Residents In a Room
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(SOUNDBITE OF MUSIC)

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.

It's important to have a diverse workforce that is representative of the diverse patient population.

Being able to take feedback to better yourself is helpful as well.

Care has become a lot more integrated and our teamwork helps make sure that we can adequately spend that time with our families, with our loved ones, and not at work.

Other attendings are like, be careful of the workforce and make sure you read all the fine print.

It's all a competition for reimbursement rates.

DR. DILLON TINEVEZ (HOST):

Welcome back to Residents in a Room, the podcast for residents, by residents. I'm Dillon Tinevez, your host for today's episode. I'm the Chief Resident and PGY4 at Advocate Illinois Masonic Medical Center. And we're here to pick up our examination of anesthesiology from the past to the present. Today we're focusing on human changes, building on last month's episode about technological changes. With me again, our residents …

DR. ARTUSH GRIGORYAN:

I am Artush Grigoryan. I'm a CA1 resident at Masonic Medical Center.

DR. KANNAN ARAVAGIRI:

Hey, my name is Kannan Aravagiri. I'm a PGY1 at Advocate Illinois.

DR. SHYAM DESAI:

I'm Shyam Desai. I'm a CA1 at Rush University Medical Center.

DR. MIKE PETRAVICK:

Mike Petrovick, CA3 at Rush University Medical Center.

DR. JANHAVI DHARGALKER:

I'm Janhavi Dhargalker, PG1, Advocate Illinois Masonic Medical Center.

DR. TINEVEZ:

So when you guys were invited to join a podcast touching on human changes in the practice of anesthesiology, what did you expect to talk about? I personally expected to talk about diversity and provider and patient populations. How about you?

DR. ARAVAGIRI:

That's pretty legit, yeah, that was exactly it.

DR. TINEVEZ:

You as well?

DR. DESAI:

I thought about the complexity of the patients and kind of the disease process.

DR. TINEVEZ:

Ok. In what way do you think human changes have impacted the specialty and how do you feel about the changes?

DR. DHARGALKER:

I think the specialty's changed phenomenally in terms of human changes alone. I think

the overarching broad picture, that of diversity and inclusion, is very much present. But also in other ways, I think we can also consider that the specialties change in the number of subspecialties there are. I think that's a very human change as well. Anesthesiologists now are seen in a lot of different spheres of the hospital, whether it's literally in the OR, in the pain clinic, to GI lab, to cath lab. We make our presence known in many different spheres of the hospital. And I think because of that, our training has hardened up to the point that we have a lot of different subspecialties. With that being said, I think the major overarching goal of I think the biggest change would be also the massive inclusion of lots of different specialties as well as women in anesthesia as well as patients and being able to cover a larger socioeconomic group.

DR. TINEVEZ:

How about this? Do you think there has been a diversification in anesthesia providers?

DR. ARAVAGIRI:

Yeah, especially just in the past 20 to 30 years. We have this impact of both diverse people, whether it be women in medicine or just people of color in medicine, entering the workforce and just being represented in anesthesia.

DR. TINEVEZ:

What other human changes has impacted the specialty. How about is this a patient population?

DR. PETRAVICK:

I think the two go hand in hand as we take care of more diverse patients. Patients often respond better to somebody who they feel looks like them, sounds like them. So maybe they can relate to better. They may open up about medical problems to somebody who they think is more like them. So it's, in some ways, our duty as providers to ensure that our practice and our colleagues match the underlying diversity of the patients we take care of.

DR. TINEVEZ:

Let's start with diversity and representation. If you put ten anesthesiologists in a room together today, they look a lot different than they would have a few decades ago. Why is it important that the specialty now includes more women or people of color or openly

gay physicians, even more clinicians from other countries, and a broader variety of cultural backgrounds? I think you just touched on that.

DR. GRIGORYAN:

I think I would agree with Mike. It's important to have a diverse workforce that is representative of the diverse patient population to support comprehensive understanding of patients needs, to share understanding and gain new perspectives in order to grow and develop professionally. As someone who was born and raised in another country, I appreciate the value that American society places on practicing equality and inclusion, regardless of background, and I believe that this approach will lead to the best possible outcome.

DR. DESAI:

I couldn't agree more with both of you guys there. I think it really helps us kind of build a working relationship with the patient. Because no patient or no person is the same or has societal or cultural backgrounds. And they do play a huge role in patients decisions to seek medical care and treatments and certain options. So I think that having a wide variety of backgrounds not only helps us better understand the patient, but also makes the patient feel 100% more comfortable with the care that they're getting.

DR. TINEVEZ:

So I'm going to follow up question for Dr. Dhargalker, since we're lucky enough to have a female resident physician with us today. It's not hard to see how access to the specialty is changing the lives of individuals from some demographics. If you're a female anesthesiologist, for example, it's not a stretch to guess that you wouldn't have had your job if you were born 50 years earlier. But how are we the more diverse workforce changing the specialty as having more women in the specialty, for example, changed the way we practice anesthesiology?

DR. DHARGALKER:

Absolutely. I think anesthesia of the other specialty still has a long ways to go in terms of having equality for for women, to have … to be in the same level of partnerships with male anesthesiologists. We're not really done until we have really the same opportunities for advancement, the same type of recognition, and at the end of the day, the same pay. And I don't think that we'll continue to make and discuss these strategies and look into these obstacles that are in our way. We've come a long way with that as well. I mean, if you read history of what some women went through in the early

pioneering days, we've certainly come a long way, but we're still not where we need and it benefits all of us. As we know, many studies, there's diversity in our workplace and especially in our leadership, the better we are as an organization, the better we're able to provide culturally competent care to our patients, as well as make sure that we adequately represent the patient population that we're treating. With having more women in the anesthesia subspecialty I think it's improved some of our patient outcomes. I think patients now feel more represented in the providers that they see. You honestly have more patients from various ethnic groups coming in and getting the care they need, especially with terms of chronic pain. There is a large disparity in the way ethnic populations perceive and deal with their pain. Having chronic pain providers that are from various backgrounds, it makes the patients feel more comfortable in coming in and getting the care they need as long as they see a face that's representing them.

DR. TINEVEZ:

Excellent answer. The 2020 NRMP match results showed that out of all the residents that matched into an anesthesiology residency, 36% were female and 64% were male. Do you think there's a reason for that? Why do you think that this is still a male dominated profession?

DR. DHARGALKER:

I think the specialty still has a lot of misinterpretation with the way women are perceived in the specialty. In some ways people think of it, or some women think of it as a lifestyle specialty. But in many studies, you'll see that anesthesiology providers are so very busy. There's a type of surgical subspecialty, even putting in as many hours if not the same as general surgeons. So with that said, I think a lot of times it's offering sources of advancements for women in specialties also lacking. You'll see there's a big discrepancy within the number of spots for academic female physicians. In many academic centers, it's harder to balance that work life balance, as you call it, and it's only getting harder with time. But at the same time, there's also needs to be an improvement in creating awareness for women in the specialty, and I think we've come a long way with that as well.

DR. TINEVEZ:

Do you think there's any advantage being a man in anesthesiology? Literally, there's other specialties where it's obviously advantageous to be female OB-GYN, for example, or pediatrician. But does anyone think that there's any advantage being a man in anesthesiology?

DR. ARAVAGIRI:

Personally I always thought of it as just like a cultural bias in the OR, to be male dominated, and that's slowly changing over time, at least in the leadership.

DR. TINEVEZ:

OR nurses are almost all female.

DR. ARAVAGIRI:

Exactly. But I'm talking about just in terms of like surgical leadership.

DR. DHARGALKER:

In part, I think you might find more female general surgery residents than there are female anesthesia residents. And that's not to say that anesthesia hasn't come a long way in terms of having women in the specialty. I think maybe because people tend to think that you are providing a service that's behind the curtains that maybe doesn't allow you to completely take charge of your patient interaction, that women who are a marginalized group continue to feel more marginalized in this field. That is one thought did cross my mind. As women, would you rather not want to be in a specialty that provides a lot of contact with the patients? Or the patient knows that you're the first primary provider? Not really primary care provider, but the first point of contact.

DR. TINEVEZ:

There's been a lot of studies looking into not just anesthesiology, but many medical specialties. Why is there a discrepancy, male, female physicians? Cramer et al in 2014, looked at the MAP match results and sent out surveys to all of the anesthesiology programs in the country and what half of them responded. And they asked questions like: Is your PD female? s your chairman female? What's the male to female ratio of your residence? And what they found was that it didn't matter if the leadership roles were female or not. They do not find that women are choosing these residency programs because of female leadership position. What they did find, however, was the residency programs that had more females currently in it where attracting more females to apply to their program. And so it appears as if women just don't choose anesthesiology because there's not a lot of women in anesthesiology.

DR. ARAVAGIRI:

Self limiting cycle.

DR. TINEVEZ:

Let's talk about how expectations of us as humans and physicians have changed. Anesthesiologists have always been humans, right? So we've always needed sleep, wanted time with family, and benefited from time off. But physicians aren't known for having light workloads. Do you think the expectations put on you are different than those put on earlier generations of anesthesiologists? If so, what's driving that evolution and how do we evolve in a way that's good for us, our teams and our patients?

DR. ARAVAGIRI:

First, you have to stop giving away that we're all robots. That's the first thing I'd like to say. It's hard to balance everything, right? We're put on a high standard at all times.

DR. DHARGALKER**:**

A lot of our work is starting to become very integrated now. You know, back in the day, maybe had one anesthesiologist kind of taking charge of one room at best. Now you have more of a supervisory role that you might have to go and monitor multiple rooms, multiple different specialists that are under you. So I think with that, care has become a lot more integrated. And with that also means that we have more health. Our teamwork helps make sure that we can adequately spend that time with our families, with their loved ones, and not at work. But I would be hard pressed to find out if maybe back in the day, how did anesthesiologists feel like they were adequately getting that work life balance? I'm sure our balance is a lot better than theirs. With all the changes that we've had and improvements in work hours. But I'm sure as we're going through it and never feels like we can strike a balance.

DR. TINEVEZ:

As residents, do you think the expectations of the residents have gone up or down in the last 30 years?

DR. PETRAVICK:

I think as residents we expect different in our in our lives compared to maybe residents of 50 years ago, some or perhaps so. So our attendings have been doing this for decades, that when I think about myself with my friends talking about what are your expectations for a family life … 50 years ago you may have been married, but you had a

wife at home with your kids. Now many of us, we want to be involved in family life in a way that they did not want, or they didn't expect to be, that and that we expect our jobs to help facilitate that because we recognize that we are people who have lives outside of work, some sort of a work life balance not ony is good for our lives outside work but is also good for caring for our patients. There are plenty of studies to say burnt out physicians provide worse care for patients. Clinical outcomes are worse when we don't recognize that we have needs outside of the hospital. So I do think we have different expectations about what our life should be.

DR. GRIGORYAN:

Also, as residents, we are required to demonstrate competency not only in medical knowledge as it has always been, but also competencies in interpersonal and communication skills, patient care procedures, skills, all those ACGME core competencies -- the professionalism, practice based learning, system based learning. And the significance of these competencies has been magnified through the lens of diversity. Another dynamic that has changed is that the responsibility in achieving objective outcomes with respect to these competencies has shifted from the program to the residents themselves. While programs facilitate achieving the Aaorementioned competencies. residents are responsible for moving from one life so to the next.

DR. TINEVEZ:

Do you think the ACGME putting limits on work hours and having rules for time between work and things like that have made residency more bearable, or better for residents?

DR. ARAVAGIRI:

I mean, it's putting a stopgap, right? It's allowing yourself to at least have some form of freedom in life, a force that allows you to do that. Instead of being like the hospital dictates, you should work as many hours, all day, every day.

DR. TINEVEZ:

30 years ago, that's what happened.

DR. ARAVAGIRI:

Exactly. That was ridiculous. The psychological effect of not having free time is destructive for anybody.

DR. DESAI:

I think that having this work life balance kind of ties into diversification. It's we're able to go out and experience things that couldn't have done if we didn't have work hours. And that has allowed us to have a better understanding of what's going on in the world, not just the hospital.

DR. PETRAVICK:

We now work in teams and we receive training in how to discuss patients, how to handle them safely. If you ask any patient, who do you like to be cared for? A resident who has been awake for 24 hours straight working and starting your case, I think most of them would feel uncomfortable with that. And we should recognize that it's not safe for people to continue to take new patients after 24 hours, work hours, reflect back. But as long as we are trained and how do we safely handle all the important details about a patient, someone who is new and fresh, there's a way for us to continue safe patient care provided by someone who is ready to start a new day.

DR. TINEVEZ:

Yeah, let's talk about teamwork. Human changes in our specialty aren't only about what practitioners look like or where we come from or what people expect of us. Changes are also about how we interact with each other and the health care teams were paired with. Effective teamwork is important for us, but is it also a key for our patients? Do human factors like teamwork and leadership in that kind of performance as our understanding of this evolved in past decades? And if teamwork does impact patient care, how do you improve those human skills to become a better practitioner? Maybe you've receive some great advice on being a good teammate or a leader like to pass on. For example, let's start with teamwork.

DR. ARAVAGIRI:

It's such a complicated answer because I think that we are evolving as a team based system. It's not just you. We're dealing with the patient.

DR. DHARGALKER:

I see what you're saying. We experience the patient as a team. We learn to deal with it as it's. But so much of what we do in the OR, whether it's orchestrated by machines or that we're forming, formulating our plans and actions as a team, it's not really taught to us. I don't think that in medical school, or going through in residency, you have specific

team building exercises. Athough that comes at the cost of your training, there isn't anything regulated to show you how to work best in a team. And that's what's expected of us on a daily basis when we step into the OR. Although now you see that medical curriculum is changing widely to involve more problem based learning, things that you could do together as a team, you could simulate a crashing patient and save that patient. And all of these are very important changes to our curriculum that show us how to evolve and better as teammates. I think that needs to be stressed even at the residency level and beyond.

DR. TINEVEZ:

And of you have any advice?

DR. ARAVAGIRI:

As long as you're able to trust your team in whatever you're doing, that's the baseline.

DR. DESAI:

Listen and take feedback is also super integral to our team member is we may think that you're doing something right, but in reality the bigger picture of the team, you may be kind of doing your own thing, whereas the team isn't expecting that. So being able to take feedback to better yourself is critical as well.

DR. PETRAVICK:

I think we all end up taking on leadership roles, even if it is in the eyes of you go from being a med student to an intern to a junior resident to the senior. At times as the senior resident, you are then the leader of the team. It's not just receiving feedback, but how do you give good feedback to somebody so that they can help improve knowing how to make it specific. They can change not just a trait about them that they they can't change.

I remember in terms of great advice being on pediatrics as a med student, talking to us about giving and receiving feedback, feedback Fridays every week. She made you practice giving both her and your senior resident feedback as a med student. And she said, what you have to comment on is something that they directly changed. Her best example was a resident who talked quickly and over everybody. She's like, What I really want to say is stop being from New York City, because she's somebody who grew up there, the attending and be president, except I know she can't change that about herself. So what I need to tell her specifically, you need to let others speak more and

better that their behaviors. So being the senior on any sort of team is a leadership role to learn. How do I give my junior residents feedback that is useful?

DR. TINEVEZ:

All right. Consolidation has led to human changes as well. Group practices erupted in the nineties and by the 2000s we had mega groups consisting over more than 100 providers. These groups have had a huge impact on reshaping the anesthesia market, which includes gobbling up smaller groups. I'm wondering how you all view this ongoing consolidation. Do you think it's been good for the specialty, problematic or both? In terms of smaller groups and large groups, what do you think are pros and cons?

DR. PETRAVICK:

I think as a small group at times you can say we are a group, we want to provide all of our providers with a better lifestyle. That's something we value that in some ways, values can be local when you have to say a smaller group is better able to apply that, whereas a large group might just have more uniform policies, some of which may be good, some less favorable to. Smaller groups give you more choice when you're going out for a job to say, I want a group that use things X, Y and Z, or if there's only larger groups, you may have less flexibility in finding a group that fits your life or the work life balance that you're trying to find.

DR. ARAVAGIRI:

Especially there's like some of these groups that are monopolizing groups as well. They have NDAs which you could work for that practice, but if you want to leave, that practice can go back into it later on. It'll take years to do so. I have like other attendings are like, be careful, go into the workforce and make sure you read all the fine print. Just me, being, just starting in residency, just something I have to look out for.

DR. TINEVEZ:

So you mentioned some benefits of being in a small group. What about a large group?

DR. PETRAVICK:

I think that we see this with all of health care. It's not limited to just anesthesia groups, but health care systems, hospitals buying up other hospitals, insurers buying out other insurers. It's all a competition for reimbursement rates. If you're in a larger group, you can generally negotiate a better reimbursement than you can as a small group. So for

you, financially, especially people who have a lot of loans coming out of medical training, that can be an advantage.

DR. TINEVEZ:

I mean, some of the things I've heard from attendings who've been part of our grou or have left our small group to go into a large group, are, it's easier to find a job. It's easier to be low key when you're in the job. Scheduling is better. I know an anesthesiologist who works for Napa and he only works six months out of the year. There's no way you could do that in a smaller practice. There's more infrastructure. It's easier to streamline your way into the hospital system.

Do you guys plan to do a smaller group or a larger group? Or undecided?

DR. ARAVAGIRI:

Unbelievably undecided.

DR. PETRAVICK:

I think as somebody who's in my CA3 year but doing fellowship, I have one more year before finding a job. It may come down to geography. More so when you think about the rest of your life. There's a place you want to be. You may take a job that allows you to be there rather than who the job is with. So I think some of that will of after fellowship.

DR. TINEVEZ:

So after fellowship I think I'd prefer actually to do a smaller group, make partner, be able to make decisions.

So let's tackle the labor union question. Some residents are members of the Committee on Interns and Residents, the SEIU, a local of the Service Employees International Union. But you're attendings aren't unionized. I have a few questions about this topic. Are any of you in unions now or have you been part of a union ever or do you want to be? But above all, is it time for anesthesiologists to unionize? What changes would you like to see when it comes to anesthesiology?

I personally have not been in a union. I've never been in a union. I think a union would help. I think it's an organization by the workforce, for the workforce, I don't see negative impact that unions have had on any workforce that I've seen.

DR. ARAVAGIRI:

It's a negotiation. You Know, negotiating for just some additional benefits that we can help us provide for us. But would I be part of a union? I would think of it. But at the moment, probably not and have not thought about it.

DR. GRIGORYAN:

I've never been in a union. In the past, I would be interested in learning more about what is possible with respect to unions.

DR. TINEVEZ:

Do you think you would benefit from an organisation that would protect your rights? Work to increase your salary?

DR. GRIGORYAN:

Definitely. But…

DR. ARAVAGIRI:

I just got worker rights. I just. I just started working and it's just like, oh, I got paid for the first time. It's like, this is nice. I think I just need some time to know what the rights are and what I can grow from that.

DR. TINEVEZ:

Do you think your salary is enough currently for the work?

DR. PETRAVICK:

Anybody would like make more money. I don't spend all the money I make each month. So for me, like I personally never moonlight because me having free time is more important than having more money. So I do make enough for the life I have right now.

DR. TINEVEZ:

You guys are okay with your salary? I am not.

DR. ARAVAGIRI:

I think I think there was a time where there's a moment in my life where I was donating plasma because I was like, oh, x or change. I was making more from donating plasma that I was from the day to day work I was doing at the hospital. There should be a law, right? We should understand what the bar is.

DR. TINEVEZ:

I think that's the next thing that needs to change in residency, I think. The work hours was an issue and now it's not so much an issue. With the salary, it's remained the same without inflation for the last 30, 40 years. So I think it's time to increase the salary. Especially for more senior residents. Sure, interns are useless. But when you become a senior resident, you're essentially the acting position. So I don't think you should get paid $64,000 a year as the sort of primary physician.

One last question before we say goodbye. What changes would you like to see next? What future evolutions -- human, technological or other -- would the specialty benefit from?

DR. GRIGORYAN:

For me, the most important change I would like to see in the OR is wireless technologies, wireless gauges, pulse oximeters, blood pressure monitors, anything that would really improve the OR ergonomics.

DR. DHARGALKER:

I think we've got a long way to go in terms of making it the ideal specialty for a lot of different types of med students who would like to consider it. I don't think that it will happen any time in the future, but I think having some strategies in place so that we kind of improve the overall awareness of the kind of specialty at a much earlier stage in medical school. I for one wasn't exposed to it until the end of my third year, beginning of fourth year. So that definitely narrowed my idea when coming - what kind of various specialties would be available. Maybe as a way to improve the number of women entering the specialty, it would be nice to have more awareness of the field from an early on.

DR. TINEVEZ:

I would like to see a very potent inhaled anesthetic as an extremely low solubility. No side affects.

DR. DHARGALKER:

Well, I think we're working on some new opioid that has no no respiration, depression or no side effects that would cause respiratory depression. Coming up with like brand new medications that's going to revolutionize pain medicine.

DR. TINEVEZ:

It's an opioid?

DR. DHARGALKER:

Yeah. It's supposed to be a new opioid they're working on.

DR. ARAVAGIRI:

Isn't that exactly the same terms they used?

DR. TINEVEZ:

No, they got sued because of it.

DR. ARAVAGIRI:

No side effects.

DR. TINEVEZ:

How about you guys? Would you like to see human, technological or other?

DR. PETRAVICK:

I agree with seeing or earlier exposure to it and not even just to anesthesia specialty, but careers throughout medicine that are more pipeline programs that when we talk about recruiting a more diverse workforce. In anesthesia, we are not the only specialty who says that and tries to do that. Start early on to have more people for all of us to recruit. I agree with wireless things in the OR. Also warm stickers … patients always say how cold they are.

DR. GRIGORYAN:

Warm ultra soft gels.

DR. DESAI:

Just warming devices for us.

DR. ARAVAGIRI:

Just auto.

DR. TINEVEZ:

The stickers.

DR. ARAVAGIRI:

I think no matter what we talk about, whether it's human or technological advances, what we want in our lives, that everyone around the globe should be able to get that. I know it’s an ASA podcast, but making sure we have global outreach, make sure that everyone has safe anaesthesia, is extremely important.

DR. TINEVEZ:

Thanks for listening to residents in a room. The podcast for residents, by Residents. We've enjoyed the conversation and we hope you have too. If so, please subscribe to residents in a room wherever you get your podcasts and join us again next month.

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