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.

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As residents, I feel like we really don't get exposure to anything but academic medicine.

I honestly don't know what my next couple of years after fellowship would be like if it's a private practice or academic.

I think I still have a lot to learn about the differences between those two.

It's just nice to hear that there's differences and we have all different kind of options.

DR. ELIZABETH HALL:

Welcome to Residents in a Room, the podcast for residents by residents. I'm your host, Dr. Beth Hall. I'm CA3 at the University of Chicago, and I'm here today with some fellow residents. And together we're going to ask an attending about transitioning from being a resident to working as an attending. This month we're talking to Dr. Jihye Ha, who is an assistant professor of anesthesia and critical care medicine here at University of Chicago, where we're recording this conversation. Unfortunately, Dr. Ha joining us via Zoom because she has Covid. And next month, we'll share our conversation with the private practice attending. But first, let's meet my fellow residents.

DR. NIKHIL NADLER:

Hi, my name is Nikhil Nadler. I'm a CA3 at Loyola University Medical Center.
DR. SEAN POWERS:

Hi, I'm Sean Powers. I'm also CA3 at Loyola University Medical Center.

DR. SHYAM DESAI:

Hi, I'm Shyam Desai. I'm CA3 PGY4 at Rush.

DR. HALL:

And Dr. Ha, can you also introduce yourself and tell our listeners about your role?

DR. JIHYE HA:

Yes, of course. And thank you for having me. First of all, I do apologize for not being able to do this in person. I started having some symptoms a couple of days ago and tested positive for Covid just yesterday. So I may sound a bit congested. As you already mentioned, I'm an assistant professor of anesthesia and critical care at the University of Chicago, and I work here as a general anesthesiologist. I did nearly all of my medical training at the University of Chicago from medical school through residency, and obviously stayed on as faculty. I am also the director of the Ambulatory Operating Rooms and also the Associate Chair for Clinical Affairs in our department. You will often find me in the ORs as the coordinator in the main hospital as well as the ambulatory surgery center.

DR. HALL:

Great. Thank you. So Dr. Ha just starting off one of the questions that I'd like to ask is how does the day in the life of an attending differ from that of a resident? And what changes should we expect when we transition out of residency?

DR. HA:

As you might expect, life as an attending may vary quite a bit depending on the type of practice you join after residency. But since we're discussing academic medicine today, I'll focus obviously on that. One of the biggest changes you might encounter is taking care of multiple patients at the same time. As a resident in the operating room setting, your main focus was often on one patient at a time. However, as an attending, you may be responsible for the care of up to four patients at the same time, especially in the care team model. It becomes even more important to communicate well with other members...
of your team, and you might need to gauge the level of training for residents and CRNAs with whom you work and tailor your level of involvement based on these individuals. At the same time, you might be expected to be prepping patients in the pre-op area as well as discharging and evaluating them in the PACU. So I often find that I'm busier as an attending sometimes than I was as a trainee. In our institution as well as others, you might still have opportunities to do cases solo. And of course in these situations it might be a little bit more similar to what you may have experienced as a resident.

DR. NADLER:

So when you said you're taking care of four rooms at once and you're going from a resident, where you're being supervised to supervising others, what have you learned from that or and how that transition occurs and what can you share about that with us?

DR. HA:

I will say that depending on your training institution and the role that senior residents often play during calls, you may have already started to develop a sense of what it's like supervising others. At our institution, we expect the senior residents to act like junior attendings assisting with all starting cases in the afternoon, developing plans with other trainees, pushing drugs for induction, being present for emergence and being involved with floor intubation. As a brand new attending, it definitely takes time to develop what your style of supervision might be like. Generally speaking, it seems like more junior attendings are more likely to be involved and hands on at first, and over time you become a little bit more relaxed as you become more comfortable in terms of supervising others. And then of course, after working with certain residents and CRNAs over time, you begin to appreciate how much supervision is needed as well as how much supervision they want. Of course you want to respect the wishes of those you are supervising, but think the most important thing is making sure that you're comfortable with implementing what you think is best for patient care.

DR. POWERS:

Do you feel like your supervisory role has affected your your own skills in any way, in any negative aspect?

DR. HA:

Great question. I think at first it definitely may seem that in a supervisory role you may have less opportunities to perform procedures yourself. However, what I've experienced
is that supervising others might actually improve my own skills because it enables me to see how others do certain things, first of all. And if troubleshooting is necessary, I have the chance to intervene. I know that some attendings try to keep up their skills by taking opportunities every now and then to practice certain things like intubations and placing IVs, especially when working with non-trainees.

DR. HALL:

Dr. Ha, why did you end up choosing academic practice and how do you think that it differs from private practice?

DR. HA:

As I mentioned earlier, I am a general anesthesiologist. I chose not to pursue a fellowship and during the time that I was graduating, it actually seemed like most of the providers in academic practices were fellowship trained. So based on this, I initially was set out on looking for only private practice jobs. However, I realized how little I knew about the private practice setting and what to look for when choosing a job. Long story short, I did end up staying in academic medicine because it ended up being the easier transition for me, especially staying at the institution where I trained. I wanted to continue practicing in a setting where I could be challenged and have all the necessary resources to provide the best care. I wasn't sure what my long term goals would be and if I would stay here long term, but here I am.

A few things that I did want to point out is that there are obviously many things that differ in academics compared to private practice -- working with trainees, the level of resources, billing for anesthesia care and how you're compensated, patient complexity, scholarly activity or advancement and the ability to have non-clinical days for academic work are some of those differences. However, I think it's also important to point out that there are certain hybrid type of jobs out there where you still might be affiliated with an academic institution, thus have the opportunity to work with trainees. And of course there are private practitioners who are motivated and still do a lot of academic work. Some private practices might be MD only type where you basically do solo cases, while others you may work with CRNAs in a care team model or it could be a hybrid of both.

DR. NADLER:

So given that you did your training at University of Chicago, any surprises that came from the transition from resident to attending?

DR. HA:
Yes, there's definitely a few things I didn't really anticipate coming out of residency. First of all, I would say the scope of academic work is very broad and it's very important to find an area of focus earlier on to be able to start having promotable work. Second, similar to residency, you get out of it what you put into it. Although there are mentorship opportunities and general guidelines for promotion, you are mostly on your own. And then third, I would say that opportunities that you never anticipated may come your way. For me, it was becoming the director of our ambulatory surgery center and then later also becoming the associate chair for clinical affairs. I never imagined I would be part of the administrative or operational side of medicine.

DR. DESAI:

So do you feel pressured by the academic ranks? Like when you first start off, you start off usually as an instructor or a clinical instructor, and then you get promoted to being an associate professor or assistant professor, professor. So just kind of feeling pressured to kind of work your way up that ladder.

DR. HA:

I'll be completely honest. Yes, I definitely do feel the pressure. And this is an area that also might differ among different academic institutions. For example, one institution may expect faculty to strive to continue on the path of promotion, from assistant professor to associate professor to full professor within a certain period of time. Whereas other places you may remain an assistant professor indefinitely. So this is obviously something that you may want to consider when looking for an academic position as well.

DR. POWERS:

If you could go back in time and give resident Dr. Ha one piece of advice, what would that be?

DR. HA:

I definitely have a lot of advice that I would have told myself, but one thing I would say is always seek advice from as many people as possible during your training regarding various aspects. Anything from deciding on a fellowship, looking for a job, you obviously will get different opinions from different faculty, but you will most often learn about things you might not have previously considered. Furthermore, you can gain a better
understanding of what to look for in a specific job and the types of questions to ask when interviewing.

For me personally, I kind of went into the interview process without as much information in the background. And so along the way I started to learn what type of things to ask for. But it would have been definitely helpful to know in advance. One other advice I would say also is to involve yourself in as many opportunities for presentations, research and attend a variety of anesthesia meetings throughout your training, because it can definitely be a little bit more challenging as you become more self specialized.

DR. DESAI:

So when it comes to academic practice, how important is a fellowship and do you think that that's kind of changing with the current atmosphere? And are there any disadvantages to not having a fellowship if you want to pursue academic medicine?

DR. HA:

The importance of fellowship is definitely really dependent on what you want to practice. Academic institutions may actively try to recruit fellowship trained providers in certain areas, depending on the staffing needs at the time. Currently, however, there is a relative shortage of anesthesia providers in general. So many places are obviously actively seeking general anesthesiologists. I would say one disadvantage of not being fellowship trained is that in academic medicine you may rarely have the opportunity to take care of pediatric patients, practice OB anesthesia or perform cardiac cases after training. If it is important for you to keep up your skills in these specialty areas, you may be better off in private practice. Or if there's one specific subspecialty, you never want to not be able to practice again of course, that one might be something that you want to consider for further fellowship training. At least in the past eight years or so, and with the recent changes in the job market, I do feel that there are relatively more residents not pursuing fellowships and going straight into practice or considering going back later for further training after they've had a couple of years as a generalist.

DR. HALL:

Dr. Ha, in private practice, I think we all kind of have this understanding that you quote, Eat what you kill. But in academic medicine, things are a little different. And what do you think we should know about billing in academic medicine?

DR. HA:
Yeah, that's a very interesting question that I feel a lot of us might not think about, especially if you already know you're going to be going into academic medicine. But most of the time in academic medicine, when we are practicing in the OR setting, we don't really need to consider most aspects of billing except making sure that certain things are documented in order for us to actually submit the charges for reimbursement. From this aspect, it is definitely an advantage compared to what it might be in private practice. We don't have to worry about the number of cases, the complexity of cases, patient insurance or any downtime in between billable hours. However, I do have a friend who does practice in a private setting and he is also salary based and similarly don't have to take these aspects into consideration as well. But it seems like in most private practices it seems your compensation is based on your billable hours. Even in academics, paying physicians I would say, are a little bit different in the sense that they probably a little bit more involved with billing because procedures are reimbursed based on RVUs, but depending on the institution, RVUs may or may not play a role in your total income.

DR. NADLER:

So in differences between academics and private practice, again, resources and personnel and equipment are very different. Can you talk to us about the types of resources that you have in academic medicine that you might not have in private practice? And along with that, balancing the cost and being cost efficient with those resources.

DR. HA:

In general, I think it's safe to say that in academic settings we are likely to have a bigger buffer in terms of resources in both personnel and equipment. So for example, in our institution, we have an ultrasound in every operating room and a large number of advanced airway equipment such as video laryngoscopes and fiber optic scopes. If you need an extra pair of hands for a more difficult case or procedure, you will likely have no problem finding additional help. Of course, I didn't personally work in a private setting, but I know that during my interview process it wasn't infrequent for me to find out that they might only have one ultrasound machine that's shared among, you know, ten providers or one fiberoptic scope. So that can be quite drastic. Of course, we want to be good stewards of our resources and not be wasteful either as you mentioned. Although I generally don't have the best grasp of the cost of various things that we have, we generally have a, you know, a general idea. And so it definitely is a balancing act. You know, we have to balance the cost with the educational aspect of trying to provide training and various techniques and using different types of drugs. But even simple
things that we can implement to reduce waste would be, for example, like not opening certain types of equipment until we know it's absolutely necessary.

DR. POWERS:

So you've talked a lot about your thoughts about academic medicine and how your day typically runs. What do you see if you could compile a list of the top pros and top cons of academic medicine, what would be in that list?

DR. HA:

As you mentioned, you know, I did definitely already point out some things already, but kind of a general summary of the pros of being an academic medicine, of course, our opportunity to teach and work with trainees, the academic opportunities that exist within the institution, and the abundance of resources, and then also the ability to focus on care and less concern about costs or billing. On the other hand, there are some cons to academic medicine as well, and as I also previously mentioned, the inability to practice certain subspecialties without fellowship training. And at times it also feels like it might be more difficult sometimes to separate out your work and personal life. For example, it might be harder to leave work at work and, you know, not do work related things when you come home because of course you might have to pre-op with residents, prepare a lecture, work on papers and other academically related things.

DR. DESAI:

What kind of leadership opportunities do you see exist inside of academic medicine and how accessible are they?

DR. HA:

There are definitely a variety of leadership opportunities that I did not previously realize myself as a resident. There are roles for section leaders, not just in fellowships subspecialties, but also in other areas like NORA or non based anesthesia and off site as well as airway ENT. Within operations we have medical directors in each of the different operating room locations. And then of course within education we have residency and fellowship program directors, associate and assistant program directors. And then also within faculty affairs, we have various roles such as chairs and associate chairs, just to name a few. Since becoming an attending myself, all of these opportunities have actually become available at one time or another. And I would say yes, they are quite easily, not easily accessible, but they are definitely accessible. I personally did not have any prior training or experience in operations or administration,
but currently have the roles that I do and have received tremendous support along the way.

DR. HALL:

Yeah, I guess, Dr. Ha, I'm wondering, do you even have a typical day given that, you know, the the wide variety of roles that you play in academic medicine? And I'm sure we could say the same thing for private practice, but I'm just wondering in general if it's possible, can you summarize what your day is like?

DR. HA:

Yeah. So as you, Beth, may have seen, oftentimes when I am clinical, I am usually coordinating the main hours ORs the dcam. So, you know, my role is probably a little bit different from some of my colleagues. But as the role of being the coordinator, oftentimes I have one operating room that I am paired with a nurse anesthetist and in addition to, of course, taking care of the patients that are assigned to that operating room, working in collaboration with the OR nursing to move cases around if necessary. You know, putting cases on from the add on board to to certain rooms as they come out, moving personnel around. And at the same time, I'm also responsible for making the assignments for the next day. So that can take up quite a bit of time.

The days rarely where I am not coordinating, obviously, you know, I oftentimes most of the faculty within our institution are supervising, you know, 1 to 2 rooms, whether it's, you know, two residents or one resident and a CRNA or two CRNAs. But I think that's a little bit more straightforward in terms of how that day goes. From your experience, even as a resident.

DR. POWERS:

With being at a large academic institution, did case complexity play any role in your decision to stay in academic medicine?

DR. HA:

Yeah, definitely. And I did briefly allude to that earlier. Coming straight out of residency. I definitely wanted to maintain my level of comfort in doing more complicated cases. And so that definitely was one of the major reasons I decided to stay in academic medicine just to continue having that keeping up with those skill sets, I guess you can say.
DR. DESAI:

And kind of piggybacking off of that, as health care advances and we have more and more treatment options, patients are becoming more complex. What are you doing to kind of stay up to date on new technologies, new diagnoses, new surgeries, new anesthetic techniques? And how do you kind of do that on a daily basis?

DR. HA:

I actually might say that being in an academic setting is an advantage from that perspective. So, for example, you know, of course, as a practicing provider, you're expected to keep up with your education, as you mentioned, and you, you know, need a certain amount of CMEs and everything like that to maintain your anesthesia accreditation, as you can say. But in most academic settings and especially in ours, we have weekly educational grand rounds that we can learn about some of these new things. And of course, there's an abundance of colleagues who subspecialize in areas where they could more focus on certain advances in a specific section, and then they can then share that information with the rest of the department. But outside of that, obviously, as in private practice, you need to also play a major role in keeping up with literature and subscribing to, you know, anesthesia updates and being involved in nationwide anesthesia groups and things like that.

DR. NADLER:

Pretend you're a right now a CA3 who's about to embark on finding their next job and they've decided on academic medicine. What are things that you think they should know before they accept a job or things that they might should ask during the interview process?

DR. HA:

Personally, I didn't really interview with other academic places, but from what I can think of, you know, you obviously have to know how much administrative or non-clinical time that you may be provided to be able to pursue your academic objectives. So, you know, how much non-clinical time do they provide? How does that affect your compensation? How much mentorship opportunities is there? Is there a structured way of achieving the path to promotion? Those are all things that you probably want to know when looking at different academic institutions.

All right. So enough about me. Obviously did a lot of talking here. So I would like to flip the table a little bit and take this opportunity to ask you guys questions as well. So first
of all, I don't personally know a few of you, so I'm just curious to know, since you guys are all CA3s, you probably might have an idea of whether or not you're pursuing fellowship. And also on top of that, whether you're thinking of private practice or academics. If you guys could take a chance to talk about that.

DR. HALL:

Oh, sure, I'll start. So I am pursuing a fellowship. I'm doing cardiac anesthesiology. And I think for a lot of the reasons that you talked about, Dr. Ha, I'm really interested in staying in academic medicine. But it's also interesting as residents, I feel like we really don't get exposure to anything but academic medicine. I want to stay open minded but that I think I will end in academic medicine.

DR. NADLER:

For me, I'm pursuing a pain medicine fellowship and after that I honestly don't know what my next couple of years after fellowship would be like, if it's a private practice or academic. But I know ultimately at the end of a couple of years of whatever I decide, I eventually want to have a solo private practice.

DR. POWERS:

I am also pursuing a fellowship in pain medicine. As of right now, I am not totally clear on if I want to do academic or private practice pain management. I think I still have a lot to learn about the differences between those two.

DR. DESAI:

I'm also pursuing a pain medicine fellowship. I think the first couple years out of fellowship, I definitely want to be able to kind of do a mixture of pain and also some anesthesia. And just based on what I know so far, I think that it's a little bit easier to kind of finagle a position like that at an academic institution. But I'm also pretty open minded, I think as years go on, I do want to just transition to solely pain medicine. So potentially down the road, just private practice, but I'm not 100% sure on that yet.

DR. HA:

I didn't realize that the majority of you guys would be going into pain medicine, so obviously this podcast didn't really talk at all at all about pain medicine, but I did have a little, little blurb about it. But sorry I wasn't able to talk more about that. I guess overall, based on the topics that we did discuss, was there anything that surprised you guys?
DR. HALL:

I think it's always interesting to hear about the promotion pathway for attendings in academia because I think it's something that is not very resident facing. So I don't I don't know what it's like to go from assistant professor to professor and the requirements and to fulfill that in a certain period of time, potentially. And like you alluded to, Dr. Ha, how much non-clinical time you get to achieve those goals. So that's all new information for me that I'm going to need moving forward and thinking about different opportunities and what's best for me. So thank you for bringing that up.

DR. NADLER:

I was actually going to say the same thing. I honestly, at our institution, I don't really know what the big difference between an associate or assistant professor is. I know a full professor is obviously the highest, but the promotion aspect is just something I was unclear about kind of walking in here.

DR. POWERS:

Yeah, I think one of the things that, you know, is not surprising, but is always. you know something I think about when especially when it's brought up, that your job as an academic attending can look a lot, your day can look a lot different than what it was maybe just a month ago when you were a resident, let's say, and how much know your day can change just in that one month. You know, going from a resident to, say, an academic attending.

DR. DESAI:

Yeah, I kind of echo everything that they've said. It's just nice to hear that there's differences and we have all different kind of options to to kind of pursue what our interests are and not kind of be pigeonholed even after residency or fellowship.

DR. HALL:

Thank you, Dr. Ha. And thank you all for joining us for Residents in a Room, the podcast for residents by residents. We've enjoyed the conversation and hope you have to. Join us next month for more.

(SOUNDBITE OF MUSIC)
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