Residents In a Room
Episode Number 9
Episode Title – The Podcaster Speaks Up on COVID & More
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.

DR. JESSICA IBANEZ, HOST:

Hi everybody and welcome to Residents in a Room. I'm today's host, Dr. Jessica Ibanez, one of the chief residents here at Johns Hopkins. Today, rather than interviewing other residents, we're actually going to turn the tables and interview veteran podcaster, Dr. Jed Wolpaw. Dr. Wolpaw is an Assistant Professor of Anesthesiology and Critical Care Medicine at the Johns Hopkins University School of Medicine, and the host of the popular podcast ACCRAC. Thank you for joining us today, Dr. Wolpaw.

DR. WOLPAW:

My pleasure. It's a pleasure to be here.

DR. IBANEZ:

Let's start with the world as it is today. We're recording in April 2020, so COVID is rapidly evolving, changing our routines and how we care for patients. It's fair to say that we're learning a lot, and learning it quickly. Can you talk about what you've learned, maybe share with the audience some of the things you think are most important to understand in this moment?

DR. WOLPAW:

Sure. Thanks Jess. This is an unusual time, maybe even an unprecedented time, and I think it is really bringing out, not only a lot of important lessons, but a lot of really

impressive uh, signs and uh, demonstrations of how we can step up. We as people in general, we as healthcare providers, um, and so I'll talk about a little of that.

One of my favorite lessons, I always try to keep in mind that I speak about it from time to time, is that we have to always be a little skeptical of what we think we know. The human brain really likes to have things figured out, and to just be able to say, all right, I know this, I have the answer, this is knowledge, I can now move on to other things. We do that in medicine a lot and one of the talks I give sometimes it's thinking about how we need to question the things that we think we know. There are countless examples throughout medical history of times where we were sure of something and it turned out to be completely wrong. And one of the things I think we seen in this rapidly evolving pandemic, is that there is that temptation again to think we have figured it out. You hear on the news and even around the hospital all the time people saying, oh, we know this. These patients need this. For example, at the beginning when we first started seeing these patients here, we thought they really benefited from high levels of PEEP. We thought that once they got on the ventilator, we put them on high levels of PEEP, not even just the standard ARDS PEEP, but high, the high levels, the kind of high PEEP table and that they would benefit from that. Now, why did we think that? Because the first few COVID-ventilated patients that we saw at, at Johns Hopkins did benefit from high PEEP, and so we figured, okay, this must apply to the disease as a whole. As it turns out, that was not correct. Those were unusual patients for a variety of reasons and it turns out that a lot of these patients actually have high compliance and they don't heal and in fact non only do they not need high PEEP, but they may actually be harmed by it.

And so we've had to re-examine what we thought we knew, and question it. I think that's something that we really need to keep in mind, that as desperate as we may be, that to be able to grasp at a new therapy or you know, someone says this drug may work or we think this might be the cause of hypoxemia, and there's all kinds of theories out there. The real answer is we don't know and in fact the, um, some of the current guidelines, there was a, a kind of meta-analysis that came out recently that, that said look, for all these therapies, all we know is don't use them unless it's part of a clinical trial because we just don't have evidence for it. And even though it's tempting to kind of grasp at straws, you want to be careful. You don't know if you may actually end up hurting patients, and without good evidence you want to be very cautious. So I think one of the things were seeing in much more rapid fashion than we normally see things in medicine is, we think we know something it turns out not to be right.

And so we want to be very careful and remember that there's a lot we don't know, and that's okay. It's okay not to know and uh, we have to be okay with that. So that's one of the lessons I think we see a lot. Another is, really what we're capable of and what I

mean is the incredible way in which, not just healthcare providers, but of course, Jess, you and I are in the midst and surrounded by healthcare providers and are healthcare providers ourselves. And so what we see, day in and day out, are our providers really stepping up. And, the, the example, I would give of course, cuz I'm most intimately involved with, is our Residency Program. And our residents have had their schedules completely upended. They've been pulled off of electives, they've been told they, sometimes the night before, that actually they're going to be deployed instead of to the operating room to a, a new ICU, maybe an ICU they've never been in cuz it's usually run by medicine. Or maybe an ICU that didn't exist two days ago because we just stood it up as a new ICU to take care of the influx of COVID-19 patients.

And almost without exception, people have stepped up in ways that I really think is, would have been hard to understand without seeing it. And that is just selflessly, bravely, without question, saying I will do what is needed. I will take care of these patients. I will work with whoever you need me to work with because this is my calling. This is my, my job. Now, we want to be very careful that we don't, uh, spread the idea that people should be doing this unsafely. We do want all of our healthcare providers, our residents and everybody to be protected to the best extent that we know is safe. So we have been lucky here that we've had adequate levels of personal protective equipment for the disease, and we make sure that they have that before they go into work with these patients, but given that they are able to be safe, people have really stepped up and, and not complained about the changing of schedules and, and the, you know, random weekend shift they didn't think they were going to have to work, but that they they now work.

So it's been inspiring to see this and then the final thing that I've been really touched by, is the response of the community. I think that you see such gratitude towards healthcare providers that really we don't normally think of, or see. Of course a patient who comes in and who gets treated and does well, will be grateful to their clinicians, but on the part of the broader community, this realization that healthcare providers are really on the front lines and are doing this work and putting themselves uh, at risk and, and to see, for example, the 7 p.m. cheer that happens in New York City every day, uh, for healthcare providers. I think that was initially started in, in Europe and Italy, I think, and, and now has spread, at least a New York, and maybe other cities, I think is really is really, um is really touching. And I think we have to realize of course that, that one of the things I hope comes from this is that there are a lot of essential workers in our communities. It's not just healthcare providers. I mean think about the grocery store clerks. If they weren't working, grocery stores had to close, right? We'd all be in trouble. How about the people who are collecting the garbage? If they weren't working, we would be having some major issues with what we would do with our trash. So there's a lot of people who

maybe we don't normally think of as essential to keeping society running, but who absolutely are. And then that's true inside the hospital as well. Of course, it's absolutely not just physicians and nurses who are the essential workers, right? I mean one of the things we've seen really clearly is, for example, respiratory therapists. When you've got a disease that's landing a lot of people on ventilators in a way that they were not before, in numbers that hospitals haven't seen before, you have to have respiratory therapists who are experts at setting up these ventilators, adjusting the modes, uh, and are very much in those rooms putting themselves at risk. It is essential that we have them, and to the point where, and, and I know I should have mentioned, another way our residents have stepped up, is actually being trained to work as respiratory therapists. Because if we don't have enough respiratory therapists, we need people who are already familiar with ventilators, which our residents are, who can play those roles. And so some of the inner play, some of the flexibility we've seen from, from everybody, is really quite inspiring. So while it's terrible, this, this time is terrible, because people are getting sick and dying there are some real glimmers of, uh, hope and of inspiration that have come from what people are able and willing to do, um, that I think really, really show the good, wonderful side of humanity.

DR. IBANEZ:

Yeah. Two of the things that you just mentioned, flexibility and the challenge of being okay with not knowing, um really resonate with me and I think from a resident perspective, certainly, this is not how I expected the end of my residency. But if I had to pick a silver lining, I do think that I'm going to be a better clinician and a better leader moving forward. You know, as you mentioned, stepping up, helping in ICUs as a chief resident working with staffing models and trying to meet the demands of the hospital, protecting our own residents and being mindful that they are getting some wellness and some time off. So if I had to say that, you know from this whole epidemic, we will have some benefits, I think it's that these physicians training during these times are going to be that much better.

DR. WOLPAW:

I couldn't agree more. I think that your generation, the generation who are residents during this time, are going to know what it is to have run a, an ultra-marathon. And for the rest of your career, I think you will, and your colleagues will, have a perspective that very few others will, because you will have made it through this. And just as, you know if you run 26 miles and then someone says, you know, oh do you want to go for a 5 mile run? That's 5 mile run feels like a breeze, because you now know what it feels like to run 26 and I think similarly, you know, this will put in perspective the challenges you will

face and, and especially for folks like you Jess, who are Chief Residents who are intimately involved with making these schedules and arranging these policies, it will be a lesson that will inform your ability to lead um, from, from here on out and I think it again, yet another positive that will come from this.

DR. IBANEZ:

Thank you for those insights. I think everybody was really waiting to hear what your thoughts were in terms of what the climate we're living in now with COVID. But let's turn to the podcast and kind of go back to the beginning. What made you even want to start a podcast? And specifically, why did you want to do a podcast, instead of a blog, or a YouTube channel?

DR. WOLPAW:

So I think to understand this you have to realize that I am not technologically savvy at all. So, you know, I, I laugh when you give me these other options because, um, I wouldn't have the first clue how to start a YouTube channel. So that makes that one easy. I am not even sure I knew at the time I started the podcast that there were YouTube channels. So, um where this came from is when I, uh, and, and you may know I initially match into emergency medicine. I thought that's what I was going to do, and I started as an intern and in fact, prior to matching, when I knew I was going into emergency medicine, I started listening to a podcast, that everyone recommended. It was called EM-RAP. EMRAP stands, I believe for Emergency Medicine Reviews and Perectives. And it was a great show. It was released uh, once a month with kind of a bulk of about, you know, about 10-ish hours of, uh, content. It was some reviews of articles, some interviews with experts, some discussion of topics and it was, as far as I could tell, listened to by every emergency medicine residents in the country. It was talked about at conferences. You would, as a resident, talk about it with your attending, bring something up, oh I heard this on EMRAP, such and such, what do you think about this? It was part of the conversation and it was a great way to study. You know, I, I, run a lot, so I'd be out running in the mornings before a shift and I'd listen to a chunk of EMRAP and then I'd come to work and I could ,you know, think about how that would apply to my patients.

So it was a really, really wonderful thing and when I decided to switch into anesthesiology, I was excited to start listening to the anesthesia version of EMRAP, but it didn't exist, and I was really taken aback. In fact, it's for a while, I thought I just wasn't finding it, but it turned out that it didn't exist, there was nothing like it in anesthesiology. And I remember as a res, an anesthesia resident, thinking, wow, this would be so great

to have. You know, I wonder if I could do something like this and just have, had no idea how one would even record, uh, this kind of content, get it out, in, onto the web or anything in place as a resident. I had very little time. Not only was I a resident, but also had, uh, my wife and I had our first two kids while I was a resident, so, it was a busy time, and, and those ideas never went anywhere. So then I came and did my fellowship at Johns Hopkins and when I finished fellowship and started on faculty, the then Program Director, my predecessor, as Program Director, asked me, I guess thinking I was a young faculty member with teaching experience, and might know about tech stuff, said to me, oh, you know, Jed, do you know about any audio resources for our residents? They're always asking me for audio resources, and I don't know the answer. And I kind of laughed, and I said, you know, I've been thinking about this now for years, um, and, and I, I'm going to try I'm going to try to make, to make something for that.

So, I didn't know what I was doing, but I figured okay, you know, there's this thing called Garageband on my computer. I looked up some videos on how to use Garageband and I just took a lecture that I routinely would give to the residents in person and I just recorded it. Didn't know what I was doing, I pushed record in Garageband, I didn't have a microphone, I just talked into my laptop, the audio quality was terrible, this is ACCRAC, episode 1. Uh, I believe it's on gas laws and I, uh, just talked. And, uh, then I figured out how to make that become an MP3 and I emailed it out to the residents at the time and I said, you know if anybody's interested here, here's an MP3. And almost immediately, I started to get feedback from residents saying this is great. Can you do more? And, uh, one very tech-savvy resident said, look, you know, you need to you need to put this online and I said sure, but I have no idea how to do that and he helped me create a website and, and learn how to post these things online and put them on YouTube and that was how it started and, uh, that was more than three years ago. And now we got, uh, now 170 episodes and more than 50,000 listeners every month, so, you know, it's, never imagined that it would become what it has become. I, I thought when I started, that, that I would just email these out to some of our residents, and maybe if they friends in other programs, they could forward these emails along, but never imagined it becoming what it has, but I'm glad because I think it's, it's been helpful for folks and it's been a lot of fun for me to do.

DR. IBANEZ:

When you first started, was there a specific group of people that you were targeting for example, residents, attendings, medical students?

DR. WOLPAW:

Yeah, absolutely residents. So, I was at the time, starting to get involved with our residency program. I think right when I started it, I wasn't yet officially involved in any kind of role, but I was doing a lot of teaching of residents and knew I wanted to be involved in resident education. And again that impetus of the, my predecessor, as Program Director saying, you know, that the residents were interested in this, and um, and so that's what I did. I, as I said, I took the, I took a lecture that I had given to residents anyway, and just recorded it. So I was very much thinking that the primary audience would be, would be residents.

DR. IBANEZ:

Were there specific knowledge gaps starting off that you wanted to address, or did you think that this was just going to be educational in terms of, uh, clinical content, and when did the wellness, um, kind of podcast start?

DR. WOLPAW:

So I thought initially that we would kind of go through the list. Not necessarily every single detail but use the ABA, American Board of Anesthesiology, keyword list as a guide and just try to cover all those topics. Uh, in recent months, uh, Gillian Isaac, one of my Associate Program Directors and I have actually started doing that. We've picked a couple of key words and gone through them. Um, so that was the initial plan, and there are a variety of prior episodes that kind of did that, but it evolved over time, partly because, I think, as the listenership grew I got a lot of requests from people. And then the listenership became much more diverse. So rather than just residents, while there are a lot of residents who listen, there'e also a lot of medical students, attendings, both in the community and at, at academic centers, fellows in critical care, some of them are medicine trained, CRNAs and students CRNAs.

So, it's really a wide audience with a lot of diverse interests. And so I've tried to be responsive to audience requests and also cover lots of different things. So we still do some very much, kind of, resident board prep stuff. But we also, I've also interviewed the lead authors of a variety of critical care articles. So it really spans the gamut, and, and even though have gone outside a little bit to do some things that aren't related to clinical care at all. So, for example, I did book review of a, just a fascinating book on intermittent fasting that I read and really was very taken by, which by the way is the most listened to episode of all time because it appeals to the lay public. Right? So it's not limited to this audience of healthcare providers. And so have done some of that, and then have talked some about what we'll call kind of well-being topics as you say. And well-being and specifically not limited to, but very much focused on trainee well being, is

a, is a real focus of mine, it's something that I'm very interested in, both as a Program Director and a physician. And so I've started to do some of the episodes that are focused on that, to really try to reach out to folks and, and help. And also to give ideas to other programs and to institutions about, uh, ways they can start to think about this very important topic.

DR. IBANEZ:

Obviously, continuing education is very important to you and you've spoken how important it is to treat residents as adult learners. Can you talk a little bit about the kinds of education administered and the learning achieved in these different phases? For example, medical school vs. residency, post residency, what that is now, and what you think, how that would look like in the future.

DR. WOLPAW:

So I think a lot of education, certainly medical school education and residency education, has been very focused on more traditional forms of learning. Now, medical schools have done a good job of doing, and it varies from school to school, but whereas 10, 20 years ago, medical school for the first two years was all lecture. You sat in lectures and that was it. And you took tests and that was your education until third year, when you went into clerkships. Medical schools, as I said, have done a lot to really try to do more small group learning and more, um, experiential-based learning, and I think, have, have done a good job with that.

Residency, is, is a different animal altogether. And it's because there is a fundamental difference between residency and medical school in that residency has this conflict built into it, where the residents are both still learners, but they are also employees. And the entire system of medicine is based on, and relies on, their labor. And so unlike medical students who nobody relies on medical student labor, we can't function, our hospitals are built to function with resident labor. And without that resident labor, we would not be able to function. And what that means is that there's a conflict between the education that residents want, and need, and deserve, and the labor that hospitals need. And those two are not always misaligned, in other words, working in a hospital does provide very important experiential education, but it's not, it cannot be limited to that.

So there needs to be additional education that happens that should be learner-centered and that is difficult because you have to pull residents away from the patient care that they're providing in order to give them didactic education, small group education, simulation education. And so there in lies the conflict, and then the other piece of this

conflict is that when the system of residency education, or residency in our country started, there were very few residents. They were all men, they lived in the hospital and they, for, for a while, they actually weren't allowed to marry or have families and so they worked all the time, but that's all they had to do. That's very different than our system now, where we have both men and women, with, some already with children some have children while they're training as my wife and I did, who are, have a lot of responsibilities outside the hospital.

And we've added a lot of non-clinical requirements, right? The ACGME requires a scholarly project, they require a quality improvement project, they require a lot of testing. So there's in-training exams that are weighted pretty heavily when it comes to fellowship applications, which is a problem, but, but it is what it is. There is the basic exam in anesthesia. There's advanced exam in anesthesia. And so you have all of this studying, project work, all of these things that residents have to do that, that have to happen separately from their time giving patient care and they have lives that cannot be just stopped during the period of their training. And yet we still have a system designed as if none of that existed. And so that's the inherent conflict and that's where I think we really need to be willing and able and creative about how we think about changing the structure of our residency training so that it fits with that, with those other obligations so that we can have residents who are well-trained, can take good care of patients, but also are well themselves and also can accomplish all those other things that they're required to accomplish, all without burning out over the course of their training.

DR. IBANEZ:

So it seems like you, you mentioned that sometimes the needs of the residents and the residency programs are misaligned, at times. There has been some evolution, um, through time, but if you had to, for example, think of the best way that learning methodologies and teaching would be for residents now, what would your picture of that be?

DR. WOLPAW:

So, I would just say, Jess, that I think it's not wrong to say that the priorities and needs of the residency program and the residents are sometimes misaligned, but I think more accurate might be that the needs and priorities of residents and the needs and priorities the hospital are, are often misaligned, because it's the hospital that relies on the labor of the residents. Residency programs have to be responsive to what the hospital needs and wants, of course, uh, because residency Program Directors answer to their department chairs, who answer to the hospital. So it all filters down, but I don't think

you'd find many Program Directors who wouldn't love to give their residents more flexibility, time off, ability to handle these other things if they could, if they were allowed to by their department and their, and the hospital. And so I think it really filters down from the top. And if you think, if you check out a couple of pieces that we published, so there's an article in Academic Medicine that really examines the history of relying on resident labor and how, uh, and I kind of been there, write and kind of challenge both the ACGME and, and hospitals and programs to really think about how can we change the priorities and the incentives and then kind of a follow-up piece, uh, that I did with a Carrie Adair at the Duke Patient Safety Center. It was published recently in the Journal of Patient Safety, where we really called on the Joint Commission and CMS to say look, you know, you're going in and citing hospitals for things like not having enough boot covers in the operating rooms. Fine. If we think that that may affect patient safety, though there's no data to suggest that it does, but there's so much data to suggest that burnout hurts patients. We know that burned-out providers make more medical errors. There's just no doubt about it.

So why isn't the Joint Commission sighting hospitals who don't improve their levels of burnout in employees, including trainees? That would change the incentives. That would mean that hospitals now are incentivized, just as they, I mean hospitals buy boot covers. Why? Not because they necessarily believe that boot covers are so important, but because if they don't they'll get cited. And so if they knew that if they didn't have comprehensive programs in place to improve the well-being of their employees, they would get cited, then they would do it. But the incentive isn't there and so they don't. And so this really has to come from, it has to be institutional change. And that's what we really need, I think, to look for.

So, that, I believe your question was around, you know, what can we do? What changes do we need to see? I think we need to see those kind of changes. On a, on an individual kind of programmatic level, there's only so much that an individual residency program can do because, of course, the program has to answer to the department, has the hospital as we said. Now I do think that we can push, and one of those talks I give regularly all over the country, is about how we can, within the boundaries of the system that we have, we can start changing things to make it better. And I think we've done a lot of this here in our program, where, within the boundaries of what is allowed, we have really tried to make residency more doable for our residents to help people still be able to live balanced lives while working. It's not perfect. I would do it differently if I could.

For example, one of the things I think we really need to think about as uh, in medicine in general as an institution across the country not just anesthesia, but every specialty, is to think about changing the structure of the work that residents do. In other words, the idea

that we, kind of, you know, are limited to 80 hours, so therefore we should be, everyone should be working, you know, 79 hours a week because that's what's allowed, doesn't make any sense. We need to think creatively. Should we, for example be having a limit to a four-day work week, where residents works four days every week? They get their weekend off and they get one weekday that's protected. Not that day that's guaranteed, you know, that we have a day for example, every two weeks that's protected for education. You still want that, but I mean, a day off. A day with no work responsibilities, a day when residents could spend time with their family, could go to the doctor, go to the dentist, pick up groceries, whatever it is that, that they need to do to be healthy members of the community and well members of their own family. Could we imagine that?

Or what about splitting residency? This has been experimented with, where instead of one person working 80 hours a week, two people would kind of be buddied up and would each work 40 hours a week. So, you know, there are, these, these things are done. In fact, that, part-time residency is being done in the United Kingdom in a couple of specialties, so, there's, this has been written about in emergency medicine, and, uh, I don't remember the other, but one other specialty. They are experimenting with this. They are allowing people to do for example of 50% time residency. Now obviously, you have to think this through. So if we did that, if we said all right, you're only going to work 40 hours a week. Do we then have to extend the training? Well, how would we know that? This then leads us to, uh figuring out, can we do competency-based advancement instead of just saying, well every single resident in anesthesia needs an intern year and three years of anesthesia training, some might, some might need more, some might need less.

So if they're working fewer hours a week, some people probably would need an extra year or two. Some might not because they're going to pick up the skills they need but we need to figure out how to know if they picked up those skills, and if they're ready to practice independently, not just time-based but competency-based. So we would need to figure that out. And then for those people who would need to do more years, what about the enormous amount of debt that they carry, right? That's a huge sacrifice to say you need to spend another couple years making a much, much smaller salary than you will eventually make, when you have this debt burden and so we need to think about debt forgiveness. We need to think about reducing the amount of debt that our trainees have uh, across-the-board.

And of course, this is isn't an issue in the United Kingdom because, because college and medical school don't cost anything, anything near what they cost here and so debt

is not a problem. So it's these things we have to be, to be thinking about, not on an individual program level, but on a society-wide level.

DR. IBANEZ:

This is some great advice and I've seen some of this on our own program. How do you think this applies to what's happening now with residents dealing with COVID, and what are your suggestions for them?

DR. WOLPAW:

You know, that's a great connection to make, Jess, and I think about this a lot because what we have right now, at our center, and I'm sure, at medical centers across the country, everybody's stepping up. But, I do think that a, a large portion of the additional work, stress, exposure is happening with residents, because again, its residents are our main labor force and so we have, for a, certainly it's somewhat dependent on the specialty. So surgery, medicine and anesthesia residents are, I think, really at the front. Now, we've had incredibly inspiring volunteers from other specialties, dermatology, neurology, plastic surgery, residents who aren't, are kind of not doing much right now because we stopped all elective procedures, stepping forward and saying, look, tell me where you want me. I will help.

But that aside, all residents are working, are under a huge amount of stress, are deployed to the ICUs. We've opened up many new ICUs for COVID patients, and, and we're staffing them primarily with residents. And so, I think, what I hope is, that individual medical centers and society as a whole will say, wow residents really stepped up. They didn't get paid any more for doing the work that they did, for putting themselves at risk, and yet they did. They worked harder than ever. They worked all this time in these high-risk units, and we as society, owe them a debt of gratitude. They save lives, countless lives, and I hope that opens up conversations that haven't been fully open before. Conversations around more aggressive debt forgiveness for resident physicians, conversations around reduction in medical school tuition so that they don't have that debt in the first place, conversations around more benefits for residents around child care, and, uh, hazard pay, and pay for additional time. Conversations around some of the stuff that I mentioned before, time off during the week. This idea that 80 hours a week is a reasonable amount of, of work is ludicrous. It may be better than 120, but it doesn't mean that 80 is, is good. And we had recently this whole debate in medicine, of course, around whether you know within that 80 hour work week, is it better to do 28 hour calls and then have a post-call day, or is it better to just do, you

know, 16 hours straight as a maximum and so that we basically went to add a day-float/night-float system, and get away with these long 24 to 28 hour calls?

And there was some difference here and there, but really not a lot of difference. And I wasn't surprised in the least that there wasn't a huge amount of difference because it's still too much. The, the study I wanna see is 40 hours a week, compared to 80 hours a week. Would that reduce burn out? Would the people working 40 hours a week be more well? And how different would their competency be? We don't know. We don't know. Everyone thinks that if we reduced time to 40 hours a week, we would have to double the length of training. I don't know. Maybe it would just mean that we'd have to be more efficient about the training that we do. Maybe we have to really just focus on the most high-yield learning and experiential, uh, training.

So there's a lot that we can think about and I hope that after this kind of sacrifice that the residents are, are making right now across the country, it opens up those conversations much like when during World War II the GI bill that was passed, guaranteeing when these soldiers came home, they would get a subsidized college education, changed the face of the middle class in this country. It changed the way people were able to access education. So this was a, a feeling in society that these men and women, mostly men I think at the time, were fighting and dying for their country. When they come back we owe them a debt of gratitude. It's not that different, what residents are doing across the country right now. We as I said, are very lucky that we have appropriate personal protective equipment, but there are hospitals that do not, and where residents are putting themselves at very high risk frequently because they don't have appropriate equipment. And yet they're still putting their lives at risk to care for these patients who need them, and society needs to open up their eyes and say this was a huge risk, a huge sacrifice, and we need to address some of the issues that these residents are struggling with.

DR. IBANEZ:

Thank you so much for talking with us today, Dr. Wolpaw. Your continued advocacy for residents is admirational and much appreciated. This is Dr. Jessica Ibanez, and that's another episode of Residents in a Room, the podcast for residents by residents. Join us again soon.

(OUTRO/MUSIC)

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