us feel like we're all in the fight together. It also creates friendships and community where, you know, if you if you need to be vulnerable, you feel like you can. Which which is another big part of wellbeing is just feeling like you can be supported even if you need to take a break or need to switch up your practice somehow. It goes back to community again for me. And how do you define your community? You know, is that is that a local community or a global community? And I feel like one thing I've learned from working in multiple different places and is that we're we're more alike than we are different. We have a lot in common and we face a lot of the same struggles, especially as anesthesiologists. And so I think having that community and seeing how lucky we are to have the resources and the systems that we have, it really is a good reminder of gratitude.

DR. STRIKER:

Yeah. Complicated issue, certainly multifactorial. And I think you touched on a number of important points and aspects that we as a society probably should look at and examine as we move forward.

Well, before we go, I wanted to just talk about the ASA Monitor issue specifically and ask each of you, as you worked on it, what stands out to you or what do you want the readers to take away from this issue on global engagement? Let's start with you, Dr. Belani.

DR. BELANI:

Well, I think I've been involved in global health since 1999. And in the beginning when I started, people were coming to the United States for their heart surgeries because we were the leader. But it appears now that they have become experts so that many people are actually going there for heart surgery because it's less expensive and communities from different parts of the world are going over there at the low cost. So this has been a great success where our programs with this engagement have shared the knowledge with each other and those places now are doing a lot on their own and they're able to do this because of these global engagement collaborations that have been going on. By the same token, we've helped them set up educational systems which are becoming so, so good over there. There are many more anesthesiologists that know how to use transesophageal echocardiography, for instance, in India, then then in the United States. But that's picking up very rapidly here. I hope with this issue at ASA Monitor, one can look at all the aspects of global health engagement, and especially for our trainees to be able to use the opportunities in their learning years to take advantage of the activities that are going on in different places at different universities, and learn from them, and then make sure that our goals of anesthesia care are globally superior and equal in different places.

DR. STRIKER:

And Dr. Crawford, how about you?

DR. CRAWFORD:

Yeah. First, I would say that it was really, really fun. And it's so great to read the ideas and the perspectives of all of our colleagues that put this issue together. There's a great discussion about cultural competency. There's great updates about the ASA's program in Rwanda and Guyana. There's updates on global health fellowships for trainees. And I personally love the scope of global health and global engagement work from the, you know, trainee years through retirement. I think capturing the value and wisdom of our colleagues that are that are nearing the end of their careers is really an untapped resource that I would love to see us harness.

As far as like a departing theme, I would just say this isn't your dad's mission trip. You know, global health and global engagement have really expanded to include building global communities and networks of people. And I think when we're building our global health programs, we really have an ethical obligation to keep patient outcomes in mind. You know, they're great tools for recruiting residents and recruiting fellows and retaining faculty. But really, we have an ethical obligation to keep partnerships bidirectional, and we have an ethical obligation to make sure that that when we build and how we build

actually has the intended outcome and motivation, and that's to improve the lives of our patients across the globe.

DR. STRIKER:

Well, thank you both for joining me tonight to talk about this incredibly important topic. It's been a fascinating conversation and I really look forward to reading more in the Monitor issue.

DR. CRAWFORD:

It's been a pleasure. Thank you.

DR. BELANI:

Thank you, Dr. Striker. And it was great doing this interview with you.

(SOUNDBITE OF MUSIC)

DR. STRIKER:

To our listeners, thank you for joining us on this episode of Central Line. If you want to learn more about this topic, there is certainly a lot more to read about in the upcoming ASA Monitor issue, and you can also check it out at asamonitor.org. And please join us again in another couple of weeks. Until then, take care.

VOICE OVER:

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** Correction: There are 110 Native American nations within California alone and 573 within the borders of the United States.