



American Society of
Anesthesiologists™

Residents in a Room
Episode Number: 45
Episode Title: Clinical Decision Making
Recorded: July 2022

(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.

You know, one of the beauties of of the anesthetic practice is the collaboration, the group work, overcoming problems together.

Even if it's not an emergency, it's really nice to have people to talk to, to just kind of bounce ideas off of.

One thing I've noticed some attendings do that I really admire is they take their time with the consent process and explaining risk benefits to a patient.

Our program director, Dr. Soto, is one of the calmest persons you'll ever meet in the room. Those are the types of people that I look up to and I like to be as an attending anesthesiologist.

DR. ERIC REILLY:

Welcome to Residents in a Room, the podcast for Residents, by Residents. I'm your host for today's episode, Dr. Eric Reilly. I may CA3 resident Beaumont Hospital in Royal Oak, Michigan. Today, we're going to dig into subjects of clinical decision making, and I can't do that alone. So let's meet my fellow residents.

DR. JOHN YOUSEF:

I'm John Yousef. I'm also a CA3 resident at Beaumont Hospital.

DR. SHERIDAN MARKATOS:

I'm Sheridan Merkatos, and I'm also CA3 at Beaumont Hospital.

DR. ERICA BOLZ:

I'm Erica Wills. I'm CA1 at Beaumont Hospital.

DR. REILLY:

Great. Thanks, everyone, for being here. I know it's tough to get out of the ORs. But we'll jump right in. So every single day today included, we're expected to make evidence, context based decisions, life or death scenarios in real time. You see someone crashing in the OR and you make a decision. Does the weight of that ever really just sort of hit you in the face? Do you ever reflect on that and how do you kind of deal with that at work or when you go home?

DR. MARKATOS:

I think most of the time it's something that kind of hits me after the fact. I think our training is really good at providing us with the tools to logically think through any emergent situations like that. And so sometimes I'm going into autopilot and just working through my checklist or my differential and knocking things out. And then sometimes after the fact, you realize how badly something could have gone. On the flip side of that, I think it's important to realize that nothing we do is benign and to never get too comfortable doing something like something like a simple procedure. It's important to know that there's always consequences and to think carefully about what you're doing at the same time.

DR. REILLY:

Yeah, for sure. And I mean, Erica, you're about two months into the ORs now. Have you noticed a difference in emotional toll doing what you're doing now versus like intern year?

DR. BOLZ:

Yeah, definitely. Just being in the OR more regularly, starting just about two months ago, I definitely feel a little bit more exhausted afterward because I do think that there is that emotional toll. And like Sheridan was saying, you don't really realize how bad things could get in the middle of it, and you're just kind of working through a differential and trying to fix whatever problems arise, and then you kind of go home and reflect on it. Luckily, I haven't run into too many situations yet, but you definitely go home and reflect

and think about, you know, what could have happened. And it's definitely an emotional toll for sure.

DR. REILLY:

100%. Yeah. I mean, I agree with you. And I think we're in a really unique spot in health care where over the last couple of years we're dealing with COVID and global pandemic and everything. You, Erica, you were in medical school when it kind of hit. John, Sheridan and I it sort of hit us in the face when we were interns. I mean, do you think that those experiences of us helping care for those COVID patients and seeing everything that we saw, has that made your interpretation of health care different? Has that changed you? John?

DR. YOUSEF:

I don't think that it necessarily changed my perspective on health care. I think if anything, it made me kind of respect the health care system a lot more as far as the program is concerned, especially here. You know, during that time, we were able to work with a multitude of different departments within the hospital. I was on my internal medicine rotation during that month and I learned a lot during COVID and how precious life could be and how fast things can be taken away. It was definitely an experience, but I felt like that we continue to be close throughout the COVID times and without the support of my residents and my family, I don't think I could have gotten through COVID with the mental health that I could have done.

DR. REILLY:

For me personally, a lot of that was ... one, I was really young in my career as a physician, just an intern. But, you know, having to make these decisions or have these conversations with families or seeing patients crash in front of me is, you know, it's scary. And there aren't always the people there immediately when you need them. You know, in anesthesia, we deal with rapid resuscitation and stabilization. Whether it's a COVID patient or you're in the OR and you're making those decisions. What do you guys rely on? Shared and kind of mentioned? It's sort of just subconscious. You just act first and sort of think later sometimes. Do you guys appreciate more so your individual skills or do you rely more unlike your team approach with your attending and those people around you. How do you factor in everything when you're making those intense decisions in the split of a second?

DR. YOUSEF:

So for me personally, I feel like the program here at Beaumont Royal Oak offers us a great training. It allows us to build skills and have these skills come back time and time again that honestly become instinct. So in those times, the training and the instincts that I've learned over the years in my anesthesia residency, those come back relatively quickly. You know, it's like the muscle memory. It's the mind memory. And those come back relatively quickly.

DR. MARKATOS:

I agree with John. I think between all the mock orals that we do, the simulation sessions, lectures, instinct is definitely there. I'm definitely quick to call for help either from another resident or of course, always letting my attending know first, too. I think it's always helpful to have like someone from an outside perspective who's walking in and saying, okay, have you checked these things in case there's something you missed. It never hurts to have extra hands. Like John said, a lot of it is instinct. It's easy to look at anesthesiologists as being like solo players. But we do have gear, especially very collegial environment, where we're always calling each other for help or bouncing ideas off of each other in the lounge.

DR. BOLZ:

I definitely agree. I think this early on in my training I felt really supported by not only my attendings but my senior residents, my coresidents. So even if it's not an emergency, it's really nice to have people to talk to, to just kind of bounce ideas off of whether we're in the OR or we're talking about a case afterwards. I think that there's a really good balance of having autonomy and being able to kind of go through a differential quickly and also having a multitude of people that we can contact for help.

DR. REILLY:

And so I think that when we're making those split second decisions like Sheridan and John and I, we have the benefit of we've seen a lot, you know, we're in our fourth year of residency and for a lot of things, we have experience handling them. But I mean, Erica, for you, you're really new to this. So you're seeing things every single day, all the time that you've never seen, never encountered. What's your personal triage system of, you know, when do I need to call for help? When do I need to get back up in here? Or if it's something where you don't think you need backup, but it's something you've never seen, what's your mental decision maker, are you saying? Well, I read about this somewhere. I saw a video or someone talked to me about this. I mean, what do you think? Maybe it's just instinct. I mean, what's your approach?

DR. BOLZ:

Yeah. So I think that I kind of go through a differential, whether you're dealing with hypoxia or hypertension or bradycardia. You know, I go through a differential, but I always am quick to call an attending this early on. Usually I'll kind of go through my differential, you know, I won't wait for an attending to show up if I think that I need to intervene. And for the most part, I think I've been able to intervene quickly and be able to figure out what's going on prior to an attending even getting there. But yeah, I think this early in my career I'm quick to call for help for sure, but I think Beaumont does a great job of, before we even get into the ORs, kind of explaining the common things that can happen, you know, helping us get through a differential. And even though it's scary, I have run into situations where, for example, a patient gets bradycardia on inflation and I've been able to handle that quickly without having to call for help.

DR. REILLY:

And being part of a greater health care team, we work hand in hand with our surgeons, so a lot of times we're in scenarios where we see patients who we're concerned about, maybe not intra but pre-op, and a surgeon may want to go back or we may have disagreements with how to proceed with the case. What skills do you take into those scenarios or those conversations to best keep the patient's interests at heart?

DR. YOUSEF:

One of the things that I definitely look into is a number one safety concern for me is patient safety. And if I feel like the patient safety is very much jeopardized, I will bring it up to the surgeon as well as my attendings, especially for an elective case. See if there is another way around it. Maybe do the elective case another time. If the case is relatively urgent and needs to go back, we'll quickly contact the consultant such as cardiology, for example, to make sure that the patient's fully optimized for the operating room. But for sure, patient safety is number one.

DR. MARKATOS:

I like to always first ask myself, is this emergent or not? Do we have time to, like John said, optimize the patient and or dig into a history a little bit further? Do we need to get their cardiologist on the phone or do we not have time for that? And then I just, like John said, like to frame it. And I'm concerned about this patient's risk for this. And I explain my reasoning to the surgeon. And I find here at least they're always very reasonable. Just this morning, I had a patient's potassium too elevated to go back um, for surgery at the 730 start time. And so it was one of those things where I said, you know, we can't go

back now, but we can try to optimize him, get his potassium down, check a, check another level and a little bit and head back. And sure enough, we were able to do that and surgeon was totally reasonable.

DR. BOLZ:

I haven't run into too many cases thus far where I have had emergent cases. There has been an instance where there's been elective cases that we've had to talk to the surgeon about whether or not this is ... the patient's completely optimized for the procedure or not. Just last week we had a patient that was unable to get any sort of access, peripheral or central access. She had one IV on the floor that wasn't working very well. And we decided to just postpone the case and have her go to IR and get access with IR. And I found that the surgeon was extremely reasonable. And it was nice to see the conversation between the MD and the in the surgeon to just kind of see how that plays out.

DR. REILLY:

Kind of changing gears a little bit. You know, a lot of the decisions we make in the interest of patient safety are often backed in guidelines or research studies. Do you ever run into scenarios where there aren't really guidelines or where you may disagree? And do you ever think that there are any specific examples where things should be reconsidered before moving forward?

DR. MARKATOS:

I've definitely witnessed that in the name of patient autonomy with elective procedures. For instance, there is a patient with complete heart block who needed a pacemaker but did not want a pacemaker, refused it, no matter how much he was educated on it, but had an elective inguinal hernia repair and wanted that done. And there was a lot of discussion amongst the anesthesiologists in the attending lounge who would do the case and who wouldn't. I think that's one of those things where there's no black or white answer or there's no really guidelines. If there are, I'm sure a lot of people would go 50/50 on it, what they would do. But in the name of patient autonomy, if the patient is alert and oriented and has mental decision-making capacity, then it's kind of hard to argue against them, although I still am not sure what I would do in that instance, just as a trainee still. But ultimately, they kept coming in to surgery every day, hoping to get an attending who would say, okay, I will take you back. But twice in a row they had an attending cancel the case because the anesthesiologist was not comfortable doing that with the risks involved.

DR. REILLY:

And that's kind of the art of anaesthesia, right? You know, we don't always have guidelines. And John probably says once or twice a day anesthesia is the greatest career in the world. You know, because we get to make these decisions and have this autonomy and keep patient's best interests at heart. Is there anything that you see in your co residents or attendings or other professions where you think people make those decisions very soundly? Any skills that you pick up on that you think is best for patients, best for care? To rephrase, do you think that there's any specific personality traits or any specific things you see in people where you say, yes, that's I emulate that, I want to act like that in my future practice?

DR. YOUSEF:

Our program director, Dr. Soto, has one of the calmest persons you'll ever meet in the room. And then he just has like a gestalt about him. Whenever he sees a patient, he can look through the record and he may see something that you may not see. And it's just years of experience and practice. And he'll say, for example, this patient needs a central line. You have no idea why the patient needs a central line. You're looking, look and looking. And then, lo and behold, the patient actually needed a central line interop. And I feel like those are the types of people that I look up to. And I'd like to be as an attending anesthesiologist because again, goes back to the ratio of keeping the patient safe and making sure that you take your time, especially with procedures, and to look through the chart and then talk to the patient when it can be done to talk to the patient in order to make sure that you do what's right and do what's best and to stay calm and those types of situations. Because I feel like that as soon as an anesthesiologist starts to crumble under pressure, the whole entire room will also start to crumble under pressure.

DR. MARKATOS:

Yeah, I agree with John. I think our attendings who are able to remain calm are super efficient at working through their differentials because I think when they have a calm exterior, they have a calm interior. And so they're carefully thinking through things. I think also a lot of people who go into anesthesia are type-A people. And so we have systematic approaches to everything. And that's kind of how you have to approach any problem that comes up. Even just like my process of prepping someone, it's very systematic. Like, I first do this and then I look at this and then I do that in order to come up with a plan. And I never really deviate That way I don't ever miss anything when I'm trying to decide whether it's safe for a patient to proceed with surgery or just what anesthetic plan is going to be best for them.

DR. BOLZ:

Yeah, I totally agree with what John and Sheridan said. You know, it's really nice to see attendings that are calm but also kind and kind of explain their thought process to everyone else in the room, especially when patient safety is a concern. I've just seen a lot of attendings do a really great job of taking their time, going through their differential calmly and slowly, and also kind of explaining what's going on to everyone in the room. So like John was saying, no one else kind of crumbles under that under that pressure, that stress of of what's going on into operatively.

DR. REILLY:

Just as you guys were saying, it all kind of reflected on communication. And I think an anesthesiologist who can come in and talk to everyone because, you know, what the anesthesiologist is doing is affecting what the surgeon is doing and what the surgeons doing is affecting what we were doing and who's in the room with what and who's grabbing what equipment is all huge. And so effective communication, being able to calmly state what you're doing when you're doing it while you're doing it, assigning tasks, assigning jobs. Just like if you're running a code, you know, you need to have organization and a group leader and someone communicating. I think it's just huge for making sound decisions and being open to criticism. When you communicate out loud, when you have a lot of people in on the process, you invite other ideas.

John, earlier you kind of mentioned emulating Dr. Soto and how he carries himself. And through his experience, he's able to make very sound decisions. In your experiences, in your past cases, you take the time to reflect or are there formal sit downs where you kind of have a chance to think about your past cases, your past experiences, and that helps guide your decision making?

DR. YOUSEF:

It does. So, you know, I'm a CA3 resident. Looking back on when I was a CA2 or CA1 resident, there's a multitude of experience that came with that. Not only that, just going home and reading about the cases and making sure I fully understand what's going on, I am able to reflect back on the cases and say, Aha, that's why they did what they did. So I think it's the years and experiences that we've gained from CA1 to CA3. And to be able to understand and read the material. What I like to read nowadays is Barish, to be quite honest, and I feel like that delves very in-depth with why something may be done or maybe need an on top of the experience that we've gained over the past three years of residency.

DR. REILLY:

For sure and I think that any academic department was included, does a good job of kind of revisiting M&Ms at conferences. And we look at these cases where things maybe went wrong and and what could have been changed. We all do difficult case reports and present it things like ASA and stuff. So I think that there's tons of opportunities for us personally at our residency where we look at these cases and we learn from each other. I think the camaraderie and the lounge, you know, we're always talking about tough cases that we had the day before or in our current day or that are coming up later in the week. We have a very strong communication among our co residents and I'm sure the attendings do as well, always kind of relying on each other. I think it's one of the beauties of of the anesthetic practice is the collaboration, the group work, overcoming problems together, casting egos aside, not trying to handle anything that you're uncomfortable handling, but asking for help quickly, I think is at the forefront of the profession. And we're kind of in a unique area with our hospital specifically we have 60 plus hours, a relatively small residency program, only six residents a year. So 18 potential OR bodies. And so a lot of those hours are filled with mid-level providers. We have a lot of CRNA help and very important part of our anesthetic team. Do any of you guys think that when it comes to decision making, whether it's a team with a resident and an attending or a team with a CRNA and attending or a resident and a CRNA and an attending, we're faced in all those different scenarios. Do you think there's any differences in the decision-making process based on what kind of team is available, what team you're working with?

DR. MARKATOS:

Well, this month, actually, I'm on my board runner rotation, which here at Beaumont means I follow around the board runner and start cases with them, whether that's with CRNAs, a CRNA with a student nurse anesthetist, or a case with a resident. So I've noticed that attendings have really picked up on who is more comfortable in certain cases or situations. For instance, we have CRNAs dedicated to our cardiac team. And so if there's ever an emergent cardiac case and there's no available cardiac CRNA, you know that attending might be hanging around the room a lot more often than they would with someone they're more comfortable with or someone who's more comfortable with the case. Just as an example.

DR. REILLY:

Erica or John, do you guys, have you ever been in scenarios where maybe the communication or the sequence of events was different or the same when you were

dealing with either a young attending or an old attending or with a CRNA or with an older resident or a younger resident. Was there a difference in how decisions were made?

DR. YOUSEF:

We had a transition period here at Beaumont, and we have a lot of fresh new attendings that bring a lot of skill from other institution, which is awesome. One of the things that I do see compared to the attendings are a little bit more seasoned, is the younger attendings will kind of hang around the room and help you out a little bit more and provide the type of teaching that they brought from their institution to here. The older attendings will hang around, but not as much. They still teach quite a bit, but definitely a lot of the younger attendings will help out with a little bit more teaching than the older attendings would.

DR. MARKATOS:

I imagine some of that too comes from just like the older attendings being more comfortable with, like handling anything we messed up. Whereas younger attendings, you know, being a, being an attending is new to them and so they ... and we are new to them as well. And so they kind of want to hang close by and make sure things get off to a smooth start. Whereas I imagine the wisdom and knowledge and just like skill set that comes with, with the anesthesia, with time, you feel like you can leave the room and quickly run back and fix whatever's wrong.

DR. REILLY:

Oh, my gosh, yeah. And I think I'm I think all of us will probably, probably be the same way we're going from a training situation where we are in the OR 100% of the time to suddenly we are in control of two or three or four rooms at once. And I mean, yeah, I think I'm just going to be sticking around those rooms all the time. But John's totally right. You know, some of our older, more seasoned attendings are very comfortable giving us, I dunno if you want to call it more autonomy in cases where maybe they recognize it's a lower risk case or they recognize they've already calculated all the variables and they know anything that could go wrong and they can come in and fix it in an instant. And that just, I think, just comes with experience, you know, and as John was saying, our our younger attendings are great. They're all bringing stuff from their own institutions where they trained. But yeah, I think it's one, them kind of getting to know us better and seeing where our skills are and being comfortable, you know, letting us do our thing and having more autonomy and also just them themselves now transitioning to this leadership role of being comfortable, letting someone else, you

know, take care of your baby, you know, for lack of a better term, you know, and sit there and be responsible for your room. You know, it'd be like if one of us was trying to get comfortable letting an intern or or a med student or somebody, you know, help take care of a patient. Like, we'd want to make sure they understood all the variables and all the things that could go wrong. So, I mean, I totally get where they're coming from for the people who hang around a little bit more and I don't mind it.

DR. BOLZ:

Definitely, I think that the older attendings and the younger attendings both bring great things to the table. I've noticed a lot with some of the newer attendings they've even helped me out with, Hey, this is how I would go through systematically preoping a patient when I was in your shoes, you know, five, six, seven years ago. And so I really appreciate that from some of the newer attendings, because they kind of remember what it's like to be a new CA1. And then with the older attendings, it's really interesting to hear kind of how the art of anesthesia has changed throughout their throughout their entire career and how they would kind of troubleshoot things when maybe there weren't certain medications that we use now when they were in residency or at the beginning of at the beginning of their career as an attending. So yeah, it's, it's it's nice to have a big mixture of attendings that are from all over the country, all different training areas that trained at all different institutions. And yeah, I've really enjoyed it so far.

DR. REILLY:

You know, earlier we kind of touched on the transition from the resident to the to the attending, going from a primary care, you're right there in the OR, to supervision. And is there anything which you guys any of you have picked up on or anything throughout residency which helps prepare you for that transition?

DR. MARKATOS:

I touched on it earlier, but I think one of the unique things about Beaumont is we have the board runner rotation that we do our CA3 year. And so you really get to see the kind of behind the scenes view of what it's like to be an attending, managing up to 4 ORs at a time and supervising both residents and CRNAs. And so I think that does a really good job preparing us for what it's going to be like to be an attending. I know a lot of us also plan on doing fellowship. I'm going to do pediatrics. And so one of the aspects of the program that I was looking for was for them to also have that supervisory month somewhere within the rotation schedule. And it was nice to see that most fellowship programs do have that. They have kind of as you get towards the later half of your year of fellowship, you're starting to supervise more. And so I think that's one way we get

prepared to transition from being in the OR all the time to managing multiple rooms at a time.

DR. YOUSEF:

I agree. In fact, one of our previous residents, Yusef Ducklo, who's over at university in Michigan for pediatrics, he actually mentioned that a second board month would be optimal for us just because we get to experience a little bit more of a supervisory role that we don't really experience as residents. One of my best friends, Hassan Khan, who just graduated from this program as well and chose to become an attending straight out of residency, rather. You know, I talked to him every day and he talks about running 3 to 4 rooms every day and how it was beneficial from the step board runner on to be able to pick up on that.

DR. REILLY:

Our CA3 year we we get a lot of more supervision type roles like right now I'm in the surgical ICU and I'm like the quote unquote float. So I don't necessarily have patients, but I'm kind of helping see everyone. So I think it's really fun being at an academic institution where you are sort of in charge of these younger residents because they end up asking really good questions and this sort of dogma type where we may be doing something and not even realizing why we're doing it. And then an intern ask you a question and you're like, Actually, I don't know. So then there's the classic response. If you look it up and you tell me later, right? But I think it's great to kind of reflect and be like, Man, maybe I knew this a couple of years ago, but I don't know why we do it this way. And I think getting those questions and being in that supervisory role really makes you think through something and understand it fully before you act.

DR. MARKATOS:

Yeah, I agree with you, Eric. I've definitely noticed now that we our CAs, our attendings definitely rely on us a lot more to help the younger residents. If we're not an OR body that day, I feel like they love to ask us, Well, what do you think about this? This resident has this situation. What would you do if you were the attending? So I think they do a great job prompting us and really making us make those decisions for ourselves and letting us carry out that decision. Of course, so long as they don't think it's going to cause patient harm. But they really let you see the consequences of if you if you do this, then this. So I think that's another aspect of our program that's great, is that they really trust us as we get further along in our training. And like you mentioned, there's those non OR months, CA3 year where you can supervise even if you're not on board runner and directly supervising.

DR. REILLY:

Coming full circle to when we started, we initially started talking about the weight of the these decisions we make. And now we've transitioned to like how we're preparing to become attendings. So in a year, John, Sheridan and I will be fellows, but the year after that will be attendings. And Erica. In three years you may be an attendee, maybe fellow, but we're all getting really close to being in that role. So in medicine, complications happen. There's a risk to everything you do, whether you take Motrin or whether you undergo a massive surgery. If you calculate the risks and you decide to do something for a patient and there's a complication or increased morbidity and mortality or something, how are you going to handle that? What are you going to take away from your training to be able to process that and feel okay at home?

DR. YOUSEF:

I keep going back to this. One of my things is I know at the end of the day I put patient safety first and unfortunately everything that we do is either major or minor risk.

DR. MARKATOS:

One thing I've noticed some attendings do that I really admire is they take their time with the consent process and explaining risk benefits to a patient. Because that I find if one of those complications does arise, they're able to then sit down with the patient and say, okay, so you know how we talked about, for instance, like a wet tap during an epidural. You know how I talked about that. If I went too far with this epidural, you had a higher chance of a headache. Unfortunately, that did happen. These are the options if this headache does develop. I've just really admired when they have that process because then the patient I find is like less upset. They knew that this was a possibility. And also it keeps it from being like something personal with you. Like, it's not like, oh, I'm sorry I messed up. I'm sorry this happened to you, but it's something that could happen to anyone. Of course, I'm always going to feel guilty, but it's less personal. It weighs on you less when you know it's something that could have happened. And it's a discussion you had with the patient.

DR. REILLY:

And Erica, you're only two months into the ORs. But, you know, a month and a half ago, you were pushing your first meds and doing some of your first procedures. You know, there's a lot of gravity with that. So you're a little further off from attending hood. But

what if you have something bad that happens in an OR, you know what, what do you do at home to try and deal with that on your own personal level?

DR. BOLZ:

So I'm glad we kind of circled back to this because I was talking initially about how there's a big emotional toll with starting your CA1 year but didn't really get to touch on how I deal with that at home. So I think first just at work, but not in the OR, we have a lot of support, both from my senior residents and my coresidents, as well as attendings. I think I probably touched on this multiple times, but being able to bounce ideas off of each other or kind of just having someone to talk to about an adverse event that happened intra operatively or post operatively. And then I think our program does a really good job of making sure that we have not only support at work, but also outside of work. We have time to spend with our friends and our family, adequate time to study. And so I think that that's just made a world of difference, being able to feel like I can go home, spend time with my friends and family, and also have adequate time to study so I know what to do when situations like that arise.

And then also going off of what Sheridan said, I think that an appropriate risk benefit conversation makes a patient feel better, but also makes me feel a little bit better too. Just recently I had a patient that was undergoing anesthesia for the very first time. She was very concerned about the risk of aspiration, even though her risk was pretty low. And I went through talk to her about things that increase your risk of aspiration. I told her things that we do to prevent it prior to extubation, but then did inform her that there is that risk. And I think after our conversation she felt a lot better and she at the end of the case, she didn't end up aspirating or anything like that. And when she woke up, she was really happy and really thankful that we had that conversation and stuff because she kind of knew what the risks and benefits of undergoing anesthesia and I think felt a lot better waking up.

DR. REILLY:

And that's the verbal anesthesia, right? You can't always find that in a syringe, but it's so important to what we do every day, helping make patients comfortable, letting them know what they're getting into. And one thing, I think even from day one of bootcamp that Dr. Soto always tells everyone is he wants you to work really hard while you're at work, but then he wants you to go home and have your personal time and have your family time and do things you enjoy. And he really harps on the work life balance, and I think that's very hard to do. It's hard not to have a complication and go home and think about it. But I think as I've progressed through our residency, it's gotten a little bit easier because of the things that you guys mentioned. You know, when we know we give a

good pre-op and we know that we go through the risks and the benefits of something with a patient, when we communicate with the patient really well and they have a full understanding of what could happen then if something does happen, you know, it's a little easier to process and trying to compartmentalize that and realize that this is a job and we are acting in the patient's best interest. We're doing everything we can. We're following the latest guidelines. We are talking with our peers. We're trying to be as safe as possible. And if something still happens, things happen. And, you know, you need to own up to it, admit it. As long as you communicate with the patient and the whole team and you did everything you could, you know, there's there's nothing more you can do. And I think trying to go home and trying to leave those emotions at work is really hard, but an important aspect of the job.

DR. MARKATOS:

We have a very supportive environment here where we walk into the resident lounge and there's always a friendly face who will talk things over with you. I think also, I mean, we've talked about it a bunch, but just how Dr. Soto supports our program. And then Dr. Esbahia assistant program director as well. Recently I was in a case where a supervising the the younger resident and the surgeon told us, I don't think the patient's going to make it off the table. And I know Dr. Soto and Dr. Esbahi always like to know that. And so I notified them and sure enough it was patient, didn't make it off the table. And so they knew that that was that younger resident's first death. And so they called her, made sure she was okay to come in to work tomorrow, which is it's just so refreshing to have attendings and program directors and assistant program directors who know that that could weigh heavily on us and could affect us into the next day. And they give us the time to reset and come back fully recharged and ready to take care of the next patient.

DR. REILLY:

Those are all great points. I think it's been a really awesome conversation. I appreciate all of you joining me. Like I said, I know it's tough to get out of the ORs. To our listeners. We'll be back next month. We're going to share our thoughts about patient safety. So please join us again for more Residents in a Room, the Podcast for Residents by residents.

(SOUNDBITE OF MUSIC)

VOICE OVER:

American Society of **Anesthesiologists**[®]

Stay ahead of the latest practice and quality advice with assay anesthesia standards and guidelines freely available to keep you up to date. Browse now at asahq.org/standards-and-guidelines.

Join us for residents in a room where we'll share timely info, advice and resources designed to help residents succeed in residency and beyond. Find us wherever you get your podcasts or visit asahq.org/podcasts for more.