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Residents In a Room
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VOICE OVER:

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

We need good intensivists and we need more of them, really.

It just lit the fire again and made me re-experience my why.

My main obstacle really was narrowing down which subspecialty that I wanted to do.

DR. JOSHUA YOUNGER: (HOST)

Hi and welcome to Residents in a Room, the podcast for residents by residents. I'm Dr. Joshua Younger. I'm an OB anesthesiologist practicing outside of Henry Ford Hospital in Detroit. I'm actually dually trained as an obstetrician and, and anesthesiologist as well as subspecialty trained in OB anesthesia. Having trained in obstetrics and gynecology prior to anesthesia, I can tell you, I know what it is to struggle with the decisions of how and what you want your practice to look like and the decision to actually plan to go into a subspecialty even further.

So let's start at the beginning. What are the common and popular subspecialties in your field?

DR. JESSICA YEH:

So I'm Jessica Yeh, I'm a CA2 at the University of Arkansas for Medical Sciences in Little Rock. I have chosen pediatric anesthesia as my subspecialty. So I'm in the process of, I've applied already, and I'm in the process of interviewing right now. I would say, at least at my hospital, chronic pain has been the overarching popular subspecialty for a couple of years now. But for my year, actually, it's a little bit varied. There's three of us going into peds, a couple going into pain, a couple going into OB and one going into

critical care. So I think there is quite a lot of variety currently in our year, which is quite nice.

DR. YOUNGER:

That's fascinating. How about, how about the rest of you, Sam? Have you chosen a subspecialty?

DR. SAM COHEN:

Yeah, I'm Sam Cohen. I'm calling in from University of Texas, Southwestern Dallas. I'm going into both critical care and cardiothoracic anesthesia fellowships next year. And I would agree there's a wide variety within my class of 18 to 20 people, I think about a third of which are going into private practice and the rest are pretty equally distributed between pain and OB. I'm the only one doing critical care and there's a couple of cardiacs thrown in, so, but it's been ranging, the CA2 class, as a matter of fact, is heavily leaning towards chronic pain and cardiac, which is a, kind of a strange mix for them. But I think across the years, at least at Southwestern, there's been a nice variety of people going into various specialties.

DR. YOUNGER:

You know, that's fantastic. So you're doing two, subspecialties is what I'm catching.

DR. COHEN:

Yes.

DR. YOUNGER:

OK, Jim, how about you? What are you up to?

DR. JIM DIERKES:

Yes, so my name is Jim Dierkes. I am a CA3 resident at Duke in North Carolina, and I will be doing a cardiothoracic fellowship at Duke next year.

DR. YOUNGER:

And Jordan, how about you?

DR. JORDAN PHILLIPS:

My name is Jordan Phillips. I'm a CA2 at the University of Oklahoma Health Sciences Center, and I'm plan on doing anesthesia critical care fellowship.

And I would kind of echo what some of the other residents have said. Historically at my program, there's been probably a majority of chronic pain as far as fellowships that were selected. But this past year, this graduating class has a pretty nice mix. There's two people going into OB anesthesia, there's one going into peds, three going into chronic pain and one going into regional anesthesia and acute pain.

DR. YOUNGER:

I got to tell you guys, there's a little bit of joy going on for me, hearing all the OB anesthesia and all the varied institutions, it's something that's near and dear to me. So to hear that you guys are sending people off from the very different places, that's something that's nice to hear.

So but the focus on you guys, when and why did you decide to do a subspecialty? It sounds like even two of them.

DR. COHEN:

Yeah. So that's a good question. I think choosing anesthesia was the biggest success story for me. I thought I was going to do surgery and that, I thought, was my final decision. I didn't think I'd have to choose anything else. And then I think progressively as rotations went by, I found that the anesthesiologists I looked up to were consulting other anesthesiologists and those were the cardiothoracic guys and the intensivists. And I realized that the days that I was happiest were working in the unit and being in the cardiac room. And I realized that the things that excited me, even if it was two and three and four in the morning, were those days in the unit or in the cardiac room. And so I think I decided end of CA2 year that I was there for doing cardiac, critical care was floating around. And then after talking to a lot of my mentors and other folks that have done, do a fellowship, I decided that that was the plan for me.

DR. YOUNGER:

And Jessica, you are applying, is that correct?

DR. YEH:

Yeah.

DR. YOUNGER:

So it's, it's still very early on. So when and why did you decide to do a subspecialty?

DR. YEH:

So hearing Sam's story is actually kind of funny and resonates a little bit with me, but I went sort of in a different direction. I initially, in medical school of thought I maybe wanted to do surgery and was interested in that and then actually found I enjoyed critical care a little bit more. And then that led me to anesthesia. So coming into anesthesia, I was fairly set on critical care actually as a subspecialty, but then going through anesthesia and then working through all the different fields, I found that I didn't enjoy critical care as much as I thought I did and I missed being in the, in the OR. And so I sort of narrowed it down a little bit more and talked to some upper levels and fellows who did pediatric training. And that resonated with me a little bit. And so once I actually rotated through a few months ago, I decided, yep, this is actually where I want to be.

DR. YOUNGER:

Awesome. You know, it's funny because there are so many different access points to critical care in the medical field. And it's almost by, by luck that you chose anesthesia. Now you're actually segueing into the area that you've even, found even more interest. So.

DR. YEH:

Right, exactly.

DR. YOUNGER:

That's awesome. Jim, how about you? You said you're applying for cardiothoracic or you're doing cardiothoracic?

DR. DIERKES:

I'm doing cardiothoracic. When I initially went into anesthesia, I knew I wanted to subspecialize, because I feel like the value of specialization was really worth it. It's really only one extra year of training. I mean, we've spent so much time getting to the point where we are. I do want to be done, but I felt one extra year was totally worth it. And I feel like as advanced practitioners become more involved and have increased

responsibility in different parts of medicine, I think that specialization for physicians, even, particularly anesthesiologists, is really important. I mean, I thought that subspecialty was going to be pain medicine when I went into anesthesia and it came kind of full circle to me, loving the OR too much to leave. So now I'll be doing cardiothoracic.

DR. YOUNGER:

Yeah, it sounds like you're going all in.

DR. DIERKES:

Yeah.

DR. YOUNGER:

Jordan, how about you? When and why did you decide to do a subspecialty?

DR. PHILLIPS:

Yeah, I was kind of the, the opposite of Jim. I, I kind of knew I always wanted to do anesthesia whenever I was a medical student, but I, I didn't really have any interest in doing any subspecialties or fellowships. But our, our intern year at my institution is very heavily leaning in critical care. And we spend multiple months as the House Officer at this private hospital that doesn't have a lot of residents. And so we've got a lot of experience doing a lot of code running and, and emergency airways, and line placements. And I kind of just got a bug for the acuity of it all. I liked managing complex sick patients and I wasn't expecting that when I came into anesthesia residency that I would want to do a subspecialty. But once I started doing some ICU rotations, that kind, I was just, I was loving all of it. So I kind of knew pretty early on at the end of my intern year that that's what I wanted to do.

DR. YOUNGER:

And I'm sure this year is actually probably giving you more than your fair share of ICU experience. I know, I know it has for us in our institution.

DR. PHILLIPS:

Yeah, without a doubt. I mean, this year has shown us that we need good intensivists and we need more of them, really.

DR. YOUNGER:

One hundred percent. So, Jordan, how much exposure were you given to the other subspecialties prior to make your decision?

DR. PHILLIPS:

I made my decision relatively early, honestly, even before, before I even did hardly any of the other specialties. And I, I wouldn't say the decision was final because I hadn't started the application process for critical care. At least this year, the application process started in November of my CA2 year, so I really have just applied. I'm in the process of interviewing. But whenever I had decided, I hadn't yet rotated through my pediatrics rotation, I hadn't yet done OB, I had done cardiac, so I hadn't really gotten a lot of experience. And when I did some of those other subspecialties, I found interest in a lot of them. I honestly considered doing peds, I really enjoyed my OB, I also enjoyed my cardiac rotation. But in the end it was the ICU that I loved the most. And so when the time came, that's what I ended up applying for.

DR. YOUNGER:

So did you feel that you had had enough exposure to make a good and honest decision for yourself?

DR. PHILLIPS:

I would say, at least that my program historically, we used to do our cardiac rotation in our CA2 year, and a lot of residents didn't like that because it was hard for them to decide if that was going to be the specialty that they were going to do if they hadn't done the rotation. And so we recently made a switch to half of our CA1's. If they express interest, can do cardiac in their CA1 year, and that allows them to get that earlier exposure.

Me personally, I felt like I had good exposure to at least peds, OB and cardiac. I didn't get much exposure to some of the other subspecialties like regional anesthesia, but that was never really on my radar and neither was chronic pain.

DR. YOUNGER:

And it sounds like you're pretty confident with your choice.

DR. PHILLIPS:

I feel, I feel fairly confident, yes, I hope so, because I, I've been doing quite a few interviews.

DR. YOUNGER:

How, how about you, Jim? How much exposure were you given into the different specialties before you decided on your cardiac direction?

DR. DIERKES:

Yeah, so we started subspecialty training at the second half of CA1 year, which is nice. So you usually get at least two subspecialties. I mean, everyone will do obstetric, anesthesia and ICU during their CA1 year, but you'll get two additional ones at the end of the year. And then when we come back for CA2 year, you get to pick your first three months of whatever you want to do. So by that point, you've hopefully have finished any kind of subspecialty would be interested in. And that was really helpful for trying to narrow down which one I wanted to do.

DR. YOUNGER:

Jessica, how, how about you? Did you have a lot of exposure prior to making your decision?

DR. YEH:

I had a bit, but the sort of rotation scheduling that Jim had sounds a bit nicer than what we have sort of set up. In CA1 year, you really only get exposed to OB and critical care. And we, we did get a bit of exposure to regional. And so before the CA2 year starts, we have to put in requests of what subspecialties we want to try and do in the first half of the year.

So my top two picks were a peds and CV, so I managed to do those quite early on. And then know I wanted to do peds and start applying. I didn't make chronic pain a priority to rotate through. So that's, that is just at the end of this year. I sort of wish I had a little bit more time to think about it before applying. I'm confident in my decision of peds, but I'm also the type of person who likes scrolls through Netflix for like an hour before choosing a show. So it might just be me that needs more time.

DR. YOUNGER:

How about you Sam, how much exposure did you have, and are you confident that you made the right choice?

DR. COHEN:

I think my answer echoes pretty much everybody. I, again, cardiac is the earliest application and I felt pretty confident that's where I was going. But, you know, at the end of the day, obviously, you've done basically two careers now. Multiple people have had several different variations of career path, taking them to where they should be. So at the end of the day, I knew that, hey, if I made the wrong choice, I spent a ton of money and wasted two years, it wouldn't be wasted two years. It'd be something that I learned from and I'd end up where I needed to be, maybe it would take me a little more time. But I think right now I'm very confident and very excited for July. But if, at the end of the day that's not what I love, then I'll figure something else out.

DR. YOUNGER:

It think that's a great attitude. So let me ask you, what were the major factors that you weighed, Sam, when you were deciding to pursue the subspecialties that you are doing, and what resources did you use to help make that decision?

DR. COHEN:

Yeah, so the things I weighed, luckily or unluckily, I have no dependents and no significant other at the moment, so that wasn't a major factor for me. So I was free to move, free to commit to two years of, you know, glorified resident salary. That was obviously a factor with multiple of my friends going into private practice and making a very nice income right out of residency. That was something I battled with just a little bit. But as I mentioned before, my ultimate happiness was what drove me to these two subspecialties, knowing that at the end of the day, the things that made me happy were taking care of these patients, collaborating with different subspecialties and doing some really great cases. And, you know, when, when my friends are out doing their thing and we're slaving away for fellowship, there's always a light at the end of the tunnel. And the things that may not be, you know, the best will at the end of the day be the things we can fall back on that other people won't have the opportunity to do.

DR. YOUNGER:

Yeah. Jessica, how about you? When, when you were debating this, what were the things that you were weighing and what resources did you seek out or find that helped you make that decision?

DR. YEH:

I was really looking for a subspecialty that I knew I would be happy doing for the rest of my career in 20, 40 years, I'd still be happy with the challenge of peds anesthesia and with the variety of cases that I would have.

I really use like upper levels who apply to peds and some of the current peds fellows at the Children's Hospital during my rotation as resources to sort of pick their brain about what got them interested in peds initially and why they've been enjoying it so much.

DR. YOUNGER:

And, and correct me if I'm right. You mentioned that peds had not been so popular in the past. So did you find those people easily accessible?

DR. YEH:

Yeah. So it definitely was not as popular as chronic pain, but, so like, chronic pain each year would have like four or five people go into that field. But, peds, there is usually like one every year. And a couple of the peds fellows, the graduates from my residency program, went on to do a fellowship at the Arkansas Children's Hospital, where we rotate through and are still working there. So they were my main resources.

DR. YOUNGER:

How about you, Jim? What were the things that were weighing on you?

DR. DIERKES:

I would say I kind of went through the thought process of do I want to primarily stay in the operating room or do I want to have some practices outside of the operating room? And then when I realized I wanted to stay more in the operating room, I talked to people from pediatrics, from cardiothoracic, and really found that what, like, I loved about anesthesiology, which is like the critical thinking, complex management, procedural work, empathetic medical care, and all of that really aligns with CT anesthesia the best. I think like senior residents, current fellows and faculty are like all great resources to talk

to. But at the end of the day, it really is about like what Jessica said, what makes you happy and what you feel like you could do for your career.

DR. YOUNGER:

Yeah. How about you, Jordan?

DR. PHILLIPS:

Yeah, I would say that for me, some of the things that weighed with me making the decision were one, I, I liked the balance, I liked the balance of being in the OR some and also being in the ICU. I liked the aspect of managing critically ill patients in the perioperative period. So getting to see patients preoperatively and optimize them, the, I liked the ability to take care of them in the OR and then also transition them to the ICU and continue that level of care. And I also liked kind of the interactions with families that you get when you're taking care of their patients that are really sick.

As far as resources, unfortunately, at my institution, it's been pretty rare to have residents go into critical care. There was only one resident in, in the past 10 years, really, that's done it. And luckily I knew him because he was only a few years ahead of me. So he was a really good resource for me. I also had some faculty mentors that helped me a lot and kind of guided me in decisions and programs.

And then other resources, I would, I would really encourage residents to look to, is the ASA website, including the specialty websites like the Society of Critical Care Anesthesia has a great website with a lot of really good information about the specialty.

DR. YOUNGER:

Yeah, that's really, probably really important and nice to know. So let me ask you, what kind of obstacles, Jordan, did you encounter? It sounds like resources may have been one of them, at least mentoring of some sort.

DR. PHILLIPS:

Definitely.

DR. YOUNGER:

It's a huge, huge decision. I mean, so what motivated you and pushed you? And what are the things that maybe held you back or challenged you?

DR. PHILLIPS:

Yeah, I would say, I would say one of the biggest obstacles for me was just not having a lot, our department in general doesn't have a lot of intensivists that are anesthesia background. And we hadn't had a lot of residents. So I really had to kind of reach out and find the few resources that I had. And that was the biggest obstacle for me because there wasn't a lot of people that could kind of tell me about the process. So I had to do a lot of it on my own. As far as looking online and figuring out how the process works, the critical care anesthesia uses a San Francisco match, so they have a great website as well. So I was on there a lot trying to figure out timelines and things like that for applications.

DR. YOUNGER:

Yeah, I mean, it sounds like you really had to do a lot of finding, and it sounds like the ASA and, you know, the various websites that you stated, really probably helped you significantly.

DR. PHILLIPS:

Yeah, I would definitely say those are great resources and, and anyone that is considering a fellowship should, should use those.

DR. YOUNGER:

Jim, how about you? What were the obstacles that you encountered and the challenges that you felt were there and what motivated to push forward?

DR. DIERKES:

Yeah, I think selecting a subspecialty and a program to train in is a very large commitment and it's a whole extra year of not being an attending, and like what Sam said, not making attending money, particularly especially when your wife, like mine, is kind of like holding on to her career plans for when I'm going to be done and I have a kid at home and all that stuff kind of comes into my head when I'm deciding not to go right out and practice. But even after weighing all those options, the value of the fellowship, I really think will be worth it in the long run. And I think the skills that I get, will give me a leg up in and help out practices that I work in in the future. So I think it isn't an easy decision, but I think it's the right one.

DR. YOUNGER:

Jessica, how, how about you? What were those obstacles that you kind of encountered and what were the things that pushed you forward?

DR. YEH:

Well, my main obstacle really was narrowing down which subspecialty that I wanted to do. I enjoy a lot of aspects of anesthesia, I mean, I went into anesthesia because I felt it was, you know, you retain all of our knowledge, general knowledge of medicine and physiology, but also get that, that benefit of procedures. So just thinking that, am I just going to do peds forever and then I'll never treat an adult or do an OB epidural? Like that was quite difficult for me in sort of making my decision. But I mean, I'm very happy with the fact that I find the procedures in pediatric anesthesia very challenging and more challenging than adult anesthesia. And so that is what ultimately is satisfying for me. So that sort of motivated me and pushed me through.

DR. YOUNGER:

Sam, how about you? I mean, I guess you've chosen two, so I'm sure you probably did see your fair share and you probably had, had a lot of emotion and motivation to push you forward. So why don't you tell us a little bit about that?

DR. COHEN:

Yeah, I think I was fortunate to, I am fortunate to train in a place where there are a few dual trained attending physicians. And I've had friends that have done the dual programs at a variety of different places. So I was able to get guidance and, and advice from them. And additionally, Rishi Kumar, who's a really strong online presence, also, he always accepts questions. So I was able to ask him for advice about the application. One of the major hurdles for anyone applying dual, is finding a program with a good integration of both critical care and cardiothoracic programs and going through the web, going through all these programs websites, trying to find, you know, who offers what and how and contacting everybody to see if one hand is talking to the other hand, that I think was the biggest struggle I had in my application process.

And then secondary to that, actually filling out the SF Match Application and doing double work and double payments, sometimes when I didn't even have to. So kind of choreographing the application process for the dual fellowship is the most difficult part. Choosing a specialty, relatively easy, but actually getting everything done was probably the most challenging part.

DR. YOUNGER:

How were you able to tease out that right fit program?

DR. COHEN:

That's a, that's a good question. I'm sure some of my colleagues on this podcast dealt with in-person and then virtual interviews. So fortunately, with the in-person, I was able to face to face, get the vibe of the program, talk to the residents, talk to the fellows, talk to the different attendings and get a good feel.

The online stuff was just starting because COVID just happened and Zoom was a new thing and that was the hard part. And what I did to find my fit was go through, because at the end of the day, to be ACGME approved, you're going to do all the cases you have to. It's a matter of what the program will provide for you in terms of their education component, how you are stacked in your ratio between doing your own cases versus managing residents, and then how the program interacts with the fellows and, and how much support they give. So I was able to select the program I'm going to based on how the fellows felt the program took care of them, which for me is, it's a very important thing to know that the program has your back when you are working like a dog every day.

DR. YOUNGER:

Yeah, I'd say that is important. That's even important, I think, when you leave the walls of fellowship. Let me ask you, what and who, I mean, you mentioned that you had influencers. So what and who has most influenced your decision and what you think you'd be doing if those influences didn't exist?

DR. COHEN:

That's a stacked question. Well, my father is an anesthesiologist, but he never pushed me into anything. I thought I was going to be a session guitarist in Nashville up until my junior year in college.

DR. YOUNGER:

It's never too late.

DR. COHEN:

Yeah, well, that's true. A lot of my friends do it and I would not want their life. So thank God we have jobs right now. But, I, I, you know, I think being in the operating room every day, seeing the cardiothoracic guys do their thing, seeing the intensivists do their thing, it's so invigorating to me. And, you know, sometimes when you just, you're not feeling it, I'm about to graduate, something happens and that flame just gets ignited. This happened to me two days ago. I mean, just the most crazy stuff happening. And a dual trained guy I was working with, I mean, resuscitated this guy after induction, threw in a chest tube right in the operating room. And it, it just lit the fire again and made me re-experience my why. So everybody influenced me. But I think it's watching the dual guys fall back on all of their training and command the room, it's just awe inspiring to me. And I, I love every day of it.

DR. YOUNGER:

Awesome. Jessica, how about you? Who and what were your influencers and what would you be doing if they weren't there?

DR. YEH:

Well, since I kind of discovered peds a little bit late, I think I have to owe it all to everyone who was there at the Children's Hospital during my rotation. That really influenced me. The hospital recently hired a lot of recent graduated fellows, so there is, there is a ton of new attendings who are young and super enthusiastic to teach and very willing to, kind of share their experiences and tips when they went through fellowship. And one of my closest friends is a CA3 who just matched into peds for next year, and so she was one of my biggest resources actually, to kind of guide me through the application process. And so I think that me enjoying the actual work and the OR of peds anesthesia, as well as just the environment and all the people that I was surrounded by, just made peds the perfect fit for me.

DR. YOUNGER:

Jim, how about you?

DR. DIERKES:

Yeah, I would just echo what they said. I think senior residents, current fellows and faculty are really the best people to talk to. And they had a large influence on both my decision to go into cardiothoracic and my decision to stay at Duke. And I think the best advice I got, though, was really kind of what we mentioned before, to focus on yourself and try not to let other people influence you too much, because, just because you're

good at something doesn't mean that that's what you want to do for the rest of your life. So if someone tells you that you're really good at it, you should do it, just make sure you do a little self-reflection and find out that it's really what would make you happy and what you want to do.

DR. YOUNGER:

I think that's a great point. That's a great point. Jordan, how about you? You, you said that you were without, I guess, certain influences in your institution. So where did you find your influences and what would you be doing if they weren't there?

DR. PHILLIPS:

Yeah, I would say that some of the main things that impacted me to make the decision were, were just the, the experiences. So the actual patient care experiences, rotating through the units and just coming up with differential diagnosis, managing patients with different kinds of shock, like that's the kind of stuff that gave me the spark, kind of like what Sam was saying. My dad is also an anesthesiologist and he never really pushed me in, in one direction or the other. But I would say without some of those key mentors that I did have, although there weren't many of them, it would have been a lot harder for me. I think I still would have made the decision based on what brought me the most joy. But I think going through the processes without mentorship is challenging, regardless of what subspecialty choose.

DR. YOUNGER:

So, so a little bit of a controversial question, I think that's out there, and I'm going to throw out to all of you guys. Do you think anesthesia is too specialized?

DR. DIERKES:

I don't really think though, I think what's really great about our subspecialty training is that all of those fellowships, no matter what you do, can really make you a stronger general anesthesiologist as well, whether you're doing pediatric or cardiothoracic or obstetric or regional. I think they all make you a strong general anesthesiologist, even if you don't end up doing full time specialty work once you get out in your career.

I think that general anesthesiologists take care of sick patients in the operating room all the time as well, and they do a great job. They may disagree with me, but I think that fellowship trained anesthesiologists offer something else in general operating rooms as

well. So I think that there's, there's a lot of value for specialization, even in private practice.

DR. YOUNGER:

Is that something you guys all echo?

DR. COHEN:

I'll kind of piggyback on sorry, what Jim was saying. If, if you look at other specialties across medicine, internal medicine or even surgery, I feel like we're almost kind of behind a little bit on how subspecialized we are. I mean, if you look at the variety of different types of surgeons that are out there and the, the variety of different specialties there are within the field of medicine, I feel like we're only just catching up.

And when you consider the fact that something that we all have to consider in our field is that there's a significant amount of mid-level providership with CRNAs. And so I honestly predict the trend continues for anesthesiology residents to start specializing more and more and more residents will start going into, into fellowship in order to further differentiate ourselves and kind of keep our value intact with expertise.

DR. PHILLIPS:

I agree with, with both those comments and the only thing I would add, you know, with the subspecialties in internal medicine and surgery and the other specialties in between, these sick patients are living longer, having babies, having, you know, cardiothoracic surgery when, you know, 20, 30 years ago these children weren't surviving to become adults, to necessitate ICU stays or cardiothoracic surgery or have children. So being consultants in anesthesia and then being even more specialized to be the consultant for these patients that weren't around 20, 30 years ago, I think makes us relevant and very important as fellowship trained anesthesiologists.

DR. YOUNGER:

So, Sam and Jordan, you guys both mentioned that you have parents who are anesthesiologists. Are they specialized?

DR. DIERKES:

My dad is not specialized. If anything, I would say he's grandfathered in as like a regional specialist because he specifically works at with orthopedics and, and does regional on a daily basis, but he doesn't have a formal fellowship.

DR. YOUNGER:

Do you think that he would agree that specialization is necessary or is ideal for the field? Or do you think that the anesthesiologists of old had it right where everybody should be doing everything?

DR. DIERKES:

I would guess that he would be, and I haven't asked him specifically, but I would just guess that he would be of the mind that it was unnecessary, because in, in his opinion, like when he was training, he did all those things so he would feel comfortable doing taking care of kids, he would comfortable doing a basic cabbage. But there's, there's some things that, that I think we're experiencing now that makes our residency training a lot different than it was back when he did it. And, and it kind of echoes to what Sam was saying is that patients are getting a lot sicker. We're starting to do a lot more advanced therapies that weren't necessarily being done whenever he was training.

DR. YOUNGER:

Ok, well, thank you guys for participating. This is great. It was really nice to talk with you guys and thanks to the ASA for inviting me to host. And I'm Dr. Joshua Younger, and we'll be back next month. So, please join us again for the next episode of Residents in the Room, the podcast for residents by residents,

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