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.

I feel like this year, as a CA3, I've finally gotten really good at just asking lots and lots of questions.

The advantage is that you get to spend an extra year and really hone in on the skill of the subspecialty.

You form those relationships by being present, you form those relationships by being engaged in what you're doing.

At the end of the day, I think the most important thing you can focus on is being excellent every day in the operating room.

DR. JOSHUA YOUNGER, HOST:

Welcome back to Residents in a Room, the podcast for Residents by Residents. I'm your host, Dr. Joshua Younger. Here again with a group of residents to discuss the topic of subspecialties. Just a reminder to our listeners of who we are, I'll go through again. I have here Sam Cohen, Jessica Yeh, Jim Dierkes and Jordan Phillips. If you guys can just say hi and remind us which subspecialties that you guys are pursuing.

DR. SAM COHEN:

I'm Sam Cohen calling in from UT Southwestern in Dallas, Texas and I'm going into critical care and cardiothoracic anesthesia.

DR. JESSICA YEH:

I'm Jessica Yeh, I'm a CA2 from the University of Arkansas for Medical Sciences in Little Rock, and I have applied for pediatric anesthesia.

DR. JIM DIERKES:

I'm Jim Dierkes, I'm a CA3 at Duke University in Durham, North Carolina, and I'll be doing a cardiothoracic fellowship.

DR. JORDAN PHILLIPS:

Hi, I'm Jordan Phillips. I'm from the University of Oklahoma Health Sciences Center and I'm applying for anesthesia critical care fellowship.

DR. YOUNGER:

Ok, so let's jump on in and kind of pick up where we left off. Let's start with you, Sam. Let's talk about the pros and cons. What are the pros and cons of selecting the subspecialty that you did if, and you want to speak to this, too, what are the pros and cons of any subspecialty?

DR. COHEN:

Sure, I think the pros are quite obvious, it's gaining more experience with supervision, it's gaining confidence in taking care of whatever subspecialty population that you are going to take care of. And it allows you to network with even more physicians than you would otherwise and become confident in your skills. Going into dual training, again, it's just having the ability to be kind of the ultimate consultant at the end of the day in both cardiac and critical care matters, and just being a lifelong learner for that.

The cons, it's a two year commitment on resident fellow salary. It's, you know, missed paying off debt. It's missed life experiences that you could have because you're taking fellow call and doing all the things you need to be doing. And it may require one move or, or two moves across country and the stress associated with it. But overall, I think the pros of the fellowship outweigh these cons because you become a much stronger anesthesiologist and consultant in anesthesia.

DR. YOUNGER:

How about you, Jessica? What do you see as the pros and cons?

DR. YEH:

I think Sam explained it very eloquently. I, I agree that, I mean, the advantages that you get to spend an extra year and really hone in on the skill of the subspecialty that enjoy and be an expert in that area.

DR. YOUNGER:

Jim, how about you?

DR. DIERKES:

The big con, giving up a year of salary, going through a match process again, not knowing where you're going to end up necessarily. But there is a lot of value in training for an additional year under an attending to ask questions to, for a whole nother year.

I feel like this year, as a CA3, I've finally gotten really good at just asking lots and lots of questions, so I'm sure I'll even be better at that next year. And then in cardiothoracic specifically, I mean, it's probably one of the more time intensive ones in the hospital. So that might be tough, but it's not unreasonable. And you really have to be in the hospital to learn how to take care of these people. So I think it's really worth it. And then, of course, the increased competence, the chest wall echocardiography, TEE will all be really helpful and be a pro of cardiothoracic training.

DR. YOUNGER:

Jordan, anything to add to that?

DR. PHILLIPS:

I think everyone's hit it pretty well. The opportunity cost is definitely something that is constantly thrown in your face by your, by your buddies who decide not to do a fellowship. But Sam, Jim and Jessica all kind of echoed a lot of the pros that, that we can throw back. It’s that you, you get this extra year of guidance, mentorship and experience, so you get to learn how to be, you're going to get that experience around an academic center, so you get to learn how to be a better teacher. You get to learn how to be a better leader, depending on where you're going and what your goals are. Like for me personally, I, I know I kind of want a career in academic medicine, so a part of that went into my decision to do a fellowship to gain more faculty mentorship and to learn some of those skills and develop some of those leadership skills that you don't necessarily get to develop as a resident.

DR. YOUNGER:

You know, I'll tell you from experience, actually, one of the things that I felt like I walked away from fellowship, and you guys kind of touched on it, but just a mentor. You know, finding that one or two people who you connect with and you see how they practice and you want to emulate that practice, and they are committed to you, and you're committed to them, and it's, it's really something special and something that goes beyond that actual one year. And I hope that all of you guys do find it if you don't have it now. But it really is fantastic and something that really you can focus on in a fellowship.

What do you guys think you'll, you'll miss the most because you're doing the subspecialty and does that concern you at all?

DR. PHILLIPS:

There, there were so many aspects of my anesthesiology training so far that I've enjoyed and kind of with the decision of doing critical care, I'm basically saying that I'm, I'm not likely to have my job where I work on the labor floor. I'm, I'm probably not likely to have my job where I, where I take care of kids unless I subspecialize in that. So those are two aspects that were a big part of my anesthesia training that I really enjoyed, that I generally will miss. But I kind of had to balance that with, with the decision about what, what do I enjoy the most and what do I want to pursue as far as for my career long term? And in the end, for me, the pro of doing ICU kind of outweighed the fact that I will generally miss kind of taking care OB patients and also taking care of kids.

DR. YOUNGER:

Jim, how about you?

DR. DIERKES:

Yeah, I've had the same kind of thought process about, like, just loving all aspects of anesthesia and having to potentially surrender some of that by doing a subspecialty. However, there are, I've been looking, there are jobs out there where you don't necessarily, you aren't, you aren't forced into practicing your subspecialty alone. You get to do some general stuff and you can kind of cross over whenever you want to. So I think that that's, knowing that those jobs are out there helps me really feel better about the future.

DR. YEH:

So what Jim mentioned about finding jobs with his subspecialty, that also has an aspect of practicing general anesthesia, I find interesting, because I, before applying for peds, I

mentioned this worry of wondering if I'd miss doing it general anesthesia with adults, and, one of the pediatric anesthesia attendings told me that there's quite a few jobs where you can do both and do, like, a couple of days a week or whatever proportion you wanted of practicing in their main OR and doing the rest of the days at the Children's Hospital. I think I'd particularly, may miss some aspects of OB and regional. But seeing as peds anesthesia itself is actually generalized in its own right, like acute pain is actually a growing field in pediatric anesthesia, I think that I'll actually be OK.

DR. YOUNGER:

I'm sure you will. And Sam, how about you?

DR. COHEN:

I'll be honest, I, I don't think I'll be missing labor epidurals and tonsils very much. I'm looking forward to my fellowships and I don't think I'll look back too much. I think everything is, is all the way forward for me.

DR. YOUNGER:

Ok, and I, I know you mentioned that you plan on specializing in two different areas. Do any of you guys have any thoughts of additional subspecialization? Jessica, do you?

DR. YEH:

Potentially. I am somewhat looking into peds CV, but I would obviously want more experience in that area before committing to it.

DR. YOUNGER:

How about you, Jim?

DR. DIERKES:

No, one, one year is plenty for me. I do know, I have some colleagues though, that are doing cardiac and peds, cardiac OB, critical care OB, and then, like Sam, the cardiothoracic and critical care. So it seems to be becoming very popular and an option for people that want to have never ending learning.

DR. YOUNGER:

But we're all, we're all lifelong learners, right?

DR. DIERKES:

Yes, we are.

DR. YOUNGER:

How about you, Jordan? Any, any thoughts about doing further subspecialization?

DR. PHILLIPS:

Yeah, I would say there's def, there's definitely some interest for me, at least in mechanical circulatory support. And so taking care of ECMO patients, and you get a fair amount of experience with that in traditional anesthesia critical care fellowship depending on what institution you go to. But, truly in order to truly get a grasp on, on managing those patients, learning about transporting those patients, and like, if I was wanting to start up an ECMO team at a different location and it would require some extra subspecialty training.

DR. YOUNGER:

So Jordan, why don't you talk to some of the listeners here who haven't gone through all this yet, this whole process. Why don't you tell them how and when did you learn about where you're supposed to be doing? What are the things you wish you would have known sooner? You know, what would you tell them if you were in their shoes moving forward?

DR. PHILLIPS:

Yes. So I would say if you're lucky enough to have an idea about a subspecialty in anesthesia before you even enter residency, that's awesome. That was not me at all. But if you're, if you're lucky enough to be that type of medical student, then you should strategically look at anesthesia residency programs with that in mind. Going back, I probably would have benefited from going to a program that had a little bit more of an intensive care presence because there would have been more mentorship available to me. I was able to find mentors, but it was a little bit more challenging for me. So that might be something that I would do differently if I had that foresight.

But without that foresight, I would just say that as you enter residency, keep an open mind. And if at any time when you're an intern or you're an early CA1 resident you have interest in a subspecialty, then you should go to your Program Director, go to your Assistant Program Directors and let them know, because in the end, they're the ones

that make the schedule and they're the ones that are going to help coordinate, usually mentorship, and really, it's, it's all about reaching out and, and making the powers that be know what you're interested in, because most Program Directors are all about helping you achieve whatever it is you want to achieve in your career.

DR. YOUNGER:

That's great advice, Jim. How about from you?

DR. DIERKES:

I'm pretty fortunate in that almost everybody in our program does fellowship. Like, in my class that's graduating this year, 100% of us are doing fellowships. So the program really has all the information available for us. We just have to ask for it. But as far as fellowship in general, for those who don't know, most of them are a match process now, particularly cardiothoracic and critical care are pretty early in the process. The applications open in usually like November or December of your CA2 year. So if those are on, in the back of your mind, you want to start thinking about them early, asking people for, for letters on the earlier side. Interviews usually start in January and February.

And the other piece of advice would be to really look at the programs individually that you're applying to, because they're, although they're all accredited the same way, they're all very different. Like at Duke in particular for the cardiothoracic program, as fellows were the primary caretakers in the operating room versus in some other programs, there's a lot more supervision. So if you favor more supervision, Duke might not be the ideal program for you. So I would just kind of think of all that stuff as you're advancing through the match process and interviewing at all of these programs.

DR. YOUNGER:

Jessica, do you have any thoughts?

DR. YEH:

As someone who thought I wanted to do one specialty and then changed my mind, I would say if you're, if you're someone who thinks you want to do a specialty but don't quite know it yet or haven't narrowed it down, to try and talk to as many people as you can of that specialty, if you have fellows in the program at your own residency program or the attendings to kind of ascertain how they knew that they wanted to pursue that specialty, what aspects of that field sparked their interest, and see if those align with things that you might enjoy or see yourself doing.

Do you want a little bit of time outside of the OR doing something else? You know, that's a really good jumping off point to start with. For the peds applications, it's, it's part of the main match. So it's, it's not an early application. So there's a little bit more time for that. Applications open in December, but most of the programs only really started reviewing applications in January and still are reviewing them right now. So there's a little bit of extra time for peds specifically.

DR. YOUNGER:

Sam, anything you want to contribute?

DR. COHEN:

I think the, the only thing I would add, no matter what subspecialty you're planning on going into, or things that you might be interested in, there's always the worry about, oh, my God, I need to play the game again. My CV doesn't look very good. I don't have research. I don't have volunteer work. I thought I did all this in college. I thought I did this in medical school. I thought I did this, now, again, this is unbelievable. At the end of the day, in my opinion, and everybody might, might disagree with me, I think the most important thing you can focus on is being excellent every day in the operating room, being present with your patients, being around, being available, trying to be enthusiastic, because it will reflect in your work and you'll be able to see things that the person that went home at two o'clock didn't get to see because you were around. You'll be able to hear stories from different cases, find things that interest you.

Even if someone says, hey, you're great at this, you should do it doesn't mean that that's what you actually should be doing. It just means you're great. Find something that you love. And I think the only way you find that is by being present, doing cases and talking to people and making connections and, and hearing their experiences.

DR. YOUNGER:

Yeah, I, I think that's a really valid and good point. And I think even goes to one of the big issues that's out there in terms of physician burnout. So you find something that you're passionate about and that every day brings you to work, you've really found something truly special and you should grab it and hold on to it and cherish it, so I, I really think you're speaking loud and clear, and with a lot of wisdom.

Sam, let me ask you, where do you expect to turn for help as you move forward? And are there some resources that you currently rely on and maybe resources that you wish you had even found sooner than you, than you did?

DR. COHEN:

Well, Google's a great resource. You can find a lot of stuff there. I always defer to my father for pretty much everything. He's a very wise man. And even sometimes when I disagree, he's usually correct.

DR. YOUNGER:

We're going to let him listen to this over and over again.

DR. COHEN:

Oh, he'll never listen to this.

DR. YOUNGER:

That's what you think. We're sending it out.

DR. COHEN:

And we'll, we'll see if he knows how to work his phone to listen to this. But, you know, I think in the future it's going to be the mentors that I had in residency and my future mentors in fellowship. I think everybody that I have grown close to, I trust, and has a high degree of integrity and unbelievable amount of wisdom. And those are the people that I gravitate to for advice. And I think even if you don't have those people, someone will come around the corner.

DR. YOUNGER:

Jessica, how about you?

DR. YEH:

I think that the mentors that I have made in my current residency are, there are some that I will definitely continuously keep talking to and asking them for advice as I move forward in my career. In terms of other resources online, I didn't really find much, or use much, for my applications, at least currently, although I'm anticipating that might change, especially as we're all moving to Zoom interviews. I'm sure that that realm will expand a lot more, so I'll be on the lookout for those.

DR. YOUNGER:

Jim?

DR. DIERKES:

Yeah, I, I think that people are really the, the resources I've relied on most, residents, fellows, faculty, although I did recently get back into Twitter, which I think is funny because in undergraduate school forever ago, 12 years ago, Twitter was not my thing and I didn't really like it. And now, though, I get like updates from the ASA and other professional societies and tweets for medical professionals that are really entertaining and helpful. So I feel like Twitter is actually really cool in the medical community now. And we've also been using Twitter to help connect us with medical students that are interested in coming to us for residency since they can't visit in person. So Twitter's been a good way for all of us to communicate with each other. So it's interesting.

DR. YOUNGER:

How about you, Jordan?

DR. PHILLIPS:

Yeah, I'm I'm definitely with, what all the other, all the other residents said that relationships, mentorship, those are, those are our most powerful resources. And, and I really loved what Sam said earlier. And you form those relationships by being present, you form those relationships by being engaged in what you're doing. And that's when people will start latching on to you and you'll form those mentorships that are really going to be impactful. And I've had the privilege of forming some of those that I know I'll continue to refer back to throughout my career.

As far as resources that I wish I would have known about earlier, the ASA, especially at their national conference, has fellowship gatherings where the Program Directors all gather in a room in like kind of an informal meet and greet session where they all have tables. And you can walk around and you can learn about the programs and get some face to face contact before COVID, of course, with people from those programs. And I wasn't aware of that when I went to the ASA as a CA1. And unfortunately, this year the ASA was virtual. They still were able to do some of that, but it wasn't quite as impactful, I think, as those kind of face to face meet ups. So I would definitely encourage lower level residents that are interested in subspecialties that get to go to the, to the national meeting, to go to those meet and greet sessions, because that's a great opportunity to network.

DR. YOUNGER:

Yeah, and Jordan, I, I wanted to ask you, what, what challenges are you anticipating encountering during your subspecialty and anything specific that may keep you up at night?

DR. PHILLIPS:

Sure, definitely one of the big challenges on my mind that keeps me up at night is moving across the country. Moving is a nightmare for me. So packing up all my stuff, me and my wife and, and going to a new place is, is scary. It's also exciting, but I know there'll be a lot of challenges there.

As far as with the subspecialty, specifically with critical care, a lot of things in critical care fit really well with anesthesiology. We're, we're good at doing procedures, we're good at quick differential diagnosis and quick interventions when things go awry. We're good at physiology and pathophysiology management, as anesthesiologists. But many times in our training, we're focusing on one single patient. We're in the OR, we've got all of our monitors in front of us, and this is, this is our one patient that we're working with. When you're running a 20-bed unit and all those patients are sick, that's kind of a different thought process. And so being able to kind of step back and look at a unit as a whole and be able to triage and manage all these patients at once is not something that I think necessarily comes naturally for us. And so that's something that I'm probably a little bit apprehensive about, but I look forward to gaining those skills throughout that training period.

DR. YOUNGER:

How about you, Jim?

DR. DIERKES:

Yeah, I actually, sleeping much better now that I made a decision. I was, I was much more nervous before I'd actually made my final fellowship decision. But now that I made it, I don't know. There's not too much. I mean, I think that there's nothing about cardiac specifically that will keep me up at night any more than just being an, an anesthesiologist would. Worrying about rough outcomes, worrying about being on my own in the future after fellowship. But I think that having a supportive family and home life will help me get through all that.

DR. YOUNGER:

And you Jessica?

DR. YEH:

Well, just hearing Jim say that he's sleeping better makes me very jealous, since I'm, I'm in that a period of time where interviews are coming up and I'm kind of making a list of places, sort of using some of my mentors as a resource for that to, they gave me a lot of feedback of programs that they thought would be great training programs. And I'm really just trying to see what the best places would be to sort of get the right balance between experience and, of course, getting all of your index cases, having enough support for any research I might want to pursue, but then also making sure that I have a fairly reasonable call schedule and that my work hours are maybe not going to be so bad as residency.

DR. YOUNGER:

Sam, how about you? What challenges are you anticipating?

DR. COHEN:

Jordan said apprehensive. That's a very nice term. I'm terrified of managing a multi-bed unit every day. The moving situation and finding a place to live in a new city is always stressful. But I think the overarching theme that would keep me up at night and does keep me up at night is the fear of, you know, doing the wrong thing by your patient, which is never your goal. You always want to do the right thing and making the wrong call or missing something or having someone disagree with your management and then, them being correct that it's a, it's terrifying to think about. And that's why we do a fellowship at the end of the day. And I don't think that's an unhealthy fear. I think, I think at this point in time, I think it's a healthy fear and something that every day will make me better and a stronger clinician.

DR. YOUNGER:

Yeah. So what are your hopes for the future of your subspecialty and how do you think you'll contribute to that? Sam?

DR. COHEN:

I think we alluded before that subspecialty training makes us more competitive, more desirable and less likely for mid-level competition. I think being a cardiothoracic anesthesiologist and being an intensivist are synergistic. And with the emergence of more and more ECMO circuits that have been produced, bigger ICUs have been produced, a new light that's been shown on the critical care units and all these patients

that are now recovering or have sequelae of COVID. I think in the next few years we're going to be seeing a lot of different pathologies and interesting things come through. And I think there's a lot of new and developing research in addition to technology that will make our specialties even better.

DR. YOUNGER:

Jessica, what are you feeling?

DR. YEH:

I think pediatric anesthesia has a lot of potential and is growing quite quickly. I mean, there's a lot of research that obviously has not been done on children, and it's really just extrapolated from adults, which is completely fair. But that means that there's a lot that can be explored. And I think, as I mentioned earlier, regional acute pain is, I think, a rapidly growing field, and there's a lot that can be expanded in that. And so I'd like to go to a training program that is sort of exploring that and be involved in its growth.

DR. YOUNGER:

Jim, what are, what are your hopes through your subspecialty? What do you think you'll contribute to it?

DR. DIERKES:

Yeah, I think to, I agree with what Sam said, and just to add in a little more, I mean, I think that as cardiac and thoracic surgery evolves, so will our specialty. I mean, we're doing less invasive procedures on sicker people and they're probably even getting less general anesthesia. But I don't think that that means that they won't be taken care of by cardiothoracic anesthesiologists. I think that the specialty training that we'll get will continue to be helpful in taking care of these sick people, even if they're not going all the way to sleep with general anesthesia. I, I myself have a particular interest in patient safety in the cardiothoracic operating room. So I hope to kind of continue to contribute to that through fellowship and afterwards in my career.

DR. YOUNGER:

Jordan, how about you?

DR. PHILLIPS:

I would say, for me personally, in the, in the part of the country I come from here in the Midwest, in Oklahoma, that the presence of anesthesiologists in the ICU is pretty weak. That goes to show that there's, we don't have a fellowship for anesthesia in critical care in the state of Oklahoma. And, and in general, that's not like a super common model in this part of the country for how ICUs are run.

Now, as you move towards the coasts, that kind of becomes the norm where anesthesiologists have a really strong presence in the ICU, especially at the large academic centers. So as far as my personal goals, I hope to go learn a lot and then kind of bring that back to my part of the country and, and kind of grow the interest in the field of anesthesia critical care, and hopefully get more residents interested in, in going into that specialty in this area.

DR. YOUNGER:

Fantastic. Guys, I, I got to say, it's been a real pleasure talking with you guys. I mean, you guys seem really bright futures, really engaged in what you're doing and excited, and, you know, the future of anesthesia just seems so much brighter, you know, knowing that you guys are going to be entering into these specialties and really fully engaged and equipped. And I'm, I'm excited for it, what anesthesia is going to bring for you and what you guys are going to bring to anesthesia. And, you know, I'm just going to finish up with one last question and then we'll wrap up. But let's get a sense of where you all see yourselves going after this and where do you see yourselves five years from now? We can start with you, Jordan.

DR. PHILLIPS:

Oh, yeah, sure, you know, it's a pleasure to be a part of this podcast and to, to kind of talk about things we're passionate about and hopefully we've said a few things that, that could be valuable for some resident out there that's, that's tuning in.

For me personally, I hope to kind of be established as, as an attending in, in an academic center. It may or may not be back here in my home institution at the University of Oklahoma. If I am back here, then I hope that I'm kind of beginning to develop our presence in the ICU and hopefully working my way up in an academic center, educating medical students and residents.

DR. YOUNGER:

Jim, how about you?

DR. DIERKES:

Yeah, I, I always thought that I would end up entering private practice, but as I've made my way through the academic world, from a medical student to an intern to a junior resident and now a senior resident, I definitely appreciate it more and started really enjoying being in an academic environment. So I definitely have a lot more reflecting to do on that front. And then we've enjoyed living in North Carolina, but all of our family is still in Philadelphia. So I'm not sure where we're going to end up on that front either. So lots of, lots of self-reflection to do.

DR. YOUNGER:

Jessica, how about yourself?

DR. YEH:

I will definitely end up in an academic institution. I am fairly passionate about teaching and education. So I do hope to be involved in a residency program to some degree. Where that is going to be, I cannot say for sure. I've lived in many places. I actually did my medical school training in Australia, so, and my fiancée is from Australia, so I don't even know if I'll be in the US. But, um, I'm sure that I'll, we'll find a great place in a great institution.

DR. YOUNGER:

Sam, how about you? Where do you see yourself down the line and maybe five years out?

DR. COHEN:

Yeah, this was one of the worst questions during my fellowship interviews and I answered the same as I'm not sure, but I do know that I will be taking care of sick patients either in the operating room, in the ICU or one or the other. But I'll be doing so as a fully trained intensivist and cardiothoracic anesthesiologist and having a good time no matter where I am. And again, thank you for having us on this podcast. It's been a great time.

DR. YOUNGER:

I'm Dr. Joshua Younger and this is Residents in a Room, the podcast for residents by residents. Join us again.

DR. DIERKES:

Thank you.

DR. YEH:

Thank you so much.

DR. YOUNGER:

All right. Good luck to you guys.

ALL:

Thank you.

(SOUNDBITE OF MUSIC)

VOICE OVER:

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