



Central Line
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VOICEOVER:

Welcome to ASA's Central Line, the official podcast of the American Society of Anesthesiologists, edited by Dr. Adam Striker. Slides and a video recording of this May 14th Town Hall are available at asahq.org/covid19info.

DR. ADAM STRIKER, HOST:

Welcome to another episode of Central Line. I'm Adam Striker. Today, we're sharing more information from ASA's most recent COVID-19 Town Hall, bringing you up to date information from our experts in the field. Here's what they said.

DR PETERSON:

Good evening, everyone. I welcome you all to this, our 7th Town Hall since mid-march. Every week, I welcome my fellow anesthesiologists, and members of the anesthesia care team, practice administrators and everyone else who joins us in seeking to make our patients' lives and the lives of our peers, colleagues and friends just a little bit easier. I'm also happy that we have earned new friends and guests each week during these webinars. You are always welcome at the ASA.

Tonight, our town hall is on the very important topic of health and wellness, a topic that has taken on more importance for anesthesiologists and those working in healthcare over the past few years, and especially in the last few months, dealing with COVID. I want to thank Jim Grant for starting the Ad Hoc Committee on Physician Well-Being, with Ron Harter as it's original Chair, as well as the current members of our Committee on Physician Well-Being led by Dr. Amy Vinson, for devoting time and energy to this important topic that affects all of us. It was these physicians who worked within ASA to make effective change happen. If you want to see change happen, join us, and become a member of the ASA. Every single member of the anesthesia care team, residents, and administrative executives are welcome to join us.

COVID-19 has disrupted your life, your family's life, and believe it or not, our professional society, too. This was the week that anesthesiologists from all over the United States would have been in Washington DC to advocate for physician-led care, patient safety, and fair payment from federal payers. This is a conference that I look forward to each year, it actually usually occurs around my birthday, which was yesterday, at a conference where more than 600 ASA members are able to speak directly with their congressional representatives face to face. We will have a virtual legislative conference on May 30th. So stay tuned and mark your calendars for further announcements.

COVID-19 has disrupted our work patterns, our employment and compensation, and probably most importantly how we interact with patients. It's also affected our personal and family lives. I received a question earlier this week from a member who had self-isolated from her family out of the sincere concern that she could bring the virus home. She was looking for ways to safely return to a normal way of life. She is not alone. We've received other similar questions like hers. That story is one of hundreds, if not thousands, of circumstances, events and decisions that we face each day. And that's why this topic on physician wellness is important. The discussions tonight will include wellness, leadership, resilience, and looking out for one another, and ourselves, during this time. We are in this together.

I'm pleased to welcome our four speakers tonight. Dr. Amy Vinson is the Chair of the ASA Committee on Physician Well-Being. Dr. Vinson is a leading voice at the ASA and will be discussing the theme of physician wellness during a pandemic, and describes different resources that are publicly available.

Dr. Joshua Morganstein is Associate Professor and Assistant Chair in the Department of Psychiatry, and Assistant Director at the Center for the Study of Traumatic Stress and the Uniformed Services University of the Health Sciences in Bethesda Mount Maryland, as a member of the US Public Health Service. He will be discussing wellness and leadership concerns during a prolonged pandemic.

The third speaker is Dr. Sasha Shillcutt, Professor and Vice-Chair of Strategy and Innovation at the Department of Anesthesiology at the University of Nebraska Medical Center. Dr. Shillcutt will talk about the importance of resilience.

Our final speaker is Dr. Zach Deutch. Dr. Deutch is the Medical Director of Perioperative Services at the University of Florida Health North. Dr. Deutch will be discussing organizational strategies for fostering well-being.

I know I'll hand it over to Dr. Vinson. Amy?

DR. VINSON:

Hi. Thank you so much. Um, my name is Amy Vinson. I am a pediatric anesthesiologist in Boston, Massachusetts, and, and as Mary Dale said, I currently serve as chair of the ASA's Committee on Physician Well-Being. I want to thank the leadership at a ASA, especially Mary Dale Peterson, Ron Harder, Paul Pomerantz and Brian Reilly for being so absolutely enthusiastically supportive of hosting this forum. I also want to thank everyone on this call for taking time out of your busy lives to explore the more human aspect of the COVID-19 pandemic on us, as anesthesiologists, and perhaps more importantly how we can lead in a way that promotes the optimum well-being of our departments, groups and anesthesia care teams. Right now at the same time. The world is experiencing something never seen before in our lifetimes. There are sources of stress seemingly coming from all directions.

At the same time we must be preparing for this new normal we keep hearing about. But there are simultaneously absolutely inspirational events occurring all over and I'd like everyone on this call to take a moment and acknowledge the extraordinary things we have all done in the past two months. We have all engaged in a sort of second medical education, a PPE boot camp, many of us learning how to homeschool our children, many of us taking on new and urgent leadership roles in our groups and departments. Some of us on the front lines experiencing clinical demands never imagined before, witnessing things that truly change a person. Um, some of us have become ill and some of us have lost loved ones to COVID.

If you remember nothing else I say, please remember this. Whatever you're feeling is okay, it's normal. These are extraordinary human times we're living through. So whatever your response is, it's normal. So please be extra kind to others but especially to yourself. And as for peer support, we are our strongest wellness resource. So ask how someone is doing. These technological tools like Zoom can foster community even in this time of physical distancing.

On a more somber, but tragically salient note, for many this experience is completely novel, but for others with PTSD, it echoes of past trauma. If you are concerned that you or a colleague may be suicidal, there are resources. They may be at your institution. But if there are none, or if you need additional resources go to [asahq](https://www.asahq.org), type in suicide in the search bar, and it will bring you to a host of resources including the Suicide Prevention Lifeline. It's a very important number.

VOICEOVER:

The Suicide Prevention Lifeline number is 1-800-273-TALK, that's 1-800-273-8255.

DR. VINSON:

We are also posting a selection of well-being related perspectives, specific to the COVID-related pandemic, to both the well-being website and the COVID FAQs.

On the next slide, we can see an array of varied resources, uh, from meditation apps and mindfulness apps, and fitness programs being offered gratis, uh, to tools to assist in the new challenges we find ourselves rising to, like home schooling our children. Uh, finally, there's information on the physician support line, which is staffed by volunteer psychiatrists to assist us in these times.

We are heading into a new phase of this prolonged pandemic, one in which we are asked to adapt to the new, yet still unformed normal, while continuing to provide safe and compassionate care to our patients. Under these circumstances, while still reeling from all of the change, we are now being asked to catch up. If that feels daunting, it's because it is. The adrenaline of the initial crisis is fading and we are wading into the unknown. This pandemic has the potential to test the endurance, resilience and dedication of even the best of us. So at this time we must redouble our focus on our collective well-being and do everything we can to sustain and tend to our morale. Please know that the good things that we will do in the coming months, in big ways and small, will make a difference in people's lives. And that is an honor. We are making a difference.

I am very excited for the panel of experts we have brought together tonight. They represent several viewpoints from which we can frame a strategy to move forward in our best way. What all three have in common is exceptional servant leadership. Dr. Morganstein is the Assistant Director at the Center for the Study of Traumatic Stress, and a Captain the US Public Health Service as well as an Associate Professor of Psychiatry at the Uniformed Services University School of Medicine. He has long studied the personal impact of prolonged pandemics on healthcare providers, and I can't imagine a more critical perspective for us to hear from tonight, in terms of framing what moving forward is going to look and feel like.

Dr. Shillcutt is a Professor of Anesthesiology at University of Nebraska Medical Center and the founder of the Are You Brave Enough Community. She's an expert on

leadership and resilience, and I'm thrilled to have her providing us with these vital personal tools.

Finally, Dr. Deutch is a Medical Director of Perioperative Services at University of Florida North and I'd like to say is fluent in both private and academic practice. His focus is on organizational strategies and will be providing us with some very practical guidance for staffing an organization going forward. Thank you.

DR. PETERSON:

Thank you Doctor Vinson, and our next speaker is Dr. Morganstein. Joshua?

DR. MORGANSTEIN:

It's good to be with you during, uh, this difficult time to talk about the important topic of healthcare worker well-being and sustainment. The topic of mental health and well-being in disasters brings up many issues of who is at risk, what are the impacts, and how best to support individuals and communities. These are detailed issues which we won't be able to fully address today. The way I have approached this talk is to provide you some brief organizing principles that may not necessarily all be new to you, but hopefully help put into words aspects of your experience around this event and provide additional tools for approaching the issue of workforce sustainment during disasters. These are my thoughts and ideas and I have no disclosures or conflicts of interest.

(Sic) What we know about the impact of trauma comes from our study of disasters, including those that are natural or climate-related, as well as human-generated disasters. Pandemics are often considered natural disasters, but as with COVID-19 the conditions that create and propagate outbreaks often have their origins in human systems and behaviors.

Historically, the psychological and behavioral impacts of disasters are experienced by more people over a greater geography, across a much longer period of time than all other medical effects combined. This is important for disaster resource planning. If history is any predictor, we should expect a significant tail of mental health needs that extends for a considerable period of time after this event.

When we think about mental health and disasters we often think first about psychological disorders, which do occur for some after disaster events. It's distress reactions and health risk behaviors that appear earlier and typically affect many more people, where psychiatric disorders frequently become more apparent over time.

Distress and risk behaviors won't necessarily show up in healthcare settings, but they create significant public mental health burden, increasing rates of family conflict, accidents, presenteeism, and medical errors. Right now, many of these issues are visible in settings that are accessible, or would feel safe to use. So for instance, the National Disaster Distress Hotline has experienced more than a thousand percent increase in utilization from the same time last year. And there's also been a significant rise and calls to domestic violence another crisis hotlines.

COVID-19 has also resulted in protracted uncertainty, isolation and quarantine, fear of shortages and misinformation, all of which have served to alter perceptions of risk. It's the perception of risk that influences how people behave, and whether they engage in recommended health behaviors. For healthcare personnel their perception of risk will impact a willingness to come to work, follow procedures, and use protective equipment, as well as degree to which distress and risk behaviors interfere with functioning at work and home. The ability to influence risk perception will alter the degree to which any group, community or population ultimately chooses to engage in or reject recommended healthy behaviors.

It's also helpful to remember that the vast majority of people, including those who experience difficulties during this pandemic will ultimately do well. Many will even experience increase perception of their ability to manage future stressors. Sometimes referred to as post-traumatic growth. Right now this is a particularly important message for all of us.

Media is an important source of health information and will shape both public perception and subsequent behaviors. Media also transmits fear and distress. Research has consistently found that increasing exposure to disaster-related media is associated with increased rates of insomnia, alcohol use, depression, post-traumatic stress symptoms and general psychological distress.

There are well-established community phases that are relatively predictable in response to acute extreme disaster events, such as hurricanes or earthquakes. Understanding these phases and their unique characteristics can inform on the timing of resource allocation and disaster mental health education interventions.

For instance, the Honeymoon Phase is often characterized by increased collaboration and hopefulness among members of an effective organization or community. COVID-19, like other outbreaks and pandemics disrupted these phases. The natural coming together has been altered by social distancing, stay-at-home orders, and quarantines. An important aspect of the unfolding of these phases is the occurrence of tipping points.

These are seemingly modest events that result in disproportionately large community responses. They're common and protracted disasters like pandemic and significantly alter the experience and meaning of the event for a community or organization.

In our health care systems, the death of a beloved staff member or a child, a perception that responsibilities or risks are being unfairly distributed, a belief that leadership is failing to take reasonable and realistic protective measures, these are all factors that can provoke tipping points. As we have seen in some settings when these events occur, organizational trust is often undermined, and work attendance, as well as participation in recommended health and other behaviors, may diminish rapidly.

Risk is a complex issue. Understanding risk is an important part of managing well-being for clinicians as well as other healthcare workers during a pandemic, what they face, what they're exposed to, how it impacts them. Ideally we'd like to select workers at lowest risk to be involved in response efforts. The pace and scope of this event don't allow for this. The duration and severity of exposure to various traumatic aspects of this pandemic are an important aspect of increasing risk, particularly for our front line health care workers in locations that are heavily impacted. A news article last month quoted an anesthesiologist who described intubating patients with COVID-19 like being right next to a nuclear reactor, a reminder about unique aspects of exposure experienced by different healthcare providers.

Those overseeing or advising healthcare systems should consider methods of surveillance that assess the duration and severity of exposure. As one important factor to inform on things like work-rest cycles as well as helping supervisors determine which personnel may benefit from temporary modification of their duties, or additional peer and organizational support. Part of understanding risk involves collecting data through surveillance. We need to be developing measures now to better understand risk factors for this current event in order to plan for the future, including how best support the healthcare workforce.

Research evidence has revealed that following exposure to trauma, the essential elements that serve to increase well-being, reduce distress, and improve functioning include enhancing a sense of safety, calming, (sic) community efficacy, social connectedness and hope or optimism. These elements form the framework of a concept turned Psychological First-Aid, which is a resilience focused, population-based framework for supporting individuals, communities, and organizations. As we discuss practical interventions to support health care workers, it will likely be apparent that each of these recommendations is based on one or more of the essential elements of Psychological First-Aid.

It's also helpful to remember that any intervention will be most effectively received when it's delivered within the unique cultural and contextual factors of a given community or organization. Our Center for the Study of Traumatic Stress has a COVID-19 resource page, with a variety of educational fact sheets and infographics for healthcare workers, families, and patients, as well as organizational, and community leaders. They're brief, easy to read, and provide actionable guidance to help you know specifically what steps to take, as well as some to avoid. In subsequent slides, I'll display some of these resources. They are applicable to both the problems of today as well as challenges emerging in the days ahead.

There are a variety of free apps and online training on Psychological First-Aid, including a course for supervisors and leaders which I encourage people to take a look at. The mobile app may be useful now or just to have as a review resource. These free trainings are both very useful for when you have the time, which may not be right now. It's helpful to remember the range of needs that people have now, and tailor the support that we provide accordingly, throughout all phases of the disaster response. As with many disasters, instrumental support needs are significant. While emotional support may help people to engage with practical instrumental supports, the reality is that it's often difficult to talk about feeling sad when your stomach is growling or you're unsure if you can pay the rent.

The words we choose when we discuss this pandemic have power. Communication is not only a means by which we deliver interventions, but is in and of itself a behavioral health intervention that can serve as an antidote to distress during times of uncertainty. Messaging and language during crisis have a profound impact on community well-being and the willingness of healthcare workers, as well as the rest of the general public, to engage in recommended health behaviors. As we all appreciate by now, the behaviors in which people engage in or avoid during this pandemic have very real implications for health and safety.

Right now may be particularly important to incorporate rituals as a means of communication and coming together particularly at a time when so many of our traditional social and cultural rituals are being disrupted or curtailed. Rituals and symbols often have the power to bridge divides, create connections and offer healing far beyond the written and spoken word.

It'll be important to gently but continuously remind ourselves and others that this has been shaping up to be a marathon not a sprint. Self-care will remain a critical and ongoing issue for healthcare workers, patients and ourselves. Regular sleep and meals improve decision-making and problem-solving and strengthen our immune system.

These are benefits we can all use right now. The media will continue to disseminate important information, but also serve as a vector that transmits distress. Reminding people to use it wisely will sustain wellness. Healthcare workers continue to have concerns about their own safety and family safety. Policies and procedures that effectively address these concerns will allow healthcare workers to focus on the tasks at hand.

In areas where the curve is rising or peaking, other issues are emerging. Exposure to human remains and mass death come with unique psychological effects, and are covered in part by work done at our center. The novelty of the experience and concerns about contamination are likely to amplify distress.

Notifying family members after the death of a patient is an area in which few healthcare workers receive any training. Our center has worked with 9/11 families, the FBI after episodes of mass violence and with the Military Mortuary Affairs community, have clearly demonstrated that the process of death notification to surviving family members often has significant and lifelong effects, both for the family members, as well as the person doing the notification.

And of course people are tired. Regardless of whether your organization is bracing for impact, in the middle of the impact, or you've reached the other side of the curve, being part of managing a crisis takes time and energy for every member of our community. Finding ways to build endurance through self care, rest cycles, duty modifications, time off will help sustain our healthcare workers.

Brooks and colleagues did a systematic review of social and organizational factors that enhance psychological well-being of healthcare workers during infectious disease outbreaks. Issues such as timely and thorough training, effective communication, facilitating connection with colleagues, and ensuring adequate equipment, are among the factors that improved outcomes. Having a battle buddy that you check in with and who checks in with you on a daily basis can be a formal way of giving and receiving peer support. Buddies remind us we're not alone and, and that there are other people that we can support.

Some of you who are leaders who'll be thrust into leadership positions and may even be advising leaders. It's important to remember that leaders exist at all levels, including team leaders, service chiefs, department heads as well as senior leaders in the healthcare facility. What leaders do and say during times of crisis has an impact not only on the well-being of personnel, but the trajectory of recovery for a community. Being present, leading by example, fighting for the things your people need, keeping an

eye on well-being, and ensuring people get help when needed, are leadership behaviors that engender trust and help to sustain a workforce.

Leaders who manage their own stress make more effective decisions and set an important example for members of their organization. What leaders say, when they say it, how they say it, are critical in establishing trust within an organization. It influences team morale and will impact compliance with recommended health behaviors. Balancing a focus on the present problems while also looking to the future is a challenging but critical task.

Grief will be a near universal aspect of how we experience this event. Leaders can promote healing and recovery within their community by openly acknowledging and addressing issues of grief, communicating with their personnel, facilitating processes that honor losses, and helping people look hopefully to the future.

What is hope during an event like this? This is a challenge for leaders, healthcare workers, and all of us. There are many challenges and this event is overwhelming for some people, particularly for those within our communities that are already living on the margins. There is certainly more distress, pain and grief that many people feel they can bear. For people to feel a sense of hope there must be an honest recognition of, and reckoning with these realities. And at the same time, we must find ways to seek out and amplify, acts of kindness, generosity and human connection. We need to remind people that eventually this will end, and the vast majority of people, including those who have difficulties along the way, will ultimately be okay.

As we address the critical problems of today, and even look to emerging challenges on the horizon, we can seek out opportunities which emerge from the chaos of this event. Finding ways to make permanent some of the recent organizational practice changes that improve access to care for patients and enhance working conditions for healthcare workers, or perhaps using some of the difficult lessons learned to ensure healthcare workers and their organizations, optimize preparedness for the next wave, and future public health emergencies. It will be the truthfulness and authenticity with which we balance all these things that will allow our communities to sustain a vision of a more hopeful future.

And with that, I'll conclude and look forward to the opportunity to take your questions.

DR PETERSON.

Thank you so much Dr. Morganstein. That was wonderful. Our next speaker is Dr. Shillcutt. Sasha?

DR. SHILLCUTT:

Thank you Dr. Peterson. Uh, I'm hoping that in the next few minutes, I can give you all some encouragement and some practical tools to embrace what I call realistic resiliency. And I'm hoping that I can talk to you as if we were sitting across from one another in the break room over a cup of coffee. So my disclosure is that I'm the founder of Brave Enough and I'm going to uh, hopefully show you and make you all kind of laugh in a minute, but we're to talk about resiliency and how to really try to personally prevent burnout in the reality that we're currently in. And then, talk about some daily tips for maintaining well-being during the pandemic.

So, next, you've probably seen this, uh, slide in, uh, maybe a previous talk or even online. And I think all of us right now are facing the reality that this isn't going away, that COVID-19 is now part of our daily discussion. It's part of our daily work and it's, it's really changed the way that we in the practice of perioperative medicine who have become so efficient and often times go through our day without having to really think about how we're going to be efficient in our job, is now, we're all faced with kind of, there's no light at the end of this tunnel. It's not going to be gone in a month. And we're faced with this new reality that we're having to look at, how do we now live and work in the pandemic?

I want to talk about the impact of this pandemic on you as a person. So often times when we're showing up everyday in our work life, we're getting information on how this affects us in our department and our patient care, but what I want each of you to do right now and I want to challenge you to do is to go internal. First, I want you to congratulate yourself for getting online tonight and being a part of this Town Hall, because this is an investment. This is, you're putting, uh, coins in the bank your own well-being. So, good job for even being here and being part of this conversation. What is happening is that we are undergoing extreme physical and mental fatigue, and you may be thinking well, how am I so tired all the time when all I did today was get online and Zoom? But even if you're on a Zoom meeting, how you perceive other people and how you're communicating with other people is not how you were before. We're not sitting next to one another and able to really see the nonverbal cues. We're having to constantly screen, or scroll the screen, and see who's talking and really pay attention and even how we present ourselves on Zoom. So there's a large amount of fatigue right now because everything that we've done, it's like the rug has been pulled out from

underneath us, and processes that we never had to think about before, suddenly become difficult and real.

We're having a large amount of stress due to the physical and mental fatigue and it's causing significant sleep disturbances for the majority of us. Now part of that is because we may be getting more consistent sleep, but we're dreaming more and we're having a difficult time actually turning off our neurons at night. So I don't know about you, but I know that I've been having lots of COVID dreams. I wake up, um, often times at 3 o'clock in the morning, and I remember it feels like I've been running for you know, 5 hours. Well, I have been in my dreams. So I think that that is a good sign that perhaps you're having a lot of unconscious stress that your brain is really having a hard time turning off, even though you might be sleeping more.

What we know is that, um, as Dr. Morganstein talked about, we're seeing a lot nationally more anxiety, depression and, and needs for mental health exacerbations, and all of those are concerning for medicine because we know that those things are often precursors or can lead to professional burnout. And at a time where we all need to show up, and we want, we feel a burden or we feel this amount of guilt, to, that we have to be present and we have to be our best for our patients and our partners. We're actually undergoing perhaps some significant stress and anxiety that, we're, that's layered on top of the stress and the cushion, the lack of the cushion, that used to be our home life. I want a really kind of hone in, and affirm you. Okay? I want you to take a deep breath, and I want you to realize that this is stressful, and what you're feeling is stress, and that it's not you, you're not a weak-minded person. You're not just somebody who needs to tough it out, that this is normal what you're feeling. And it's because, number one, we're on information overload. So the reason that we're having a hard time sleeping is because our brain is constantly pulling in information. We're constantly reading up-to-date emails. What we learned yesterday has now changed today, and is not the way we, maybe, where we get our PPE or how we test patients. We're having occupational hazard stress. I mean, this is, um, I'm a cardiac anesthesiologist, this is kind of my get go of patients often that I see everyday, but this may not be something that all of a sudden you're used to taking care of. Then this is now our reality.

So, we're, we're, many of us are asked to do things or we're learning new things we've never had to do before, myself included, and it's, it's a significant um, stress at work occupationally. And then, we might be facing limited resources in our communities and have longer hours. All of that can be added and is real, so I want to affirm you, I'm not trying to be negative with this slide, but I want you to feel that, and know, that what you're going through and what you're feeling right now is legitimate.

So I want you to take a deep breath and recognize that resilient physicians, and this is something that I've studied for the last several years, and I'm not going to bore you with all the data tonight, I, cuz I really wanted to give you an empowered and encouraging message. That resilient anesthesiologists, they experience guilt. They don't live through life like a unicorn with sunshine and roses and never let anything bother them. That's not the attributes of a resilient physician. Resilient anesthesiologists and, and, anesthesia, um, workers and our whole team, our whole healthcare team, the most resilient teams, experience grief, they allow themselves to grieve.

They also can experience sleep disturbances and have varying amounts of stress. The difference is, that they recognize that, and they show up the next day, and they reach out and they're vulnerable with their colleagues and they share that with their teammates. That's the difference, that's, between people who are resilient and people who burn out. It's not that one is stronger than the other, it's that they're actually vulnerable and they share. And so I want to encourage all of you to have a battle buddy. And if you don't have a battle buddy, reach out to somebody in the society or on Twitter. I mean, I have a lot of friends on social media that I consider to be my battle buddies.

I want to really have you stop for a minute, and check your own pulse, to check your own well-being pulse. We don't do this. We're so good at checking the pulse and checking the vitals of the person that's laying on the table. Right? Or that, we, we're rushing to help. But we often don't stop to take our own vitals. So what I've been trying to do in my own life, and in those that are in my view, that day, and that's kind of my mantra, like I'm trying to look out for the teammates that are in my view. How are you doing? How is your mental check? Just give yourself a mental check. Um, the other night, I was on call and I felt myself getting a lot of anxiety about an emergency coming in, and I just had to stop and take a, a grateful moment and to, and excuse myself for a minute and take a big mindful minute, and just big deep breaths, and count to 5 and go, okay. I'm getting a little anxious. I just need to calm myself down.

Ask yourself how you're sleeping. A lot of times, we think we're okay, but then we look back and recognize we haven't been getting good sleep. That might be a sign that you need to take care of your own well-being and maybe you need to either get outside and exercise, or you need to pull back from something, or you need to talk to your battle buddy about it.

The other thing that a lot of people are recognizing right now, and they feel that it, it, they shouldn't be feeling this, or they shouldn't be experiencing it, is you're going to have varying degrees of stress in a single day. So you might be really good in the morning, but by noon you might be a little stressed about something or feeling anxious

about something and that's completely normal right now. And then the other thing is, that it, it's okay to have joy right now. I'm also hearing the flip side. People are, are laughing and they almost feel guilty at work for laughing, or they feel like this sense of, we should be in this grief state, and we don't know how to smile or laugh or have joy right now and it's okay to have joy. It's okay to laugh and have humor to get through our day.

And then, have a purpose. Um, I think there's so much we could do. Whether it's encouraging one another, whether it's working on um, protocols or pathways, or whether it's reaching out to our communities. So I think what, what I've tried to do is find a purpose every day and just simplify that purpose to three tasks that I want to achieve that day. And maybe it's getting a patient safely to the ICU, maybe it's asking my trainee how they're doing and how they're coping, and maybe it's, you know, making sure that I connect with one of my children that night.

I want to really encourage you on these six steps. Okay, number one, do meaningful work for you. Because what's meaningful for you is not the same as what's meaningful for me, and the way that we express stress is different, but it's also the way that we find joy is different, and we need to respect that amongst our teams. Make sure that you're developing good sleep hygiene. Try to go to bed at the same time and try to really develop that bedtime routine. Stop the scroll and the blue light at night. I know the more I read on the news, the more stressful I get, so I've just told myself that an hour before bed, I have to get offline. And I have to start my bedtime routine of getting my brain ready for sleep.

Get outside. That is such a simple, um, mantra, but it's so helpful right now to get even 15 minutes in the sunlight just to improve our endorphins. Um, don't underestimate community. Chances are if you talk to somebody at your, in your workplace, they're probably struggling in similar ways. And so try to reach out, and I think this is really important because what to do when we're stressed is we do this secondary blame, like I shouldn't be stressed. I shouldn't be anxious. I'm weak, so I withdraw. But what we really need to do is reach out to one another and not underestimate the power of our community. We have an amazing community.

Beware of numbing, and this is a hard one. But I really want to point this out. If you find yourself coming home at night, and you're numbing, you're adopting behaviors to just numb your brain, and numb yourself, that's a red flag. That means that you're not doing well and you probably need to get some behaviors that are positive and encouraging around you. Get outside, call of friend, text a friend. Numbing behaviors can lead to a lot of bad behaviors, substance abuse, um, relationship problems, and all of us find

ourselves doing this that times, myself included, where I don't want to talk to anybody and I just want to watch Netflix for a binge. Um, I want to just tell you that if you're finding yourself doing those all the time and withdrawing from people, you're probably very stressed out, you just, it's unconscious, it's in your subconscious, and you haven't really identified it yet.

And then, control what you can, because there's so much right now we can't control. So, when, what you can't control just give yourself those three tasks a day to complete and give yourself a lot of grace.

And finally, I want to encourage you to give yourself permission to pull back, and step away, and tell yourself that you're doing enough. I just recognized this in myself about 10 days ago, and I was getting very anxious and stressed and I was projecting that on everyone around me, my family, my co-workers and I needed to pull back, and take a wellness day, and really understand what I was doing that was not adding positivity, or healing, or vulnerability to the, my team. So what I did was, I just said, I need to pull back today, and I need, I'm not doing well. And that's leadership. That's saying it's okay to do that, and that's modeling that. But it's also being human and being real.

So, I hope that I left you with some encouragement today, and I hope that you all recognize how valuable you are, and how important your own personal well-being is. So, thank you for listening.

DR. PETERSON:

Thank you so much Dr. Shillcutt. Our final speaker tonight is Dr. Deutch. Zach?

Amy. I know that you already gave us sort of the slide and all about, you know, about what, what people should do if they're suicidal? So we've got lots of resources out there. Anything else you want to emphasize about that, or Josh you can weigh in on that as well?

DR. VINSON:

Yeah, what I'd say is that it's a very real problem. Um, it's a very real problem in our community. I think most people know somebody who's taken their life, um, in anesthesia. Um, it's been a problem for, for a long time. Um, it's a problem in other areas of medicine as well, it, in, it is well established, um, that we lose at least 400 physicians a year to suicide, and, that is, horrible doesn't even start. Um, it's an, an awful problem. So from a high level standpoint, you know, we're doing things, um, to, to

try and address the culture that's creating the situation and what I mean by that is that some of the high-level things that groups are doing around the country is removing barriers to asking for help. I think one of the most encouraging things that's happened in the last couple years is, states have stopped asking people if they've ever had a mental health condition. Um, and now they've mostly all moved toward giving it parity with physical health conditions. Um, so that people aren't afraid to ask for help if they need help.

Um, I think the best thing you can do, when you're creating a culture of wellness within your group or department, is to have in your mind the ultimate goal of creating a culture where if someone needs help, there's no barrier to them asking for help. Um, to what I would say to someone who is thinking of harming them, themselves, that this is, this is a permanent solution to a temporary problem. And it's a very real problem, and you need help, um, and you need to ask for help. Um, it's probably the most courageous thing you will ever do in your life, um, but asking for help in that moment is not weakness, it's strength. There's resources, we have them on the ASA website. But if that's daunting, start with a friend, call somebody, connect with somebody, um, and, and keep connecting until you reach someone that can help you.

DR. PETERSON:

Thanks so much. I mean our final speaker tonight is Dr. Deutch. Thank you Zach.

DR. DEUTCH:

I do have some useful information I want to be able to impart to everyone. A lot of it is very practical, and I think is useful. I have spent a lot of time in both private and academic practice just so you know, so I think I can speak to both. And the learning objectives, we kind of already touched on that as well. Um, the key concepts in each slide will be in red. So I put stuff that I think it's really important for people and that I really, and messages, that I really want to get across, in that, those, um red phrases or sentences.

Um, I will talk about how I defined a pandemic in three phases. This is just the way I did it. A Preparatory Phase, a Treatment Phase, and a Recovery Phase. Um, the Preparatory Phase, we've kind of already, all of us have been through already, so I'm not going to waste a lot of time on that. The biggest issue with that being the real great reduction of the normal type of work we do, we do in the perioperative setting. Um, so, the Treatment Phase and the Recovery Phase is really where most practices are right now. So we're going to spend more time on that.

Most of us have been through this already in terms of how we're going to husband our resources weather personal-wise or equipment-wise. Reduction of OR volumes is an issue. Basically, when, you know, we're going from doing all of what we do, to 20% of what we do.

What are the operational concerns of this change of going from doing all the stuff you doing nothing and being prepared for a group of patients we don't know of what acute, of what a, acuity level, and what number? In the public sector, where we are really salaried employees essentially, weather we're being paid by a hospital or by an academic system, university, whatever it is, the biggest issue we come across is how do we deal with a sudden excess a personnel? We have all these people, yesterday let's say we were running 20 rooms. Now, we're running 3. What do we do with these people? How do we justify that staffing, uh to the Dean or CEO? And, um, what are we doing to do? Are we going to take pay cuts? Are we going to have to, where are we going to park people, basically? Also, you know, another little side light, this very unpleasant side light is the idea of negotiating budgets for the fiscal year in this particular setting, is, is just a, a very uh, painful thing, in that you're talking about a hospital which is facing a financial crisis like it's never faced ever before really in recorded history. And now you going to come to them and say, well, what about the, this new hire we wanted, and this equipment? I mean you can only see how painful that would be and how difficult it would be to extract anything.

In the private sector, really were talking about, can we meet payroll? Can we deal with the, do we have enough enough cash on hand to pay people if we have no revenue coming in? What does our account receivable look like? Publicly traded companies, you know, there's an issue of stock prices and financial stability for the investors, and in a private company, a limited partnership, what about our part, partners compensation? For the shareholders, are we going to get paid, how much we getting paid, what are we going to do? I'll talk briefly about mitigating factors, in other words, in other words, things that make this better for group practices. What aspects of what's happening make it better? A loyalty to a group practice health system or community, uh, you know, in a small community that's very tight-knit, a hospital that's a really, a people's community hospital where everybody knows each other. They're very loyal to the practice, very loyal to the community, that helps to get over these things, because people are willing to do whatever it takes in those settings. Also people that tend to be selfless or altruistic. That ties into it.

There is federal stimulus money out there. Many small businesses have benefited from that, and anesthesia practices are no exception. Some practices as a whole, and some individuals, have employed, have applied for unemployment benefits and obviously that

is some form of fix. The ability to do short-term, or Locum work. We've seen some nurses in this area, for example, that had no work in the perioperative setting go up and do lucrative local assignments in the tri-state area, and some of them have returned already. And then there's a voluntary furloughing, we will talk about that a little bit later. People that really just don't want to be around, and are like, you know, um, I, I don't care whether I get paid or not get paid. I just rather not be here.

There's a widespread anxiety. We all feel it and we're in a very bizarre situation with the lack of the usual social supports, you know, we can't even hug a grandparent, we can't high-five people, hug, fist-bumps, whatever it is that we normally do that makes us feel connected to other people. A lot of that is taken away. You know, you jog down the street and someone goes six feet out of their way to avoid you. They're trying to do something that's proper and nice, but it feels unnatural. We have an injection of uncertainty into this field, which is one, most of us are, sort of very organized, very type-A, and we love the predictability and we love that sense of, you know, having everything in it's orderly place and now none of us have that. That's all gone.

There's a lot of misinformation and outright fear-mongering that's there and clearly social media is a contributor for the good, for good and for ill. For spreading of good, for spreading of good, reliable news and also for spreading the news that is, whether you call fake, or fear-mongering, whatever you want. It's just something that's not productive for us psychologically. Anybody who had personal or group instability, that was financial instability prior to pandemic, in other words, if you were doing poorly financially prior to this time sure, surely now, you're not doing well now either. So that's going to exacerbate. Um, many have legitimate concerns as we've also discussed for the welfare of themselves or their family. And as I know some of the questions come up in the chat, differing risk profile to the anesthesia practice members. Does that mean differential treatment? If you're a certain age, with certain co-morbidities, if you're pregnant, if you're immuno-suppressed, if there are other people in your house that are immuno-suppressed, and we'll talk about that as well.

Moving forward, this is the slide that I think has the most useful information. It's really the right way, again in an ideal world, to operationalize all this. How do you make it as meaningful for people as possible? How do you preserve the wellness? How do you try to make people feel as right as they can? So, the first thing is transparency. So much mis, misinformation. Only give people the facts, what you know for sure, what's useful to them, what they need to know. How much is our practice behind financially? How many people do we really need every day to work? Tell these things explicitly. People need to know so they can see the scope of what the problem is. The solution can possibly be

worked on together in that regard. Open lines of communication, everybody in a practice situation needs to be heard. That means everybody who's involved in your practice.

That goes from anesthesia techs, to trainees, to attendings, to whoever, whatever type of setting you're in, anyone who you feel your practice has a responsibility for in some way, daily email updates, Zoom meetings, every person invited. The type of questions that people are going to want to answered, how much PPE do we have? What's the testing situation? What tests do we have? How many hours? When do we do them? Will they run out? How long will this continue? Um, fairness in how people are treated is super important. If you're going to make pay cuts or adjustments to compensation, ideally, you're going to want to do this across the board. You're going to want to put each individual group, in a set, in, in a certain box and say these people are going to be responsible for this, which is reasonable, but the idea that some people might suffer more than others is not something that's going to go over well in terms of group wellness dynamic.

Ideally in a hospital situation, the C-suite will lead by example, that would be ideal and I think that goes a long way towards establishing credibility and really getting people to follow along with that. Bottom line is don't expect to cut people loose and have been willing to come back during the Recovery Phase, like nothing has happened. That won't work well. We see, we have some novel uses for our personal in phases, phases one and two in the Preparatory and the Treatment Phase, intubation teams, research, education initiatives. These are stuff probably a lot of people have explored. These are the types of opportunities you think about traditionally are kind of an academic-type pursuit, but they abound in both the academic and the private setting. And it's an opportunity for people be put in a meaningful role that aren't necessarily doing clinical or perioperative medicine, and also for a department, an anesthesia department, whether private or public, to prove its worth to the health system, to be involved in the front lines of treating and dealing with this pandemic, and really strengthen the practice in that way so it has a two prong benefit.

We're going to talk about the Treatment Phase, which many places are in right now. Won't be the same everywhere. We've seen different levels of experience in the tri-state area in Detroit which particularly hard, versus other cities which were not. In this situation, I think we see it as an all-hands-on-deck scenario in which whatever needs to be done, you're going to go ahead and do it.

You know, it's, it's a public health emergency. Ask what the institution, ask not what the institution wants to do for you, you go ahead and just do it. I think that's really what you need to do. I think that's right way to do it, and it positions any practice for a very, um,

good point of negotiation later saying, we were there. We did this, not only was it the right thing to do ethically, it's right thing to do logistically for your practice.

Now, this is the phase I think everyone's very concerned with now, which is the Recovery Phase. Do we go back to normal? In other words, back to where we were before March? Before they sing started to happen? Every health system is hurting very badly, we're all aware of this. Um, in order to stay solvent, many systems have taken advance payments from Medicare. These are going to accrue interest if they're not paid back. Um, if you've got payroll to meet, they've got all sorts of financial disasters. With other things being equal, everyone's going to want to make this lost revenue up, as soon as possible. Um, so can we go from 0 to 60 in just a few seconds? Can we go from, you know, our volumes, then cut by 80%, then back to 100%? So do we have testing and PPE that are adequate? Um, do the patients want to come back? Do the surgeons want to do cases? Is it going to be staged approach, or what exactly are we going to do? Um, and each system is going to have to answer that question on its own. But there's no question, every system is going to want to start seeing money roll into their, their accounts receivable, and into their bank accounts, because they'll be hurting.

The next slide shows us the scenario of a supernormal recovery, which means we did go from 0 to 60 in under 3 seconds. Not only are we doing what we did before we're doing more. And indeed, that's what's happening our health system here at the University of Florida, Jacksonville. We have expanded our perioperative functions with higher patient volumes, greater number of rooms, and they're running later.

Does this mean we need later shifts for our personnel, weather it be periop personnel or anesthesia personnel? We're adding extra rooms. Maybe we're doing things on the weekend. I know many health systems are exploring this, had not been doing it in the past. If that becomes de rigueur, what are we going to do there? There's not a lot of money out there, but do we create incentives shifts, or just we just say this is extra call for people? This is what you're going to have to do. This is not a good time to go back to the administration with needs and wants. Saying, hey, you're asking us to cover all these new rooms. And this is going to cost us. I mean, it's, it's just the idea of being able to get financial support there, I'm, I'm seeing that as blood from a stone. And, I really honestly don't think anyone has a good answer there.

So we're going from famine to feast if this supernormal transition is really the case. In which everyone who was idle, or under-utilized, will be working quite a bit. Now, they should, if you've done it right, have prepared them for this, so the transparency, the open communication we talked about on our right way to do it slide. And basically said, look it, you guys are going to be sitting around for 4 to 6 weeks potentially, but when we

come back, you know, we're going to be firing on all cylinders. I think that's got to be made clear to everybody because, um, that's just the reality of what it's going to be. For better for worse, we're going to have to adjust. Those who felt they, they have been treated unfairly or not properly dealt with over that period of time are going to be extremely dissatisfied if they're brought back and asked to work a lot. The credibility of the group on that basis is undermined and there's going to be some ill-will that sown from that. Whether these people have anywhere to go or not at the present time, is one thing, but the seed is planted and they'll be some, that's just a poison against the group, and likely these are the people who will likely try to exit the scenario. You really want to try to avoid that. You wanna be straight with people and say, look we're all in the same boat. We're all kind of twiddling our thumbs wondering what to do, anticipating this, and then when everything is over with and we've gone through our surgery, and we've treated our patients, we're going to be pedal to the metal.

So my final points are on the next slide. All of our practices are now in Phase 2 or approaching Phase 3. We hope this pandemic and it's challenges are relatively unique. I really hope that in the sense that there's some lessons we'd like to learn. Um, you know, lessons about how to share resources, multidisciplinary critical care teams, you know proper use of PPE, reuse of certain PPE, those are all things we can use in the future. But some of these lessons I don't think we want to use again in the future. I personally don't ever want to look at a situation, which is a financial disaster for the healthcare system like we've seen over the past two to three months. I hope we never have to put those lessons in place again. All the challenges we saw in the past, whether they're personal, or related to personnel, group dynamics, or economics. They look ridiculous in comparison to this. And so again, I hope we don't face it again.

Um, as a medical community, we are indeed stronger by sharing our experiences. Because of the FSA which I belong to, and the ASA, we have a national and an international platform for doing so, which I think is great looking at all the web-available postings, to emails that come out, the chat groups, and this is when social media is very useful. People sharing things they've done, whether in the ICU or the EDs, this is when, you know, we see the very, um, the community of medicine come out and really help people, help us, help other people. And, that's very encouraging.

Um, on my final slide, I would like to thank Dr. Vinson, Dr. Peterson for the opportunity to participate here. Uh, Dr. Sherman and Dr. Hallows helped me prepare the presentation. I hope I've added something valuable. I'm, I'm looking forward to taking part in the questions. Um, and if you have any questions for me in particular, um, my email address is there and my Twitter is there, and thank you very much.

DR. PETERSON:

Thank you so much, Zach, and if I can if I can get our other presenters to come back online. I, I have a lot of questions. So this is really great. Um, Zach, I'll start with you, um, while we're getting everybody else online. So one, um, of them is, as operating rooms are ramping up and they try to make up time lost, how does one maintain wellness when the days may be long or they go to weekend ORs?

DR. DEUTCH:

Very tough question. My computer is going to restart in about 1 minute, so that gives me 50 seconds. I think, I think that, uh, you know, it depends what you can do. Likely you don't have money to throw at the problem. Nobody's got money lying around. In the past, you say it's time or money. We can give people, say there's some people that want to do these shifts, we'll give them money to do it. It's not there. And then, you'd be able to give them comp time off after their shifts, that's not there either. I think what you do is you just have to be real honest and say, as a practice we have to eat this, and this is the amount of shifts we have, and these are the people that we have, and we're going to divvy it up in a way that's equal and fair, and if it takes a group governance to try to decide that, to some extent you do it if it's not too bulky, but there's going to be some pills we just have to swallow and I think you got to be honest with people and say this duty is onerous, it's coming to us, and I don't really know how we can cushion the blow, other than spacing it out in a way that's fair and equal to everybody. That would be my advice.

DR. PETERSON:

Thank you. So Josh, we got a number questions for you. You're, you're popular tonight. Um, one of them is having experienced a recent likely anesthesiologist suicide in the area, we wonder how to detect those truly at risk. On some days, it seems almost everyone shows worrisome signs or concerning comments. We don't want to miss another one, please advise. You know, and then there was another one, that was kind of similar, um, to that on, you know, what do you do when people don't want to engage kind of thing, and you're worried about em.

DR. MORGANSTEIN:

I really appreciate, um, initially, I, I should say appreciate Amy's impassioned comments about the importance of caring for one another and looking out for our colleagues. And I also appreciate the sort o direct, um, and clear message about, um, a regard for the

safety and well-being of our colleagues. Um, I think one thing that's probably important to keep in mind is that approaching issues like suicide is, is obviously very challenging. Um, there's still a sense that asking people about how they're doing, or when we really think people are in crisis, asking them directly questions about their safety will, um, somehow put that in their mind or make them think about doing it. So, I think one important piece of information is that there is no literature to support, and in fact somewhat to the contrary, that directly talking to somebody about that particular issue, um, is not, isn't likely to actually enhance the likelihood that they'll engage in suicidal behavior.

But suicide is very complex issue. Um, who, when, um, and these things evolve over time, and also very rare outcome overall. Um, it's a tragic one, and it's the ultimate bad outcome that people want to prevent. I think one of the most helpful ways of approaching suicide, um, is to be aware of what are modifiable risks associated with it. So we know that increased consumption of alcohol, people engaging in family conflict, these are things that increase people's risk of suicide, and enhance their network of stressors. So to the degree that people's network of stressors, at home, and at work, and elsewhere, are increased without things to buffer against it, those can certainly lead to a sense of sort of hopelessness for people. But I think focusing on modifiable risks is one important way to address underlying factors that put people at greater risk for suicide. I mean it's a much more difficult issue to tackle directly on an individual basis, but from a public health perspective, those modifiable risks are um, a useful target. And for people to be aware of in colleagues and for themselves.

DR. PETERSON:

Thank you very much. Sasha, here's one, maybe not quite as difficult, but sometimes maybe it is. Uh, what do you do when you wake up at 3 in the morning and you can't fall back to sleep.

DR. SHILLCUTT:

Well, that's, there's conflicting, um, there's conflicting data out there on actually what you should do. Some people, well what you definitely shouldn't do, I just talked to one of my friends who is a sleep doctor about this last week in preparation, and she said what you absolutely should not do if you're laying there wide awake and you're starting to do the list. Um, it's not working. So get out of bed, and actually get up, uh, go to the kitchen drink a glass of water, um, do something, like even if it's read for 15 minutes, read a book, or, uh, don't get on your phone, but like read something to try to reframe your

thoughts. Um, but if you're just laying there, and you're wide awake in your head, in your mind's going a million miles an hour, you actually should get up.

Um, one of the things that I've also read that works that I, I personally do, is, um, it's almost like a meditation, and I lay in bed and I start my toes, as silly as this sounds, and I just try to relax my toes, and I try to relax my legs, and I just imagine like relaxing my whole body, um, and it actually works. And if you go, if you kind of start and do that, it does, I don't know how, but it does it works for me. If I just try to relax myself, by the time I get to my head, um, if you can relax your body, your mind will follow. So if you're laying there and your heart's beating fast, you probably should get up and read something to get you to calm down, and then you should try to lay there and try to fall asleep from your toes up to your head.

DR. PETERSON:

So Sasha, what about, you know, if you're worried about so many things, what about journaling, or writing down those to-do lists so that you can get it out of your head? Is that a method that people can use, too?

DR. SHILLCUTT:

That's a great method, Dr. Peterson, that's, a, another thing, um, that our colleagues in sleep medicine say to do. To get up, to either read something or write something down, but just remove those thoughts from your head, whatever it takes, and then go back to bed. Um, but even if you give yourself like three, you know, people say I don't want to get up, cuz then I have to go, but I have to get up in 2 hours, but if you actually get up and then go back to bed, you, that time is not wasted if you can actually fall back to sleep.

DR. PETERSON:

Okay, great.

DR. MORGANSTEIN:

I just might, I might piggyback real quick, Mary Dale, I appreciate Sasha's very, um, the pragmatic advice around progressive muscle relaxation, and other interventions. Um, I'll mention that on the site that I referenced, our COVID-19 response page, um, our chronobiology lab has put together a very practical and brief fact sheet that provides information about enhancing sleep, um, and reducing insomnia for, um, healthcare

workers addresses issues around shift work and things like that as well. So, its another resource if people are interested, that might augment some of the other great information that was just mentioned.

DR. PETERSON:

Yeah, I, I think that isn't it special challenge for us. You know, you have a call night, or you have a series of nights and you've gotta go to days, and so I think, um, it's exacerbated. You know, and then you've got all the stress of, of dealing with everything everyday, but I think those are some great tips.

So, Amy's here's one I'm gonna punt to you. I am truly grieving, let's see I lost it now, uh, these questions are coming in so fast, basically, it's I'm truly grieving the loss of a career I have loved. I honestly don't see that there will be much improvement for a long time in the future. N95s all day. No one can hear you talk without yelling. Inductions that used to be smooth are awkward. Any ideas on how we can bring back any enjoyment?

DR. VINSON:

That's a great question. Um, no, it really is, and I think everyone's head is nodding in this group. And, you know I think we've all experienced it. You know I, I practiced pediatric anesthesia, and you know, we're all terrified of the asymptomatic carriers and that sort of thing and so, you know, all these cases that were once fun and interactive and you do a mask induction on a cute little kid, and now you're terrified of them, and it's, it's, it's definitely taken a lot of things from us that, um, that we are grieving right now, and we're going to have to find a way forward into the new normal.

Um, and I agree, you know, you, you can't hear each other in N95s, and, and you don't have the same kind of connection with your patients that, that you had before because now you're, you know, to some degree we're looking at our patients with a degree of personal fear, um, and that's a very new interaction with, with our patients on such a large-scale. And so, especially when you look at the fact that, that physician-patient relationship is probably one of those things that gives us our, our highest degree of professional resilience. It's that interaction, so anything that comes in between, that's going to breed burnout.

Um, so what do we do going forward? And, and you know, I suspect Sasha would, would agree with me here. Gratitude and focusing on good things. And, and I'm not saying that like a Pollyanna kind of way. If anybody knows me, you know that my middle name is pragmatic. Um, focus on positive things and you'll find more of them. Um, you

have to be intentional about it. You have to enter into your day with a, with that as your mindset. If, if you don't want to call this mindfulness or gratitude, you can call it cognitive behavioral therapy for executive function, if that feels better. You can do that, um, but honestly, trying to find the good things is going to be your best way forward on this but, but you know what, allow yourself the opportunity to grieve the things that we've lost and that are going to be different going forward.

DR. PETERSON:

Thank you. Zach, I see you're back. So, I, I've got a question for you. Um, it has to do with um, anesthesiologists over certain age groups. Will you take 60, 65, 70 or those that are immuno-suppressed, or whatever. I guess, any advice on how you manage that from a group level and deal with, with those uh, colleagues or coworkers?

DR. DEUTCH:

This is a big question. Um, you know, we all feel that, we know, that there are differences in, in the people that are in medical practice, of their risk profiles. We know this. And we feel for that on a human level, the need to one protect those that are close to us, whether their co-workers, friends or family. The problem is one of logistics. I think in a practice that has a hundred people, and there's a limited amount of people in a certain risk category. It's, it's not that unreasonable, logistically, to say we're going to put these people on a different type of duty, we are going to do different things with these people.

But when we have a group, let's say we have 16 guys that are in a private group, and, and all of them are over 55 and they really haven't had any turnover, and they haven't recruited anybody else into this group. Then who decides, who, is going to be the person? That can become very unpleasant and ugly, and I really don't have a good answer. I, this problem is a very ubiquitous problem, and I think we've all faced in our practices. The bigger the practice, like anything, the easier it is to accommodate. I think in a smaller group, it's going to be hard, and there's going to have to be open discussions about what does the group value? What does the group think? Because it's, it doesn't, it's kind of incongruous to say we're going to give, let's say we have a group where we have 30% of our people meet these risk factors, and yet our hospitals now asking us to run 18 rooms instead of 15. Those things don't, don't compute. And, I don't have a good answer other than getting together as a group, and saying guys this is our problem. How do we solve it?

DR. PETERSON:

Yeah, I, I think it is a challenge. I know that I think one of those things that we have to do is really make sure that everybody has the maximum amount of PPE that they think they need to feel protected because the data coming out now I think is somewhat encouraging that um, you know the risk of, of getting COVID is significantly reduced if we properly use our PPE, so I think that's where, you know, the ASA has been very strong and its stance about, um, you know, if people are in a community with community spread, then we probably do need to be using N95s, even though they're uncomfortable, or whatever. But I think that, that can be reassuring. Um, I know that our anesthesia staff feels reassured that we're testing preoperatively as well. Now, obviously, we're only testing elective patients right now. You can't, we don't have enough, quick enough turnaround time, for you know, emergencies, and it doesn't change necessarily, you know, that you're gonna need to do them anyway, but it's, those kinds of things have been reassuring cuz we have a number that are you know, well over, 65 and so has been reassuring to them. But you know, it's a small group and we can't afford to have people that don't participate unless they want to take, you know, I mean everybody could take FMLA or whatever if they wanted to, but it would put a huge strain on the group to do that.

DR. DEUTCH:

I think the ideal scenario, is a group that can sustain it personnel-wise in a person who says look it, it's too, I'm too uncomfortable. I'm anxious. It's not going to work for me. I just want to go home. I don't care what you pay me or, or don't pay me, but we're not all in the luxury of having people in those situations and that's when it gets tricky.

DR. PETERSON:

Yeah. So I have one that's, you know, writing in and saying, um, she would like to consider a shift in words, words do matter, and she's suggesting it maybe instead of calling them battle buddies we should call them compassion buddies, uh, since studies have shown the values of compassion whenever it appears that nothing can be done with suffering. Um, so, uh, there is a safe, a way to create a safe space with proper training around suffering to protect our mental health. So anybody want to comment on that, um, suggestion that's out there?

DR. MORGANSTEIN:

Well, the concept of a battle buddy, um, is a term borrowed from the military, um, that's really the underpinnings are about safety and social connection. Um, but a buddy system is not new. There are swim buddies, there are buddies that are part of 12-step

programs. There are there many occupations that require a buddy system, um, to ensure people remain safe. I think that the term that people use should be what works for them in their organization. I would not apply, whole hog, um, a military concept to and non-military setting. I think that, um, the benefit of using something and figuring out what works for you and a, adapting it for your own environment. I really like that compassion buddy, um, and that may work for some people. Um, I also feel like the term buddy is maybe something that's a little bit more gendered, also. Um, just as a, kind of a question, I don't, I think males tend to use that term more than females, I, I could be wrong, but I do think finding language that works for any person or group or organization, um, is really ideal and very much important for encouraging adoption of that process.

DR. PETERSON:

Thanks, Josh. So, a couple more for you and they're, they're kind of along a similar path. So one of them is, should there be mandatory mental health evaluation for anesthesia care providers in addition to all the self-help options previously mentioned?

And then another question that, um, I think is kind of on rights of the individual, is how do you balance one, asking people how they're doing, with two, individuals' rights to privacy with their choice not to share details about their family situations? So we kind of have, you know, two extremes of, of, you know, how you, you know, communicate with people and work with people but then respecting people's privacy, um, which I would think if you required everybody to have an evaluation, um, obviously if there's issues then you may be forced to, but, could you comment on those two things?

DR. MORGANSTEIN:

Well, I think the, the issue of mandatory mental health evaluations, perhaps, what's more important than a mandatory evaluation is anonymity, to some degree. Um, and this may not help when we are on this, if you're trying to specifically identify issues for unique individuals. So there's good data to show that anonymous surveys result in significantly higher report rates of mental health symptoms. Um, somewhere on the order or magnitude of two to three times the rate is reported. We've done this in the military, um, and when people do not believe that their results are anonymous or going to be recorded it even in their own medical records, um, they report dramatically lower rates. So I think, um, if your goal is to find out what's going on with people, there many ways to do that. Um, I would be concerned about uh, mandating mental health evaluations for several reasons because I think it would likely increase barriers for many people, um, and the perception of mental health being used sort of weaponized, or used

for the organization's purposes. Um, and I also think that report rates would likely diminish. Um, if you, if you mandate something like that. And, and in particular, right now is a time where people are feeling a great deal of control is being taken away from them and their lives in general. So I would be very remiss to recommend any process that further compounds or exacerbates feeling loss of control, or out of control, um, particularly when it, it's unlikely to yield positive results.

But I do appreciate the sort of, how do we get at, what are the challenges in the stressors that people are dealing with? And when we're dealing with, or trying to engage other people, I think there's a couple of questions, um, one of the speakers mentioned, uh, looking inward. And so when we're trying to reach out to somebody and connect with them, an important first question is how we're going about that. So when we approach somebody by first leading with, um, talking about their behavior, that often can make people feel defensive. When we approach people by talking about our own feelings, which we're always entitled to, so you seem stressed is different than, I'm concerned about you. Um, something looks different. Those are two different ways of approaching people in those are just examples and those are my words. People have to find their own words. But certainly, um, the idea of how we approach an individual.

Also, what's the relationship that we have? Um, often times leveraging, um, partner relationships or significant other relationships? So this is somebody that you care about, if they have a significant other, a lot of research has also shown that people who are most effective at engaging and individual in help-seeking behaviors or their intimate partners. So, if someone has an intimate partner and you have any contact or connection with them, that might be another means of reaching out and expressing concern because someone is far more likely to respond to that person's expressions of concern. Um, or, if you are very close friend with that person. But again, how we lead. The language that we choose to engage somebody whether we talked about our concern for them and desire to be helpful or supportive, versus focusing on their behavior and what they need to do different, often elicit very different responses from people.

DR. PETERSON:

What about if you, sort of, share your own for vulnerabilities? Does that open up other people to share theirs as well?

DR. MORGANSTEIN:

I think you're bringing up the important point, um, Mary Dale, of leadership, um, in a sense there. And leaders absolutely create a culture of help-seeking by doing things like normalizing of reactions, by um, alerting people, letting people know where and when to get help, by publicly um, making sure that that everyone knows that it is encouraged to get help and letting everyone know where, what resources are available. And then by ensuring that when people actually do want time off, or do need to go do something, to make sure that their own self-care is taken care of, and address these issues that you're consistent with your behavior. So it's got to be more than words, because the word will get around very quickly that the boss says one thing, but when you, when you actually need that time off, they're not willing to support you. So I think you're talking, or you're really talking about a culture of leadership, and the role that leaders play.

Um, there's a very interesting story that's still told in the military about a decade-old, the um, senior ranking enlisted member of the Army, um, the Command Master Sergeant of the Army, at a huge resilience conference in Washington DC, during his public remarks outed himself as being involved in behavioral health treatment for post-traumatic stress disorder from his combat deployments. It was considered kind of those kinds of a milestone, or a kind of a bell weather, because those kinds of leadership self-disclosures, um, are things that our junior members of the military now, are, have become aware of, its become of them are socialized. And I won't pretend that stigma barriers to hear don't exist anymore, but it's those single acts that slowly alter the trajectory of community cultures. So absolutely leadership behaviors at, at all levels, matter.

DR. PETERSON:

Thank you, Sasha. I've got a pretty, uh, quick one for you, I think. Could you give us some examples of rituals I could bring to work tomorrow?

DR. SHILLCUTT:

I sure, so one thing that, um, Amy talked about was gratefulness, and just being grateful. So I do this pause in the morning, uh, that I learned actually attending a conference at the Cleveland Clinic wear before I get out of my car in the morning, I put my hands on the steering wheel, and I tell myself three things I'm going to be grateful for today. Um, and it also can work at the end of the day, when you're getting in your car. When you put your hands on the steering wheel, take a pause and think about three different grateful things, so if that's an easy ritual.

Another thing that I really want to encourage you to do if you are in the hospital and you do have 5 minutes, 10 minutes, go to a window. I think so many times, we don't do that in our, in the realm of surgery and anesthesiology. We just never are, see the sun. And so I've been trying to do this. If I have to make a phone call or I have to get on a conference call in the middle the day, I try to find a, a sunny window and stand there and have um, my moment in my mask, on my phone, or listening, but even just standing out in the sun for about, in your window, for a few minutes. Those are some rituals that you can kind of incorporate some wellness into your day.

DR. PETERSON:

Thank you so much. Well, this has been a truly amazing panel. I've been given my time warning here. So I'm going to start concluding the session, but, um, it's really been, um, all great presentations and great discussions. We will have, um, the slides and all of the recording available in 24 hours after this Town Hall concludes. Um, I, I encourage you to visit our ASA COVID-19 website where we do have the links to the wellness resources available. Amy has done a great job with the ASA Committee on Physician Well-Being website, and I want to thank her and her committee for all of their hard work.

We're all dealing with uncertainty of the future and grieving for what could have been this year, the graduations, weddings, funerals, religious holidays, to name a few. Even the most mundane of daily tasks like grocery shopping has become more of a chore. Have I gelled enough? Not to mention making sure your kids are getting educated at home or your elderly parent stays safe. And that's not even counting what happens at work. No wonder we're all having trouble sleeping at night.

In the past, these Town Halls have included discussions on personal protective equipment, purposing anesthesia machines for ICU use, finances, and organizational leadership perspectives. Tonight, we have acknowledged the stress we are all dealing with, and how we can manage it. We can talk with each other, support each other, forgive the slights of the day, and find what is still beautiful around us, and give thanks.

We expect to continue these webinars to provide you with the most recent information to help you in your daily work. I hope you will join us for future Town Halls. Stay well, get some sleep, God bless you, and goodnight.

(MUSIC)

DR. STRIKER:

American Society of **Anesthesiologists**[®]

Thanks for joining us. We'll continue to keep you updated here on Central Line. And, for more information, you can find video of the original Town Hall at asahq.org/covid19info, where additional COVID-19 resources can also be found. Stay safe, and join us again soon.