



American Society of
Anesthesiologists™

Residents In a Room
Episode Number 8
Episode Title – COVID-19 Stories from Residents
Recorded April 2020

(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.

The anticipation is emotionally draining.

Just being over-prepared has helped us a lot.

And you're seeing friends with COVID, and it feels very personal.

KANDICE:

Hi everyone. Um, my name is Kandice Olson. I'm an anesthesiology resident, uh, currently working at Baylor Scott & White in Temple, Texas, and welcome to Residents in a Room. Um, I have myself an, uh, some fellow anesthesia residents joining in on this podcast to talk about COVID-19 and how it's affecting us as residents in our day-to-day life.

So as an anesthesiology resident, um, I feel like my experience is a little unique. I am currently almost 36 weeks pregnant with my third child, um, and facing a lot of uncertainties with being a resident was being potentially exposed COVID-19 and what it will, what it will look like for myself in the near future and, you know, long-term as well.

Currently, um, with hospital policies, I'm not permitted to take care of anyone who is confirmed positive COVID-19, and, and they've allowed me to be working from home a lot in my last month of pregnancy, which is incredibly helpful, um, but also very different. I was, just this week, also notified that I was, I'm going to be one of our chief residents for next year as well, so I'm doing a lot of work from home trying to prepare for that responsibility. Um, a big concern I have being at the end of my pregnancy is, you know, what it's going to look like it at, at time of delivery. If I'm sick, will I see my infant for a

while, you know, or will the infant be quarantined away from me? Um, what's it going to look like in the delivery room, will I have support of someone being there with me and plus coming home with a newborn, what kind of support I might have. Or how much isolation I'll be in to care for, for a newborn. And it's hard also being a resident, and seeing all my colleagues, you know, kind of rise to the challenge of taking care of patients, or planning to, and me feeling little helpless in the background. It's completely, you know, I can't, I won't be able to help that way, but, um, hopefully in other regards in the hospital, whether, you know, planning the rotations, um, or helping with OB or, our pain management team, so I can be of some use as well.

A lot of things have changed in our residency program and I'm sure Rajeev and Bryce will speak about this as well. But we've completely disbanded all of our rotations, um, most of our residents are now working in the main operating room. Um, some, very few are working tele-medicine like the pain management services. And but really at this point we haven't had, seen a surge COVID-19, but we're in, we're deep, deeply preparing for the possibility of this, of a surge and contingency plans with that, um, which is where the focus for the residency has been. We've had residents, um, to try and kind of conserve our people so I'm working from home, and others being in the, in the hospital. We've completely stopped doing any elective surgeries, we just have urgent or emergent surgeries going, which, on any given day that may take four or five of our residents and the rest have other responsibilities that were trying to delegate. Um, we're also preparing to take care of critical patients in um, a perioperative service ICU where we've kind of changed our day surgery and our PACU to bring in anesthesia machines to ventilate patients that may need it, kind of overflow from our medical ICUs. We've also created a plan with our residents for who will staff those, the ICU and who will take care of those patients.

Um, I'm another issue that I'm, you know, I've heard across the country as well, is the personal protective equipment shortages, and here as well, in central Texas we're experiencing that as well. Um, a lot of our residents, you know we'll get one mask that we check out each day and then turn it in at the end of the day, in, in attempts to sterilize and use a mask up to maybe 4 times, um, if we are able to reuse them. We've also had many, um, people donating supplies to us. And also many of my colleagues are improvising trying to make their own pro, protective equipment, you know, like a respirator with a snorkel mask or things like that. And then also planning how, um, we'll intubate patients, you know, with protective barriers on top of our masks and, and goggles. Lots of changes, lots of concerns, again, we haven't had a surge or, you know, cared for many patients with COVID in the operating room or in the ICU, but the anticipation is emotionally draining.

BRYCE:

Hello. My name is Bryce Austell. I'm a PGY4, um, anesthesia resident at Rush University Medical Center in Chicago, Illinois.

It sounds like a lot of my experiences have been similar to Kandice's. Um, I mean, our, as residents, obviously rotations are kind of gone or more flexible, um, just given the fact that all of our emer, or all of our elective cases have been canceled. Even for a week, we went without urgent, uh, cases, but as this continues, some cases, like oncology cases, um, like cardio cardiac and, um, thoracic cases need to go. So we've been introducing those more slowly, um, but that leaves a lot of rotations, um, not able to be done, like regional rotations, um, and you're more standard rotations like reg, regional 2, um, that would involve more advanced blocks and things like that. But you still have OB going on, um, pain is affected, a lot of telemedicine visits and they've had to cancel all of their outpatient procedures, so lots of changes. Um, we've also, like, started some MASH ICUs as well. We surged a couple weeks ago. I think currently in inpatient we have about a 150 COVID-positive patients, um, so we filled four of our ICUs and we filled one of our MASH ICUs and we're about to start filling our second and third.

Um, we're in Chicago right now, so, we're not quite as bad as New York, um, but I think we've had a little more time to prepare, um, in terms of staffing and getting PPE. Um, thankfully our hospital was kind of, it was built in the last 10 years and it was kind of designed to be a disaster preparedness, kind of like, mass casualty type of hospital, so they had a lot of PPE stores in, in storage um, so they're telling us we have enough until August or September. So, I mean, I've definitely heard these stories, heard stories, read articles, talked to uh, other trainees across the country that are definitely having PPE shortages similar to Kandice's situation, but thankfully we've, we've been okay. Um, and we're basically we're wearing our N95s as long as we can throughout the day, um, but once we, they're soiled, or we take them off, we do dispose of them. And then they're requiring everyone in the hospital to wear masks. Everyone has to get a temperature taken as, as you come in the hospital. Um, no visitors are allowed, um, which is, you know, really sad for the patients. Um, it does make our job easier and makes it our job safer and that's why they're doing it, but it, its a very sad aspect.

I'm in my last year right now and do a lot of scheduling has one of the Chiefs, so it has been a nightmare in that regard. Um, just moving everyone from regular rotations to, um, our surge rotations. We've been getting surge residents from all kinds of specialties, ortho, um any kind of more sub-specialized rotations, um, like optho, even derm, pathology, um, all kinds of residents, but they kind of been looking to anesthesia for um,

leadership in these rolls cuz it's a lot of intensive care responsibilities, and lines, and airways, and vent management and we've been using our, we ran out of like normal respiratory therapy vents when we filled up our 4 ICUs so in all the MASH ICUs we're running anesthesia vents, which has been a journey in and of itself, just figuring out how to, which modes to use, and how to, you know, use the equipment to make it last for a long time because some of these patients are intubated for so long. But we've had a separate, like, rotation for just anesthesia residents, just, we just calling it "vents" where they're kind of like a liaison between, between respiratory therapy and the, the anesthesia ventilators.

We've also like, created an airway team. So usually we just have our residents from the ICUs or our call team be in charge of airways, but because they're so frequent and it, you know, requires so much um, time to don and doff your PPE appropriately, um, we've had, uh, we started with like, a resident and an attending on, and now, we have a resident, two residents and a CRNA just in case we start, there have been two concurrent airways for COVID intubations. Um, so that's currently what I'm on. We haven't had too many calls, but we may later today. And then just for PPE, for the airways, I mean for anesthesia, you know, we've been using the goggle, the goggles in the and N95s, as Candice was saying, um, when we're going to see patients, but especially for intubating, we've been using additional PPE. We've been using the cappers. If you're using a capper, we don't necessarily use an N95. You might use a surgical mask or, or you don't, you don't even have to, but we use the ... which is basically, a it's like a viral filter and then we've been using the gowns, double gloves or even triple gloves, boots on the feet, and then, um, ortho hoods too, which is just an extra layer of protection, um, but that's what we've been doing for all of our intubations. And then all of the intubations in the OR, they've been having people wear N95s and then we had some of these aerosol boxes made that can help just be an extra layer of protection against aerosolation during intubation, intubation and extubation. Those have been primarily used in the ORs, but in theory could be used in the ICUs, too, if people are running low on PPE. Tons and ton of changes, and it is literally a day-by-day organizational feat.

KANDICE:

Bryce, can I ask you a question?

BRYCE:

Sure.

KANDICE:

More curiosity just cuz we haven't had the surge or experienced it, but our team have. Like for upper level residents, there's a plan, at least at our institution, um, depending on how many people we're needing to take care, but, um, especially the CA3 residents pretty much acting as an attending, meaning less to min, to none, minimal supervision. Um, a lot of the procedures and intubations and things, is that something that you had to transition to, or needed to do, or something that's in place for you guys as residents?

BRYCE:

Yeah, that's a good question. Um, actually, I mean, given the fact that so many of the elective procedures are canceled, a lot of our attendings have been more free and our residents are more free, but we're now busy in different ways. Our group is a private group, so but we're at an academic institution. So it's a little different that maybe if you're just say it an academic institution. Um, initially, it was just like residents and CRNAs involved with airways but as more recommendations came out for, to be the most experienced provider, um, taking care of airways, our attendings have been involved since kind of that recommendation. I think, usually the airways are, like, we let our senior residents take care of the airways if they want to intubate or push meds, we usually they just have two people go in.

And I think senior residents are usually pretty comfortable with, with airway management unless it's seems to be a difficult airway, or you know, there's going to be some kind of exchange, airway exchange, which we've now made a protocol for, because that happens frequently, then we'll make it have, make it be the attending on call or the attending that's on the airway team for that day. That's another thing, there's a lot of airway exchanges, there's a lot of these patients that, get laryngeal edema because they're being intubated for 10 to 14 days, um, and they're also being prone. We are proning a lot of our patients, and we are paralyzing them beforehand, but we're running out of like, cisatracurium drips. So we're having to push, like ... before we prone them and then sometimes the tube gets dislodged, and then you have that whole situation, emergent airway management. Um, so we're trying to have our attendings be involved in every step of the way and I think they're available for that, um, is just a matter of making it known that, you know, you want their involvement. And they're, they've been giving tons of input in the MASH ICUs because those are, we're making MASH ICUs in our pre-op areas, in our like, PICU, ICUs, and then we've moved a lot of our, our regular floors, because we've moved a some of our floor patients to the atria, or to our lobbies. It's just kinda, kinda crazy. But overall, I mean, I really think that just

being over prepared has helped us a lot, and I think things are relatively under control. We've been able to learn from a lot of other countries, and, and New York.

RAJEEV:

My name is Rajeev Saxeena, and I'm the Academic Chief at the University of Washington department of anesthesiology. So you know, I think this conversation shows really so many different approaches that both Kandice, as well as, Bryce kind of brought up at their hospitals. I think that, you know, what I can add is a little bit of a unique perspective being in Seattle, where this kind of initially, infamously, I guess, kind of the epicenter of where this started. You know, so I remember about 3 weeks ago, you know hearing about, you know, that basically in our greater Seattle area, um, in some of the nursing homes, how there were, you know, patients with COVID-19. And I think probably most residents relate to a combination of, you know, we got this far by being resilient and not by over-reacting, but at the same time kind of hearing the stories out of Italy, and starting to become kind of, more concerned. And so I think it was around three weeks ago that, you know, there was just a lot of fear starting to mount in the hospital, and flexibility has sort of been the name of the game.

I think we're at a point now where everybody is a bit more comfortable with the uncertainty. And with the reality that policies are going to change sometimes multiple times in a week. You know, for us, we I think had a little bit of a different approach I think than what kind of Bryce is outlining in that it seems that we aren't using quite as much PPE for, kind of, standard intubations. I think our approach has primarily been aggressively testing everybody and then trying to avoid using PPE if we're able to. So we have over 100 patients in our hospital that are COVID-positive, for one of our hospitals, um, we have multiple hospitals.

And so, about a week and a half ago, you know, we did likewise, I think under the guidance of the ASA, as well as other bodies that sort of recommended cancelling all elective cases, the challenge, it's not a unique challenge, that we faced, is that we do a lot on oncologic, neurosurgery, cardiac surgery and "what is an elective case" becomes a very real question. For us, eliminating elective cases still resulted in about 30 to 40% of our clinical volume. And so, it was not sort of a complete operating room shut down, and so naturally there were a lot of fears from residents, from nurses, from recovery nurses, in terms of potential for aerosolized exposure for some of these patients.

And so what we've seen in Seattle over the last two weeks, is testing basically go from about a 7-day turnaround to 3 days, to 1 day, to now a rapid test which is 2 hours. Um, it's still limited in capacity, but we're able, in terms of how many people can get the 2-

hour test, but all of our operating room patients get this 2-hour rapid test. And you know, obviously there been mistakes along the way, implementation hasn't been perfect, however, we were able to move into now, no operating room case goes until we COVID status. And that's really changed the approach in the sense that we do obviously, then, a lot of intubations without, with just our standard PPE, because we have sort of within 72 hour documented COVID status. Um, urgent and emergent cases are treated, um, if we're, usually they can wait 2 hours for that rapid test. But if they're unable to then we wear full PPE. Um, I think about three weeks ago, maybe because it initially kind of started here, we, I think have benefited a lot from places like the Institute for Health Metrics and Evaluation and, kind of honestly, leadership across all our different hospitals, kind of banding together. So we started a COVID specific ICU about three weeks ago and I think kind of what Bryce illustrated too, I think we were fortunate to have a lot of PPE, relatively speaking, I mean nobody has an abundance of it, but we seem to have enough PPE, and I think starting earlier allowed us to sort of contingency plan well.

So I think from a hospital standpoint, you know our COVID ICU feels like a very different place than the rest of the hospital. Certainly our emergency department feels very different. Our operating rooms actually feel extremely safe, because, for the most part we know the status for everybody. It's probably the safest place in the hospital. Uh, I think as one of the Chief Residents, you know, we spend an extraordinary amount of time with our Program Director as well as, uh, for me, with the Administrative Co-Chief that I have, talking about scheduling and essentially we moved from a model where we have residents staffing at four different hospitals run you know, by three, run by three Academic Chiefs, into one hospital staffing model where we've spoken with Chiefs from other west coast programs to talk about pods, to talk about all the different types of model in which we would basically be able to rapidly mobilize, uh, residents depending on ICU needs. Um, so, so far we haven't had like a COVID-specific, or airway team, or like a surge team yet. Um, which has just, um, but you know of course, that's something that we thing about a lot.

I just want to emphasize one more time, I mean, the IHME models, um their websites are really incredible, and it's allowed us to really kind of understand that while expect the peak to be in mid-April for us. And so just continuing to be able to mobilize residents as needed knowing that people are going to be out due to vulnerabilities, whether it be pregnancy, immune-compromised, elderly parents, you know, at any given point there may be 10-20% of residents out for these reasons, so we've had to remain very flexible. But fortunately, thus far, we haven't really had to develop full pods or surge staffing models. We just moved kind of individual residents here and there to, to meet the needs of the day.

BRYCE:

Just to kind of piggyback on Rajeev's comments and, and Kandice being on, congratulations on almost, being so close here, but yeah, we've really taken it, taken it upon ourselves to protect people who are at risk, you know, we have pregnant residents, attendings, um, people that are immune-compromised, um, more elderly attendings, and we've kind of put them in places that are more distant from the COVID unit, whether that be like in a pain clinic, doing tele-medicine visits, or you know, just letting them stay at home and work on assignments, and kind of, one of our attendings is you know, doing oral board reviews, or mock-orals with, with residents who are at home. Just kind of making that a priority, cuz, I mean, like what Rajeev was saying, you know, you can have up to 10 to 20% of your residents out at one time. We've already had 2, we have about 80 residents, we've had 2 test positive and 15 to 20 at least get tested and, you know, during that process, ours hasn't been quite as quick as Rajeev's. Ours was taking 24 to 48 hours as of a week or two ago, so, you know, people are out for a decent amount of time during that, and they're still symptomatic. And, you know, who knows how sensitive and specific the test is? Um, so it's up to, we're relying on our employee health services to kind of give us the A-OK whether or not they can come back to work or not, but um, often times it takes days to weeks, um, so just a lot of flexibility is required.

RAJEEV:

One thing I wanted to add, you know, it's, I find when this initially started a week or two ago, it was very easy to delve into policies and differences between policies and what made sense, but I think obviously we're not over this yet, um, but I think all of us can relate to it. This pit has become smaller and smaller, and we're in this pit, and you're seeing friends with COVID, either near or far, or you know, relatives, and it feels very personal. And I think that it's never been more important to like, have good leadership in hospitals. And so, you know, I feel very fortunate that, you know from our Chairman to our, kind of, administrative leaders have really sort of kept the peace, so to speak and really tried to communicate. I think kind of, this shared vulnerability has really made it uh, very challenging, right, and the human nature of just simply like, you know, this local restaurant donated some food, you know, to the staff. I mean that, that's gone like a really long way. And you know, this idea of like, you know being afraid to come into your own home for fear of like infecting your significant other. Right? I mean, it really, sort of, puts us in a mentality that I think most of us, certainly me, I mean I've never had to experience before, so, and so I think sort of hopefully, one of the lasting impacts of this will be our shared sense of community and the responsibility we have to sort of uplift one another. Stay motivated together.

KANDICE:

Yeah, I'll definitely agree with all of that. One thing that's been a major change in our program, we have a smaller program, there's about 10 per class, and being in a smaller area in Texas as well. It just, we really have like a close family feel in the program, in the department, and for about the last month, a little less than that, um, we've stopped all of our in-person didactics where we would meet every morning to discuss topics together and, and learn before the operating rooms started and they've also discouraged any group gathering. So we when we go into our, our resident lounge, know if, there's more than like three people in there, people will turn around and walk out just to try and respect the, the distancing of the residents, which is good that we, we're thinking about those things and trying to protect everyone, but at the same time, it's really, it's really hard to not have that physical connection and feel as close that way.

But, we've tried to do more virtual connection, touching base with everyone, at least through the phone and, and I don't know, online teams or work spaces for support that way. Um, and our GME has been really great at communicating with us on the current state of the COVID-19. I think we have less than 10 in our, um, ICU that's currently admitted. So very, drastically different from what you guys have, and um, still kind of in the planning and preparing stages for, for who we might take care of. We're expected, I guess, to search at the beginning of May, end of April, um, so we're kind of working toward that. But huge changes as far as like, how we get our support, and keep our morale up at this time. You know, it's been recommended at least daily, to disconnect and try and do something normal, to not read about COVID, to not like, look up all those things. Do something that you would do in your normal life. And I think from all of this, this just to ground yourself and not get burnt out from everything cuz it's draining. Even for us, without having, you know, experienced the volume that you guys have, and the stressors that come with the changes that you've experienced.

RAJEEV:

I think one thing, um, Kandice, you were mentioning emotionally draining, I think one of the challenges of a resident is that, you know, at least for cases, for example, you know you need to have an attending of record and you know, we're not quite able to practice completely independently yet, that's partly why we're residents, but, you know I've found myself sometimes in a bind, too, with COVID intubations or re-intubations at night, when I'm like the one OR resident in house and seeing that potentially my attending may be vulnerable and kind of wondering, you know, uh, who should be doing this intubation? Our general philosophy here has been, the minimal amount of people required, and so if there are no concerns about the airway, generally speaking for an ICU intubation, then it

will just be the anesthesiology attending, the bedside nurse, to push drugs and a respiratory therapy. Um, and so, the job of the anesthesia resident is sort of like runner to maybe hand meds in, or, or maybe if there's some concern to be addressed in the ante room, so you can come in if needed. And the same is true for COVID-positive operating room cases. But, you know, you find yourself, you know many of our attendings themselves maybe on the older side or pregnant or have you know, vulnerabilities, and it's never quite, it's never quite black or white. And so I think that, thus far, you know, there isn't a policy that anyone can make, that can sort of determine, you know, what the right thing to do in that situation, and so in some respects, I feel like it's made the distinction between provider, providers very small. And, you sort of just have to evaluate. You know, who is the best person to do this, what is the risk and how are we going to get the job done. A very different mentality than kind of, typical residency business as usual.

BRYCE:

So kind of in addition, um, one thing we've been concerned about is, you know, how is this affecting residents' education, um, just given the upending of our, you know, standard rotations, and our standard didactics, and everything like that and how is it effecting our, our training? I mean, in one way as we sit here on Zoom, is that we've been trying to make a lot of our didactics within social distancing guidelines. We've been using Zoom, we've been using, you know, phone and we've been using more written, um, presentations, and, and lessons. Um, we do those every morning and then we've been doing our grand rounds over Zoom as well. Um, and there's other apps out there, too, that can allow you to do video conferencing. Um, I think what people are most concerned, though, is probably in terms of their numbers. I mean many residency programs get, you know, tons of numbers, and maybe some other, some programs only get the bare minimum.

Um, so there's a wide variety there, and I think every program is gonna be worried about different, you know getting those different case loads of whatever they're, maybe, you know maybe not so heavy and um, but I know, just talking to CA0's and 1's, they're already concerned, you know. I was talking to people who were on ... which is where we do all of our epidurals for our ortho procedures, and they didn't get any epidurals this month, and now they're on OB, and, how are they going to, you know, know how to go an epidural for, for a, a pregnant patient? Um, so that's just one example, um, I mean, thankfully OB will continue to be strong and a lot of are more emergent cases like Rejeev was alluding to, you know, you're emergent neuro cases, your emerging, you know, cardiac cases. You're going to still get some of those numbers, but you're not going to get the plan, planned elective cases. Honestly, I feel like we haven't even had

time to think about what we're going to do to, you know, take care of it. It's been so quick and hopefully and, you know, in couple months we're going to be back to normal, quote unquote or whatever that, that means. And we're going to be able to get it a lot of these elective cases back up and running and hopefully we'll be able to make up for some lost, lost time there. So, it's in the back of our minds, but as of now, we're just reassuring our juniors, who are the ones that are concerned, you know our CA0's and 1's, um, that, that it's going to be okay. That's, that's about it for now.

RAJEEV:

So I think about this often, um, as the academic Chief at University of Washington, where, generally speaking, my, my role would be thinking about didactics and education and trying to figure out how we can kind of revamp our curriculum. Um, but I would say reality is that we're dealing with something much more important right now than our immediate didactics and short term sort of education goals. We have, I think, similar to what Bryce and Kandice described, you know, moved to Zoom. However, I will say that, you know at this point that was only about a week or two ago and it seems that things are changing so much that I'm not even sure who's going to be able to attend those didactics, and whether or not even if you attend will be focused on it. I think, you know, we are all learning from this own experience and hopefully in four to six weeks or so, you know, we'll be at a point where we kind of resume our didactics full, full fledge.

I think the practical kind of response that we have is, you know based on the time of year, where we're at, you know, everybody had a request for CA3 year, CA2 year you know, and electives and all of that will probably get turned upside down, because many people may need to make up case numbers, for example, in cardiac or in regional, where volume is significantly lower, um, and perhaps, you know certain other rotations based on where at our institution people get a lot of numbers, maybe they won't have to do those rotations and so I think a lot of this will be determined based on like where people feel if they may need higher cases, case numbers. Um, you know, this is also not quite black or white. So the ABA has basically said, you know, they're willing to waive the typical requirements for graduation. And for many people that would be okay cuz they may feel competent with the number of cases they have. For others, they may not, and so I think that it will require some flexibility in terms of rotations over the next eight months to a year probably to kind of really make this up. But right now that's a problem that we're kind of thinking about down the road, and kind of looking squarely at the problem that we face right now.

BRYCE:

In, in a way, it's kind of a very cool learning experience in and of itself. I mean as awful as it is, it really is right up our alley, we're doing intensive care, we're doing airway management, we're doing disaster preparedness, we're like you know, using the resources of the hospital in working interdisciplinary across all professions, it's really, in a way, it's an interesting time and as a senior resident, I find it very rewarding because we kind of already have been exposed to everything and you know, it comes at a perfect time. We have almost become comfortable being, you know being, an attending, almost. And it's like our last test, um, which, that's how I like to look at it. Not everyone can look at it that way, but.

KANDICE:

Right, I agree with you. I think it's a very unique opportunity for us as residents in training during this time. You know, it's hard to say what the long-term effects will be in our education given, you know, the current state, but I guess it's my hope that residents can take this time to enhance their learning. You know, you might gather skills or things that you otherwise, would not have, you know, in in planning for a response to changes and communication, organization, and you know, different things like that. I've, I've been reading from anesthesiologists who are in like, private practice or things where they're without work or you know having to adapt and and take on new roles to help the hospital and adapt to these changes too, so, I think as us being in training and having this opportunity we can, it would do us good, to to try and enhance our learning, although it's very different from what it looked like a couple months ago.

BRYCE:

All right. Well, this has been a super interesting conversation and I really appreciate hearing from Kandice and Rajeev and kind of hearing the different perspectives from across the country and it really is helpful to, kind of, put our heads together and, um, come up with a plan, uh, to, to take care of us, and to get through it together. Um, so thank you for joining us on this special episode of Residence in a Room, uh, COVID-19 Edition.

OUTRO/VOICEOVER:

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