Residents In a Room  
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VOICE OVER:

This is Residents in a Room, an official podcast of the American Society of Anesthesiologists, where we go behind the scenes to explore the world from the point of view of anesthesiology residents.

*I think we’re called every day to be an ally, but it’s not necessarily easy.*

*The time for being a spectator is over. It's time for us to speak up and stand for each other.*

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People will always disagree. People will always have differing beliefs. People tend to seek out people like them.

NICK DAVIES:

Welcome back to this month's episode of Residents in a Room, the podcast for residents, by residents. I'm your host for this episode, Nick Davies, currently a medical student at the University of Florida and the president of the ASA medical student component. I'm looking forward to talking to our resident guest today about the important topic of allyship. Would you like to introduce yourselves?

DR. MOHAMMED HAKIM:

I'm Mohamed Hakim. Friends call me Mo. I'm a current CA2 at the Ohio State University and the current ASA president elect for the resident component.

DR. LEILANI SAMPANG:

And I'm Lelani Sampang. I'm one of the CA1s currently at Loyola.
DR. OLIVIA SONDERMAN:

I'm Olivia Sonderman, one of the CA1s at Stanford, and I'm also the alternate delegate to the AMA from the ASA for the resident component.

NICK DAVIES:

Welcome. Thanks for being here. So in last month's episode, we talked a lot about advocacy, both broadly and with respect to professional advocacy. But today we're going to turn our topic and our conversation towards allyship. So as a broad question to get us started, Olivia, I want to look to you first and say, what does allyship mean to you?

DR. SONDERMAN:

It's probably a little bit lame to start with a definition, right? But for me personally, allyship is about developing relationships with those who are underprivileged or disadvantaged in some way. And I know last time we spoke about advocacy and I do think for me, advocacy is about being active in my allyship and being not just in relationship with especially my patients, like as someone who supports them passively, but doing something to hopefully improve their health.

DR. SAMPANG:

Yeah, I think allyship is just like you said, a relationship. It's getting to actually know who you're speaking for, making sure that you're understand what their issues are and how you can best serve them, rather than just assuming things for them and speaking for them in a way that you think would be better for them, actually understanding who they are and where they're coming from.

DR. HAKIM:

I think advocacy and allyship to me are like two ventricles beating together. They can't function without each other. It is very important and vital for us to understand that the beauty of our speciality is accepting differences. I would say this is a bridge to understanding your patients better, to be better advocates for our patient and understand what their goals are and align them to our goals of taking care of them.

NICK DAVIES:
So what are your thoughts with respect to allyship towards patients? Does the field of anesthesiology and the way we work within it make that easier to feel like an ally for them or harder?

DR. HAKIM:

We are actually taking care of an unconscious patient whose life is in your hands for that moment. And being able to relate to those goals of what your patients want from you, for example, a Jehovah's Witness who said prior to the surgery that I do not want a blood transfusion, what do you do? There is where allyship comes, where you're like, I understand your values and I abide by your values. And that is part of our discipline now to understand their values and be a part of it and rather, I would say, supplement instead of being a hindrance to it.

DR. SAMPANG:

I think as anesthesiologists, there are different ways that we’re involved in patients care. So let's say you're a pain provider, so that might be a little bit easier to be an ally because you're a primary provider in a certain aspect of that patient's care. Same thing where if you're in a critical care setting, you're the main provider, you can definitely talk about your patient in a more personal way. Where I think it is difficult to be an ally, where it can be, is because you have such limited time in the perioperative period. Sometimes you just get to know patients in like the 5 to 10 minutes and you have to try and gauge what their most important values are just before you take them to the operating room and they're asleep. A lot of times they will have conversations with their families. They're already prepared for things that they want to know about before surgery or certain, you know, my knee hurts or like I just got new eyelashes. And there are ways that you can definitely make a patient feel more comfortable. But obviously there are also larger values, like you talked about, where I'm not comfortable getting blood transfusions that sometimes surgeons in their clinics, they just talk about the surgical procedure. But as an anesthesiologist, you tend to get a bigger picture of who a patient is. Even within the operating room as a patient's asleep, you're the one watching as the patient in pain. Should we be watching their positioning? You're the ones who's actually speaking for the patient because you're the one watching their vital signs to try and tell them, hey, they're uncomfortable, Hey, they're getting a little bit unstable. We need to just take a pause. But that's also your communication with surgery and speaking for the patient while they're asleep.

DR. SONDERMAN:
Kind of going off of that point in terms of whether it's harder or easier to be an ally as an anesthesiologist, I think we're called every day to be an ally, but it's not necessarily easy in terms of we have like a lot of pressure or time pressure like Moe alluded to and pressure from our surgical teams at times, pressure from the hospital administration to do things a certain way, that there are obstacles to being a good ally. But we have the opportunity to slow down and have the important conversations with our patients and the opportunity to be really mindful of how we care for them while they're unconscious. That allows us to be an ally in in every relationship we have with our patients.

NICK DAVIES:

So taking this one step further and going into sort of that active application of allyship that you talked about, Olivia, a recent study by Allies in Action found that 90% of men believe they give women credit for their contributions, but only 40% of women report actually witnessing men act as an ally or they they would feel that way. So clearly, people generally want to feel like they're good people. Most people, it seems like you would ask them if they would identify as an ally to various groups. They would think of themselves as one. But it's a lot different to talk to your friends about allyship sharing a beer after work. But another thing to actually stand up in an uncomfortable situation for someone, maybe a coworker or a patient and maybe have to push back, maybe even against someone with authority. So how do we avoid performative acts or performative allyship, and how can we train ourselves to sort of create a mindset where it's not just something that we think of of ourselves, but actually can exemplify that on a daily basis.

DR. SAMPANG:

Within my generation, at least in medical training, people have been getting a lot better about this. So when I was in internship and I was going through internal medicine rotations, there was a story of somebody saying that a patient had actually been looking to the medical student wearing their white coat, addressing them as the doctor rather than the female attending physician. I think it was really appropriate because they had actually just started looking towards the attending and just redirecting, saying like, Hey, yeah, so like doctor something, this is the question that like, what do you think is, you know, what is the care that we're going to be having for this patient today, you know, just like softly redirecting the patient towards the attending physician. In terms of other things where I might be in the preoperative area, actually one time did have a patient answer the phone, and I had introduced myself as the doctor anesthesiologist, and they were like, Yeah, we're just finishing up talking to the nurse. And my attending had approached me before and they're like, you know, I realized like, this is still an ongoing issue. I'm like a white male. And I understand that I have this like already based status that people assume of me. But I want you to recognize that I recognize you need to put
more effort into having people realize that you are their provider, you're their doctor. And so I will support you to make sure that people recognize that. So people are constantly trying to actually support that women are physicians and they have the same role as males do in this field.

DR. SONDERMAN:

I can relate to being always thought of as the nurse, which is something that I have had colleagues be supportive of, of reminding patients that I'm their doctor, which is always appreciated. And I think it can be difficult to know when your allyship is performative versus active. And I think part of that is whether it's to your colleagues or to your patients, asking them directly, like, what can I do to be your ally? And having those conversations is really a way to figure out what they need.

DR. HAKIM:

I've experienced this as I walk in and I meet the patient and I have my colleague who's a coresident from an underrepresented minority, and she walks in too and he says, Is this your nurse and you're the physician? I said, No, she's the physician and I might be her nurse. And that was just me giggling there and said, No, we both are physicians. You got to address it right there, but in a fashion that does not hamper patient care. And that's where it comes to that fine balance where you've got to convey the message and not be a spectator. I think the time for being a spectator is over. It's time for us to speak up and stand for each other. And I will say it again the beauty of our speciality is diversity in itself, and that's what makes us stronger.

NICK DAVIES:

So speaking of speaking up, obviously medicine is a complicated hierarchical power arrangement with long established political norms, so that has to be navigated to do things like this. What do you think are the best ways to speak up or challenge or correct or demonstrate being an ally for a friend or coworker or patient, whoever might have been victimized by it? Do you think humor is the right way? Do you think calling them out, taking them aside in private? What do you think in your experiences are the best way to rectify sort of a situation that happened?

DR. HAKIM:

I think the first thing we got to know is fire and fire gets the fire bigger A lot of times, it's us understanding their circumstance and the situation. So I would say situational awareness and emotional intelligence. Like let's say you talk to an individual who is not
in the right spirit or has a bad day and, you know, maybe they lost a loved one. I think the key is understanding the situation and listen to their side. The key is not to jump to conclusions and I think a lot of us are guilty of that. We look at an instance, we just jump onto conclusion. And the problem with that is a lot of times you don't know the backstory. I think the best way to get to an individual is coffee time or, you know, sitting together. As individuals, we all know that you just need a moment. So sometimes it's just that moment where someone has something that they would like to talk about. And I call it a coffee talk timeout. You take your colleague on the side say, Hey buddy, let's go out for a slice of pizza or, you know, let's go down to our cafeteria and just have lunch together. I would say awareness of the situation is key, whether you speak about it at that moment or talk about it later.

I would like to caution our trainees. For those trainees who are facing any issue, the best way is to share it with someone who you trust and ask for guidance. You don't have to put yourself in that position. You're learning, you'll have encounters with different individuals who probably don't think as you are or your alignment is different. In those circumstances, I would say it's important for us to have a safety net, know who to trust, and especially when it comes to faculty. Reach out to someone in your department who is part of, let's say, DEI, who understands you, somebody of your same, somebody of the same ethnicity or somebody of the same background who might relate to you. So things like that I think are key. And definitely, it is it is crucial for us to definitely be a voice of our voiceless patients.

NICK DAVIES:

I feel like this is a prototypical medical school interview question You're you're working with an attending and you overhear them say something mean about a patient. What do you do? Yeah, it's not so easy, correct?

DR. HAKIM:

Correct.

DR. SAMPANG:

I would definitely agree, though, with the situational awareness part. If you can get away with humor, sometimes it's the most fun way to do it. But some people really just need to be told outright that you just need to be told, You know what? That was really inappropriate. Never talk to me like that again. Other people might get instantly offended or are really soft and you know, they would rather be told like a lot more nicely and then they'll soak it in a lot better. I would also be careful. I think a lot of people will think
allyship will be to speak for them or say, you know, somebody just had been insulted and then they'll be like, No, you can't talk to them like that. Sometimes there are actually some people who like to be spoken for themselves. So instead of trying to speak for that person, allow them to speak for themselves if they want to too. Sometimes because you don't want to further that by speaking for them. Just like that patient almost tried to speak for them, let them speak for themselves.

DR. SONDERMAN:

For me, one of the experiences I had early on in my CA1 year was an experience where I wish I had reacted and I did not. And that was a surgeon I was working with was yelling at a nurse in a way that I found very demeaning and very aggressive. And of course, this is early in CA1 year when you're nervous and and I'm just focusing on my patient and like having to do the tasks at the beginning of the case to make sure your patient is safe. And so I didn't find a time or the space to speak with a surgeon in that moment. And I never did. I ultimately, like left that site and rotated to a different space. But I think in a best case scenario, I would have wanted to have pulled the surgeon aside after the case. Once the patient's safety is out of my hands. And that's not going to be an issue. And just speak with that surgeon about, you know, hey, I'm concerned about some of the ways you were speaking to this nurse. And and I think that, you know, we're all part of a team that you can can be more respectful to every member of this team. But as I mentioned, I unfortunately didn't get that opportunity. But it is something like an experience that stuck with me in terms of, I think my interactions moving forward of like what my benchmark is for a way that I would like what I would do in that situation if it would arise again.

NICK DAVIES:

It's interesting. It seems like the operating room is a weird place where people just behave differently. There may be pleasant or kind outside.

DR. SAMPANG:

Depending on the day.

NICK DAVIES:

Yeah, they walk in that room.

DR. SAMPANG:
In the next ten minutes maybe. Sometimes you're yeah, sometimes you're joking around and you're like, Alright, we're not going to joke around anymore. Sometimes they're serious and then all of a sudden they make a joke and you're like, Oh, okay, we're joking around now. It's yeah.

NICK DAVIES:

Everyone has such a morbid sense of humor. And clearly it's a it's a stressful place to work and people have to cope with it in different ways. We talked a little bit about standing up for people like coworkers, but obviously the center of care is the patient. And we've heard a lot of stories in the news over the years of patients who secretly recorded teams during procedures and hearing some terrible things that were said about them, often patients dealing with obesity, trans patients, the things people say when they're unconscious. So do you think that that's any more or less egregious, any different than standing up for the coworkers that we see and work with? Do you think we have a higher responsibility even for the people that are under our care?

DR. SONDERMAN:

The way I think about it is every person you interact with every day is someone who could be your patient, both your colleagues and your patients. They're humans. Everyone's everyone's a human. And so they all deserve your respect and your allyship. Obviously, when you have someone who's in your care, who's unconscious, there is a different level of how much you are the acting voice for that patient. So it does somewhat change that. But at the end of the day, everyone you interact with in some scenario is your patient and you should treat them as such.

DR. SAMPANG:

Yeah, I think it's hard as an early CA1, we're definitely in those situations. Sometimes you hear those people just speak inappropriately basically about a situation. But I really think it talks deeper to how much stress probably those physicians are going through. You're so much more removed from those, like more personal patient interactions, and it's just a way for them to just let off steam and just feel really close with their team. And then there's obviously more pressure with the people around them to feel included and go in on the conversation. I actually did have one situation where I felt like I really did need to speak up, but because it was I was really early in my training, I was uncomfortable with just like trying to speak up with the surgeon. But really, I think if it were to happen today, I would actually just be like, Hey guys, can we just relax and maybe talk about something else? Just take a stop because really, right, if it's inappropriate, you need to speak for your patient.
DR. HAKIM:

The beauty of our specialty is we're the voice of the voiceless. We are at leadership roles and when you're a physician, people look up to you. Let's say you're in the OR. And somebody really said something while they were, you know, doing a procedure and everyone looked up to us for a response. It gives you that sense of responsibility and urgency to say, no, this is not the right way. We should address it the way it should have been. So I think the key here, and I would say it again, is situational awareness. If you think that this will cause more harm to the patient at that point of time, a wise idea is to, as Olivia was saying, is get the case going after the case is done. Make sure you have a debriefing. These drops can form oceans tomorrow. You don't want to be in a situation where this is taken as a part of your culture. I think the least we can do as physician leaders of our perioperative medicine is stand up for our patients, not just in the OR but outside the OR.

NICK DAVIES:

That's great. It's obvious that this topic is very important to the three of you and that you take your responsibility very seriously. I think much like the topic of advocacy, it's sort of a personal thing that has to sit in your heart more than a cognitive thing that you just understand. So that sort of is something that's developed out of experiences. So I appreciated some of the personal experiences you've shared. Are there any more that really either positive or negative ones that sort of really solidified the importance of this for you and kind of made you feel like this is something that's an important part of your identity as a physician?

DR. HAKIM:

There was a day when we had a patient who had no home. He came in and there were a few folks who commented on his physical hygiene. And that day, it really struck me. I said, this is an individual who has nothing above his head. You got to understand and relate to your patients. We are at loss if we don't give heed or pay attention to those individuals of different backgrounds. And that's our strength and that's the beauty of understanding different cultures, different backgrounds, different orientations, different beliefs. The time has come where we need to really equip ourselves with understanding of people from different backgrounds. And part of it, and I'll end with that, is knowing that you would do this for your loved one and going back home with that feeling is just a feeling of gratitude and gratefulness.

DR. SONDERMAN:
I speak Spanish and I'm currently trying to get certified as a bilingual physician at Stanford, and I think the times when I've been able to use my language skill, which I'm very fortunate to have gained throughout my education, to connect with patients who sometimes aren't able to voice all their concerns and be heard. I think that's something that, you know, when you hear a patient be like, Wow, I'm so grateful that I can talk to you about this or speak about this. I think that's a moment that I've been grateful for that skill. But even simple things like just taking the time of day to sit with your patient, all those small moments when you're going out of your way for your patient to understand how much you care. Each of those choices that you make, just even for 30 seconds, those really drive home and you can tell that patients know when you are taking the time.

DR. SAMPANG:

For me, I think just in general, I'm just glad I have attendings who are a good role models with allyship. I love seeing when they sit down and take their time with patients. When I'm starting to get ready for a case and I feel sometimes overwhelmed with it, they make notes of ways that I can take better care of the patient as a whole. And so I think to think of somebody who's that far in their career and still is making all of those small things, all those small changes for patients, I hope that I can also be the same way and maintain that.

NICK DAVIES:

It's interesting, Olivia, what you talk about language interpretation. Surgery is already so scary for patients. I can't even imagine what it must be like when you can't as the patient, even communicate anything to the hospital team that's about to take care of you.

DR. SONDERMAN:

It's funny you mentioned that. A practice that I've been doing in the past few months is when I am rolling my patient back to the OR. I will get the interpreter back on the phone, whether it's a mandarin interpreter or a Vietnamese interpreter, because I do think for all my English speaking patients, I'm able to provide them comfort of like, this is an oxygen mask. This is pain medication that I'm putting through your IV. And it's been a little bit cumbersome because you do have to figure out like, Oh, I put this on my phone, how do I set it next to the patient so they can hear it like so many people are talking when you come back to the OR. But since you know, like I'm unable to really comfort my Mandarin speaking patient, I think trying to have the interpreter there up until the last moment
where it's appropriate when they're like going off to sleep or when you need to focus more like specifically on the anesthesia tasks at hand. It's something that I've been trialing. It's not a perfect system, but because that's such a vulnerable time for patients, it's, I think, a way we can step up to continue to provide them the same type of care we give to our English speaking patients.

NICK DAVIES:

Yeah, there's a lot of verbal anxiolysis that goes on in that little trip from the pre-op to the OR.

DR. SONDERMAN:

Exactly. Yeah. And even just the things that you like as you're rolling your patient back. The things I typically ask about where are you from? What do you do when you're not coming to surgery? It's like you lose that if you if you aren't able to to speak in the patient's language.

NICK DAVIES:

So to piggyback on something Moe was talking about, I'm really curious to get your thoughts on this, which is related but from a different angle. Moe, you talked about the importance of putting yourself in the patient's shoes and understanding them and appreciating their values. What about when there's a conflict there? What about when you as an individual are being approached with something that may be ideologically or principally or politically or whatever disagree with? We we know this happens across the country, whether it be abortion care, trans health care. You mentioned Jehovah's Witnesses refusing blood transfusions. Patients take these stands and request these services and it's up to physicians to provide them. And a lot of times there's conflict. So what do you think is the appropriate course of action when there's that fundamental sort of disagreement and how to navigate that.

DR. HAKIM:

If these fundamentals do not align to an individual's belief or ideology or whatever you want to call it, that should not affect patient safety. If we're not comfortable with something that is not aligning with what an individual believes, the last thing you want to do is make that patient feel uncomfortable just because your belief does not align with that individual.
For example, you have a parturient who is unfortunately sick and there's an anesthesiologist who does not do abortions, does not believe in abortions. The best route for this would be not to confront the patient saying I'm sorry, I can't take care of you, but rather be prepared and say reach out to your staff the day prior and say, Hey, I'm assigned to this room and this is something I might not be able to do. Can I have someone else? Your patients should be your top priority. Yes. If your fundamentals do not align, that's part of your advocacy and allyship that you say, okay, this is my patient's belief and I respect it and I want them to get the best care, but unfortunately, I might not be able to provide it. So it's our responsibility, making sure that they are taken care by safe hands. Yes, there are differences. That is part of our profession that you will always have differences. The last thing you want to do is make your patient feel uncomfortable. And there are moments where you have to stand and say, okay, if it's your attendings, say, okay, if this is not what you believe in, I'm happy to work with another attending and stand firm.

As a trainee, there will be instances where you'll be like, Should I speak or should I not? When that gut call comes in, speak up. And the reason I say this is because, let's say, and this has happened to me multiple times, let's say if I don't speak, I go home thinking about it for the next 48 hours and I'm like, I should I have spoken something or should I have not? So when you think and you're like, you have a gut feeling, you're like, No, my conscience is I got to talk, speak it out and speak it in a way that it does not come across, you know, judgmental or you're not hurting another individual's emotions. Anesthesia is not the profession where you're behind the drapes.

NICK DAVIES:

It's funny. People will always disagree. People will always have differing beliefs. People tend to seek out people like them. But really, the fact that patients might have different viewpoints of the world than us, it's really something to be celebrated and it doesn't really preclude us from being their ally. As long as we can have the right perspective of our relationship with them, we don't have to try to make them feel like us or have them feel like we do, or change our mind to feel like how they do. But if we have respect for a differing viewpoint, we can still be an ally, even if there is a conflict.

DR. SAMPANG:

The question of when you have conflicting views and how do you take care of that patient appropriately, it's always going to be some kind of gray zone. There's never going to be an easy standard guideline that you can outline for these situations. It's just like you said, have personal respect for each other. I think the only time it might be more black and white is if there's an obvious concern for patient safety given any of those. But
if you're able to work around with coworkers or, you know, whoever you work for and
with the patient and are able to move forward with the procedure safely, I think that's
great. But sometimes, yeah, there can be some serious conflicts that you might have
personally with a patient's beliefs, and I'm not really sure what the answer would always
be. I think it's going to be very situation dependent and very hard to make a decision
there. You could probably go either way.

DR. SONDERMAN:

I think this was very prevalent early on in the pandemic with patients who were close to
being intubated and heading to the ICU who had a diagnosis of COVID and were still
not believing that they had COVID. And I think that was a challenge in intern year for
me, was working with those patients to really still respect their beliefs, but also try to
educate them. And I think there's a balance like the the bottom line, like Mo was saying,
is like they're not treated differently, like they still deserve the best of your your training.
And then it's really just making sure that you're adjusting that training to respect their
autonomy.

NICK DAVIES:

So to wrap things up, as far as creating an ethos, you know, everyone comes into work,
goes home, comes back in, goes home. It's easy to get burnt out, jaded. Forget some of
these things that are important. So what's something that people can do on a daily
basis? What's what's a little thing that you can do when you go into work, whether it's an
interpersonal thing or a mindset thing, to help people just not lose sight about the
importance of of advocacy and allyship.

DR. HAKIM:

I think the biggest thing as as physicians and those who are in the medical field is
sometimes we really don't give ourselves credit. I tell this to everyone that there should
every day be a minute or two of mindfulness. And when I mean mindfulness, you can be
in the hospital, you can be in your car either driving to work or from work and say, hey,
what what did we do today to make a difference in humanity? Or what did we do today
that really, you know, was my positive energy? As you rightly said, there is a
phenomenal amount of physician burnout. Things like this are definitely key and
important for our mental health and physical well-being.

NICK DAVIES:
How about you, Olivia? When you wake up in the perfect weather of Palo Alto, California, every single day of the year, I'm not jealous at all. How do you keep the humanism and the empathy? How do you keep going with that?

DR. SONDERMAN:

There's a few ways I try to center myself during the day. One is if I am able to go outside in between cases or on my breaks, just, you know, as you alluded to, enjoy the Palo Alto weather for five minutes even and take a few deep breaths, just kind of center myself. And then--this is my silly life hack--I do try with every meal to think of something that I'm grateful for, even if the day is really stressful, like something went wrong or you're upset about something that happened, kind of centering yourself with something that you're grateful for and tying it to something that you're going to do each day, hopefully, which is eat. It means that you will remember to have that reset of your your mental focus towards gratefulness.

DR. SAMPANG:

If we're talking about making sure that we keep going, being a good ally, being a good advocate, and we're saying the best way to do this is to make sure that you still have passion for it, make sure you're still connecting to your patients. You can think, okay, what do I even remember about my patients today? Did I know my patients today, or am I so caught up in the stress of myself and work that I didn't even process who I was taking care of? And then on top of that, kind of, like you said, making sure you're taking care of yourself, like, am I just going through the motions or am I actually enjoying my interactions with the patients, with my coworkers and that I'm actually happy right now to be able to have those effective relationships and advocate be a good ally. If not, maybe check in, like maybe you need to just rant with somebody, maybe you need to talk to somebody about it and just recheck in again. Maybe you need some time off so that you can just rebalance yourself. Realize like, Hey, this job is really cool. I meet some cool people. I work with some really smart, awesome, talented people every single day. And this job is great. Instead of, you know, you're just going through it and you're like, Man, I got another case. I'm like, really stressed. Why is everybody yelling at me all the time? Who even are you? I mean, just I mean, those days are kind of funny, right, to reflect on again, but just make sure you keep coming back instead of sitting on it for months and months and months. And then you get lost and then, you know, you lose the personalization of the whole specialty in yourself.

DR. HAKIM:
I really have to say this to Olivia, and your point is this really struck me and this was a day during my residency, especially CA1 year, where the patient told me, Doc, I'm thankful that you're on the other side of the drape and you got your morning Starbucks coffee, even though as a resident, we know five bucks for my coffee is not going to be the right decision. But things like as simple as Olivia was alluding to, is like being grateful for those things. And I have to say this again, for all those residents who are going to be listening to us, treat your patients not just as physical bodies or numbers on the screen. Treat them as someone's loved ones. An attending of mine told me when I started CA1, and I'm grateful to him, he say, Mo, there's one thing if I had to tell you is whenever you push your drugs, know that these are going into living beings and not just bodies with numbers on your screen. So that is advocacy, that is allyship that you look at it as an individual's life.

NICK DAVIES:

I think it's humbling and a great conversation and a great topic to end on. Definitely appreciate the three of you and sharing your points of view. And to all the listeners who are joining us, that's the end of our episode for today. So tune in next month for more Residents in a Room, the podcast for residents, by residents.

(SOUNDBITE OF MUSIC)

VOICE OVER:

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