Residents in a Room
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(SOUNDBITE OF MUSIC)

VOICEOVER:

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.

DR. JED WOLPAW (HOST):

I'm Jed Wolpaw, host of ACCRAC. We recorded at Anesthesiology 2021 in front of our first ever live audience in San Diego. And in addition to publishing it on the ACCRAC website, I'm delighted that ASA is publishing episodes of their two podcast series Central Line and Residents in a Room based on the event that we held live at Anesthesiology 2021. Check it all out.

I am absolutely thrilled to be here with two amazing guests, Dr. Doug Bacon and Dr. Aditee Ambardekar. We are live from Anesthesiology 2021 in San Diego. It's incredible. It's beautiful. It's sunny out. And for the first time ever, we have a live audience here. Give it up for you guys for being here. Thank you. Thank you.

Now, I am really grateful to ASA for hosting us, for supporting us and letting us do this here. I'm incredibly grateful to our guests and of course to all of you for being here in the audience.

So, we're going to get started. I'm going to introduce our two guests and then I'm going to take about 15 to 20 minutes to chat with each of them and then we're going to open it up. This is a live mic here, so we're going to have audience Q&A. You guys can ask the guests anything you want. And then of course, we will have random recommendations for you at the end.

All right. So let me introduce. We have with us Dr. Aditee Ambardekar who is an Associate Professor and the Residency Program Director at UT Southwestern. I see some of her residents over there coming out to support her. She is also, as I said, the Residency Program Director. She is the Director of Burn Anesthesia at Parkland Hospital and specializes in pediatric burn anesthesia. She is

also the Chair of the Anesthesiology Review Committee for the ACGME. So, for the residents in the audience, that means she has quite a lot of influence over your life. And if there's any Program Directors in the audience, that means she has total and complete control over your life. Good thing is, she is a kind and generous person, and we are really thrilled to have her with us today. She also is an Oral Board Examiner for the ABA, so as is Dr. Bacon. So both of them, those of you who are residents may see them down and (sic) when you take your applied exam, hopefully they will be kind to you.

Dr. Bacon has a long and illustrious career. He is the Chair currently at the University of Mississippi Medical Center, Chair of Anesthesiology. He's also a Professor there, of course, and he is a real guru and has an interest and always has in history and especially the history of anesthesiology. In 2012, he actually was named the Laureate of Anesthesiology History by the Wood Museum of Anesthesia History, which made him the youngest person ever to be named with that honor. So really impressive. He has, he and his wife have, one daughter, four sons and four rough collies, which makes for quite a full house, I am sure, but very impressive. My wife and I are still trying to figure out how to do three, so I am very impressed.

So welcome to both of you. Thank you for being here. Let's start with you Aditee. So thanks again. Let me start by asking you to just give us in the audience here a little bit of background on how you got where you are. What do you do? What's your everyday kind of look like and what would you recommend for people interested in kind of that kind of path that you've taken?

DR. ADITEE AMBARDEKAR:

So thank you for having me. If I had to describe myself, as my residents, know, so I'm a pediatric anesthesiologist by training. I'm a mother to two boys that keep me super busy. I'm the spouse to an EP cardiologist who works probably 100 hours a week, a Residency Program Director, and a burn anesthesiologist.

So, my clinical time is spent two days at Parkland, the storied Parkland Hospital, taking care of burn patients. I spend a day a week at the Children's Hospital and spend a lot of time running the residency program, being available to my residents, as I'm sure you know as well. When I'm not in the hospital, I'm usually working on ACGME work related to running residency programs and making the rules that come down from the ACGME functional and acceptable to our community, and do a little bit of education-based research. So studying simulation, studying feedback and actually studying a little bit about pediatric burn anesthesia as well. So, I do all three things teacher, clinician, a little bit of a researcher.

DR. WOLPAW:

You stay busy. Absolutely. So, give us an idea because, I think people are familiar with obviously clinical work, and, and, you know, obviously the residents in the audience have all, they all have Program Directors. They know that Program Directors and faculty have an idea. But I think the ACGME piece is something people don't know a lot about. How much time do you spend on average on your ACGME work?

DR. AMBARDEKAR:

So, when I was a volunteer, so I, my tenure on the ACGME is six years plus an extra two since I just got voted the Chair. I spend probably, as the Chair of the committee three to four hours a week negotiating questions that come out from the community. Right now, we spent, we are spending a lot of time rewriting the milestones for various subspecialties within anesthesiology. We have very long meetings looking at your programs and how your programs are running, and so all that probably boils down to three to five hours a week.

DR. WOLPAW:

Ok, so not insubstantial. And then I know that comes in chunks because you guys have official meetings where, probably these days virtually, but you spend, you know, a day or two straight working on that.

DR. AMBARDEKAR:

In my role, I'm in Chicago. Pre-COVID, once a month.

DR. WOLPAW:

Ok. Yeah. So that's quite a lot. All right. And so, let's talk about program leadership. You've done, you run an anesthesiology program, you run the review committee, how, and you're still pretty early in your career. So talk about that journey. How did you get where you are? A lot of people in the audience may be thinking, you know, they'd like to be in programmatic leadership one day. They maybe want to be a Program Director. They want to be involved with ACGME. How, how do you recommend people walk that path if they're interested?

DR. AMBARDEKAR:

So, I had to think about this a little bit when you sent me the invitation, and I think I could sum it up in three phrases, taking advantages of most of the opportunities that came my way. And I know that goes against a lot of the wellness and the boundary setting we've been hearing about lately, but really taking a lot of those opportunities to heart and learning about whether you enjoy those things. The engagement, dedication and generosity of mentors and sponsors along the way. I couldn't have done it without people that made these things available. And then a little bit of luck, to be honest.

I've had a long,sort of journey. For those of you who know me well, I started my career at the University of Pennsylvania Children's Hospital of Philadelphia and got involved in simulation-based education there and got an opportunity to run the fellowship really, really early in my career under the mentorship of Dr. Alan Schwartz. And it was through those experiences, if I had said no to, I would never have learned that I enjoyed teaching and I actually went back and got another degree, which I never thought I would do. So, I got my master's in medical education at Penn while I was a, a young faculty at CHOP. And it was through that that I learned that I enjoyed research in education and that I enjoyed curriculum development, and I enjoyed learning about how to debrief and give feedback to my trainees. And it were, it was all those experiences that really led me.

Unfortunately, life happens, and you have to follow where your family needs to go. And so I left CHOP five years later, five years into my career and landed in Dallas. And I think it was actually all of those things that made it possible for me to be given the opportunity by my Chair, who's very supportive of education in our institution, probably one of the most supportive Chairs I have heard of. And so he said, you know, I can't have you run a residency or fellowship, but why don't you help revamp the medical student curriculum? And so I did that with gusto. I had an opportunity again. I knew nothing about it, but I sort of took it on and it gave me the opportunity to sit at institutional tables where people that had institutional leadership and national roles, just like mine now, got to know me. And so the little bit of luck was that I had a sponsor in that little community of leaders at UT Southwestern who said you'd be a great nominee for the RC. And that's how it happened. You've just got to say yes, maybe it's yes, but, but you have to say yes to these opportunities.

DR. WOLPAW:

That's great Aditee, thank you. And would you say, you know, a lot of times I tell junior faculty and, and residents who are getting ready to be faculty that it's kind of important to say yes a lot early on, and then to learn to say no later on. And I, you

know, I think we hear a lot about learning to say no, which is really important, especially when we talk about wellness. You can't say yes to everything, and that's true. But I think early on, if you try to say yes to a fair number of things, it opens up opportunities later on, which is what it sounds like you're saying.

DR. AMBARDEKAR:

Yeah. And I, you know what? Admittedly, I didn't know what I wanted to do in academic medicine when I started and I had sort of told my mentor at the time, I'm going to say yes to, I want to do one of everything until I sort of settle into a niche. And so, when you join a department or you join an organization where those opportunities are available, you kind of luck out.

DR. WOLPAW:

Yeah. So let me ask you this. Maybe folks in the audience who are thinking, hey, I'd like to be on the RC. How exactly does one get on the RC?

DR. AMBARDEKAR:

That's a good question. There are three nominating bodies for the RCs and I, and I believe this is the case for most specialties, but for our specialty specifically, the ASA actually has three, I believe it's three nominate, three seats where they nominate three individuals. The ABA, so the Board and then the AMA. And I believe the AMA has seats on every RC. And so, every six years, or every two years they get to, you rotate off, they get to nominate two or three new individuals. So at any one time there's somewhere between 10 and 12 individuals, including a public member, a resident member and, and the board ex-officio that helps us negotiate some of the Board discussions.

So you get nominated by one of these three societies and you submit an application and you talk about all the things that you'd want to do if you sat on the RC and why you feel compelled to do so. And then the RC members vote and they decide whether you, amongst the other nominees, are qualified.

And, and I have to say, you know, we sort of think of the ACGME as this scary building that makes these big rules that we all have to follow. But I've learned that the people on these committees, and I'm not just saying it because I sit on it, are really kind, hardworking, they really want to do the right thing. And so much so that I am the youngest member of the RC. I think my children are the same age as many of the grandchildren of, of the members on the RC. And so when I started,

admittedly had major imposter syndrome. It it still exists, I think, in, in our stage of our careers. And, but I said, if I'm going to make the most of this, I just have to go and learn and listen and speak up and ask questions. And that's exactly what I did.

DR. WOLPAW:

That's great. Thank you for sharing that. Let's, last question about the, the RC. Who sits on it? I actually learned recently it isn't all Program Directors.

DR. AMBARDEKAR:

No.

DR. WOLPAW:

So, I knew there's a resident member in a public member, and I'm sure there are some Program Directors like you, but there are also Chairs…yeah…

DR. AMBARDEKAR:

Chairs, Vice Chairs. You can actually go to the ACGME website and look up the Anesthesiology RC and see all of the names of the individuals on the list. Yeah, we have a really great makeup. If you want specific names, I can name them.

DR. WOLPAW:

That's ok, we'll look them up.

DR. AMBARDEKAR:

We have a Chairman, we have Vice Chairs of Education, Directors of Simulation, Program Directors and a, a public member as well.

DR. WOLPAW:

Great. Well, I won't make you tell us what the internal debates are there. I, I imagine that there are some things between, especially Chairs and Program Directors that may have different points of view on some stuff, but really interesting. And actually, we have, of course, a Chair and a Program Director here today, but we won't reenact that. Well, thank you. Thank you. That's really interesting stuff.

The last thing I want to ask you and then we're going to turn to Dr. Bacon is your, your interests both I know research-wise, and clinically in pediatric burn anesthesia, and I'm particularly interested because it strikes me, I certainly don't do pediatrics or burns, but it strikes me as probably an incredibly challenging, both from a practice, but also an emotional standpoint. So, what advice do you have for folks who may be doing this kind of anesthesia, maybe residents who rotate through to kind of maintain their own emotional well-being while taking care of what probably is one of the most difficult populations to, to kind of separate yourself from, especially if you have kids and you're seeing badly burned kids. I imagine that's really tough.

DR. AMBARDEKAR:

Yeah, my children know we don't have candles in our house. We don't have a lot of things in our house because of the injuries we've seen. But you know, it's hard. I think a good doctor feels compassion for their patients, and these children are super vulnerable. Many of them come with families who hurt them. And so sometimes I know them better than anybody else in their, you know, in their lives, which is really sad.

So, it wears on you. I think you have to decide what is your outlet to feel well when you leave the hospital. And for me, it is being with my parent, my children and my husband, my family. And I think, you know, you just have to find that community that keeps you healthy and happy. And we take care of a lot of sick patients and a lot of, not just pediatric burn, but, you know, the cancer patients we take care of the traumas that happen because people are trying to do the right thing and they happen to have a bad, bad luck that day. So I don't know that it's unique to pedia burns. It is an emotionally exhausting practice because you get to know the kids, actually quite well. They come back to see you, which is kind of nice. You get to watch them get better most of the time and grow. But I think it's important to have those activities outside of work. And, and I, there's days where I say, I'm not going to do any work today. I'm just going to be well.

DR. WOLPAW:

Yeah, well, great. And we'll end with this. What do you do for, to stay well, other than spend time with your kids? What do you do when you're not working and you decide, I'm, today is for me.

DR. AMBARDEKAR:

So I play tennis. My, my boys and I play, play tennis together and we go biking a, a fair bit. And fortunately, in Dallas, after work, usually especially this time of year, it's starting to cool off.

DR. WOLPAW:

I bet. It's probably beautiful. Well, thank you, Aditee. A pleasure to chat, and we'll let the audience ask questions in a little bit.

All right, Dr. Bacon.

DR. DOUG BACON:

Yes, sir.

DR. WOLPAW:

So, let's start with the same question for you that I started with Dr. Ambardekar. What, how did you get, and, and, and you know, you could, I'm sure, talk for quite a long time because you've done so many amazing things. But if we just think about your kind of interest in the history of anesthesiology, how did that develop and when did it develop? And, and kind of how did you build on it over the course of your career?

DR. BACON:

Well, before I, I really start, I'll tell you a little funny story.

DR. WOLPAW:

Please.

DR. BACON:

I have an undergraduate degree in history, so it goes way, way back, and we had a really wonderful professor, Orville Murphy. And today is this 90 something-the birthday. He was a submariner in World War II, and he came in one day and he was very frustrated and awful, was one of the most calm, quiet guys you've ever met. And he's, you know, Dr. Murphy, what's the problem? Because I just came out of a faculty meeting, you know, his damn history professors, they can stand up and talk

for 45 minutes, whether they have anything to say or not. So be careful when you ask me questions.

DR. WOLPAW:

Fair enough. We don't have 45 minutes, but we are interested to hear what you have to say.

DR. BACON:

The interest in history very, very quickly and very succinctly. History has always been something I've been very interested in. I did my undergraduate work at the State University of New York at Buffalo. I have a BA in history and a BS in medicinal chemistry. I then went to medical school and I struggled in my first year academically, and our, one of our Vice Presidents was a guy by the name of Dan Fox, and he held a history session starting in second year where he would provide lunch. We brown-bagged or he would provide drinks for our lunch, we brown-bagged it, and we read a chapter in a book or something and, and started analyzing. And that's what the history of medicine really got in.

My real, my outside interest is more of what you heard this morning. I've read Doris, a lot of what Doris Kearns Goodwin has written. My real interest is in Germany 18,1875 to 1945, and how the unification of the German states destabilizes Europe. Very, very boring. Good stuff to read when you can't get to sleep at night, but that's what interests me.

DR. WOLPAW:

Fair enough.

DR. BACON:

But what about the history of anesthesiology? Well, in my senior year of medical school, there was a contest by the American Association of the History of Medicine called the Osler Prize, and it's for the best undergraduate essay. So I competed in that. I did not win, but I started learning about anesthesia, and in that time, I was able to go to the Wood Library Museum in, at that point, it was in Park Ridge, it's now in Schaumburg, Illinois. And I met the most wonderful person, Patrick Sim. And Patrick was the librarian, and I started reading the minutes you can of the original Long Island society that started in 1905 and all the way through to, you know, the

current American Society. And when you're touching paper that people you have read about have touched, it is an incredible sensation.

Now it's interesting because I did the same thing you did. I went, graduated, did my residency. I took a job at Roswell Park Cancer Institute under Mark Lema was our Chair. Mark is a past president of ASA, and Mark wanted each one of us to do something academic. Well, I watched my colleagues struggle with the IRB and I said, I ain't doing that. And so I said, look, I want to do history. And he said, and Mark was really, really good about it. He said, yeah, that sounds great. So I decided I needed training, so I went back and got my Masters. At the same time, I had two young kids and a third born during the five years, it took me to do the Master's in history. And from then I just started, you know, publishing and working, you know, finding things to write. And one of the cool things about doing the Masters was I took a writing course with Dr. Murphy and we would have to produce a manuscript every three weeks and we, with two other colleagues and we would criticize each other's writing and then you'd bring another draft back and so forth. And about three publications came out of that.

My, the colleague I was working with was history of obstetrics and gynecology, so I know a little bit more about that field. And then I, my clinical work, I left the Roswell Park Cancer Institute went on to be the first Anesthesia Service Chief at the VA in Buffalo. And then from there, Mark Warner recruited me to Mayo Clinic, and Mayo was a phenomenal place because Mark wanted me to do history, and history at Mayo, and history of anesthesiology. And they have this phenomenal archive of John Lundy's papers and John Lundy in the 30's wrote with everybody else. And you know, again, you're touching papers that somebody else has touched. And what most people don't understand is the, that in history you try to answer a question. It's like science. There's a hypothesis. And the question I've been trying to answer for almost 30 years now is something that a surgeon proposed that there was no organized anesthesia prior to the Second World War. And actually, all of the infrastructure that we currently enjoy comes from prior to the Second World War. I can actually explain to you why the triple, why there are three committees, why that is the way it is, because it evolved in the late 30's and our Board was first incorporated actually as a Sub-Board of surgery in 1938. So how did it get there?

And then I keep finding all these fascinating things. Um, recent, talk I'm going to give tomorrow morning, I was doing some research and we found somebody at the Mayo Clinic that the Mayo Clinic is, is an alum in anesthesia that the Mayo Clinic people didn't know about. And, and it happens to be a woman, and Lundy had written a letter that, we find it better that if the if the doctors are male and the nurses are female, everything works a lot better. Which I find hilarious mind you. But so, but

then in, this person was one of his favorites and he really enjoyed teaching her. So it's, it's, it's fascinating. And that's what keeps me going.

DR. WOLPAW:

Yeah, it seems like, you know, with history, you keep discovering new things and it keeps you hooked if you're, if you're interested in it. So, you have not only been interested, but as you said, you have found a way to make this a scholarly pursuit and, and actually built an academic career around it. Is there any tips you'd give? Because I think they're, you know, we always have residents, and I'm sure Aditee does too, who want to do academics, but they don't really want to do as you said, they don't want to do basic science research. They don't want to even do clinical research. So they need to find some academic focus. If they're interested in something, you know, more in the humanities, something like history. What would you recommend? Would you point them in the direction of doing a Master's in in that area? Or, or what would you recommend?

DR. BACON:

Well, actually, I think you pointed it out so beautifully. You've got to find what you're passionate about. You know, there's that old saying, if you love what you do, you never work a day in your life.

You know, wanting to do something, I have a lot of people because I'm the Chair. They want to come and do their, their, their project, their intellectual project with me. And I tell them, If you don't love history, please don't do it with me because it will be painful for you and painful for me. But if you love it, I am happy to do whatever it takes. I have good friends that are heavily into ethics and I think we need more of that. We need people who are who, actually, as you stand there and you say, you know, I take care of these children that are, you know, terribly injured, and sometimes it's the parents that have injured them on purpose. And how do I deal with this? And what is the ethics around that? And how do I deal with the parents? You have a passion for that. And if you were into ethics, that's what you would be doing. And you, you, you that's what you, you need to find.

When I started, it was very hard to get published in the peer reviewed literature. And, you know, we've created a journal now that's indexed in the peer reviewed literature. I'd like to say I did it, but it isn't true. But you know, we, we, we worked through and we worked with a lot of people who were very influential who said, yeah, this sounds like a good idea. And what you want to do is, you want, don't give up. I was told many times you'll never, ever make professor if your research interest is history. And

I stand before you today, probably the only tenured Professor whose research is, is history. But it can be done, and it's about persistence and it's about doing your passion.

DR. WOLPAW:

Yeah. Well, thank you. That's great. And congratulations on having forged that path. I think it'll open that up for other people who are interested. Let's talk about World War II anesthesia, and so I'm not going to steal your thunder for tomorrow. I know you're giving a whole talk on it, but maybe tell us one or two things you find really fascinating about the anesthesia that happened during World War II.

DR. BACON:

Well, a couple of things that are fascinating about it is, first of all, there's something called the 90-day wonders. And what happened was, at the onset of the war there was, it was known that there would be a need for anesthesia services. And so what they did was they took young physicians that were drafted and they gave, they assign them to specialties, and anesthesia was one of them. They spent 90 days, three months, at a, several places, Bellevue in New York, University of Wisconsin in Madison, Mayo Clinic and some Harvard at Mass General. And what they did was they learned the principles of anesthesia in 90 days and then were shipped out. It was wildly successful. Why did it work? Because they were taking care of health, by in large, healthy, fit young men who were seriously wounded, which is a very different occupation than what I do every day with, you know, 70 year old people who have concomitant disease.

The other thing is they taught them regional anesthesia and they taught them regional anesthesia because they could have a corpsman watching the vital signs of the patient at the same time that they were running two or three or four rooms. And one of the more fascinating things was, one of the guys that I won't be talking about tomorrow, Sam Lieberman, who was from Buffalo, whom I met, was, he discovered that you could do continuous spinal anesthesia. And he, he related a story to me about a very serious abdominal wound where the guy was wiggling his toes, talking to the surgeon while they were reciting his spleen. And the, the point of all of that was Sam, by thinking about it, by being an anesthesiologist and by taking care of that and fluid management, he dropped the theater, he dropped in his hospital, the mortality from serious inter-abdominal wounds from 60% to 12.

DR. WOLPAW:

Wow.

DR. BACON:

So it changed, and what the other thing that was interesting is we were able to trace at Mayo and subsequently they've been able to trace it at the University of Wisconsin, the folks that did the 90 day course, about 40% of them wound up being ABA certified anesthesiologists. And it was this exposure by, to the specialty, and exposure of surgeons to what an anesthesiologist could do that radically changed our specialty in the, you know, in, in the latter half of the 20th century.

DR. WOLPAW:

Well, that's fascinating. I want to come back to what you said because what a striking statistic from 60% to 12 and this was, what, what was it that made…?

DR. BACON:

He did spinals. He did them under regional anesthesia as opposed to putting everybody under general. They, he was in the South Pacific, ether, it, it was hot, it's muggy. It's hard to get the things to vaporize. And so he was looking for a better way to do things.

DR. WOLPAW:

And so the, was it that general anesthesia carried with it, such a high mortality rate back then?

DR. BACON:

No, no. It just that, that wound, that place, that time.

DR. WOLPAW:

It worked.

DR. BACON:

It worked. I mean, it's, it's like in your hospital. I'm sure in my hospital are things that work for the way we do things and with our equipment that may not work at your place or your place.

DR. WOLPAW:

Yeah.

DR. BACON:

You know, and it's just kind of who you have, what talent you have. But it, it was quite fascinating.

DR. WOLPAW:

It is fascinating. And what, what were they using? I mean, was this spinal back then similar to what a spinal is now? Was it bupivacaine?

DR. BACON:
Oh no, no, no, no, no. It was Novocain

DR. WOLPAW:

OK. And they were using it continuously?

DR. BACON:

Yeah, there's something called a lemon needle. Now the lemon needle, it doesn't, no, it doesn't look like a lemon. That's usually the first thing everybody thinks of. It, it's, it has a malleable center. And what you can do is it's actually a solid, you know, it looks like a regular needle. It's got a, a trocar in it and you a stylet it in it, and you put it in till you can see, you pull the set, stylet out, and you get CSF and then you can bend it 90 degrees and it, lumen does not crimp. It does not obstruct. And so then you can attach a piece of tubing to it, run it up somebody's back. You remember there's no plastics. You also have to remember IV fluid therapy during World War II is steel needles in people's veins. Plastic IV, the, the plastic IV that we're used to is a 19, mid-1950's invention.

DR. WOLPAW:

Hmm.

DR. BACON:

Which is another fascinating story. It was invented on somebody's stove.

DR. WOLPAW:

Wow. So, they were using in, in, you know, in the vein, metal needles. But this lemon needle…

DR. BACON:

This lemon needle, you put in, you could then bend it. They had a special mattress that had a, it had a, a channel in it that you put the tubing in and then you had the syringe up at your head. Similar to what we would do with a continuous epidural today or continuous spinal today, the needle being replaced by a piece of plastic tubing.

DR. WOLPAW:

And I assume they didn't have infusion pumps.

DR. BACON:

Oh gosh, no.

DR. WOLPAW:

So this was just manual.

DR. BACON:

This was just, yeah, you know, I was starting to feel something. Yeah, oh, yeah, I'll top you up, OK? And it worked. It worked.

DR. WOLPAW:

And it, and it improved mortality. Amazing. So, all right. World War II anesthesia. If you had to say a couple of things that when you look back and you think about how it was done. How, what can we learn? How can we improve our practice from either what was done in World War II or just the history that you've studied of

anesthesiology? What do you look back and think we need to learn from this, or maybe we already have, that we could really shape our practice today?

DR. BACON:

Well, a couple of things. First and foremost, we, we've actually kind of seen it over the last 18 months. We have gone and pivoted from an unexpected problem, and our specialty has walked away, has walked away from being in the OR and walked up into critical ICUs taking care of people that are dying and pretty much did a fairly decent job of saving a lot of lives that would have gone a, another way.

It's our ability to pivot, to change, to think, to see systems, and that's what they were seeing in World War II. They saw that if the anesthesiologists took a pre-op assessment area and did fluid therapy and resuscitated prior to the OR, mortality dropped. Today, what are we talking about? We're talking about optimization, talking about the perioperative physician. It's nothing new. It's been going on forever. It's just that there's never been enough of us to really make it happen on the scale in which it needs to happen.

You know, I look at the acute pain service is another thing, because that's something new, quote unquote, but no people are always worried about pain. It's just the techniques have changed as we've gotten better drugs and better techniques. I think that's one of the things. The other things is that, you know, it, it is the exposure and my medical school, there is no mandatory anesthesia rotation as in, I would imagine a lot of the medical schools. And so it's, I always like industry to ray, radiation oncology. How do you know you have any interest in radiation oncology? Because unless you know a radiation oncologist, you never get exposed unless you really know or have heard about anesthesia until you hit surgery, you never you, you really have no idea what we do.

DR. WOLPAW:

Fantastic. Let me ask you this, when you look back, it seems like we've made such strides. You think about, anesthesia is not that old, right? I mean, 1850…

DR. BACON:

40, 40, 1846.

DR. WOLPAW:

1846. And ,and till now, we went from nothing to incredible anesthesia. We have now…

DR. BACON:

175th anniversary, by the way.

DR. WOLPAW:

There you go. 175 years. Does it give you hope? Do you think we learn so much and, and yet there's so much more left to learn and we're going to make similar strides? Or do you think that we're not going to see the same kind of strides forward in the next 175 years that we saw in the last?

DR. BACON:

Well two, two questions, two things, two comments. First question is, or first comment is, do we know how general anesthesia works on the brain? And the answer is we know just about as much today as they did when Morton passed gas in 1846. There, and the joke always was when I was a resident and as a junior faculty member, Doug, if you figure out how anesthesia works, you'll win the Nobel Prize. I haven't won the Nobel Prize yet. Neither is anybody else.

DR. WOLPAW:

Still got time.

DR. BACON:

Second thing is, how many times do medical students or junior or residents come to you and say, do you think, what's the viability of the specialty? I have heard that we were going to be replaced by nurses for about 35 years now. Nobody is, no, I don't know anybody that wants to sit in my chair, and I don't think that you all will ever be replaced. We bring things to the table that people that follow algorithms don't. And while I think that AI may help us going forward and there's a whole, there's another whole area to explore where I think things may be helpful to us, I don't think the, at the end of the day, the intuition, the experience and the ability to rescue will ever disappear. And that's what we do best.

DR. WOLPAW:

Yeah, thank you. And you know, what I love about history is the perspective it gives you. Doris Kearns Goodwin said this morning that she looks back and she studied so much history and she sees that, you know, we've been at these kind of terrible seeming points before where it seemed like there was just never going to be a way forward and we were never going to find a way to get along. And yet, of course, we made it through those. And so maybe it gives us some amount of hope to put our current dilemma in perspective and think maybe we will get through this, too. And it seems like you're saying the same thing. You know, that, that it may feel like there's a crisis now that our or especially has no future. And yet this is not new. It's been said. And yet here we are still working.

DR. BACON:

When, when the Board was formed, there is essentially 10 nurses for every anesthesiologist. That has changed, and a lot of it changes with the fact that if you're in, if you show up and do your job right, people understand the value you bring to the, to the table.

DR. WOLPAW:

So let me ask you finally this. When you think about your journey to being a Chair and you know, again, there may be people in the audience who think, you know, I'd like to be a Chair of a department one day. You may or may not think that's a good idea.

DR. BACON:

Oh, I think it's a great idea.

DR. WOLPAW:

Ok, good. I'm glad to hear that. What advice would you give? What, if people, you know, Dr. Ambardekar gave us thoughts on kind of going down the path of becoming a Program Director and being in these leadership roles? How about you for being a Chair, what would you recommend people do, whether it's young faculty, whether it's residents thinking about being in academic medicine, how should they go about preparing themselves for a job like yours?

DR. BACON:

I don't think you can ever completely prepare yourself for the job like mine , because you, you never quite know what's going to happen next. The most important thing is to, first and foremost, develop a core strong academic research portfolio. People do not really want you to be Chairs if you haven't.

The second thing is to start to understand the business of anesthesia. And I don't I mean, you know, like, how do you get how do you make money? How do you build appropriately? What are the rules around all of that? Because that is, things you'll be asked about the bottom line all the time and you need to know, for example, our residents actually with all the things they do outside the OR, actually a cost-effective replacement for CRNA's. And that is also very dependent on where you are and how much time you spend outside the OR and how you have your program set up.

But most importantly, you want to be a good citizen, both of the department and of the medical center. You want to be somebody that is looked at as a positive and as a leader, and that means that like, if you're given the schedule to do who takes the extra call, the guy that the, the gal that does the schedule, not jumping it on somebody else, you try and have be, you try to be the person that you know, when there's a problem they call you, you come into the room and people say, yeah, I'm glad, I'm glad he or she is here. And you want to be, you also want to the person people can come and kind of tell things that are bothering them and listen without being judgmental. And when you do those sorts of things, you will then get the administrative roles and you'll move up in both the medical center and in the department.

And somewhat of becoming a Chair is also a little bit of the opportunity at the time at the place. And the reason I'm in Jackson, Mississippi, I mean, when I said to my wife, I said, well, the chair is opening in, in Mississippi. And we saw in Jackson a lot of potential. And I've really been very happy there, it's been a great learning experience. We are an incredibly low resource environment and I, the residents who come out of our program, I, I always joke if I gave them a beeper and a wire, they could have an infusion pump in 20 minutes. But that's, you know, that's kind of how you, you, you look for the opportunity, you look at, you, you know, it's like when you look at a house and the wall is this ugly pink. Well, the paint isn't the problem. Is the structure sound> If the structure is there, you can fix the paint and that's, you know, you, you've got to be willing to, to put in the effort to make it happen.

DR. WOLPAW:

Well, that's great advice. Thank you. And Doug, when I can't imagine you have a lot of free time as a Chair, but when you do, if you do ever carve out time for yourself, what do you do? How do you spend the time?

DR BACON:

How do I spend my free time? Well, I, I, I like to tinker. I like to repair things. My wife makes me watch Hoarders, Hoarders. And I finally threw out the Christmas string light from 1985 that I've been going to fix. I see there are a few people in the audience that can relate to this.

I, I like to do some woodworking. I happen to live on a fairly small lake. And so when, on some days I walk out the back door and I take my fishing pole and really the bass don't care what happened that day. And I would tell everybody to have a dog because it does two things for you, one, you have to walk them so you get some exercise, which is important. And two, nobody will love you like a dog. I have a rough collie named Laurie. And my dog Laurie still thinks she's a puppy and still thinks she can at 70 pounds, can sit in my lap and she will come up. And after she gives me her, her, her kiss, she'll put her chest, her head on my chest and listen to my heart. And there is nothing that fixes your day, then that, that feeling when I'm sitting on the couch.

DR. WOLPAW:

That's great. Thank you for sharing that, Doug. All right, let's do random recommendations and then we're going to go to the audience for questions.

So, Aditee, would you like to start? What would you recommend that the audience check out?

DR. AMBARDEKAR:

I have gotten very interested in Brene Brown lately. I think this idea of leadership, daring leadership, vulnerability, learning how to be a good leader, it's important for all of us as anesthesiologists. You don't have to have a title, you don't have to have, you don’t have to run a program or a big department. And I really like what she teaches about authenticity, vulnerability, you know, shame and how to sort of deal with that in your daily life and your career. So she podcasts.

DR. WOLPAW:

And say her name again.

DR. AMBARDEKAR:

Brene Brown. She's a psychology researcher out of UT Houston, and she's got several books. Actually, there's one on parenting, which I have read a few times.

DR. WOLPAW:

All right. Take all the advice I can get.

DR. AMBARDEKAR:

For sure.

DR. BACON:

Just remember, kids don't come with a manual.

DR. AMBARDEKAR:

That's true, especially middle school age children.

DR. BACON:

Oh, you have my deepest sympathies.

DR. AMBARDEKAR:

But she's just a lovely individual to learn from. And I have a girl crush on her.

DR. WOLPAW:

Very cool. All right. Well, people can check out, and it's Brene Brown, people can check that out.

All right, Doug, what do you recommend that people check out?

DR. BACON:

Oh, I'm torn because what I really want you to check out is not anything that you can go to the library and get, or get online. It is become more and more apparent to me the older I have gotten, and I know I look incredibly young, but you know, that you really need to spend time with your family. At the end of the day when you fall off the roof shoveling snow and you've broken your wrists and they're both like this and you can't even click the remote. This happened to a patient of mine. Who's going to be there for you and who's going to be there for you at the end of the day? And I've spent a lot of my time building my career, and I have a little bit of regret about some of the things that I have, have done and not spent time with the boys like I wanted to. My four sons are all out of college and out of the house, and so I have a, you know, of a 10 year old daughter and she is a challenge because girls are, raising girls is very different than raising boys. And raising boys that are hockey players is very different to begin with. But you know, my wife and I have, my wife has taken on a new job and she's been incredibly busy, and I am 62-1/2. I'm looking towards retirement. My part of my career, my, my, the, the goal climbing is over and I'm trying to think about, OK, what is really important? And I wish I'd thought about that 20 years ago.

So, I wish I could tell you a, a specific thing to check out a, you know, a how to book. It isn't there, but you've got to find it inside yourself. And that is the most important thing. And I think the most important thing as the physician is to know yourself. We all go through what you go through with the pediatrics. I was thinking about it. I have a son who's a police officer and he has PTSD over some of the things he sees on a daily basis. And I think back and you know, there, there are cases that still haunt me, you know, and we just don't think about those sorts of things and we don't think about, you know, and you know, as corny as it sounds, I should be telling my wife that I love her a lot more. She packed a lunch for me, for the plane, and I opened the napkin and there's this post-it note, you know? That, I think is what, you know, if I can give one piece of advice to most of you ,and most of you in the audience are a lot younger than I am. That would be my piece of advice to you, be kind to the people around you. You have that choice, even when they're nasty to you.

DR. WOLPAW:

Well, thank you, Doug. That's a wonderful recommendation and totally fine that it's not anything specific. I think it's a wonderful one, and I hope we all take it to heart.

All right. Let's open it up to audience questions. The mic is live, I hope. And if anyone's got one, come on up.

JAKE:

My name is Jake. I'm a fourth-year medical student, I, I just want to say it's, it's an honor to see you guys in person.

So my question is for Dr. Bacon. You've kind of expressed some, some regrets about, what I'm getting at is, a non-optimal work life balance in the past. And there's obviously a lot of medical students going into residency here at this program. And I think that's on, that's part of the forefront of what we're thinking about right now. And there has been a recent shift towards more optimal work life balance and residency. Do you think that we're doing enough now, or still not?

DR. BACON:

Well, first and foremost, remember I trained before hours regulation. In fact, in New York state, the Bell Commission came in July 1st, 1989. The reason I remember that date is I graduated June 30th, 1989, and so you know, my, my worst call in the ICU was I started at 5:00 a.m. with rounds, did 24 hours and was relieved at 11:00 p.m. the next day.

JAKE:

Wow.

DR. BACON:

And, you know, so, I also come from, as a boomer, I come from the generation that you work until the work is done and you know, it, it, it is what it is. So, I, I, I do believe we are doing a lot better. There are hour hours regulations. We talk about it. I think that that is the thing that we don't do as well as I would like to see us do. And that's to talk about the pressures, the issues. Taising children during residency is stressful. You know, having a spouse in the profession is stressful. Having a spouse not in the in the, in the, in medicine is difficult because they have no understanding about what you're doing. And why, when the patient, you know, when the patient was bleeding, you couldn't just, you know, turn it over to somebody else. You felt this ownership and you needed to do it.

So I, I mean, I think those are the issues we need to get more out in our residency. You know, I never really understood child-care issues when I was in the earlier part of my career because my ex-wife stayed at home. My current wife is an OB-GYN who works crazier hours than I do. And so, you know, I understand, oh, you know, the baby's sick. You can't take it to daycare. What are we going to do? You know,

those sorts of things. And, and I think that there's a lot of knowledge that we just don't share because it's kind of a taboo subject. And I would love to see us expand that more, and I'd love to hear your thoughts on it as a Program Director.

DR. AMBARDEKAR:

It's a really important conversation we're having at the national level. Several of these guidelines that have come down from the ACGME are, you know, instituted, followed, you know, pretty closely by programs.

But I think we have to remember that well, we're first of all, it's work life harmony, I think is a better phrase. And sometimes it's a cacophony as I tell my husband. But work life balance and harmony and wellness isn't that you're not working hard, it's that you're working hard and you're feeling like your work is meaningful and you're feeling that you're, you're supported. So, I think the work hour requirements are important, but it's not the only thing. You have to go and be in a place, and recruitment season is upon us. You have to find a program that supports you in which you know you're going to thrive and that's going to be different from everybody else's.

So, wellness is a really interesting concept, and I think we have to sort of pivot, what, how we approach that. It's not about how much you're working, it's how you're working. And I think that's my feeling about wellness.

DR. WOLPAW:

Yeah, I, I think that's incredibly well said, Aditee. I would say that, you know, I tell all our applicants that we, we work really hard as I know you do, too, on making sure that we support our residents, that we pay attention to wellness. But that residency is still hard, right? I mean, it may well be that we should be completely restructuring it and have it be less hours, but, but we can't do that overnight. And so for right now, residency is what it is. And anywhere you go, any program in the country, you're going to work about the same number of hours. So you're going to work the hours. So the question for wellness is not, is it a few hours less or a few hours more? It's am I supported while I'm working those hours? Do I feel like someone's listening when I have something going on? Are there people who are mentoring me and supporting me along the way? Because it's hard. Residency is hard and anybody who says it's not is not being honest with you. So you've got to be supported while you do hard things.

DR. AMBARDEKAR:

And my residents will know I say, I quote Brene Brown all the time. If we're not, if it's not hard, we're not learning, right? So if you, if you come to residency expecting to know all the answers, to, expecting it to be easy, then you're in the wrong, you're in the wrong place.

DR. WOLPAW:

Yeah.

DR. BACON:

Thirty-two years as an attending and I'm still trying to figure out what the right answer is, you know? But you know, I, I, I loved your comment because hours are easy to measure. It's like what, it's like in physiology. What do you really want to know? You want to know blood flow to an organ. You really don't care what the pressure is if the flow is adequate, but you can't measure flow, so you measure the surrogate, which is pressure. We can't measure all of the things you just mentioned easily or adequately, at least in my opinion. But we can measure how long you work. And I, you know, I, I, I really believe that the latter is much more important than measuring time, because then we become nothing more than shift workers. And we, a long time ago, when I was ASA Newsletter Editor, I wrote an editorial about that and my, my wife will tell you, it drives me crazy when somebody says, well, my shift's over. No, your clinical responsibilities are done.

DR. WOLPAW:

Yeah, thanks, Doug, and thanks, Jake. Great question, great question.

ERICA:

Hi, I'm Erica. I'm a CA-1 at Stanford. This is kind of an extension actually of the previous question, but in considering a career in academic medicine, I've been told often that especially as an early career attending, it's, you're taking extra time that isn't, you know, built in. You're basically taking your free time to take on a lot of extra responsibilities, which you had kind of alluded to, Dr. Ambardekar. Do you think that there's a way that academic medicine could be restructured to kind of give more support towards those early career faculty? Because I think that, that tends to drive a lot of people away from academics and into private practice. And it, I think it takes a lot of like brilliant minds away from what, what could be, yeah, a great career.

DR. WOLPAW:

I think it's a great question, Erica and I am interested in hearing what both of you think. Maybe we'll start with you, Doug, since you have, you are in charge of many young faculty. What do you do to support them and what do you wish you could do, maybe that, that you don't do?

DR. BACON:

Well, the, the, as unfortunate as, as it is, it boils down to money, a lot of times. And also, if I'm going to invest a nonclinical day, which is the time that you get to do these sorts of things is an investment in the department. I need to know. I need to have some indication that you, to give you that time, that you are going to use it productively.

I have been in departments where everybody got a non-clinical day and the people that really weren't interested in trying to do anything were getting their haircut and going out and doing it, which caused a lot of resentment. The, and the people that were putting in (sic) and busting their butt, you know, they, they were there at 5:00 in the morning and going home at midnight on their nonclinical day, and they were viewed as not working because they weren't in the OR. So, if to, for junior faculty beginning, I want to see what are you interested in? How committed are you to that? And I don't mean like, you know, every Saturday and Sunday, you're, you're not, you're working doing that. But you know, yeah, occasionally on an evening, you're putting in some time doing that. You're making sure you're if you're in the residency, you're showing up at things like what we have, for example, our fourth years, when they finish their rotation, they do a they we have a, a, a Zoom meeting with them, doing a presentation, a 15 minute presentation. Are you, you know, you're not one of the faculty mentoring, but you just show up to listen. Are you interested? Are you engaged? And then I'm much more willing, and then I'm also going to make sure that you have a mentor and that we're following a, a timeline, and a progression that we want to see certain milestones hit so that I know that the investment that I'm making is going to pay dividends. I also know that I'm going to invest in 10 people and if I get one out of them, that is a superstar, I have succeeded beyond my wildest dreams. You know, you've got to give everybody a chance. And, but to get the chance, you have to show me you're interested. You have to show me some commitment.

DR. WOLPAW:

Thanks, Doug. Aditee, any thoughts?

DR. AMBARDEKAR:

Yeah. You know, I've always been a part of departments where non-clinical time is earned. It's not an entitlement. And I think there's a little bit of activation energy that goes into demonstrating that. And so while I understand and I think it goes into the sort of the wellness and the, the balance piece, I think there is some commitment that you have to show. And my residents, I do the same thing for when they want a research month. You have to demonstrate to me that you're going to use that month. Show me a proposal. Show me that you're going to work, sometimes on your post-call days, and then you've earned that time. And I think it's expensive. We're expensive and we and for those, the, the students in the room, we are, as my Chair says, we are a yes, conditional yes, department. We provide a service. So for example, when Dallas had its horrible Snowmageddon in February and the whole world stopped, my residents and my colleagues showed up for work. And so, you know, there is that expectation. So extra stuff that you get to do, I think you have to earn that, at least in the beginning.

DR. WOLPAW:

Yeah. Thanks Aditee. And Erika, you know, I would say that I think part of this also is incentives. You heard, Doug, say it costs money, right? And he doesn't have a bottomless pit, as does, no Chair does. Right? So you have to have, in our current environment, you have to have something that's worth the money. But you could imagine a situation where we made wellness more worth it.

So how does that happen? Well, right now, what is the motivation for hospitals and health systems? The Joint Commission comes in and they say, you need to make sure everyone has boot covers in the OR, right? They do. In fact, we got dinged because we didn't have enough boot coverage. So what happens? The hospital spends, it doesn't matter, any amount of money to buy more boot covers, because if they don't, then their federal funding is at risk. And yet, how many studies have tied boot covers to patient safety? Right? Zero. But wellness, provider burnout, study after study has shown that burned out providers make more medical errors and cause patient harm. So why isn't the Joint Commission coming in and saying, here's the problem. Your employees are too burned out. You need to show year over year improvement in that, or you will get your funding taken away. And then the motivation for the health system is to say to Dr. Bacon, hey, I want, what do you, how much money do you need to make your employees less burned out and to improve their wellness? But until that, until that's the motivation, until we have those incentives aligned correctly, then Chairs can only do so much. So I, I really think we all need to be pushing at that level to say we need incentives that align with research

and align with what we need as practitioners because we're the ones out there fighting the fight and we're going to work in the snow and we're working through COVID. And so, you know, we need to have this and that fight has to be coming from our whole community.

ERICA:

Thank you so much.

DR. WOLPAW:

Thanks, Erica.

MIRA:

Hi, my name is Mira Vissan. I'm a fourth year medical student, and I just want to say thank you for the podcast.

DR. WOLPAW:

Thank you, Mira.

MIRA:

My question is for Dr. Ambardekar. It's two parts. First, what drew you to specifically pedes burns? And secondly, you wear a lot of different hats, as you've told us. And my question is, how do you feel clinically? Do you still get the time to be available and there for your patients to undergo some very, you know, traumatic things and feel that you can do that, be there for your residents, and also continue your research for anyone that wants to go beyond just clinical or just stick with clinical and try venturing out?

DR. AMBARDEKAR:

Yeah, thank you for those two very, very good questions. There's not very many of us that do pediatric burn anesthesia and talk about it, so it's quite a niche area. And to be very honest, when I landed in Dallas, there was a need. And I thought, OK, I can teach myself. I had never done burns in residency, never done burns in fellowship. In fact, I'd never done burns as a faculty member at CHOP. And so I, that’s testimony to you have to go to a program where you learn how to learn. I taught myself how to do burns. I taught myself how to figure it out, and I'm really

proud of that, and I get to now teach others to do it, too. So opportunity again, to work at a really great place and take care of some vulnerable patients.

My residents will tell you that I'm busy. But when I'm in the OR, I'm in the OR, and so I sit in the back of the OR with them and do a little bit of work. But also I'm there with them. I think, I actually really love my OR days because I can use that as an excuse to not answer emails and to not answer my phone calls and from various individuals around the institution. It is why I chose this job, and I don't ever want to get into a leadership role where I won't be in the operating room because I actually really enjoy taking care of patients. So actually, clinical work is my respite, in some ways. I know that sounds really funny, but those days are actually easier than my days that are filled with meetings with people all over the institution. I hope that answered your question.

MIRA:

Yeah it did, thank you.

DR. WOLPAW:

Thanks, Aditee. I love one thing that you said, which is that you feel like you really, what was key, was knowing how to learn. And I love this because I sometimes have residents who will say to me, you know, I'm, I'm about to graduate and I feel like I don't know everything yet. And I say to them, you definitely don't do it. Neither do I write what you have. I hope when you graduate from residency are the building blocks so that you can continue learning and building as you go on for the rest of your career. And I bet that Dr. Bacon would say he doesn't know everything yet, either. So it's an ongoing problem.

DR. BACON:

I am, I am amazed at my ignorance every day. The one thing that I would love to comment about is, you know, I, I spend at least one day clinically a week in the OR and I'm the backup when somebody's sick or something. I'm, I'm the. I'm the disaster quarterback, if you will. And as one of my faculty said, you know, Dr. Bacon, for the number of cases you do, you're up in front of us at M&M an awful lot. But my OR days are, also I'm a, I am a physician and a clinician, first and foremost. And I, that's what I love and the other thing that I love, and I don't know if you see this, but when the medical students come to me for the Chair letter, I love that time. I love it. When the residents come in, I have an open door policy at the door is open, come on in. Whatever it is I'm doing, I stop, whether it's a faculty member or resident, a medical

student. That's where, you know, that's my engagement. And that's what keeps me sane when I have to go and sit with all the other Chairs and hear about our budget crisis or that crisis or whatever else is going on. And you know, that rejuvenates me and that's what keeps me going. And I think the other thing is it's all about balance. It's about doing many different things. We're anesthesiologists. We're all probably have a little bit of ADHD because we all like to do this and that. And, you know, it's really kind of you're not really having fun unless your hair's on fire and you're flying at Mach three, right? So that's from Top Gun, by the way. Glad somebody got the reference out there, but that's, I think that's part of it as well.

And, and you know, I think you've really illustrated that beautifully that, you know, when you're in the OR, you're in the OR and you're teaching and you're enjoying and you're taking care of patients. I've always said that I've been really blessed with an anesthesia career in that I get to be with people at their most vulnerable. I get to see, there are two things that still, I am still amazed that every time I see them, the first is the beating heart in somebody's chest for open heart surgery. I'm a reformed cardiac anesthesiologist. And the other is birthing of a baby. Seeing a new life come into the world. It is always just a, an incredible honor to be present with patients at that time. Remember that, you know, we talk about our careers or this or that. That, to me, is what it's all about.

DR. WOLPAW:

Yeah, thank you. And thanks for the question.

MIRA:

Yeah, thank you.

LAURA:

Hi, my name is Laura (sic). I'm a CA-3 at Stanford. Thank you so much for coming in and sharing your time with us today.

DR. WOLPAW:

Thank you, Laura.

LAURA:

I had a question specifically, Dr. Ambardekar, you had mentioned kind of dealing with imposter syndrome as moving through these different stages of your life. And I think as medical trainees, we also face that at many times. I know I've struggled with that a lot through various career stages. Still do. Do you have any advice for how you process that work to keep going through it?

DR. WOLPAW:

I'm just going to repeat the question, Laura, because I don't know how well that mic got it. So the question is for everyone and for the recording is about imposter syndrome. So Aditee had mentioned, you know, the fact that she, even now well into her career still feels imposter syndrome, as do all of us, I think. And so the question is, do you have any advice for folks, especially trainees who are, are feeling it now and then going into being junior faculty who we know feel this and suffer from it, as to how to approach it, how to deal with it?

DR. AMBARDEKAR:

I want, I have a mentor, still, Dr. Schwartz. He's recently retired and he said to me, I have imposter syndrome when I go and stand up in front of a big crowd and speak. And so I think that's the first step. I think the second step is you just have, you have to take advantage of where you are and what you're doing. And so it's OK to speak up. That's, usually you've been given that opportunity because somebody has believed in you to be there. And so if you exercise your voice and you do it more often, it gets a little bit more comfortable.

And then finally, I think it's important to know that you have to be around your people, right? So you find your people, you find your passion, you find your joy. When you, when you're around your people, that syndrome is not as bad. So I know that's not a great answer to your question, but I think you have to know that you're in those roles because you're deserving of them and go do your best job

DR. WOLPAW:

Yeah, I think that's huge. And you know, I would just add that I think those of us who are in attending roles, especially senior attending roles, Chair roles, Program Director roles, we have to talk about our mistakes. We have to talk about our failures because that's how hopefully our trainees and our medical students can feel like, oh, OK, you know, it's OK when I make a mistake, too. And the fact that I've made one and hopefully even the fact that I've made one and I feel like I can talk about it doesn't make me a bad doctor. It doesn't make me a failure. It just makes me the

same as everyone else. And I really try. I tell my CA1's every year a story of when I was an intern and had a, a patient death, I had a really bad outcome. And I did not at the time have any knowledge that this, you know, wasn't the complete end of my career, that it didn't mean I was a terrible doctor and I felt incredibly, incredibly isolated by that, and I didn't even tell anyone. I wasn't willing to talk about that for almost 10 years because I felt like it was so embarrassing. And it wasn't until I started to hear other people's stories that I felt like it wasn't just me. And I think we have to tell those stories. It's why I tell it to my CA1's every year. And I would encourage everyone faculty, those of you who are trainees, CA3's, talk to the CA1's. Tell them about when you've made a medical error. Tell them about when you've had a bad outcome. And if you haven't yet, you will, because we all will. And when it happens, don't be afraid to talk about it and make sure that your trainees and your students know about it so that they can know, hey, we all make mistakes. It's how we learn, it's how we grow.

DR. BACON:

The other thing is, when you know somebody made a mistake, it's really important to support them. I had a senior, one of our senior people, was changing out at an endotracheal tube and lost the ari, airway, and the patient died and he was beside himself, this guy with 35 years experience. And you know, can I really do this job? Where I work, we, you know, we are the level one trauma center. We get all sorts of really crazy stuff. And I said to him I said, no, this could have happened. You did everything right. This could have happened to any of us. Please relax. You're going to be OK. And you know, the imposter syndrome can paralyze you. And it's really, unfortunately, it's all you, because, as you said, somebody believed in you. Somebody thinks you can do this, and I know that each and every resident that we graduate can walk into any operating room anywhere and figure out what the problem is and fix it because we have put them through that kind of stressful environment. And they oftentimes don't feel that, but I know they can. And I know that when I promote faculty to doing certain things, they may not feel comfortable doing it. Being outside your comfort zone is good for you. Lord knows, my Dean keeps doing that to me all the time. And, but I'm not the world's expert on anything, and I've just, I've come, to I've come to realize that I do the best job I can with what I got in front of me. And, you know, if that's not good enough for people, well, then please help me become better.

DR. WOLPAW:

Thank you, and thanks for the question.

LAURA:

Thank you.

DR. WOLPAW:

All right. Let's take one final question, and then we're going to wrap up.

ANDREW:

My name is Andrew. I'm from the University of Mississippi Medical Center.

DR. BACON:

Yeah!

ANDREW:

So, I'm familiar with Dr. Bacon. But I have a question, kind of for both of you. Dr. Bacon mentioned that his son is a police officer and, you know, has experience with PTSD and also Dr. Ambardekar experiences a lot of pediatric burns, a lot of very emotionally challenging situations. How do you guys personally cope? I know medical schools and residency programs often offer employee assistance programs and ways to reach out, but, you know, how do you, you know, take that, and move forward? Like, how do you incorporate it into your personal life and really separate yourself clinically, like without becoming a robot?

DR. WOLPAW:

And I'm just going to repeat the question again, because that that mic is a little low. So, and the question is, you know, in reference, Dr. Bacon, you mentioned a son who has PTSD and, and Dr. Ambardekar, you mentioned, you know, the struggle with, with your pediatric burns and how that can be tough. And we all know, you know, as Andrew, Andrew, right? Yeah, as Andrew said, that we have kind of support networks for faculty. I think it's required, in fact, by the ACGME. So every residency has this and for faculty, too. But the question is, you know, what advice do you have? How do you cope when things get really tough? When you're faced with a difficult situation or difficult outcome or difficult day at work? Either one of you can start.

DR. BACON:

I, I have a flippant answer that I won't use, but for, for me, the, I, I kind of trained in an era where you didn't talk about stuff. Where you know, you just you learn to com, compartmentalize it. And for me, the psychic wall broke down when my mother passed and I really didn't handle that well. But as a Chair, that helped me understand what was going on with everybody else. And so, I am fortunate that my current wife is in the profession. You know, she has her issues, and, and I understand that shoulder (sic) is absolutely terrifying even to us, but even more so to them. And, you know, having somebody that I can talk to who can understand it, who I can bounce ideas off, is really critically important.

I see in a lot of the single faculty, I get my most venomous emails over trivia from my single faculty, independent of gender, because they don't have anybody to decompress with. And that's where family and everybody becomes really, really important. I worry about my son because he's single and, you know, and now he's out there every day dealing with it, and in an environment where people really don't like police at the moment. And so I worry about him, and he seems to have become more and more withdrawn. And that, I think, is a real problem.

And I really, you know, we as physicians, you know, we're, we're all healthy. We're all OK. We don't need to worry about it. And at the end of the day, we do. And we, you need you need to be on the lookout for your colleagues. And it doesn't matter whether you're a resident or a medical student or an attending. You need to be on the lookout. And if you, you know you don't feel comfortable, talk to somebody like, come to me and say, hey, look, I'm really worried about Dr. X because, you know, I've been watching this and, and he's not himself and, or she's not herself, and something's really bugging her. And, you know, sometimes I can go and talk to them, or I can, I know who their friends are, kind of figure out what's going on and say, hey, maybe we really need to support this person right now. And you know, that's, I think, the most helpful thing.

DR. AMBARDEKAR:

Yeah, I think the first thing to remember is we're all human. Even the faculty members that are doing cases with you in the operating room and I think relating to the people with whom we work makes people feel comfortable to speak up and speak out. We have some systems in place in the residency where they don't have to answer these questions every other week, but we send out something called a fuel gauge, and it really is just a, how full is your tank? And I, I reach out to every resident that says that they're half tank or lower. Checking in, everything OK? Anything I can do. And you know, some residents don't respond and that's OK. But

at least they know you're there. And so, I again encourage you to find for those of you in recruitment, to find those departments where you know that those people exist. Talk to the residents, see if they feel supported. We have a tremendous wellness center on campus just for our med students and residents. That is open door policy for almost twenty-four seven.

Then as for me, it's, I have a physician husband who gets it. And my kids are learning all the medical terms, too. But you know, I go home, I play on the piano with the boys. I run around the block with them. And I think that there is that and I do worry. I worry about my single residents or the residents that have moved to Dallas and don't have a support system. And actually, during the pandemic, that was my biggest fear was that we were going to marginalize or isolate those right because of all the social distancing. And we had some things in place where we had some buddy check-ins. I don't think it lasted very long, but we, we tried putting those things in place, too.

DR. WOLPAW:

Yeah. Thanks to both of you. You know, I think, I think this ties in really well to the last question about imposter syndrome. And I would say that if just like with imposter syndrome, we have to be willing to talk about it. So when you have a tough day or a tough patient outcome or you're going through a tough time in your life, whether that's related to work or whether it's related to things outside of work, it's not a sign of weakness to reach out for help. It's actually a sign of strength. And I think we, as leaders need to make that clear to our faculty, to our trainees, that it is not good to just not show up at work, but to reach out and say, I don't think I can be safe at work. I need some time. That's a sign of strength and self-awareness. I want that in my trainees. I want them to feel like they can do that, that they can be comfortable. So we need to provide the, the kind of environment that makes people feel like they can reach out. And I have seen people who have really been struggling, who need some time, and just knowing that they can have the time and then getting it, even if it's just three or four days can turn it around. I mean, people go away in a bad place. They get some help support, whether that's from family or a professional, and they come back like a different person. But you have to be willing to give them that time and they have to know it's OK to ask for it. I think that's really, really key.

ANDREW:

Yeah, thank you.

DR. WOLPAW:

Thank you. All right. Well, let's give a big thank you to our guests, Dr. Ambardekar and Dr. Bacon. Thank you for being here. And a huge thank you to our audience. It's been so much fun to be in front of a live audience for the first time ever. We hope to do more of these, and I will end as I always do by saying, and I truly mean it, thank you for everything you do. What you do every day is truly important and valued. Thank you.

(SOUNDBITE OF MUSIC)

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