



RESIDENTS IN A ROOM PODCAST SERIES  
Episode 4 - Transcript  
The Transition  
Recorded in October 2019

(SOUNDBITE OF MUSIC)

VOICE OVER:

This is Residents in a Room, an official podcast of the American Society of Anesthesiologists, where we go behind the scenes to explore the world from the point of view of anesthesiology residents. This episode is sponsored by ASMG, a physician only, privately owned practice group serving the San Diego area. The ASA thanks ASMG for their support.

Preview:

So, make sure you do everything under a protocol every day, every time. Being that person who's being called upon in a rescue situation.

SHARA, HOST:

Welcome back. It's time for Residents in a Room again, ASA's podcast for residents by residents. I'm Dr. Azad and today we're going to dig into our hopes and fears for the transition coming our way with my guests, Joe, Ricky and Wei. Ah, so the transition from residency to practice is big y'all. Some might even say scary. What are some of the challenges you foresee for the transition?

RICKY:

Being that person who's being called upon in a rescue situation is probably the thing that scares me the most. There have been plenty of circumstances where I have leaned on my attending, or someone, usually my attending to rescue me from a line that I can't get, from an a line that I can't get, from an airway I can't get, or just in an emergency situation, and to think about in a few short months being that person who's going to respond to that. And being expected to be able to do that 100% of the time is scary.

SHARA:

I think that I might be the fresh out of training attending who micromanages and, um, like, does a lot of things for the person they're supervising or tells them like "oh you should have done it this way", but that's not really the type of supervisor you should be. Um, but I think when you're like very nervous, having like as much control as possible is what sort of gets you through your nervousness. Ah, so one of the fears I have is that I actually might not be a very good supervisor for probably the first few years.

WEI:

After graduation, most of us are likely not working at program or the hospital that we get training. Soon we have maybe we are going to move to another location, or like from the east coast to the west coast with who knows what kind of culture they have there, like so I think adaptation is going to be a, quite an issue. Maybe in the beginning, like for a couple of weeks or months?

SHARA:

Do you feel ready to work with nurse anesthetists? I think that's a practice model that we haven't really talked about as much.

RICKY:

I think that's going to be a challenge. I think, I think it's going to be a challenge from the perspective of there are many nurse anesthetists who are wonderful at what they do. In some ways I think who am I to come out from a training and tell someone no, you should be doing this xyz, abc. I think balancing the fact that you have a patient in front of you that you need to take care of, but also, you know, towing that line of working together as a team in a safe way can be challenging. Will be challenging.

JOE:

Yea, I definitely agree with what you said. Um, I think also, kind of, I am excited in a way too, because you can learn a lot of things from anybody. It doesn't matter if they're an md/do or whatever or nurse anesthetist. I mean, they may have, you know, different ways of doing things that you never, that not, by not going through a residency program maybe they picked up, and it's kind of different, and maybe you like that and that can be a way to to get new experiences and learn new things so. I kinda like that, too, but, um, yeah, that will be an intimidating factor.

SHARA:

I think it's also hard for us as physicians to know what the limits of a nurse anesthetist's knowledge might be because we didn't go through the same training as them. Um, with a nurse anesthetist, too, maybe primarily did like joint procedures or something like that where they're very comfortable working independently, but now you're in like a craniotomy with them, or something, and that's not something that they know how to do, but you don't really know that they don't know how to do that. Or like what, um, exactly like the limits of their ability to manage critical situations are. I think that's actually, like, maybe the scariest part as a supervisor, so it's like good to have like a conversation with whoever you're working with, whether it's a resident or a nurse anesthetist, to be like, "OK, what things do you know how to do? And like what would you like help with."

So, we have talked about some of the hurdles in the next steps of our career. Um, how do you all anticipate overcoming your perceived hurdle? For me, um, sort of talking about being a micromanager. I

think part of, ah, overcoming maybe a annoying personality, or maybe a temporarily annoying personality trait is sort of like being aware that you're, if you were the trainee or the nurse anesthetist listening to yourself, um, you would not be a fan of being micromanaged and perhaps the way that I would want to be micromanaged. So, it's good to be a little ego-dystonic, or perhaps self-aware and know that, ah, you need to let the other person make their mistakes or have, ah, time to shine. Ah, ego-dystonia being like when you're aware of your defect, as opposed to ego-centonia where it's just like is part of who you are, and you don't realize that it might be wrong to other people.

WEI:

So, um, I feel like being positive. People make mistakes, I have weakness, it's fine as long as I didn't do anything bad to my patients. Patient's still safe. There is like, uh, the bottom line, but if everything is about the bottom line, it's okay, like you practicing your style, and I practicing my style. Life needs to move on. Um, we still need to work together, it's okay. So, I feel, I feel like the attitude is very important, too.

SHARA:

What do you feel the most confident in about your preparation for the future and what is the most daunting to you?

For me, it's pretty daunting that people are going to perceive my opinion as an expert opinion. Sometimes I think that I'm just sort of, not making it up as I go along, like it is based on something, but it's not necessarily like the right choice. Like maybe there is no right choice. It's just they're looking on me to make a choice, so I have fulfilled that role for them. Um, like a patient or a team perhaps, um, but then it's daunting to like see other people listen to you and go along with it like you're some sort of authority, technically, we are. Yea, and there's always like probably other options, like you've just chosen this option for them right, like for example um, say you've like decided to pursue like pressure therapy or something in the ICU, as opposed to a patient going back for surgery, and everyone's sort of looked on you to make that decision, so you made that decision for them but it's not necessarily the right decision.

RICKY:

But I think one thing that I've learned and come across is that if you, if you can have the knowledge and the expertise to make these decisions in an evidence-based, sound physiologic manner, and if you can confidently defend your decision making, that we do know, you know, what we're talking about and we are experts even though there's definitely a component of impostor syndrome every single day. But, if you know the evidence, if you know the data, and you know how something is going to benefit a patient from a physiologic perspective, then you can confidently defend your decision making in the OR in the ICU. I think that's a big part of what we're learning how to do.

SHARA:

I think it is the biggest change from being a trainee, though, because you always had the backup of your attending, and at that point you don't necessarily, but it goes back to the fact that like you're not truly alone as an attending either. You can always call upon one of your colleagues to, um, like offer their two cents and maybe they'll come to the same conclusion as you or maybe they'll say with something that you maybe haven't considered at all.

So, let's hear some advice. Are there any noteworthy "do's" or "don'ts" that you've picked up from doctors who are currently in the field?

I think that I have heard a lot about how it's really important to be respectful about, um, like, other types of providers that you encounter in the profession, so like to always be kind to nurses that you work with. Um, or like if you have like trainees, or um, like nurse anesthetists with you to always be very, very respectful towards them, and I think um, like sometimes there's a bit of a counter-culture, some see as some other types of practice models might be newer, or I think, um, nursing is more unionized these days and it's not necessarily like the traditional hierarchy of medicine that it used to be. It's more of, like, a team sport. Um, but, because it is a team sport, like to just know like everyone has like a really important role, and that, um, respecting everyone else in the room like really takes you far. If you're in a crisis situation, but also just like for career longevity, like people could really make your life very difficult if you're not nice to them, so it's very important to be nice to them.

RICKY:

In, in the same line with that, something that, a piece of advice that I got very early on as a medical student before I even knew I wanted to, to be an anesthesiologist, was, when it comes to caring for a patient, there should never be any piece of work, any piece of anything when it comes to taking care of a patient that you should feel like you are above. If you're in the room with a patient, and the patient asks you that they want a glass of water, and you know where the water machine is, and they're not NPO appropriately, uh, you should do that for them, even if it's not your job. In my opinion, it's the right thing to do and it's best for that patient. Um, if you're breaking down your anesthesia machine, or if you're finishing a case at the end of the day, and your circuit needs to be replaced, and the tech is busy running around because, you know, the techs are busier than we are, you know, you should never feel like it's above you to replace your circuit and wipe down your machine. That's how I approach my practice and I think it's; it creates a nice team atmosphere.

SHARA:

I also think when you are with a tech or with, for example, a circulating nurse, and they can teach you, where like the blood samples go, or how this particular, like, anesthesia machine is, like, taken apart, um, there's so much we can learn for them, from them, and then when we're alone in the middle of the night or something or like we don't have, um, sort of this extra staff that we might have during the day, ah, just making sure to like speak to them actually helps you a lot when you are actually by yourself.

RICKY:

Yes, system, system stuff that folks that have done this at your institution for like a lot longer than you have. Cuz the anesthesia and the medicine stuff, you know...

SHARA:

It's not really like that different, you know.

JOE:

Yea, but where to find something... Huge.

SHARA:

Can you relay some real practice or related scenarios that come to mind when you're giving advice to those just entering the professional world of anesthesiology?

JOE:

Not like a specific example, but I was just saying in general, um, when you're first starting out, just if you have any questions or anything concerning is going on, and you're by yourself, just tell your attending. I think most attendings will say that nowadays, but um, I think it's still true. Um, if you're worried about anything, you gotta remember, you're dealing with a patient's life in front of you. It's not like, you know, oh, it's like simulator or a model, or a dummy. You know, it's a real person, and I think you gotta remember that. If there's anything that doesn't look right, you just call 'em. Just, even if it's nothing bad, or it was like a false alarm, I'm sure 99% if not all of them would be more happy that you called, and that you shows that you were thinking about things, um and concerned then if you didn't and something went bad to the point where now they're trying to play catch-up, or you, or something bad happened as a result of it. Um, even last week, I was in a very long case, and something went wrong with the machine. I honestly had no idea what was going on, I had never seen this happen in my life, um, in my short two years of doing this, but I called my attending right away, and they easily were able to fix it but it was not something I had ever seen and they were like, well yeah happens infrequently but this is how you fix it, and I learned from it, too.

WEI:

Yeah, I think that's very important because, um, prior to my, um, anesthesia experience, my style is like, I try to fix the problem myself, like I will try my best. I will always tell myself like that, but anesthesia, after some experience, of like laryngospasm or patient decel an getting worse like so fast, there's no time for you to like fix it yourself. If you don't know how to do that, don't hesitate to call the attending and or senior or anybody help you to fix the situation as soon as possible. Anything can happen, like we use a mnemonics to set up our rooms. Sometimes, especially, uh, like the turnover time is very important, like if you try to rush yourself, you sometimes I like skip skipped some steps. Like the suction are usually doing fine, but don't thinking that way. Anything can have some problems, so now I'm usually, I always check if there's a uh, the bougie, if there's like a anvil bag, and, uh, what is it, all the cylinder of air, of oxygen and all the nitrous are fine. Because, whatever, uh, if anything bad happening to those things and you didn't check it, you gonna regret it. So, make sure you do everything under a protocol. Every day. Every time.

RICKY:

Very similar to that, I had a situation midway through C1 year-ish, where, and I don't recall exactly what happened, but we lost fresh gas flows in the middle of a case, um, and it was probably the scariest situation. Fortunately, because we did our, we had our checklist, we had a reserve tank of oxygen right there ready to go. That was full. And we had an Ambu because we checked. Just boop boop, switched it off, switched to TIVA and figured it out. You know... But, if we didn't check, we would have been in a very precarious situation.

SHARA:

I induced anesthesia down an MRI recently, which is like no-man's land in this hospital, it was bizarre, it's basically in a trailer because the MRI area is under construction and it like can't be adjacent to the building because the machine has to be like on its own. Uh, and there are, like, a lot of rules about like what you can like bring in to like the MRI trailer and stuff like that. And so we basically induced anesthesia in the hallway and then brought the patient into the MRI machine, and I was like I practice anesthesia on the street, like, (LAUGHTER) I need like an IV and I need an Ambu bag, and like, I'm good. (SOME CHATTER)

And, I was like I can do that here. So, like, kind of like being in these neo-scenarios, like, we realize oh, some things really aren't that different.

RICKY:

I think too a lot about, I'm on a, I'm on cardiac now, I think about taking a patient who just had open heart surgery from the OR up to our ICU, which is far-ish away from our, it's a, it's a good 5 minute, which in, you know for us is an eternity, so many things can happen, but you're basically running a mini traveling ICU. You have all the medicines you need to support this place, patient's blood pressure up, down, heart rate, you're breathing for them, you're keeping them sedated, you're running a little mini ICU there. And it's like, whoa. This is crazy. What we do, um, but it's also very fun.

JOE:

Yeah, I've never thought about it like that, but it is true. It is crazy.

RICKY:

In an elevator, too. (Laughter)

MUSIC/OUTRO:

SHARA:

It's been great working on this ASA resident podcast series. Has the ASA been a valuable resource to any of you, and if so, how?

RICKY:

Yes, I was very fortunate and, and lucky to actually receive the American Society of Anesthesiologists, the Resident International Anesthesia Scholarship. Um, it's a great program that the ASA puts out and so us, as a result, I am going to have the opportunity to, to work and teach abroad for a month as a part of my

residency thanks to the American Society of Anesthesiologists. (laughter) No, I am truly grateful. That's, that's, you know, it's a, it's a great opportunity and I would recommend anyone listening to this, uh, if you're interested in doing that kind of work, to apply for it.

SHARA:

Yea, and likewise, so now that I am a resident, um, I serve on the ASA Resident Component, which has opened the door to all sorts of opportunities that I would not have otherwise expected. Ah, and it kind of gets into the idea that like there is a wide breadth of things that you can be involved with as an anesthesiologist, and the ASA is like a good gateway into sort of learning about all of these things that exist out there.

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