Examining Dogma Through the Lens of Literature
Dr. David Hao

Tell us a little about yourself.
I’m currently a CA-2 resident in the department of anesthesiology, critical care, and pain medicine at the Massachusetts General Hospital. As a medical student, I was the general manager of a local pizzeria and ate pizza and pasta every day for two years straight. I spend a lot of time outside the hospital doing “sports” and a lot of time inside the hospital limping from injuries.

What is Depth of Anesthesia?
Depth of Anesthesia is a podcast with residents and attendings at the Massachusetts General Hospital that critically explores our clinical practices.

Medicine is full of claims and anesthesia is no exception. A claim is a practice decision that we either believe is true or is something we default to. I believe that for every claim, we should strive to know what is supported or refuted by evidence and what claims have no evidence but “stand to reason”. The Depth of Anesthesia podcast is an exploration of these claims.

What inspired you to create this podcast?
My program director here at Mass General, Dr. Daniel Saddawi-Konefka, started a series at our Grand Rounds earlier this year in which he explored the evidence behind common claims in anesthesia. I thought that this was exactly the type of content that would not only suit a podcast but have the potential to advance knowledge in our field.

Comprehensive literature review is exceptionally time-consuming, especially for controversial topics, and I strongly believe that understanding the literature or lack thereof is the right thing for our patients. Through this podcast, we hope to familiarize our listeners with the literature and to inspire people to question their own practices.
As the landscape of medical education continues to change, I think that new forms of media including podcasts will find more and more roles. Dr. Wolpaw’s ACCRAC has paved the way in showing that podcasts are a popular tool for medical education and we hope to continue to expand the availability of anesthesia educational materials.

Any other projects you are currently working on?
A childhood friend of mine and I just piloted a health literacy translation service called Entendere (www.entendere.com). Throughout my medical training, I’ve found myself constantly deciphering medical jargon for friends and family. I quickly realized that the vast majority of patients do not have access to resources to understand medical documents and the implications of poor health literacy are serious. Entendere is a 100% free service in which we translate documents into understandable language to help patients better understand the care that they are receiving. We are always looking for people to help with translation and would love to have you on the team.

What are your goals after residency?
I have plans to pursue a fellowship in chronic pain management but beyond that, it’s all up in the air. I saw a quote the other day in Dr. Hadzic’s Textbook of Regional Anesthesia though that I buy into.

If you have any claims that you think would be worth investigating, email us at depthofanesthesia@gmail.com or tweet us @DepthAnesthesia. We’re always looking for new topics and guests for the show.

“The most dangerous risk of all is the risk of spending your life not doing what you want on the bet that you can buy yourself the freedom to do it later.”
Propofol to Pampers: Transition from Anaesthetist in Training to Motherhood
Dr. Kate Barrett

Tell me about yourself
I am an anaesthetic ST3 trainee living in south west London. I went to Oxford medical school and have completed my general foundation training and core anaesthetic training in south west London. I am nearing the end of maternity leave for my first baby, Oscar, who is now 10 months old. I have a very supportive husband, who works in the telecommunications industry.

My husband and I are both very keen on exercise, the outdoors and travelling. Our ideal weekend involves the local park run followed by lunch and a cycle. We have just bought a bike seat for Oscar so we can now do our cycles as a family!

What year in training were you when you got pregnant?
I found out I was pregnant in the final year of my core training. In the UK, we do 2 years of general foundation training after medical school and then our anaesthetic training consists of 2 years of core training and 5 years of specialty training as an anaesthetic registrar, before becoming a consultant (attending).

The timing wasn’t ideal for me, but I don’t think there is ever a perfect time to get pregnant. I was about to apply and interview for a specialty training number. I interviewed in my early pregnancy, in the midst of first trimester morning sickness, and I didn’t get the job I wanted. I interviewed again later on in the year (this time heavily pregnant) and secured a job as a registrar in north west London.

How is the maternity leave set up for you?
Our maternity leave entitlement in the UK is 52 weeks. This can start at any time after your 29th week of pregnancy. The amount of maternity pay you get depends on how long you have worked for the NHS (national health service).

If you have continuous employment with the NHS for over 1 year, as I did, then you are entitled to NHS maternity pay which includes:
- 8 weeks of full pay
- 18 weeks of half pay
- 13 weeks of statutory maternity pay (SMP) paid by the government (£148.68 per week)
- 13 weeks of unpaid maternity leave

If you have less than 1 year continuous employment with the NHS but over 26 weeks then you get statutory maternity pay paid by the government. Which includes:
- 90% of salary for 6 weeks
- 33 weeks of SMP
- 13 weeks of unpaid maternity leave

You can also add on your annual leave and bank holiday entitlement which is paid at full pay.

Paternity leave comprises 2 weeks leave at full pay starting the day after your baby is born. We do have the option to do shared parental leave now too where the 52 weeks can be divided between mother and father to allow both to have some time off.

When are you going back to work and how will you fit childcare around work?
I am returning to work at the beginning of November after 13 months off. My current plan is to return to work part time, at 60% of a full time rotation. My working pattern will likely be either working 3 normal days a week or a combination of 1 on call day/night and 1 normal day or 2 on call days/night.
As for childcare, Oscar has started settling in to a local nursery. He will go there 2 days a week and then be looked after by his grandparents 1 day a week. Thankfully they live very close to us! The main difficulty we will have is around nursery drop-offs and pick-ups. I start work at 7:45am and finish at 17:45 and my job is an hours commute away from the nursery. The nursery day starts at 8am and ends at 6pm. So, my husband will have to do both drop-off and pick-ups the days I am at work. Luckily his job is a lot more flexible than mine, and he can make up the extra time in the evenings if needed.

I have learned many things on maternity leave but the main two are flexibility and patience. I have made a plan to return to work that I think will suit me and my little one, but I am prepared to alter it as life/work/family changes. I think it is important to understand that changing the plan is not failing, but adapting to make life better. By working part time now, it will take me longer to become a consultant and I will have to be patient. The time extra time I could spend working now, would mean missing out on Oscar’s early years; a sacrifice I’m not willing to take.

**What advice would you give residents (both female and male) who are thinking of starting a family during training?**

Make peace with the idea that there is never a ‘perfect’ time to have a baby. Medicine/Antesthesia is a vocation and lifelong job, which will be there when you get back from maternity/paternity leave. If you want a family, you will make things work for you.

Listen to what advice others have to offer you but don’t take it as gospel. When it comes to having a baby and raising children, everyone loves to impart their opinions on what’s best, which is always well intended. Make sure you use what works for you and your family and be prepared to use a lot of trial and error for the rest. Every family and baby is different.

Most importantly, once you have made your decision, embrace it. Try not to compare yourself with your colleagues/peers as you will now be at different stages of your career. Don’t underestimate what you will learn and how you will develop as a person when you become a mother or a father. It is an amazing and steep learning curve for both you and your baby and one I wouldn’t change for the world.

---

**Emerging Leaders Scholarship**

Through the ASA Emerging Leaders Scholarship Program, 10 residents receive reimbursement up to $1,000 to attend PRACTICE MANAGEMENT 2020, January 17-19, in Las Vegas, Nevada.

Program directors nominate and submit two letters of recommendation and a 500-word essay from the nominee describing their interest in practice management and leadership.

All materials should be emailed to residentcomponent@asahq.org by October 31, 2019.
MoMD Reentry

Lindsay L. Warner, M.D.

When deciding the ideal time to have a baby, the start of my internship was not my first choice. However, due to a prior gynecologic cancer, my physicians indicated that if I wished to have children, it was "now or never."

My fears were similar to all first-time moms, but were magnified by a looming internship and residency. Professionally, I worried that my studying would suffer or that I wouldn't know the right answers to all of the clinical questions I would be asked. Worst of all, I was afraid of losing my career by being "mommy-tracked." I feared my supervising staff would think of me as less motivated than my peers and trailing their less-fettered progress, potentially passing me over for opportunities simply due to the assumption that my sole focus was at home.

I had my baby before medical school graduation and returned from maternity leave to start intern year. I woke up extra early that first morning to nurse and, after meticulous planning, I decided to save time and pump in the car. However, I then forgot to hook up the bottles and pumped milk all over my new suit. An excellent start to the year.

After pre-rounding on all of my patients before my co-residents had even arrived, I rushed to hunt for an open lactation room. Finding all of them occupied, I found a bathroom to pump in prior to patient-care rounds. When my pager went off, I answered with my cell phone in the tiny space with the motorized pump and its attendant background noise. I hadn't realized this beforehand.

"Is this Dr. Warner?"
"Yes."
"What is that weird whirring noise?"
"I'm pumping."
"You are doing WHAT?"

After a long day of patient care, didactics and two more bathroom pumping sessions, I rushed home just in time to miss my daughter before she went to bed. As I sobbed in disappointment, I questioned myself and my career choice. I felt like I was in this all by myself ... underwater ... with no end in sight. My husband was a champ at washing pumping supplies, but couldn't relate to my daily struggle.

Things improved over time. I found the discreet places to pump that were less busy. I brought a bigger cooler and extra freezer packs to keep my milk with me so I didn't have to run back and forth to the refrigerator. I became more efficient at my clinical work, so that I could leave on time in the evenings to see my daughter while she was still awake. Looking back, I know there were other residents with babies, but I was so busy just trying to make it successfully through each day that I missed any chance to get to know them.

These difficult days spurred my interest in creating a brand new Maternity Leave Reentry Program for the residents and fellows at Mayo Clinic in Rochester, Minnesota. Having a new baby during training is difficult for any parent, but returning from maternity leave is inherently unique. Not only is there a physical recovery from the toils of childbirth and breastfeeding and pumping at work, but also the well-described isolation of new motherhood and the penalty described to accompany it.4

Fortunately, Mayo Clinic has a century-old, highly functional association for its trainees in graduate medical education, the Mayo Fellows Association. I volunteered to serve as one of the Mayo Fellows Association's wellness chairs as I believed that I could have a positive impact and really change the experience for new physician moms. To start, I reached out to many of the current physician moms at Mayo and compiled their collective wisdom on returning from maternity leave. The resulting compilation addresses questions such as:

- "What insurance should I sign up for?"
- "How much will delivery cost?"
- "Where and when should I sign up for day care?"
- "How have other residents managed pumping and operating room or hospital service duties?"

My wellness colleagues and I believed that it was most important to find new physician moms on the first days of their return to work and show them that they had a support network that would help them through these new
and daunting unknowns. Many of us remembered that first day back from maternity leave so clearly – how sad it was to leave our baby at a brand new daycare, to have her cry as we walked away – and how overwhelming it was to simultaneously manage patient care. We wanted to see these new mothers on their first days back, to tell them in person that they are supported and we are all part of a caring community.

Initially through word of mouth and now, online, we identify pregnant trainees prior to maternity leave. We then contact the new moms during maternity leave to check in and ask about their timeline for returning to work. Monetary support from the Mayo Fellows Association helped purchase supplies and create maternity leave reentry welcome gifts. Our gift bags included water bottles, lactation cookies, a list of lactation room locations, snacks, toiletries, a magnet photo frame for lockers, and a personalized reentry note (see images at right). On the day of their return to work, experienced resident moms meet with the new moms to hand off the gifts and offer support. We have established an online Facebook community group to share our individual experiences, socialize and share essential baby items.

We started this program in August 2018 and so far we have provided 30 new moms in residency training with maternity leave reentry welcome gifts, and there are many more planned for the end of this academic year. Our Facebook community group has over 60 members and continues to grow. One of the crucial aspects of our reentry wellness program is its inclusive, institution-wide design that applies to all physician trainees. There are residency and fellowship programs with very few mothers (even among attending staff). Our program has allowed us to connect physician moms across specialties and decrease their risk of isolation.

While our project was funded, we believe this type of program could be established with little to no budget by following the same principles of information-sharing and community building. Every workplace culture is unique, and every maternity leave re-entry program will need to be tailored to a specific institution. We sincerely hope that other anesthesiaology programs and institutional schools of graduate medical education will choose to create similar programs to support all new moms reintegrating into the workplace. Physician moms who return to training better supported will not only have improved personal wellness but, will also be better clinicians and colleagues.

Reference:

Special thanks to Dr. Bridget Pulos, Dr. Sarah Dodd, and Dr. Susan Moeschler for their mentorship and tremendous support of this project and my story.
Microaggressions and the Retention of Minority Residents in Academic Medicine
Dr. Tolulope Oso

When I graduated medical school, I was certain of two things: I was now a physician, hence my words mattered and I was still an internship year away from Anesthesia. My intern year started with Internal medicine wards. One of the things I was most impressed with was the diversity within my team. My attending was Middle Eastern, the residents, myself included, and medical students came from different parts of the world and walks of life. I had never been in a more diverse setting in my life, and for the first time in a while, I felt comfortable in the professional setting. As a team, we took on the collaborative effort and there were many innovative ideas that were brought to my mind that reflected the views of each individual. Shortly after, I received an email about the Diversity Mentoring Program and the grant through ASA. In all honesty, I didn't think that I had enough knowledge in Anesthesia or experience as a physician to apply. However, I knew that I valued diversity and I knew that I had to at least try so I did.

Upon discovering that I won the award, I was shocked. I did not believe it at first, and waited until my mentor, Dr. Omonedu Nwokolo confirmed it as well. My research project is in healthcare disparities and focuses on the effect of microaggressions on the overall satisfaction of minority residents in Anesthesiology. A microaggression is a term used to encompass those brief and commonplace verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory or negative prejudicial slights and insults toward any group.

This project was incredibly important to me due to my life experiences. Growing up, I have always been the minority and as a result, I have been "privy" to the range of biased (intentional or not) comments directed at minorities. I can recall several moments in college where I overheard many classmates stating that people who looked like me were given admission, rather than earned it. Even when I proved that I earned my admission, it was never enough, as I always felt like a second-class student. In 2013, the AAMC documented the following statistics concerning the ethnicity of the physician workforce: 4.1% African American/ Black, 4.4% Hispanic/ Latino, 0.4% Native American, 11.7% Asian and 48.9% Caucasian. Within the field of Anesthesia, similar numbers were found when considering full time faculty at Academic Institutions: 3.4% African American/Black, 1.8% Hispanic/ Latino, 14.7% Asian, and 62.1% Caucasian. While there are many factors leading to lack of diversity and attrition of minorities in medicine, I wanted to find out if confrontations with microaggressions have led to the formation of a non-inclusive environment within Academic Anesthesiology.

I have been pleasantly surprised to see how the mentorship grant has allowed me to become more involved with ASA. I have had the privilege of meeting amazing people doing even more amazing things throughout the field of Anesthesia. As a part of the grant, we are encouraged to join committees in ASA to further our impact on the organization. This is of utmost importance because it helps promote diversity.

My mentor is Omonicetu Nwokolo, MD. I truly appreciate her mentorship. When applying for the grant, I simply asked if she knew anyone that could mentor me, or if I needed to rely on my connections from medical school. She instantly took me as a mentee and has helped to grow, refine and develop not only my project but my role in the advancement of diversity in ASA. Dr. Nwokolo is not only an Associate Professor in the Department of Anesthesiology, but she also serves as the Assistant Operating Room Director at Lyndon B Johnson Hospital and our inaugural Vice Chair for Diversity and Inclusion. Her role in promoting this inclusion is one of the main reasons why I chose UT Houston as a choice for Residency. The department showed me that they valued all types of people, and that to me was of utmost importance. People sometimes take it for granted how important it is to feel supported. Dr. Nwokolo and UT have helped me feel supported and protected, for that, I am grateful.
At this point, we have undergone IRB review, developed the survey and are making the necessary changes in order to get it ready for distribution to Anesthesiology residency programs across the nation. I am hopeful for a good response rate to get adequate data. Knowing the prevalence of microaggressions in Anesthesia, will be a first step in improving the way interactions with minority residents occur. We hope this will open up the lines of communication to augment change in our specialty to create an environment that is collaborative, welcoming and progressive. I hope to continue to grow and learn more through the ASA Committee on Professional Diversity. In addition, I plan to incorporate myself in more committees that tailor to my other interests in the field of Anesthesia, not only because I want to, but I know that it is necessary.

**Thoughts on Being Chief Resident**

**Dr. Viviana Ruiz**

Every year anesthesiology residencies across the country go through the exciting process of selecting one or more Chief Residents. Unlike surgical residencies, in which usually every senior resident automatically becomes chief, senior anesthesia residents are usually voted into this coveted position. The selection process varies among programs. At my home institution, all CA-2 (soon-to-be CA-3) residents are eligible to become chief. The staff and residents vote via an anonymous e-survey and the person with the majority of votes is elected chief.

I learned that I would be this year’s chief resident during a busy February morning. I was called for an impromptu meeting with my program director, the vice-chair of education, and the education manager. I must have had a puzzled look (and a hint of worry) on my face, because immediately after I closed the door behind me my PD said smiling “let me just say it, you are not in trouble,” and she went on to deliver the news. Of course, I was incredibly excited and honored to be chosen among my talented cohort. My PD said this would be a “challenging but rewarding” year -- if I chose to accept the role. Then my mind filled with questions: what would my job be (besides making the schedule)? Would I have time to do it? And does anyone decline being chief?

Turns out most newly minted anesthesia chief residents have similar questions. I know because I met dozens of them at the Society for Education in Anesthesia (SEA) Leadership Program, which was held in May in Denver, CO. In order to demystify what being chief resident entails, I decided to share some pearls I learned from the SEA workshops, as well as from exceptional leaders in our specialty whom I deeply admire. I hope this information helps you execute your current and/or future leadership roles.

1. **Decide the type of leader you want to be**

   There are two types of leaders, those who want to serve people, and those who want a title. If you choose to be chief, I suggest you choose the former. Not only will it be more rewarding, but it will bring you clarity. When I’m having difficult conversations with program leaders about decisions that affect residents, remembering that I am representing forty plus people whom I care about has given me the courage to speak up and has made all the difference.

2. **Understand your role**

   Your program should have a Job Description for chief residents, which will likely ask you to be a leader (promote clinical excellence, service, collaboration, scholarship), educator (teach interns, medical students), liaison (be in numerous committees), and very likely, to make the schedule. At the very core, your primary role will be to serve both, the residents and the leaders of the program. This can be a difficult position to be in, because each side might have unique interests and you will find yourself caught in the middle. Which leads me to the next point.
3. **Don’t work alone**  
Identify other resident leaders in your program - for example, residents involved in advocacy or committees - and work with them to make decisions. Ideally, you would have a team of diverse minds who think differently and can help you recognize blind spots. Dr. Jeffrey Kirsch, Emeritus Chair of the Anesthesia Department at OHSU and one my all-time favorite leaders, once told me that the way to get buying in from people is to include them in the decision-making process. So, create an advisory board. They will help you come up with much better solutions and likely result in increased resident and program leaders’ satisfaction.

4. **Represent the consensus.**  
Find out what matters to the majority of the residents. Remember that you and your co-chiefs are probably like-minded people willing to work longer hours, take on extra assignments, etc. You might not have an accurate picture if you limit yourself to discussions with your close circle of peers. Some residents will not feel comfortable approaching you or disclosing information to you. So is useful to identify influential residents in your program and approach them to get their input – they might know of concerns that others don’t feel comfortable discussing publicly.

5. **Not everyone will like you or approve of you**  
Some people will resent your decisions, be unhappy with a situation, or simply not like you. That’s not pleasant, but don’t let it stress you. As long as you are fair (don’t play favorites), transparent (communicate frequently, and honestly), and have thought-out reasons for your decisions people will respect you. So, focus on your core values, create concrete goals, and work with your co-chiefs and advisory board to come through with results.

6. **Making the call schedule will be your most valued role**  
Creating the schedule will be, by far, your most important job. Why? Because it is the most tangible way you will impact resident morale and quality of life. For this reason, it is absolutely critical that you prioritize the resident schedule. Publish it in a timely fashion, have a system to track the number of calls, and be able to easily identify who is getting overworked. You should be able to review a resident’s schedule and show them how their call burden compares to others, with concrete numbers. Importantly: do not volunteer to take every call. You will get burned out and nobody benefits from an exhausted leader. Meet frequently with your call committee to discuss call and duty hours, review call assignments and call distribution, and assess overall fairness. In short, keep the process transparent.

7. **Establish boundaries**  
In my opinion, 3 of the most important boundaries to develop early on are:  
(1) **Keep confidentiality:** don’t discuss resident issues with co-residents or outside parties unless you are concerned about their safety, in which case you should report it to your PD at once.  
(2) **Stop the urge to solve every problem:** Your colleagues will come to you with an assortment of concerns and complaints. Your job is not to solve every problem (that would be a heavy burden to carry) but to listen and provide support. Realize that sometimes your colleagues just want to vent and are not looking for you to solve their problem. But If they want you to intervene, discuss it with the appropriate party (i.e. the PD) who can provide a definitive solution.  
(3) **Set time limits** – decide on a time to deal with “chief” stuff, and don’t allow it to spill into your personal or educational life. This is most relevant to emails and text messages. Being chief resident has been as challenging as my predecessors forecasted but the growth, sense of duty, and ability to create change have been immensely rewarding. The non-clinical days are too short to address all the needs and, I confess, I occasionally violate my “time limit” boundary. But having been in this position for over 4 months, I am getting the hang of things. And of course, I don’t work alone!

There are innumerable books and articles written about leadership, and the SEA Leadership Program for new chief residents, which I highly recommend every chief to attend. I am still wondering if anyone rejects being chief. Clearly, I did not, and I hope you don’t either if you get the choice.
Global Anesthesia Opportunities for Trainees: Closer to Home Than You Might Think
Dr. William F. Powell, Jr.

Tell me about yourself.
I grew up in Southern Mississippi and moved to New England to attend college at Middlebury College. After that, I spent a few years working as a research assistant in Boston while getting my MPH from Boston University. I went to medical school at Albany Medical College, and since then I have spent the last several years in training at Brigham and Women’s Hospital (General Surgery Internship), Beth Israel Deaconess Medical Center (Anesthesiology Residency), and, currently, Tufts Medical Center (Pediatric Anesthesia Fellowship).

When did you start getting involved with global health?
I had always aspired to get involved in global anesthesia, but it wasn’t until my CA1 year that I finally took the plunge. We have a group here in Boston called the Harvard Global Anesthesia Initiative (HGAI) that is resident-run, faculty-mentored, and open to anyone interested in global anesthesia. HGAI meets periodically to network and discuss journal articles and issues related to global anesthesia. It’s been a great group to be a part of and has been instrumental in my learning more about global anesthesia efforts and getting further involved.

Did you do any global health work during residency and if so do you encourage it?
In addition to HGAI, I have attended conferences and courses related to global anesthesia and surgery, helped with research on global anesthesia issues, and co-authored a tutorial for the World Federation of Societies of Anesthesiology (WFSA), which is forthcoming in the near future. I was also very fortunate to be selected for the ASA-GHO Resident International Anesthesia Scholarship Program and spent a month in Uganda earlier this year working with anesthesiologists and participating in educational activities.

I certainly encourage anyone who is interested in global anesthesia to get involved during residency. There is a great deal to learn about the challenges facing anesthesia providers in low- and middle-income countries (LMICs), and there are numerous ways to get involved in addressing these challenges.

What are ways that residents can get involved with global health during training?
I think a lot of people envision global health work as travelling to a LMIC to complete a specific project or task. Don’t get me wrong, such an experience can be very exciting and rewarding, and if you have the opportunity you should definitely take it. However, there is so much work that can be done from here as well. Simply start by asking around for any global anesthesia enthusiasts in your program or city, and if there isn’t already a local interest group, start one. Meeting with like-minded individuals is a great platform for further educating yourself about global anesthesia issues. I mentioned the WFSA previously, who publish a series of Tutorials of the Week on anesthesia topics targeted at anesthesia providers across the world, and they are looking for people to help write these tutorials. You can also help raise money for global anesthesia causes. A great example is the ongoing ASA-Lifebox Resident Challenge which is helping raise money for an organization called Lifebox that, among other things, provides pulse oximeters to anesthesia providers in LMICs. If you haven’t heard of Lifebox, you should look them up and get involved in the fundraising challenge. I’ve been working on raising money here in Boston, and if your program doesn’t have a team yet, I encourage you to create one!
What are landmark papers that you think any resident interested in global health should read?

Two papers I would recommend starting with are the WHO-WFSA Standards paper, which outlines the equipment, personnel, and medications necessary to provide safe anesthesia; and the Global Surgery 2030 paper, which outlines the need to address disparities in access to safe surgical and anesthesia care in LMICs.


Death and All His Friends
Dr. Claudia Sotillo

Mr. R lay in a frozen nest of padding and plastic tubes coming from every possible vessel in his body. His family formed a quiet vigil around him as he completed the protocol for therapeutic hypothermia. By all accounts, the person in front of me was nothing more than the pale shadow of the man described by loved ones.

Earlier that afternoon, Mr. R was celebrating his 89th birthday with his entire extended family from Colombia. They ate, drank, and were merry in what was described as an epic party—an epic party that came to a sudden and unexpected end when Mr. R suffered a cardiac arrest while salsa dancing, leading to his presence before me in a cardiac ICU.

Over the course of weeks, I came to know his sons and daughters, the beat of his heart, and the soft exhale of his lungs. His hospital course was like watching a computer reboot itself, complete with a language barrier in the form of an endotracheal tube keeping him mute.

Every day, I would talk to him and present his case on rounds. Unlike many patients, he graduated from the mechanical ventilator and slowly progressed to blinking back at me with a blank stare. His family said he interacted with them, even following commands. Yet day after day, he initially did nothing more for me than flail about, darting his eyes across the room without fixating on anything in particular. The accounts of his family were so different from what I saw that I brought his daughter to the bedside to coax him to not be afraid, to understand that we were not there to hurt him.

What happened in the subsequent few days is best described by the song, “Tryouts” from the Rudy motion picture soundtrack.

On rounds, when asked to stick out his tongue, he did.

When asked to give a thumbs up, he did!
It was like the victory scene of the movie, except instead of being carried off the field on his teammates’ shoulders amid a stadium of cheers, Mr. R was carried to a general hospital floor by a team of transporters amid the sounds of monitors. I can confirm that he walked out of the hospital a week later.

However, Mr. R’s miraculous recovery from an out-of-hospital cardiac arrest is the exception, not the norm. Out-of-hospital cardiac arrests with initial non-shockable rhythms carry dismal survival rates, with 5.9% of patients reaching hospital discharge\(^1\) and 4.9% achieving 30-day survival\(^2\). Most survivors who leave the intensive care unit do so with severe disability and poor functional recovery.

The reality is that no one wants to die or even confront their own mortality. Most Americans report they would prefer a gentle, quick, and natural death at home that does not provide their families a financial burden\(^3\). Yet, many patients, wishing to prolong life by any means, will readily agree to have “everything done,” even if that means going against all of their original wishes.

Advances in modern medicine eliminate a quick death from the dying process through the continual increase in placement of implantable defibrillators, ventricular support devices, feeding tubes, endotracheal/tracheostomy tubes, bridges to transplant, and oftentimes, bridges to nowhere. The modern death has evolved into a slow and prolonged dance as patients bounce from in-hospital care to skilled nursing home care, back to the ICU, back to the nursing home, and so forth. The reality is that by the time a patient reaches an intensive care unit, the “quick and gentle” death option is usually far-gone.

As physicians, we live in a system that rewards us for doing everything possible to save a life, but we often receive little guidance on when to stop. At what point is the treatment also the harm? At what point do we let go and welcome death and all his friends?

A study comparing physician attitudes toward advance directives between a cohort of physicians in 1989 (two years before the Patient Self Determination Act\(^1\) was enacted) and 2013 showed no significant change in the interim 23 years. In fact, an overwhelming number of physicians (88.3% to be exact) chose do-not-resuscitate (DNR) status and wanted to be organ donors, suggesting that physicians provide aggressive measures for terminally ill patients yet personally decline such care for themselves\(^5\).

This is reflective of the inherently unequal physician-patient relationship. Doctors know what is coming and what the procedures, devices, and therapies offered involve. In an ideal world, care would be standardized, but despite advance directives, living wills, and healthcare proxies put in place to facilitate patient autonomy, individual doctors’ practice styles or institutional capacity predominate and direct care instead. More than 20 years after the publication of the SUPPORT trial\(^5,6\), we still struggle to honor patient wishes whether confronted with traditional or non-traditional advanced directives, such as the unconscious patient with a signed DNR tattoo on his chest\(^7\). Is it enough to encourage more frank conversations and open lines of communication between intensive care teams and seriously ill patients and their families? When these are unavailable, how many times and in how many ways must our patients reassure us of their wishes?

At times, I cannot help but wonder if we prolong death more than we prolong life. It is human nature to push the limits of mortality, but is sudden death after a ferocious salsa at your 89th birthday party the worst way to go?

**Literature Review:**
2. Resuscitation. 2018 Dec;133:147-152.
Dear ASA Residents,

It has been wonderful serving you as Secretary and Editor of the ASA Resident Component Newsletter this academic year.

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

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

Lizbeeth Lopez, MD
Secretary, ASA Resident Component
Editor, ASA Resident Component Newsletter