



CENTRAL LINE PODCAST SERIES
Episode 1 - Transcript
The Surgeon General
Recorded in October 2019

(SOUNDBITE OF MUSIC)

VOICE OVER:

Welcome to ASA's Central Line, the official podcast series of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. STRIKER, HOST:

Hi. I'm Dr. Adam Striker, the chair of the committee on communications for the American Society of Anesthesiologists and I'm here at the American Society of Anesthesiologists' annual meeting, Anesthesiology 2019 in Orlando. And today, I am joined by the United States Surgeon General, Dr. Jerome Adams.

DR. ADAMS:

I'm Vice Admiral Jerome Adams, the twentieth United States' Surgeon General. Dr. Striker, Adam, we go way back and it's just a pleasure to be here with you today and, uh, to talk about some of these issues that are affecting our profession.

DR. STRIKER:

Well it is certainly a pleasure and, uh, certainly a long way from our days together in Indiana. But, um, it's got to be quite a different feeling to take on the role you have.

DR. ADAMS:

Absolutely. It's, uh, it's different. But it really, uh, I think is a nod back to my advocacy roots that were, uh, developed, groomed here at the ASA meetings and so there are differences but there are many similarities too.

DR. STRIKER:

Well, obviously you've attended many anesthesiology meetings. How does it feel to attend this one in your new role?

DR. ADAMS:

That's a great question. You get to see old friends and that's a great part of the anesthesia meeting. And, uh, there is a degree of pride, um, being able to feel like you are, uh, a representative of the profession. I do take pride in the fact that I'm the first anesthesiologist Surgeon General. And that I'm having an opportunity to show the world what the practice of anesthesia entails and, uh, all that we can do to lift up health across the board. One of the things that, uh, folks often say is: An anesthesiologist? How'd that happen? Why? Are you comfortable in this role? And, when you think about the opioid epidemic, who better than an anesthesiologist to talk about acute and chronic pain management, and to talk about the dangers of fentanyl, and to talk about how naloxone works. And so, uh, again being here really is a validation of all the work that the ASA has done and that so many of those folks who came before me have done to promote our profession as patient advocates.

DR. STRIKER:

You said that it was a source of pride. I think I can speak for all anesthesiologists, as a specialty I think we take a source of pride in having you as the first physician anesthesiologist in this role. And I agree, I think, you know, we're a specialty that not a lot of people, they may hear about us, but they don't really know what we do on a daily basis. And I think it's really important to have, uh, you out there representing, obviously public health and being the nation's doctor, but our specialty in general. You mentioned a couple issues already that I know are near and dear to you and, um, I just want to give you the opportunity to maybe talk about one or two or however many issues you'd like about what is most important. What would you like to stress on to the public, to anesthesiologists in general?

DR. ADAMS:

Well, one of the things that I want to stress to folks is that health is so much more than just healthcare. And, uh, we need to understand that we can do the best anesthetic and have the best surgery administered to the patient possible, but that still doesn't change the fact that they're going home to an environment where they don't have complete streets, and can't exercise, and continue to become more and more obese. And, uh, even though you had that wildly successful knee surgery with multimodal analgesia and all the great things we're learning about here at the anesthesia meeting, you're not really ultimately changing the patient's outcomes. And so that's whether you're talking about opioids, whether you're talking about obesity, um, whether you're talking about cancer. There are so many ways an anesthesiologist can have an impact upstream and turn off the spigot of poor health, versus simply being a safety net to catch people when they fall further on down the road.

So, that's in a very broad sense. In a very specific sense, uh, we're focused like a laser beam on the opioid epidemic because it's the public health crisis of our time. We have a person dying of an opioid overdose every eleven minutes. And I put out an advisory last year calling on more people to carry naloxone. I think anesthesiologists, more of us need to walk the talk and be willing to carry naloxone with us when we're out, both so we can respond, but also so that, uh, so that we can lead a conversation about what naloxone is and destigmatize it. I also put out a Surgeon General's digital postcard listing five steps that every American can take to respond to the opioid epidemic. And they include things like safe storage and disposal of your opioids. They include things like discussing multimodal analgesia with your patients and helping them understand that, uh, there are alternatives to opioids that are as good as, and in most cases better than, opioids. I think as a profession we've embraced multimodal analgesia more than, uh, than in the past. But I still don't think we do a good job educating the patient, explaining to the patient why it's a better option, a safer option, a more effective option for them. So opioid epidemic is a big topic. One other topic I'm very concerned about and leaning into involves the rapid normalization of marijuana usage in our country. And a lot of that's been done, uh, in the name of the medicinal benefits of marijuana. But the fact it there's a lot that we don't know, more that we don't know than what we do know about the potential downsides of marijuana from a public health point of view. We've seen motor vehicle accidents go up. We've seen ER admissions go up for overdoses and accidental ingestions. We've seen, uh, more people having psychotic episodes because of this new, more potent marijuana. And I think it's important as anesthesiologists, who are truly clinical pharmacologists, we talk about that fact that there's no other medicine out there—and I'm doing my air quotes here—that we tell people to grow in their backyard, and roll up into a joint and smoke, or to bake into a brownie and consume. And that that's an accepted, legitimate, prescription from a, uh, from a healthcare provider.

I also think it's important—and this is an area that I'm really focused on in regards to marijuana—that we loudly say, no pregnant woman, no young person should expose their developing brain to this new, highly potent marijuana. Marijuana was 4% THC content on average in 1995. It's now 20-25% THC in most dispensaries, and that's before you look at these concentrated forms and edibles. Or in oils that can be vaped you can get up to 80, 85% TCH delivery. It is a fundamentally different product, or as I say to folks, this ain't your mama's marijuana. And, uh, we need to help more folks understand the dangers, uh, that can come with rapid legalization, normalization of this product.

Twenty years ago, when you and I were residents, they told us that there was a medication, and this medication was safe, it was effective for a variety of illnesses, there was no upper dose limit to it, it was not addictive. And, uh, they even told us you were a bad doctor if you didn't prescribe this medication. That category was

opioids. And we're not trying to clean up the mess that we that created over the last twenty years. It just astonishes me that you hear that same rhetoric being used to describe and promote marijuana usage across our country. And I worry that twenty years from now, we're going to be looking back and saying how could we have done that? And trying to clean up a similar mess.

DR. STRIKER:

Why do you think that is? Why do you think, um, there is that push now for just marijuana use in general?

DR. ADAMS:

Well, I think what folks need to understand is that this is a multibillion dollar industry already in the United States. And a lot of this is being driven by folks who seek to profit at the expense of the public health of our communities. And again, what's interesting is you're now seeing opioid lawsuits based on folks who sought to profit off of the medicalization of something that had dangerous, uh, downstream affects. And so, seeing it play out all over again.

But that said, they're doing it under the guise of a number of different issues. And speaking as an anesthesiologist the one I'm most concerned about is this idea that marijuana in a plant form is a magical, cure all medication that is appropriate for everyone and has absolutely no danger whatsoever.

I think, I also am worried about the fact that the practice of medicine is being taken away from us. Instead of doctors and scientists determining the best way to utilize the components of marijuana to treat different maladies, you now have legislatures who are blanketly saying, here are the twenty things that, from now on, will be determined as an appropriate medical usage of this plant.

And so we need anesthesiologists to speak up and be advocates, uh, because, uh, again, uh, we've seen this play before.

DR. STRIKER:

It's, um, I think it's a great point in comparing it to the opioid epidemic because it's such a stark reminder, and a prescient one, that medical knowledge continues to evolve and why it's so important, I think, to have physicians involved in the medical care of their patients and also public health policy. I'm glad that you, uh, you made that comparison because I think too often we, you know, we see what's in front of us at the time and don't appreciate some of the even recent historical, um, comparisons.

DR. ADAMS:

And I want to give a shout out to the ASA here because the house of delegates has trained many of our future leaders to go out there and be advocates in their communities. FAER has trained a number of people to go out there and given them the opportunity to become researchers. And we need more research. We need better research. We need it to inform policy. And we need that policy to reflect the best available science.

DR. STRIKER:

Absolutely.

Speaking of getting residents involved, or younger physicians involved, maybe circle back a little because I think you have an interesting story on how you got to this position. And I think a lot of people would be interested to kind of just hear a brief account of how you got here.

DR. ADAMS:

Absolutely. There are many different pathways to leadership roles. My pathway heavily involved organized medicine. I actually got involved with the American Medical Association as a medical student and, uh, got the advocacy bug. And then once I got into my anesthesia residency, I was selected as the resident component from my state, the representative to the ASA. So, I got to go a meeting. A little bit overwhelmed, because it's a big meeting. But there were many people there who took me under their wing and, uh, and really helped me understand the many different ways I could get involved in the organization.

And so then I ran for a seat on the resident component governing council, and won. And that exposed me to more and more, uh, leaders within the ASA, helped me expand my network, got me in front of Congress, got me to testify in my state legislature and that got me on the radar screen of then governor, Mike Pence, who needed someone to run his state department of health. And, uh, he, uh, asked me to come in an interview. I got the job. And during that tenure, dealt with Ebola, dealt with Zika, dealt with the largest HIV outbreak related to prescription drug use in the history of the United States in Scott county Indiana. And that allowed me to have a little bit of the credibility dealing with complex public health issues that, um, that helped me get confirmed after my name got thrown into the hat for Surgeon General of the United States when governor Pence became Vice President Pence.

So the very short description of that long story is that, uh, without the ASA and the opportunities I was afforded, I, uh, wouldn't be the Surgeon General of the United States right now. And I really 100% mean that.

DR. STRIKER:

Well it's such a, it's so inspiring especially to a lot of our younger physicians who I think, um, you know now days, it's, um, it's challenging to get younger physicians involved in these societies and recognize the value and, um, importance in being part of a collective that's, uh, involved in healthcare and promoting patient care and safety, and things like that. So, I think it's a great account.

DR. ADAMS:

So many skill sets that you have an opportunity to hone within the ASA translate into other parts of life. And I don't think we appreciate it. I was on several different committees, going back to when I was a resident: the occupational health committee, the professional diversity committee, which I eventually chaired, and the, uh, governmental mental affairs committee and the regional anesthesia committee. And those translate into skill sets that allow you to get involved on hospital committees, and in your community, and to show the value of anesthesia in your home environment and, uh, determine how medicine is going to be practiced where you live.

Interestingly enough, I was an oral board examiner for the, uh, for the ABA. That opportunity came about through folks I met at the ASA meetings and people who advocated for me. And, uh, I got to tell you, that there was no better practice for a senate confirmation hearing than, uh, going through the oral board examination process and ultimately becoming an examiner. So even something that you would never see as being, uh, directly related, very much helped prepare me for this new stage in my career.

DR. STRIKER:

Yeah. That's certainly, uh, that's got to be refreshing news to all of us that have had to go through the oral boards process to think that there is some, there is some benefit outside of just the, uh, sole purpose that it's meant to do, to, that we all could benefit from, so...

DR. ADAMS:

Exactly.

DR. STRIKER:

I know you have served on a number of committees in the American Society of Anesthesiologists, can you tell me about your experience with those? I think that'd be really, really interesting to hear about.

DR. ADAMS:

The ASA committees are a great way for young people in particular, to get involved, to learn more about all that anesthesia entails and can have an impact on, and, um, to develop your leadership skills.

I actually got involved on the occupational health committee as a resident. And here's a tip for the residents: the competition for those spots is, uh, less when you are a resident than when you're out there competing against all the other staff. And so, uh, I encourage residents to apply for committees because once you get on the committee, and you get to know people and you get to develop those skill sets, then it makes you more competitive to stay on them once you're done. But the occupational health committee, we talked about health and wellness, we talked about physician reentry, we talked about safety in the operating room, and, uh, so many issues that, uh, are important to our profession but that the average person doesn't think about on a day to day basis unless and until something goes wrong. That led to an opportunity for me to be on the professional diversity committee. And, uh, really just loved that, served on that committee for a number of years and was actually chosen by the ASA leadership to chair that committee. And, uh, that opened the door for so many different areas for me. And, uh, I, I want young people to understand that these committees are a great way for you to, uh, ascend to a position where you are, uh, getting, uh, an opportunity to manage a budget, getting an opportunity to, uh, to oversee a number of different people, getting the opportunity to work with our great ASA staff.

After that I got on the governmental affairs committee and the regional anesthesia committee. Two committees that are, um, quite competitive, very hard to get on. But because of my experience, uh, on the occupational health committee and the professional diversity committee, uh, I, uh, again was able to develop a skill set and the networks to make myself competitive for these, uh, other committees. And I had a really enjoyable time on both of those committees, uh, delving into other facets of, uh, anesthesia advocacy.

So, the committees are a great training ground, um, and the skill sets that you take

from there, will, uh, will be helpful to you for the rest of your life. They're also a great way to give back to your profession. A lot of the statements, documents, policies, um, guidance that comes from those committees, uh, really directly impacts the practice of anesthesia and of medicine across our country.

DR. STRIKER:

Absolutely. I think, uh, it's, it's imperative to be involved but I, you just touched on it there at the end, about not only improving skill sets but giving you additional skills that you may not have had but, um, actually effecting real change in the society, in our specialty. And, you alluded to it before, but your work on the committee on professional diversity, I mean there's some, talk just a briefly about the results from that committee when you were a chair.

DR. ADAMS:

We actually had a mentorship program, that, uh, was developed by my predecessors in the professional diversity committee and, uh, one of the things I worked to do was to increase funding for that mentorship program. And, uh, there have been dozens of projects over the years that have come out of that committee and the mentorship program but, uh, one of the things I'm really proud of is that the women in anesthesia group got started with a grant given to Dr. Rekha Chandrabose through the professional diversity committee mentorship program. There was another grant, uh, that was given to Dr. Mike Lubrano to initiate the LGBTQ meeting that, uh, occurred here at ASA, uh, 2019.

And so, a lot of work, um, a lot of mentorship, a lot of progress for the ASA has come out of that committee. And I'm just so proud to be able to work with the great members of that committee to, uh, promote anesthesia, and diversity within anesthesia.

DR. STRIKER:

Absolutely. Would you say, even if, you mentioned that the committees are highly competitive, for all anesthesiologists to get on, but would you say that, it's still, if you have an interest in a certain area as a resident, or as a young physician starting out out of residency, still, engage with, uh, committee members or other contacts you have just to get involved with the work, even before you're official committee member.

DR. ADAMS:

Absolutely. One of the things that I tell folks about that they don't really know—not

enough people know this—committee members are open to any ASA member. If you're interested in regional anesthesia, uh, you don't have to wait until you get selected to be on the regional anesthesia committee, you can show up at the committee meeting and introduce yourself to the folks there and say, hey, I'm interested, I want to learn about this committee, I want to figure out if there's a way that I can help out. And, uh, then you get known to the committee members and to the chair, who ultimately then have to decide who's going to be on the committee next go around. And it increases your chance of being on the committee.

Dr. Elizabeth Rebello, who, uh, was the chair of the ASA professional diversity committee after I was, she came to one of our committee meetings before she was even on the committee and said, I'm interested, let me know how I can help. And then she helped us out with the mentorship program. And that showed us that she really had a commitment, and that she had a skill set that we could utilize. She eventually got on the committee, and then became chair of the committee. But it started with her taking the initiative to actually show up to that committee meeting, and show her interest, and get involved.

If I had my way, every committee member, um, would be tasked with finding a younger person, or an early career person, or a diverse person out there, who's not on a committee, and bringing them to your committee so that they can see what's going on and be exposed to that whole process.

DR. STRIKER:

I think a lot of time when you're out in the community and, maybe you're not quite as involved in the Society, but you do see a lot of the work products that come out of it, you see a lot of guidelines or standards, uh, from our Society. And I don't think a lot of people may quite understand the, the work and the, um, the length of time it takes to procure some of these results. And, um, it's, I just think it's valuable if nothing else just to, just to, just to witness a little bit of that process so, uh, you understand just how that information gets to you on the ground level.

DR. ADAMS:

Couldn't agree more. Couldn't agree more. I'm a big proponent of the ASA committees and the opportunities.

DR. STRIKER:

Am I correct? Are you getting your Fellow American Society of Anesthesiologist designation here this year?

DR. ADAMS:

I am. And I'm very proud to, uh, be able to get that designation. I think it really is yet another way to recognize the, uh, contributions that an array of people make to their specialty. But also, uh, I think appropriately to help people know that anesthesiologists are more than gas passers, they're more than, uh, than proceduralists, and, uh, the FASA reflects that. And actually, uh, in order to be eligible for that you have to show that you've given back to your profession in a way that goes beyond just simply, uh, doing procedures in the OR.

DR. STRIKER:

Well stated.

One thing I'd like to leave all the listeners with, because, primarily, most of our audience is going to be physician anesthesiologists and I would like to have you tell us, what do you think the one or two things that we can do as individual physicians help you with our public health goals, or help our patients. What do you think?

DR. ADAMS:

Well, first of all, I would say, that um, a lot of the problems we see in the health of our country relate back to inequities, and a lack of diversity, and a recognition of unique plights that different subsets of our population have. Rarely is there an issue from a public health point of view that is equally distributed across the country. There's always some pocket that has been forgotten about, that has been downtrodden, uh, that hasn't been heard, that, uh, that represents the lion share of the burden. And so, I would one of the things that we can do is support diversity within the ASA. And yes, I'm biased. I used to run the professional diversity committee. I used to be the Chair of it. But I also have seen many leaders within the ASA come out of that professional diversity committee.

Nothing makes me more proud than to come to this meeting, and know that, uh, the ASA will have three female presidents in a row after, uh, a long run during my career of having very few to no women in leadership roles.

I was just blown away when I visited the resident component and medical student components about the diversity represented amongst our young physicians, who are interested in anesthesia and interested in the ASA. And I think we need to do a better job of, uh, reaching out to them and connecting them with committees, connecting them with research opportunities, connecting them with advocacy opportunities so that we can groom those, uh, future leaders to take over after we're done.

I think that's one of the things we forget about leadership: that leadership isn't

about camping out in a position for the rest of your life. A good leader is always thinking about the succession plan. And, uh, thinking about who's going to come after me, and do this job even better than what I did it. And what am I doing to groom the individuals who are going to come after me and, um, and be my legacy, and continue to lift up the things that I care about.

I think that's critically important. The other thing I would say is anesthesia presents an array of unique opportunities to have a wider impact. No, uh, great potentially impact point of your life than when you're coming in for surgery. We tend to think of it as routine. And, uh, Dr. Verghese at the, uh, opening lecture, talked about how it's easy for us to get trapped in the idea of our daily routine. But for someone coming in to get their kid's ear tubes, or for someone coming in to get, uh--well they didn't come in to get an epidural, they came in to get a baby--but getting an epidural for a labor that they're going through, uh, for someone who's coming to visit their loved on in the ICU, that is a critical point in their life that they will never forget, and at which they're open to change negative behaviors that either may have led them to this point or that may actually affect the outcomes down the road. So, we need to take advantage of those opportunities when you're putting in that epidural and the room smells of cigarette smoke, it's a great time to ask about smoking, advise them about the benefits of quitting, and refer them to the quit line: 1-800-QUITNOW. When you're in the intensive care unit, uh, talking to the family, it's a great opportunity to talk to them about the value of flu vaccinations and just simply ask, hey did all of you get your flu vaccination because that could not only impact you, but could impact your loved one. When you're doing a pre-op visit for that pediatric anesthesia case, it's a great opportunity to talk to the child, if age appropriate, alone about vaping and find out if they're vaping. But it's also an opportunity to raise it with the family member and the child and make sure you're having a discussion about the dangers of these new products out there that are enslaving a new generation of youth to nicotine.

So, so many opportunities for us to get involved, to lean in, and to have that greater impact. And I'm convinced that if we find those ways to have a greater impact, we will get more value in our day to day lives, we'll be less burned out. And that's a big topic we're talking about right now. I'm convinced a big portion of the burn out is related to the fact that we are doing procedures, we're going through routines, but we're not really seeing a, uh, a change in outcome. The definition of insanity is doing the same thing and expecting a different result. My challenge to folks is to think about how you can just do one little thing differently, and, uh, and try to achieve a better outcome and a different result for your patients and for your profession.

DR. STRIKER:

You hit on such a key point, uh, which is that we are physicians first. And I think bringing up Dr. Verghese and the opening session, I, he just did a phenomenal job of bringing it all back for all of us as to why we got into medicine in the first place, and that is it's about the patients and what we can do to help them. And, as you said, anesthesiology presents the opportunity for all of us to make a difference in a short period of time but a profound difference and, uh, I think that's such a great, great message and a great way to, uh, end the interview.

Dr. Adams, I, uh, thank you very much for your service, and your representation of all of us in the public health community. And I thank you very much for joining us today.

DR. ADAMS:

It's been my honor, Dr. Striker, and, uh, again, look forward to working with you and all the other anesthesiologists, physician anesthesiologists, and care team members out there to, uh, put more care back in health care.

DR. STRIKER:

Thank you.

DR. ADAMS:

Thank you all.

(Audience noises)

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VOICE OVER:

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