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from training through retirement.

American Society of Anesthesiologists Resident Component Newsletter

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Q & A with Dr. Jed Wolpaw – founder of ACCRAC & Johns Hopkins Residency Program Director

1. Tell us a little about yourself and how you got to where you are today?

I had a fairly atypical path but one I wouldn't change even if I could. I grew up outside of Cleveland, Ohio, in Shaker Heights, and went to public school there. I went to Brown for undergrad where I majored in History. I went to Harvard for a master's in education and got my teaching license. I taught high school history (9th grade World History) for 2 years, which I loved, but there was more and more pressure to teach specifically to the graduation test and I didn't like that aspect of it. So I decided to switch things up and did pre-med classes and went out to UCSF for medical school. I initially matched in EM but fell in love with critical care and back then you couldn't do it through EM. So after a lot of thought I switched to Anesthesiology, went back to UCSF and completed my residency there. My wife and I had our first 2 kids while I was a resident and decided to try to get closer to family for fellowship so we moved to Baltimore for my SICU fellowship at Hopkins in 2014. I stayed on faculty when I finished and got involved in the residency program and took over as program director 2 years ago.



2. What advice can you give residents on ways to be successful/efficient during residency?

It's hard to narrow this down to just a few things but I would say first of all, take care of yourself. Residency is hard, partly because of the long hours but also because of how little control you have over your life and time. Take some time for yourself when you can, to work out, to be with your family, whatever keeps you well. It won't be as much as you'd like, but it's important to do it when you can. And if

things get too overwhelming, or you are feeling burned out, reach out for help. It's not weak to ask for help; it actually shows impressive strength. Don't misunderstand me, we need to work on system-wide, structural changes to support well-being. The last thing we should be doing is telling residents that it's their job to avoid burnout. But while we push for system-wide changes and support at an institutional level, we want to support our residents as much as we can to have this time away from work to recharge and be well.

Another marker of a really strong, successful resident is someone who is a team player. Remember that the residents who are seen as consummate professionals, the ones who are the most lauded by their attendings, are the ones who are there for their colleagues when they need help. Staying the extra few minutes to help a colleague with a difficult case, or to offer someone a break before you leave, without even being asked to do so, will really make you stand out as an impressive trainee. The temptation to leave the moment you are relieved, or the moment your cases finish, is strong, but taking the time to check in with your colleagues and see if anyone needs help will rarely cost you much time, but really builds the kind of reputation that will follow you, and open doors for you, for your entire career.

Finally, as you get further along in your training the pressure to know all of the answers grows. If you don't know them, you often feel like an imposter and you worry that people will find out that you don't know the answers and will "discover" that you don't deserve your position. The most important thing to know is that everyone feels this way. You are not alone. Do everything you can to fight this pressure. You'll find that senior attendings are often more willing to ask for help than junior ones because they no longer worry about being "found out". Take a lesson from those senior attendings and ask for help when you need it or when you are unsure. Don't worry about someone deciding that you aren't competent because you asked for help. In fact, ask more often. Ask the nurses, ask your colleagues, bring everyone into the discussion. Keep an open mind, be comfortable with not knowing, and you will be much happier, and more successful, than if you feel you must always look like you know all the answers.

"I know that too often it feels like no one cares about the work that you do, or appreciates how much time and effort you put into it. Being a resident, especially, is an often thankless, extremely difficult job. If there's only one thing I hope you will take away from reading this, it is that despite how it often feels, what you are doing every day is incredibly important and truly valued. Thank you for all that you do."

– Dr. Jed Wolpaw

3. What advice would you give residents/fellows interested in pursuing a career in medical education?

If you're interested in an academic career in medical education I think the most important thing to realize is that it isn't enough just to like to teach. You need to figure out what your academic pursuit will be. Take some time to learn what educational research looks like and whether you might be interested in that. Learn about program building and curricular development and consider whether that excites you. Talk to as many people as you can who have built a career in medical education, whether in anesthesiology or any other field, so you can learn about their path and start envisioning your own.

4. What recommendations do you have for those preparing for their Oral Board Exams in terms of resources and preparation?

The most important thing to do to prepare for oral boards is to do as many practice stems as possible. Find a partner or a group of people and, in the months leading up to the exam, give each other timed exams as many days as possible every week. Beyond that, use any resources that you want to fill in the gaps in your content knowledge. It's the practice that is the real key. For the OSCE, make sure you are familiar with the stations, what they can contain, and feel comfortable with the style and length of each one. Make sure you know the TEE views that can be tested. And make sure you are familiar with the language of quality improvement projects.

5. What are your thoughts on wellness in medicine?

Wellness is another major topic and I touched on it in my answer to your question about advice above. We have a system of training that was designed to be centered around resident labor where learning was assumed to follow from the labor. What we need is to rethink the entire system to make it learner centered and wellness centered. We have to move away from our reliance on resident labor and focus on learning and well-being. It's a major undertaking, a complete rethinking of what we do and how we do it, but it is work that is incredibly important and needs to be done. In the meantime we need to do everything we can to support our residents in a system that is not conducive to supporting well-being. That means acknowledging that what they are doing is hard and supporting them in every way we can including encouraging them to ask for help when they need it, to take time off when they need it, and finding ways to give them time to take care of the rest of their life. We can't ask people to put their lives on hold for 4 years, it doesn't work and it isn't reasonable. We have to move beyond giving lip service to well-being and we have to realize that it isn't the trainee's job to avoid burnout. It's our job to redesign our system to make it a supportive one, not one that produces burnout.

6. What is your routine/ habits to stay up to date with our practice (reading articles, learning the latest evidence, etc) and what do you typically recommend trainees to do to stay up to date?

Staying up to date is hard but I think there are great resources out there. I would sign up for table of content alerts from Anesthesiology, A&A and sub-specialty journals of interest. Scan through them when they arrive in your inbox and read articles that seem interesting to you. Follow some great blogs like Pulmcrit, TheBottomLine, and LifeInTheFastLane. And, of course, talk to your colleagues and attendings about what they're reading and learning.

7. What are your thoughts on the importance of anesthesiologists being involved in leadership opportunities (ie., within the political arena)?

I think all residents should think about what leadership means to them and learn about different leadership styles. We, for example, teach Serving Leadership. As for political involvement, I think it's an individual decision and one that each resident, and attending, can make for themselves. A serving leader sees themselves as serving the members of the organization and seeks to empower those in the organization to be successful and achieve their goals. Instead of seeing themselves as sitting on top of a pyramid issuing orders to those underneath, a serving leader sees themselves as sitting at the bottom of an inverted pyramid, supporting all of the people in the organization, helping get barriers out of their way, so that they can be successful.

8. How did you decide on creating ACCRAC and what was your inspiration?

When I was an EM intern I listened to some great podcasts (EMRAP, EMCRI) that everyone in EM seemed to listen to. When I switched to anesthesia I was surprised to learn that there was no equivalent podcast. I didn't have time, as a resident, to start one, but when I became an attending I thought maybe I would. Then, when I heard my residents saying they wished they had more audio resources, I decided to do it. I honestly thought it would be something that no one except some of my residents would use, and have been completely blown away to see that more than 35,000 people now listen each month around the world. I love getting emails from people from all across the US and the world. I'm inspired by the work that they're doing and their passion for their patients, their practice, and their colleagues.



9. If there are individuals interested in helping with ACCRAC, how can they get involved? Are there other podcast you listen to and recommend?

If people want to get involved in helping with ACCRAC they should contact me at accrac@accrac.com. We could probably think of some fun ways for people to get involved. If anyone out there wants to create some possible theme music, I'd be happy to consider using it as an intro.

I listen to EMCRIT, which I definitely recommend. I don't know of any other really good anesthesia podcasts but am certainly interested in hearing about some if anyone knows of any good ones.

You can find the podcast at <http://accrac.com/>

Q&A with Dr. Michelle Au

Author of [This Won't Hurt a Bit \(And Other White Lies\): My Education in Medicine and Motherhood](#)

Tell us a little about yourself and how you got to where you are today?

My name is Michelle Au, and I'm an anesthesiologist at Emory-St. Joseph's Hospital in Atlanta, GA. Born and raised in New York City, I graduated from Wellesley College in 1999 with a degree in Psychobiology, and received my medical degree in 2003 from the Columbia University College of Physicians and Surgeons in New York.

During my third year of medical school, I started penning the "Scutmonkey" comics, a series of cartoon strips inspired by the absurdity of the medical education process. Some of the more best known of these comics include "The Twelve Types of Medical Students" and "The Twelve Medical Specialty Stereotypes." In the years the years since, these comics have been published and presented in journals and at medical conferences around the world.

In 2008, I completed my medical residency in Anesthesiology at the New York-Presbyterian Hospital at Columbia University. During my final year of residency training, I wrote a medical memoir entitled *This Won't Hurt a Bit (And Other White Lies): My Education in Medicine and Motherhood*, about the challenges of medical training and juggling the demands of residency with new parenthood. The book was published by Grand Central Publishing in 2011. I am currently working on a second book (tentatively entitled *Knocked Out*), a hybrid memoir about the history of anesthesiology juxtaposed with my own clinical experiences in a field of medicine that it sometimes feels like no one really understands.

At present, I'm also completing a Masters of Public Health at the Mailman School of Public Health at Columbia University, and have been selected to be in the Georgia Physicians Leadership Academy through the Medical Association of Georgia. My hope is to expand the scope of my medical service to help not just patients at the bedside, but to work on more population-based health policy initiatives. On the side, I live outside of Atlanta, GA with my husband, the oculoplastic surgeon Joseph Walrath, and our three children, whom I'm trying not to ruin.

What advice can you give residents on ways to be successful/efficient during residency?

This is a tough question, because the pace and demands of residency means that often, "success" is defined as just getting through the day. Particularly for those people who have significant outside of work obligations, residency can at times feel less like a phase of enrichment and growth than an exercise in pure survival.

However, I have a couple of thoughts on how to approach residency, and part of this is simply framing the experience in the correct mindset. Because in the end, medical training is intense, compact, and above all, *temporary*. In anesthesia, we're given four years—five with a fellowship—to transform from well-intentioned but ultimately clueless medical school graduates into fully-formed, competent, seasoned clinicians able to handle anything the world throws at us. (In the operating room, at least.)



So how we should view those years is not simply as a grim, desperate survival gauntlet but as an opportunity few are afforded. *This is your chance.* This is your moment to gather your tools to become the best clinician you can be. What you get out of residency sets you up for the future. What are you going to do with that time?

I realize that I'm about a decade out from training, and time does have a way of softening memories into soft-focus retrospect, but: *make the most of this moment you're given.* This time when you're not supposed to know everything. This time when you're surrounded by teachers ready to guide and elevate you. This time where the unstated goal of every day at work is to become better at what you're doing.

So jump in. Try everything. Do as many big cases as you can. Relish the difficult experiences. Collect the stories. It's hard, it's tiring, you're not going to get enough sleep, and you're going to have far too many meals consisting of graham crackers and foil-topped cranberry juices. But realize you only have a brief time in residency, and really just one chance at making that time count. And at some point, soon, it'll be over. Don't throw away your shot.

Remember that, in many ways, residency is like parenthood. The days are long, but the years are short.

What are your thoughts on wellness in medicine?

These days we're all having more and more discussion about wellness in medicine, work-life balance, and physician burnout. I think that's wonderful, because awareness around these types of professional hazards is likely one of the most important steps to combating their corrosive effects. We live stressful lives, but they don't need to be lived in isolation.

I don't think there's necessarily one way to approach "wellness" in medicine, because each of us requires a different balance of things in order to feel well. But generally speaking, I'd say there are two important elements to maintaining wellness in medicine, and these elements apply throughout your career.

The first is that you should always find something else to love. A maxim often pushed as a trenchant truth in medicine is that no matter how much of your blood, sweat and tears you give to your work, the hospital will never love you back. And that's true, of course. The hospital *won't* love you back. But we shouldn't do what we do in order to be loved back. We do it because *we love the work itself.* Because the work itself has meaning, and purpose, and a value that is not transactional.

But it's important to also find something else you love just as much as you love medicine. It can be in family, friendships, creative endeavors, simple indulgences, spontaneous acts of fun. Love generously and widely. In residency, sometimes it seems like our little slice of life becomes the whole world to us, because medical training is so immersive and all-consuming. We come in before dawn and leave well after dark, and sometimes it seems that the outside world just ceases to exist. So it's important to remind yourself that the world is a big place, and find something you love out in that world that grounds you there as well.

The second important thing, somewhat related to the first, is to always find meaning in the work you do. So much of physician burnout is tied to the fact that sometimes, the work we do becomes divorced from the satisfaction we derive from devoting our energy to a higher purpose. And it's easy to understand how that can happen—it's difficult to feel any gratification from fighting for hours a day with your EMR, and it's hard to argue that these frustrating efforts have helped anyone, particularly the patients in our care.

But I think it's important at the end of the day to take inventory on what you did that day that had purpose. And it doesn't have to be a big thing each time. We'd *all* be burned out if we needed giant successes and miraculous intra-op saves to sustain us. The big things are great, of course, but much more often, it's the little things that have more meaning. A small family interaction. A moment of connection with a colleague. A patient's experience that was the better because of your involvement. Even the worst days have these small moments tucked inside them.

We tend to forget the little things, because we unfortunately work in a field where perfection is the default assumption. But remember what gives you purpose, and find the small ways you fulfilled that purpose at the end of each day.

What is your routine/ habits to stay up to date with our practice (reading articles, learning the latest evidence, etc) and what do you typically recommend trainees to do to stay up to date?

I'm certainly not as good at staying up to date as many of my more brilliant colleagues (both during training and after), but one thing I've tried to do my entire career is always learn something based on my work each day. If I meet a patient with an unusual condition with which I'm not familiar, I'll print out a review article and read that. If a patient asks me a question that I can't answer readily, I'll look up the latest practice guidelines and review those. If a surgeon come in with a novel technique that I've never heard of, I'll look it up, and try to review the anesthetic implications of the approach.

Granted, this approach can be a little scattershot (and the ASA has more formal systematic review courses for larger topics at my disposal), but as a matter of bite-sized daily learning, I find connecting my reading with my day-to-day patient care incredibly effective, because it feels intimate, and immediate, and instantly useful. It's not the *only* form of study I'd recommend to stay up to date, but as a matter of keeping yourself in check and not defaulting to assumptions and reflex, tying daily learning in with the patients right in front of you is a tremendous motivation.



ASA Statement on Personal Leave

Developed By: Committee on Young Physicians

*Original Approval: **October 17, 2018***

The ASA is committed to the health and well-being of anesthesiologists both at their workplaces and at home. **A successful career in anesthesiology should allow for the opportunity to respond to personal or familial needs. The ability to take a leave of absence promotes work satisfaction and career longevity, which should contribute to higher quality patient care.**

All employment, including anesthesiology training programs, academic, or private practice group contracts, should have explicit written policies that support and define leave. These policies should apply to situations that may involve: a personal serious illness, the birth or adoption of a child, the care of a sick family member, and/or the safety or cohesion of the family (including mental health emergencies). The category of leave (i.e. vacation, sick, parental, family, disability, unpaid) should be clearly delineated within the contract and should include clear wording on the extent and terms, including a) duration allowed, b) whether leave is paid or unpaid, c) insurance coverage during leave, and d) whether clinical/nonclinical schedule accommodations are allowed.(1) A leave of absence should not be more restrictive than institutional or governing board policy and applicable federal, state, and local laws.(2)

It is the responsibility of the physician anesthesiologist or anesthesiology residents/fellows to notify their employer of a change in personal or family status as soon as is reasonable to ensure appropriate coverage of responsibilities and patient

care. For practices with partnership or advancement requirements, leave policies should clearly delineate how leave time affects potential partnership or career advancement. Anesthesiology residents/fellows should be able to return to their program within a reasonable amount of time after leave without the loss of training status; however, residents/fellows must be compliant with current Accreditation Council on Graduate Medical Education (ACGME) policies. Programs should clearly communicate to the trainee whether make-up time will be required and whether eligibility for board certification will be affected, as defined by the American Board of Anesthesiology. This should be discussed prior to leave if possible. Efforts should be made by residency and fellowship programs to accommodate off-cycle trainees to support career aspirations (3-5).

Personal leave:

Physician anesthesiologists and anesthesiology residents and fellows are at high risk for burnout due to workload, long work hours, and cognitive and emotional demands. Burnout is a recognized workplace hazard and can have serious personal repercussions, as well as affect quality of patient care and productivity.(6) **Employers should promote wellness and foster a culture that is conducive to physician well-being, which includes allowing leave for personal and mental health reasons.** Personal leave policies should be clearly delineated by the employer, including time allowable and paid/unpaid status.

Family leave:

The health and integrity of an anesthesiologist's family relationships are essential to personal well-being. A leave of absence to assist with family need, such as illness or aging parents, may be necessary and should be encouraged. Family leave policies should be clearly delineated by the employer, including time allowable and paid/unpaid status.

Parental leave:

Adequate parental leave is linked to improved physical and mental health of parents and infants, as well as increased worker morale and retention. Employers, training programs, and groups should encourage a supportive environment for physician anesthesiologists and anesthesiology trainees who become parents.

Ideally, physician anesthesiologists and anesthesiology residents/fellows should be offered maternity leave of at least 6 weeks (vaginal delivery) or 8 weeks (Cesarean delivery) and paternity leave of at least 6 weeks with the option to extend the leave. Parents should be able to choose less leave time if desired and all leave offered should be in accordance with federal laws. Physician anesthesiologists and anesthesiology residents/fellows who become parents outside of pregnancy (such as via adoption or surrogacy) should be extended the same benefits. Ideally six weeks of paid parental leave, separate from vacation time and sick time, should be available; however, it is ultimately the responsibility of the employer to inform employees on all policies regarding parental leave. Parental leave policies must be clearly delineated by the employer, including time allowable and paid/unpaid status. These recommendations are consistent with those from other specialty societies, including the American College of Surgeons, American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the American College of Physicians.(3, 4, 7, 8)

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“Showing Interest” – Easier Than it Seems

Richard M. Missett, DO

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I began anesthesia residency with basically zero research or academic interests outside of clinical work and was somewhat intimidated when I matched to a program that I perceived as highly academic. I soon realized that this presented an amazing opportunity for professional growth, though I lacked direction on how to get started. At the beginning of my anesthesia residency, I was given the advice by a senior faculty member that the best way to get involved with an academic focus is as simple as “show interest.” This sounds all well, but what does that really mean?

I started making a habit of researching the academic interests of the staff I was working with on a day-to-day basis. If you’re anything like me, one of the least favorite questions of the day from your attending is “What do you want to talk about today?” Early on in my anesthesia training, I started using this question to pick the brain of faculty members about their interests outside of the OR, to allow me to try to develop an academic focus of my own. I came to realize that my staff for the day can usually have a lot to offer besides clinical teaching. Personally, I wanted to learn more about global health and international outreach, because I knew that type of work was going to be a large part of my academic career beyond medicine.

As a result, I ended up with a few informal mentors – faculty who have helped me learn about the essential anesthesia and surgical global health literature. Together with other residency programs across Boston, we meet as a small interest group to discuss topics pertinent to global health on a semi-monthly basis. This strategy of simply “showing interest” can hold true to any academic focus one has or wants to develop during residency – research, quality improvement, administration, global health, and can parlay into relationships and projects that can be carried beyond residency. While I still certainly have a lot to learn, this has allowed me to come a long way in pursuing something that can hopefully positively shape my career going forward.



What is the ASAPAC and Should I Be Involved?

Chad R. Greene, D.O., Resident Physician, CA-3/PGY-4, Vanderbilt University Medical Center

What is ASAPAC?

ASAPAC is the bi-partisan, non-ideological political arm of the ASA and the voice advocating on behalf of our specialty on Capitol Hill. It was founded to advocate political issues important to our specialty on behalf of all anesthesiologists. Our political action committee is an important tool in ASA’s lobbying efforts and allows us to effectively participate in important regulatory and legislative activities. The ASAPAC supports candidates in Federal and some state races across the country and allows us to elect lawmakers who understand and demonstrate their commitment to patient safety and quality of care. Political decisions directly impact our specialty, playing a key role in determining how much we are paid, the regulatory environment in which we practice, and the role of non-physician providers in our practices. Ultimately, the PAC provides ASA members access to legislators whether they are home in their districts or on Capitol Hill.

History of ASAPAC?

The ASAPAC was founded in 1991 after the ASA House of Delegates recognized the importance of having a single, effective voice to engage policymakers in the legislative process. The ASA Committee on Governmental Affairs then proposed the formation of the PAC to the ASA Board of Directors at its interim meeting in 1991 and was subsequently presented to the House of Delegates for approval at the ASA annual meeting in San Francisco that year. The mission of the PAC was to advance the goals of anesthesiology through bipartisan support of candidates who demonstrate their commitment to patient safety and quality of care.

Why is it important to join the ASAPAC?

ASAPAC contributors recognize the challenges our profession faces — attacks on physician-led anesthesia care, underfunded Medicare payments for anesthesia services and a burdensome regulatory and legal environment. They understand that political involvement is critical to meeting the challenges that we face. The ASAPAC is an effective political voice for our profession and under its influence, we raise the visibility of anesthesiology and have an opportunity to directly participate in the legislative process.

What are some of the issues the ASAPAC prioritizes?

Politics help shape public policy and public policy affects our priorities as physicians. Here are some examples of issues the ASAPAC is fighting for:

- Drug Shortages
- Truth and Transparency in Healthcare
- Scope of Practice
- Out of Network or “Surprise” Medical Billing
- Strategies to Combat the Opioid Crisis
- Graduate Medical Education (GME)
- Rural Pass-Through Legislation

How do I get involved?

As the future leaders of our field, it is critical that we be involved and invested in the policy decisions being made. As residents, we are not expected to fully shoulder the financial burden associated with advocacy. However, we can and should join the ASAPAC, make a small monetary contribution, and be vocal supporters of the future of our great specialty! A unified, well-supported PAC makes for a powerful impact on policy decisions. Remember, any form of participation is welcome and appreciated. We must all make our voices heard and unite to protect the future our great profession!

Donating is simple. Visit asahq.org/asapac and make your contribution.

Physician Wellness: New Concepts to an Old Problem

Dr. Taysir Awad & Dr. Annie Wang

The World Health Organization defines health as: an optimal state of physical, mental, and social wellbeing. Over the past decade, *physician* health and wellness has gained more recognition in residency programs and medical schools nationwide. This article seeks to highlight two key factors on physician wellness: burnout and depression, with latest insights on how these factors are being addressed today.

Physician Depression:

According to the Centers for Disease Control and Prevention (CDC), suicide is the tenth overall cause of death in the U.S., with the rate amongst physicians significantly higher compared to the general population.^{1,2} Female physicians, in particular, have a much higher risk (relative risk 2.27), whereas male physicians have a mildly higher risk (relative risk 1.41) relative to the general population.³ Approximately 300 to 400 physicians each year in the U.S. die by suicide, which is equivalent to the approximate size of two medical school cohorts.² Major risk factors of physician suicide include major depressive disorder (M.D.D), bipolar disorder, anxiety, adverse life events, and substance abuse, with M.D.D being the most significant risk factor for suicide.⁴ These risk factors also adversely affect the mental health of trainees, as medical students are 15-to-30% more likely to have depression than the general population, according to the American Foundation for Suicide Prevention (AFSP).⁵ Indeed, a study of depressive symptoms among medical interns from 13 institutions and multiple specialties found that suicidal ideation increased over 370% in the first 3 months of the intern year.⁶ Medical interns who met the Patient Health Questionnaire (PHQ-9) criteria for depression increased from 3.9% prior to beginning internship (baseline) to 25.7% during internship.⁶ Several factors measured prior to internship (e.g., female sex, positive



history of depression, lower baseline depressive symptom score, trained in a U.S. medical school, higher neurotic traits, and difficult early family environment) and during internship (greater work hours, stressful life events, perceived medical errors) were associated with increased depressive symptoms during internship.⁶

Physician Burnout:

Physician burnout is typically defined as emotional and physical exhaustion from work-related stress and can be further characterized by physicians’ feelings of cynicism and/or detachment toward their patients and reduced sense of personal accomplishment. Symptoms of burnout can be problematic to the patient-provider relationship, as it can erode physician morale and professionalism, contribute to increased medical errors, suicidal ideation and rate of attrition, in addition to being a risk factor for subsequent substance abuse and relationship conflicts internally or externally in relation to work.⁷ Syndromes of burnout amongst training physicians and medical students have increased in prevalence compared to the general population.⁸



Prevalence and Strategies for Improvement:

The prevalence of distress, including depression and burnout occurs at each stage of training rather than in isolation.⁸ Specifically, medical students in their third and fourth year of school are more likely to report suicidal ideation compared to first and second year students.⁹ Often cited barriers to seek professional care amongst medical trainees and physicians include issues with time, lack of confidentiality, perceived stigma associated with mental health services, fear of unwanted intervention, and potential negative effect on career.¹⁰ Acknowledging this issue by having open, frequent discussions and educating physicians, especially trainees, on the impact of burnout and depression are important steps to demystify the stigma of mental health and prevent suicide at all training stages.



Given the detrimental, ubiquitous, and stigmatizing nature of depression and its contribution to burnout in physicians and trainees and potential health care costs, we feel a program specific to providing resources to help trainees and physicians cope with symptoms of depression would be beneficial in order to normalize and validate their emotional experiences so that they may more readily seek available mental health services. Considering the barriers to seeking mental health services as noted above, we would like to propose two empirically-validated methods of providing treating depression and preventing suicide among physicians and trainees.

The first method consists of a Suicide Prevention and Depression Awareness Program that was implemented at the University of California, San Diego School of Medicine, in order to address physician depression and suicide.¹¹ It consists of a two-pronged approach by providing a) screening, assessment, and referral services, b) education to medical students, residents, and faculty physicians.¹¹ Moutier and colleagues utilized a website with customized software created by the AFSP to generally identify participants suffering from depression and experiencing suicidal thoughts, subsequently providing participants with prompts and confidential referrals for primary care and mental health services for those who request them. More specifically, the web-based program contains an anonymous and confidential online screening tool composed of the PHQ-9 as well as other measures relevant to screening for suicide (i.e previous attempts, affective states, etc.). Data are processed and sent to a counselor via email to allow for further evaluation. A counselor then provides a detailed and personalized assessment, which can be accessed confidentially by the participant. Within the individualized assessment, the counselor provides participants with an educational introduction, relevant contact information and an avenue where the participant can communicate with their respective counselor online in a manner requiring no identification other than user identification. In addition, the website contains links to information and resources that address topics regarding wellness, depression and suicide. The web-based program also includes a list of carefully selected health professionals, including those within the community, who participants can readily access for help. The above-mentioned web-based program is implemented in combination with a robust educational program throughout the entire medical institution.¹¹

An alternative method, which can be particularly useful for individuals who have several barriers to seeking professional services, is a web-based cognitive behavior therapy (WBCBT) program.¹² Many studies have shown the effectiveness of WBCBT in treating various psychiatric disorders, particularly depression, with the added benefit of cost effectiveness.¹² WBCBT was specifically delivered to incoming interns prior to the beginning of internship year, with findings showing a significant decrease in suicidal ideation compared to participants whom were assigned to receive only receive weekly emails containing wellness education and resources.¹² This program may be particularly beneficial to younger generations of physicians and trainees who utilize the internet in their daily lives.¹²

Summary:

We hope this article further spreads awareness, invokes insight, and highlights a growing problem within the medical community—one that can be said to pre-date the invention of the stethoscope. We truly believe that it is time the medical community further invests times and focus on physician and trainee wellness in order to better our lives, and in turn, the lives of our patients.

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Saving Lives through Safer Surgery - Lifebox

Brief history

Lifebox is the **leading non-profit organization making surgery safer worldwide**.

Unsafe surgery is the world's **fastest growing** global health issue.

Lifebox works to ensure that **millions of people are leading healthier, more productive lives**.

Lifebox supports surgical teams working in the most challenging environments in the world by providing the tools and training needed to make every operation safer. Lifebox-supported teams care for pregnant women facing complicated births, children injured in everyday accidents, and people with surgically-treatable illnesses or conditions that prevent them from living productive lives.

Lifebox is a pioneer in creating innovative cross-sector partnerships for safer surgery. Leveraging frontline expertise and technology, we deliver more effective tools and proven support strategies (Forrester et al 2018). Through a broad network of partnerships, our approach is highly responsive and adapts programs to address cultural, social and local needs.

Lifebox was founded by **4 of the world's leading medical professional organizations**:

- Association of Anaesthetists of Great Britain and Ireland
- Brigham and Women's Hospital
- Harvard T.H. Chan School of Public Health
- World Federation of Societies of Anaesthesiologists



The magic of Lifebox comes from recognizing that by doing these simple things, we're safeguarding individual patients one by one. **Dr Atul Gawande, Co-founder and Chair of Lifebox**

Gaps in Surgery Globally

Nearly 5 billion people in the world do not have access to safe, affordable, and effective surgery (Lancet Commission on Global Surgery, Meara et al. 2016). Massive deficits persist in the gap between medical providers around the world, and the steady supply of tools, training, and techniques they require to perform safer surgery for their patients.

In resource-poor settings the **risk of death or complications** from essential operations is up to **1,000 times higher** than high income countries.

Surgery is a critical, life-saving health intervention. In a groundbreaking 2015 study, the Lancet Commission on Global Surgery estimated that nearly 5 billion people in the world do not have access to safe, affordable and effective surgery (Meara et al. 2016). Global health priorities will never be met without addressing the approximately 30% of the global burden of disease that requires surgery for proper treatment (Meara and Greenberg 2015). From cancers (65% need surgery), to road traffic accidents (14% of the surgical burden), to neonatal mortality (which safe cesarean sections can reduce by up to 70%), the need is enormous (Meara and Greenberg 2015).

According to recent estimates, at least 10% of deaths and 14% of the total global burden of disease is attributable to diseases treated by essential and emergency surgery

Lifebox has identified two major areas of need for providing safe and timely surgical care: functioning and fit-to-purpose equipment and providers trained in effective operating room teamwork and other proven safety strategies.

Lifebox is developing low-cost and effective tools and programs for addressing the massive gap in access to safe surgery in low-resource settings.

Approach

The World Health Organization (WHO) Surgical Safety Checklist is at the heart of our work, providing medical teams with the foundation for building high-quality surgical systems. The Checklist is a simple communication tool shown to reduce complications and mortality in the operating room by up to 40 percent.

Ten years after Haynes *et al* revealed a one-third reduction in mortality and surgical complications, the WHO Surgical Safety Checklist remains an undeniably **transformational force in the global safe surgery**.

An innovative pioneer making a lasting impact, Lifebox works with existing surgical teams — from surgeons and anesthesia providers to nurses, cleaners, and hospital managers — to offer the essential equipment, skills, and partnerships they need to provide the highest standard of care for their patients.

Critical Pillars of Safe Surgery: Lifebox concentrates on three core areas to make every surgery safer:

1. **Reducing surgical infections** - Lifebox trains on strategies for improved compliance with critical standards and processes known to reduce the risk of surgical site infection
2. **Improving anesthesia safety** - Lifebox seeks to ensure essential patient monitoring during and after every surgical procedure.
3. **Promoting operating room teamwork** - Lifebox supports a patient-centered approach by working with surgical teams to break down hierarchies and improve communication;

The lack of effective communication and a hierarchical culture which often prevents team members speaking up in the operating room is another key barrier to safe surgery. Numerous studies in the past decade have shown the benefits of introducing team-based communications tools into the surgical setting, foremost among these the Surgical Safety Checklist which was launched by the World Health Organization in 2008 and which, when used appropriately, can reduce mortality and morbidity from surgery by up to 40% ([Haynes et al. 2009](#)).

All Lifebox programs focus on **tools, training, and partnerships** to build capacity and leave a lasting impact.

Impact

Lifebox has made **20 million surgeries safer through work in 110 countries**, ensuring millions of people are leading healthier, more productive lives.

Since its founding in 2011, Lifebox has

- **Distributed 20,000 pulse oximeters**
- Worked in 113 countries
- Trained over 6,000 healthcare workers
- Carried out 150 training workshops
- Partnered with 200+ national and international organizations

In 2018, Lifebox:

- Distributed **2,115 pulse oximeters**
- Worked in **49 countries**
- Conducted **25 workshops** in safe anesthesia and safer surgery
- Partnered with **33 national and international organizations**
- Trained **1,459 healthcare workers**

Program Area	Impact
Safe anesthesia	<ul style="list-style-type: none"> • 18,000+ pulse oximeters in the hands of healthcare workers in 100+ countries • Trained 6,000+ anesthesia providers on essential monitoring • Delivered \$1M project w BMGF to develop a more effective pediatric probe • Set up innovative global to local distribution networks through links with professional associations • Developed strong and sustainable partnerships with anesthesia societies in 100+ countries
Infection prevention	<ul style="list-style-type: none"> • Launched Clean Cut program in Ethiopia • Scaling up with Ministry of Health nationwide starting in 2019 • In partnership with SPECT, developed instrument sterilization/maintenance training <ul style="list-style-type: none"> • Launching in 2019 • Developed specifications for LMIC specific surgical headlamp <ul style="list-style-type: none"> • Launching in 2019
Promoting surgical teamwork	<ul style="list-style-type: none"> • Worked with partners to introduce Surgical Safety Checklist to 4 new settings: Congo, Madagascar, Rwanda, Nicaragua • Developed new teamwork-based SAFE OR training course • Launched Surgical Teamwork Fellows program in Ethiopia



Your support is vital for Lifebox's mission

When you raise funds for and donate to Lifebox, you are helping us save lives by improving access to safe surgery every day for millions of people across the world. You are investing in a high-impact non-profit that delivers essential tools and training through vital partnerships to those on the front lines of care:

- Patients receive the highest standard of care because of YOUR support
- Surgeons and anesthesia providers work tirelessly with the tools they need to succeed
- Residents and students learn and receive mentorship so that they can contribute their skills to their communities

You will see the direct impact of your support - lasting change in people's lives. **Lifebox supporters make ALL OF THIS possible.**

Thank you!

What is the ASA-Lifebox Resident Challenge?

The ASA-Lifebox Resident Challenge supports Lifebox's work making surgery and anesthesia safer. One of our key goals is to equip all operating rooms worldwide with pulse oximeters, along with training and the protocols defined by the World Health Organization Surgical Safety Checklist. There are still over 50,000 operating rooms without a pulse oximeter worldwide. In addition, thousands more ICUs and PACUs lack this vital monitoring tool as well.

The ASA-Lifebox Resident Challenge is a chance for resident programs all over the country to raise funds for Lifebox. The annual friendly competition is open to all programs across the country and the winner is announced at the ASA Resident Assembly during the Anesthesiology Annual Meeting.

Join the Challenge and start fundraising for Lifebox!

SUBMIT AN ARTICLE TO THE ASA MONITOR

We are looking for submissions for the Resident's Review column!

Submissions are essays with 1-2 citations, ideally 800 – 1200 words long.

For more information, contact Layne Bettini or Shara Azad at asamonitorsubmissions@gmail.com

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Dear ASA Resident Members,

It has been wonderful serving you as ASA Resident Component Secretary and Editor of the ASA Resident Component Newsletter this academic year. I welcome any feedback on the current and past newsletters, as well as suggestions on topics you would like to see discussed in future newsletters.

The newsletter comes out **quarterly** and if you are interested in writing a piece in the Summer Newsletter please contact me at email below. I strongly encourage you to become involved with ASA and to run for an ASA Resident Component Governing Council position for the 2019-2020 academic year.

Feel free to contact me at asa.residentsecretary@gmail.com. I look forward to seeing you all in Florida in the Fall.

Lizbeeth Lopez, M.D.
ASA Resident Secretary & ASA Resident Newsletter Editor

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