



SAAAPM

SOCIETY OF ACADEMIC ASSOCIATIONS OF
ANESTHESIOLOGY & PERIOPERATIVE MEDICINE



2021 Annual Meeting Program

November 5-6, 2021

Virtual Meeting

Register Online at www.SAAAPM.org

Program Information

Target Audience

This meeting is designed for anesthesiologists in Chair, Core Program Director, Subspecialty Program Director and Program Administrator positions. Members may invite physician and non-physician guests. The program is designed to present and discuss areas of topical interest to attendees in keeping with our collective attempt to improve academic department's structure, function and the educational programs associated with academic learning.

About This Meeting

Topics for this meeting were selected by various methods. Suggestions for topics were derived from evaluations of the 2020 and other previous Annual Meetings, Council members, the membership at large and reviews of the published literature with the highest impact on the anesthesia specialty. These suggestions were discussed by our authorities in the field of anesthesia education or previous meetings.

The purpose of this Annual Meeting is to educate and share information that will enable academic anesthesiology departments to improve management and care.

This Meeting Will Provide:

- Institutional resources to support the educational, research and clinical missions essential to the day to day management of a successful academic anesthesiology department.
- Solutions to challenges in educating the next generation of trainees on issues of interpersonal communication skills, professionalism and systems-based practice.
- Ideas to design new modalities to incentivize their faculty to become best performers in fulfilling the educational and/or research missions of a successful anesthesiology department.

Special Needs

The Society of Academic Associations of Anesthesiology and Perioperative Medicine fully complies with the legal requirements of the Americans with Disabilities Act and the rules and regulations thereof. If any attendee in this educational activity is in need of accommodations, please contact the SAAAPM at (414) 389-8619.

Program Faculty

Aditee Ambardekar, MD, MSEd

Associate Professor and Residency
Program Director
UT Southwestern Medical Center,
Department of Anesthesiology and Pain
Management
Dallas, TX

Magdalena Anitescu, MD, PhD

Professor of Anesthesia and Pain Medicine
Section Chief, Division of Pain
Management, Director, Pain Medicine
Fellowship Program, Department of
Anesthesia and Critical Care
University of Chicago Medical Center
Chicago, IL

Keith Baker, MD PhD

Vice Chair for Education and Faculty Affairs
Massachusetts General Hospital / Harvard
Medical School
Boston, MA

Kathy Bauer, MEd

Administrator
Cleveland Clinic
Cleveland, OH

Helen Bean, DO

Program Director, Anesthesia Residency
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Virginia Mason Medical Center
Seattle, WA

Jeffrey S. Berger, MD, MBA

Seymour Alpert Professor and Chair
George Washington University School of
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Anita Bergh, BA, BS CTAGME

Manager Anesthesiology Programs
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Garrett W. Burnett, MD

Assistant Professor
Icahn School of Medicine at Mount Sinai
New York City, NY

Malin Cannon, MEd, C-TAGME

Residency Program Coordinator
Riverside University Health System
Moreno Valley, CA

Fei Chen, PhD, MEd

Assistant Professor
The University of North Carolina at Chapel
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Chapel Hill, NC

Ellen Y. Choi, MD

Assistant Professor
University of Chicago/Comer Children's
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Randall M. Clark, MD

Associate Professor
University of Colorado
Denver, CO

Joanne M. Conroy, MD

CEO & President
Dartmouth-Hitchcock & Dartmouth-
Hitchcock Health
Lebanon, NH

Rebecca Dale, DO

Program Director, Pain Medicine
University of Washington
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Allison Dalton, MD

Director, Anesthesia Critical Care
Fellowship, Associate Chair of Education
University of Chicago
Clarendon Hills, IL

Carol Diachun, MD, MSEd

Acting Associate Dean for Educational
Affairs Associate Chair for Education
& Residency Program Director Clinical
Professor of Anesthesiology
University of Florida College of Medicine –
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Sunil “Sunny” Eappen, MD MBA

Chief Medical Officer
Brigham and Women's Hospital
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John B. Eck, MD

Program Director, Pediatric Anesthesiology
Fellowship
Duke University
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Jim Eisenach, MS, MD

Professor of Anesthesiology
Wake Forest School of Medicine
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Ilana R. Fromer, MD

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Robert Gaiser, MD

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Yale School of Medicine
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Erin Hennessey, MD

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Education Specialist
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Ann Arbor, MI

Laurie Zoloth, MA, MA, PhD

Professor
University of Chicago
Evanston, IL

Future Meeting Dates



2022 Annual Meeting

November 11-12, 2022

Swissôtel Chicago • Chicago, Illinois

2023 Annual Meeting

November 3-4, 2023

Swissôtel Chicago • Chicago, Illinois

AAAC Concurrent Session



Friday, November 5 (All Times in Eastern Time Zone)

10:00 – 10:05am **Welcome and Announcements**
Moderator: Michael C. Lewis, MD, FASA

10:05 – 12:00pm **Extending Your Impact as Chair**
Moderator: Michael C. Lewis, MD, FASA

10:05 – 10:35am **Institutional Roles**
David A. Lubarsky, MD, MBA

10:35 – 11:05am **Civility is Critical to Safe Care in the Hospital**
Sunil “Sunny” Eappen, MD, MBA

11:05 – 11:35am **Moving Beyond Anesthesiology**
Joanne M. Conroy, MD

11:35am – 12:00pm **Q&A**

12:00 – 12:30pm **Break**

12:30 – 12:45pm **Business Meeting**
Moderator: Michael C. Lewis, MD, MBA

12:45 – 3:00pm

Afternoon Sessions

Moderator: TJ Gan, MD, MBA, MHS, FRCA, FFARCS (IRE), Lic Ac

12:45 – 1:05pm

RRC Update

Aditee Ambardekar, MD, MSED

1:05 – 1:15pm

Q&A

1:15 – 1:50pm

Perfect Storm

Charles W. Whitten, MD

1:50 – 2:00pm

Q&A

2:00 – 2:50pm

Ethics in a Pandemic

Laurie Zoloth, MA, MA, PhD

2:50 – 3:00pm

Q&A

3:00 – 3:30pm

Break

3:30pm – 4:30pm

Diversity & Inclusion – How Do Chairs Help Shape Future Leaders?

Moderator: Cynthia A. Lien, MD

3:30 – 3:55pm

Chair as Coach

Frank Rosinia, MD, MHCM

3:55 – 4:20pm

Faculty Development

Lisa Leffert, MD

4:20 – 4:30pm

Q&A

4:30 – 4:35pm

Concluding Remarks

Moderator: Michael C. Lewis, MD, FASA

AACPD Concurrent Session



Friday, November 5 (All Times in Eastern Time Zone)

10:00am – 10:45am **Updates from the ABA (With AAPAE)**
Moderator: Charles A. Napolitano, MD, PhD

10:00am – 10:20am **ABA Update**
Robert Gaiser, MD

ABA Exams Update
Mark T. Keegan, MB BCh BAO MRCPI
DABA MSc FCCM

10:20am – 10:45am **Q&A**

10:45 – 11:45am **Roles of the APD & Succession Planning**
Moderator: Manuel Pardo, Jr, MD

10:45 – 10:55am **The Assistant/Associate PD: Structures and Approaches**
Kaitlyn Mitchell, MD

10:55 – 11:00am **Q&A**

11:00 – 11:10am **11 Years as an APD – Joys and Regrets**
Susan M. Martinelli, MD

11:10 – 11:15am **Q&A**

11:15 – 11:25am **Tips for the APD to PD Transition in 2021**
Emily Peoples, MD

11:25 – 11:30am **Q&A**

11:30 – 11:40am **Program Director Emeritus - How and When to Make the Transition**
Manuel Pardo, Jr., MD

11:40 – 11:45am **Q&A**

11:45 – 12:15pm **Break**

12:15 – 12:35pm **Business Meeting**
Moderator: Charles A. Napolitano, MD, PhD

12:35 – 1:05pm **AACPD Meet & Greets**
New Program Directors
Associate Program Directors
Moderators: Jed T. Wolpaw, MD, MEd & Julie L. Huffmyer, MD

1:05 – 1:35pm **Mistakes Made: Lessons Learned as a Program Director**

Moderator: Kristina Sullivan, MD

1:05 – 1:15pm **Helen Bean, DO**

1:15 – 1:25pm **Laura M. Pinault, MD**

1:25 – 1:35pm **Q&A**

1:35pm – 2:30pm **From the Chair's Perspective**
Moderators: Jed T. Wolpaw, MD, MEd & Julie L. Huffmyer, MD

1:35 – 1:50pm **Jeffrey S. Berger, MD, MBA**

1:50 – 2:05pm **Cynthia A. Lien, MD**

2:05 – 2:20pm **Stephanie B. Jones, MD**

2:20 – 2:30pm **Q&A**

2:30 – 3:30pm **Assessment and Feedback for Residents**
Moderator: Daniel Saddawi-Konefka, MD, MBA

2:30 – 2:45pm **Evaluation and Feedback**
Keith Baker, MD, PhD

2:45 – 3:00pm **Situational Judgement**
Ilana R. Fromer, MD

3:00 – 3:15pm **EPAs**
Pedro Tanaka, MD, PhD (Medicine),
MACM, PhD (Education)

3:15 – 3:30pm **Q&A**

3:30 – 4:00pm **Break**

4:00 – 4:45pm **Milestones 2.0 (With AAPAE)**
Moderator: John D. Mitchell, MD

4:00 – 4:15pm **Development of Milestones 2.0**
Aditee Ambardekar, MD, MSED

4:15 – 4:30pm **Implementation of Milestones 2.0**
Carol Diachun, MD, MSED

4:30 – 4:45pm **Q&A**

AASPD Concurrent Session



Friday, November 5 *(All Times in Eastern Time Zone)*

10:00 – 10:05am

Welcome and Announcements

Moderator: Magdalena Anitescu, MD, PhD

10:05 – 10:45am

Fellow Education During Pandemic: The Silver Lining

Moderator: Lynn R. Kohan, MD

10:05 – 10:20am

Lessons Learned from a Quickly Adaptable Process: What Will We Keep Moving Forward

Chris Spofford, MD, PhD, FASA

10:20 – 10:35am

Hands-on Virtual Training: Teaching Clinical Procedural Skills in a New Way

Garrett W. Burnett, MD

10:35 – 10:45am

Q&A

10:45 – 11:25am

Career Development as a Program Director

Moderator: Feyce M. Peralta, MD, MS, FASA

10:45 – 11:00am

Protected Time for All Anesthesia Subspecialties: Administrative or Scholarly Use

Rachel M. Kacmar, MD

11:00 – 11:15am

Techniques to Manage and Focus Energy of PD on Building and Shaping a Successful Fellowship Program

Justin L. Lockman, MD, MEd

11:15 – 11:25am

Q&A

11:25 – 12:05pm

Fellows Wellness, Time Off and Return to Work: Personalized Views and Institutional Angles

Moderator: Erin Hennessey, MD

11:25 – 11:40am

Maternity and Paternity Leave: How Do Institutions React and Accommodate New Parents

Corrinna J. Yu, MD, FASA

11:40 – 11:55am

Mental Health and Burn Out: Resources and Responsibilities

Allison Dalton, MD

11:55 – 12:05pm

Q&A

12:05 – 12:30pm

Break

12:30 – 1:15pm

Workshop Block 1

- **Private Practice vs Academics: How to Succeed in Each**
Moderators: Magdalena Anitescu, MD, PhD / Tjorvi E. Perry, MD, MMSc
- **How Well Do We Know our Fellows?**
Moderators: Doyle Lim, MD, MMM, FAAP / Ellen Choi, MD
Additional Moderator: Jody Leng, MD, MS
- **Fellows Recruitment: What Does the Future Hold?**
Moderators: Edward R. Mariano, MD, MAS, FASA / John B. Eck, MD
- **Multi-institutional Collaborations: How Effective is it?**
Moderators: Erin Hennessey, MD / Lindsey Loveland Baptist, MD, FASA
Additional Moderators: Rebecca Dale

1:15 – 1:30pm

Move to Workshop Block 2

1:30 – 2:15pm

Workshop Block 2

Repeat of Workshop Block 1 (See previous block)

- **Private Practice vs Academics: How to Succeed in Each**
Moderators: Magdalena Anitescu, MD, PhD / Tjorvi E. Perry, MD, MMSc
- **How Well Do We Know our Fellows?**
Moderators: Doyle Lim, MD, MMM, FAAP / Ellen Choi, MD
Additional Moderator: Jody Leng, MD, MS
- **Fellows Recruitment: What Does the Future Hold?**
Moderators: Edward R. Mariano, MD, MAS, FASA / John B. Eck, MD
- **Multi-institutional Collaborations: How Effective is it?**
Moderators: Erin Hennessey, MD / Lindsey Loveland Baptist, MD, FASA
Additional Moderators: Rebecca Dale

2:15 – 2:30pm

Move Back to General Session / Main Room

2:30 – 3:00pm

AASPD Business Meeting

Moderator: Magdalena Anitescu, MD, PhD

3:00 – 3:45pm

Updates from the Subspecialties

Moderator: Magdalena Anitescu, MD, PhD

- **Regional Anesthesiology and Acute Pain Medicine**
Edward R. Mariano, MD, MAS, FASA
- **Critical Care Medicine**
Erin Hennessey, MD
- **Pain Medicine**
Magdalena Anitescu, MD, PhD
- **Pediatric Anesthesiology**
Justin L. Lockman, MD, MEd
- **ACTA**
Douglas C. Shook, MD, FASE
- **OB Anesthesia**
Andrea Traynor, MD

AAPAE Concurrent Session



Friday, November 5 (All Times in Eastern Time Zone)

10:00 – 10:45am **Updates from the ABA (With AACPD)**
Moderator: Charles A. Napolitano, MD, PhD

10:00 – 10:20am **ABA Update**
Robert Gaiser, MD

ABA Exams Update
Mark T. Keegan, MB BCh BAO MRCPI
DABA MSc FCCM

10:20 – 10:45am **Q&A**

10:45 – 11:00am **Welcome and Business Meeting**
Moderator: Lara Zisblatt, EdD, MA, PMME

11:00am – 1:00pm **SNAP Talks**
Moderator: Fei Chen, PhD, MEd

11:00 – 11:15am **Developing an Online Presence**
Rena Gresh

11:15 – 11:30am **Test Taking**
Rachel Moquin, MA, EdD

11:30 – 11:45am **“2021 Pronouns: Not What I Learned in 6th Grade Grammar”**
Callie Keller

11:45am – 12:00pm **Documentation in Case of Litigation**
Carolyn Iezzi

12:00 – 12:15pm **Utilizing a Learning Management System to Support Anesthesiology Education: Recommendations and Best Practices**
Ashley Grantham, MA, PhD

12:15 – 12:30pm **Process Improvement**
Lucine Torosian, BS

12:30 – 12:45pm **Positive Communication**
Lara Zisblatt, EdD, MA, PMME

12:45 – 1:00pm **Q&A**

1:00 – 2:00 pm **Lunch Break**

2:00 – 3:20pm **Everything You Wanted to Know**
Malin Cannon, MEd, C-TAGME

3:20 – 4:00pm **Round Tables (20 Minutes at Each)**

- **Career Development Path**
Kathy Bauer, MEd
Elisabeth A. Hudson, C-TAGME
- **Clinical Competency Committee**
Anita Bergh, BA, BS, C-TAGME
Rossela Martinez
- **Diversity, Equity, and Inclusion**
Rena Gresh
Vu Willey, MS
- **Educators**
Faye Hagger, EdD
- **New Coordinators**
Malin Cannon, MEd, C-TAGME
Stephanie Harris, MBA, C-TAGME
- **Program Evaluation Committee**
Susan Morris, MSHROD
Janine Roberts, BS, C-TAGME
- **Step-by-Step How to Write an Abstract**
Fei Chen, PhD, MEd
Sally A. Mitchell, EdD
- **Wellness**
Alicja Martins
Lucine Torosian, BS

4:00 – 4:45pm **Milestones 2.0 (With AACPD)**
Moderator: John D. Mitchell, MD

4:00 – 4:15pm **Development of Milestones 2.0**
Aditee Ambardekar, MD MEd

4:15 – 4:30pm **Implementation of Milestones 2.0**
Carol Diachun, MD, MEd

4:30 – 4:45pm **Q&A**

SAAAPM Presentations



Saturday, November 6 (All Times in Eastern Time Zone)

10:00 – 10:05am	Welcome and Announcements <i>Moderator: Michael C. Lewis, MD, FASA</i>	1:00 – 2:15pm	Choosing the Best Applicants <i>Moderator: Charles A. Napolitano, MD, PhD</i>
10:05 – 11:45am	<u>Promoting Diversity, Equity and Inclusion</u> <i>Moderator: Cynthia A. Wong, MD</i>	1:00 – 1:40pm	Effective Interviewing Techniques Jane Risen, PhD
10:05 – 10:35am	Presentation William M. McDade, MD, PhD	1:40 – 2:00pm	Assessing Resident Applicants with Meaningful Metrics Maya Hammoud, MD, MBA
10:35 – 10:55am	The RADAR Initiative Matthew C. Wixson, MD	2:00 – 2:15pm	Q&A and Discussion
10:55 – 11:15am	Presentation Meghan Lane-Fall, MD, MSHP, FCCM	2:15 – 2:45pm	Break
11:15 – 11:30am	Presentation Felipe D. Perez, MD	2:45 – 4:15pm	<u>COVID-19: Triumphant Over Darkness</u> <i>Moderator: Lara Zisblatt, EdD, MA, PMME</i>
11:30 – 11:45am	Q&A and Discussion	2:45 – 3:25pm	Responding to Social Isolation Julianne Holt-Lunstad
11:45am – 12:15pm	Break	3:25 – 4:05pm	Digital Learning: Challenges and Opportunities Faye Haggar, EdD
12:15 – 12:30pm	SAAAPM Business Meeting <i>Moderator: Michael C. Lewis, MD, FASA</i>	4:05 – 4:15pm	Q&A and Discussion
12:30 – 12:50pm	ASA Update Randall Clark		
12:50 – 1:00pm	FAER Update Jim Eisenach, MD		

HANDOUT



Institutional Roles

David Lubarsky

Friday, November 5
10:05 AM - 10:35 AM

HANDOUT



Civility is Critical to Safe Care in the Hospital

Sunil “Sunny” Eappen

**Friday, November 5
10:35 AM - 11:05 AM**



Workplace incivility—Why does it matter?

Sunil Eappen, MD MBA
Chief Medical Officer and Interim President
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SAAAPM Annual Meeting
November--2021

No Disclosures

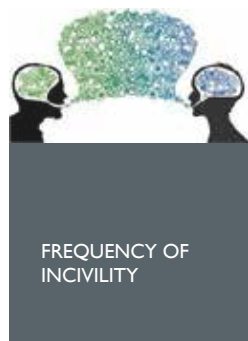
Cases

- A senior anesthesiologist physically pushes a nurse out of the way because she didn't hear him asking for her to move after repeated attempts. She actually falls into the wall but doesn't sustain any physical injury.
- Staff walk down the halls of institutions not even noticing others (particularly the nonclinical or lower "status" staff) far less saying hello or smiling as they walk by each other..
- Women on multiple committees complain that they are often interrupted, and leaders treat them dismissively when speaking.
- You are the last person to board a plane with your carry-on bag, but there is no room in the overhead storage. The flight attendant starts to take your bag to check it in. One of the passengers gets up and takes his duffel out of the overhead and places it under the seat to allow for your bag saying, "I know how it feels."

CONTENTS



- Demographics and Consequences
- What is civility/Incivility
- Why?
- What do we do when people are rude
- How should we live?
- Setting up your organization



FREQUENCY OF
INCIVILITY

- 95% of America thinks we have a civility problem
- This number has been going up over the last two decades.

- 95% reported encountering disruptive behavior
 - 14% weekly
- 22% of surgeons
- 12% of anesthesiologists
- 21% of OR nurses reported seeing it weekly

Webster DO. Physician Exec 30(6):6-14, 2004, Disruptive practitioner behavior. HBC Suppl. A May 2006.

CONSEQUENCES OF HOSTILITY (HARASSMENT/BULLYING)

Employee

- Distraction from tasks
- Loss of motivation
- Psychological/physical illnesses
- Absenteeism
- Turnover
- Victims turn into abusers (modeled behavior)

Financial

- Anger management classes
- Legal costs
- Settlement fees
- Compensation for consultants, therapists
- Cost of hiring additional workers

Manager (you)

- Time spent calming and listening to employees
- Time spent calming customers
- Time spent disciplining
- Time for documenting
- Time recruiting new staff
- Burnout

Organizational

- Impaired improvement to systems
- Reduced innovation and creativity
- Reduced cooperation and cohesion
- Reduced discretionary effort
- Impaired ability to attract the best and brightest

Am Journal of Nursing 2005;105:54-64.
Modern Healthcare 2003;33(12):40-42.
Physician Executive 2002;28(6):9-11.

CONSEQUENCES OF INCIVILITY--\$500 BILLION/YEAR

- 50% decrease work effort
- 50% deliberately decrease time at work
- 40% decrease quality of work (deliberately)
- 80% spend time deliberating event(s)
- 66% spend time avoiding the offender
- 66% felt their performance declined
- 80% felt that their commitment to the organization declined
- 12% left their job (due to incivility)
- 25% acknowledged that frustration leaked out to customers
- Stressful work environment equivalent to smoking and obesity on health
- 70% of workplace accidents are due to stress
- Healthcare costs are 50% higher for stressed employees
- Robs you of performance and creativity
- Customers will make other choices if possible if they witness incivility

Seppelt B and Cameron K. Proof that positive work cultures are more productive. *HBR* online December 1, 2015. <https://hbr.org/2015/12/proof-that-positive-work-cultures-are-more-productive> accessed February 25, 2021.
Parrish C and Perreweé C. The price of incivility. *HBR* Jan-Feb 2013.
Parrish C, Perreweé C, and Holmes W. "Witnessing incivility among employees": reflections on consumer anger and negative inferences about companies. *Journal of Consumer Research* 37(2):290-305, 2010.

CONSEQUENCES OF INCIVILITY IN MEDICINE

- 70% of doctors and nurses tie disruptive behavior to medical errors
- 25% had attributed a death to bad behavior
- 70% of physician executives believe disruptive behavior occurs at least once/month in their institution and has a negative consequence.
- Simulation studies repeatedly show that capabilities of participants drop in both diagnostic and procedural performance in "rude" scenarios versus civil scenarios.

Rosenstock AM and O'Daniel MN. A survey of the impact of disruptive behaviors and communication deficits on patient safety. *Joint Commission Journal on Quality and Patient Safety* 34(8):464-71, 2008.
MacDonald G. Disruptive physician behavior. www.qualityandpatient.com/qualityandpatient_informal.pdf
Bakula A et al. The impact of rudeness on medical team performance: A randomized trial. *Perfusion* 37(5):487-95, 2015.

DOWNSIDE OF INCIVILITY/HOSTILITY

Consequences

- Inhibits sharing of ideas and effective communication
- Unlikely to take chances
- More likely to hide mistakes
- Less likely to reveal error
- Leave workplace

The Joint Commission Sentinel Event Alert, Issue 40, July 2008

ANAGRAMS

- Remdue = _ _ _ _ _
- Demure
- But did you think of **murder**?

WHAT IS CIVILITY?

- Being civil means being aware of others;
 - weaving restraint, respect, and consideration into the fabric of this awareness.
- Choosing to do the right thing for others
- Empathetic
- Behaving in a manner that takes into account the feelings and comfort of others



WHAT IS INCIVILITY

- Behaving in a manner that does **not** take into account the feelings and comfort of others.
- Is in the eyes of the recipient
- Regardless of whether people were actually disrespected or treated insensitively, if they felt disrespected, then we have a concern.
- My belief is that it occurs due to ignorance rather than malice the majority of time



- Workplace incivility has been defined as deviant behavior with ambiguous intent to harm the target. Uncivil behaviors are characteristically rude and discourteous, displaying a lack of regard for others.

Stawicki M. New York Times VEO.org behavior will matter. <https://www.nytimes.com/2015/01/21/us/politics/veo-org-behavior-will-matter.html> Accessed January 25, 2021.
Parrish C. The price of the rise in work. *Sunday Review*, New York Times. June 19, 2015. http://www.nytimes.com/2015/06/21/opinion/andrews-on-work-behavior.html?_r=1

CAUSES OF INCIVILITY

- Greater egocentricity
- Too busy
- Poor modeling
- Ignorance
 - Lack of self-awareness
- Fear of failure
- Staffing shortage
- Cultural differences
- Differing Work Styles
- Unchecked Incivility

PERSONAL/MODIFIABLE CAUSES OF INCIVILITY

- Alcohol or substance abuse
- Personality disorder
- Physical or emotional illness
- Overwork, stress, personal strife, death in the family



“Happiness does not depend on outward things, but on the way we see them.” --Leo Tolstoy

- Depends on the quality of your thoughts
- We have little control on the events of life that surround us, but we do control the way we respond to them.

BRIGHAM HEALTH
BRIGHAM AND
WOMEN'S HOSPITAL

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

THE RULES

- Pay Attention
- Acknowledge others
- Think the best
- Listen
- Be Inclusive
- Speak kindly
- Don't speak ill
- Speak quietly
- Give Praise
- Accept No
- Respect others' opinions
- Mind your body
- Be agreeable
- Mind your volume
- Apologize earnestly
- Avoid personal questions
- Accept and give constructive feedback



Forni P.M. Choosing Civility. New York: St. Martin's Press, 2002.

PAY ATTENTION/THINK THE BEST

Pay Attention

- Be aware of what is around you
- Without being attentive, you don't have the information in order to know how to be civil
- Opposite is "autopilot" as we drive/walk...
- Who is around you—ACKNOWLEDGE Others
 - Say hello, nod, greet
 - Deny Invisibility
- Inhabit the situation
- Car merging into bumper-to-bumper traffic

Think the best of others

- Attribute goodness, honesty and sensitivity
- Leads to others behaving similarly
- You must be confident in your intentions to attribute to others
 - Being comfortable with who you are
 - Don't project your least attractive traits onto others
- Have great expectations
- Don't be naïve, foolish, etc



LISTEN/BE INCLUSIVE

Listen

- Focus on the speaker
 - Actively tell yourself to listen
 - Eliminate distractions (tv, phone, etc)
 - Not on what you want to say (next)
- Don't "disregard and proceed"
- Don't interrupt
- Give Shape and Direction
 - Reframe
 - Ask questions

Be Inclusive

- Diversify
- Re-evaluate your dislikes
 - Give someone you dislike another try
- Notice and engage quieter peers
 - Elicit feedback from everyone in committee
- Welcome new colleagues



SPEAKING KINDLY/BE LIKEABLE

Speak Kindly

- Remember that words can hurt others
- Consider silence
 - Nothing to contribute
 - Showing off
- Slow down and allow others to respond
- Moderate volume/tone
- Explain anger
- Don't label/name-call
- No profanity
- Don't ridicule/embarrass/belittle
- Turn your body and face towards your colleague

How to be likeable!

- Set the mood
 - Engage in a friendly manner
- Draw people out
 - Get people to talk about themselves; don't talk about yourself
- Be loyal and dependable
- Criticize carefully
 - Tactfully, quietly, kindly, privately
 - Be open to different styles
- Offer help when they need it (before they ask)
- Show appreciation
- Don't be mean-spirited; Don't respond in kind;

DON'T SPEAK ILL OF OTHERS

Consequences

- We hurt others, their reputations, their feelings.
- Our remarks can give others the "right" to do the same and abuse others
- They aren't present to defend themselves (cowardly)
- Others may judge our actions and us negatively
- Others become uncomfortable/angry
- Words get out and the person you are disparaging strikes back against you

What should we do?

- Leave
- Ignore
- Say something positive
- Change the subject
- Openly communicate to the attacker

Why do we do it?

- We are unsure of our own worth.
- Finding faults in others that we think we don't have makes us feel better.
- We believe we will look better if we make them look bad.
- It is easier to point out other people's problems than solving our own
- We exact revenge on others who haven't been nice to us
- We raise our standing in a group.
 - We feel empowered.
- We seek acceptance in a group when the other person isn't around. We think we can strengthen our connection

RESPONDING TO RUDENESS

- Cool off
- Calm down
- Don't take it personally
- Decide what to do
 - Ignore
 - Report
 - Confront

Confront

- Speak in private
- Pick the right time
- Be serious
- Remain Calm and kind
- State the facts
 - Identify and describe the issue or the behavior
 - Empathize if appropriate
- Inform the other of personal impact
- Request for future interactions
- Document

Creating Safety around Conversations

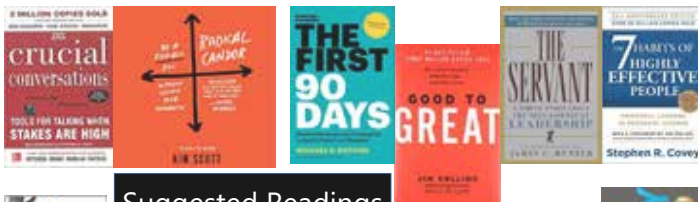
- Listen Well
- Understand your style under pressure
- Look for signs that conversations are getting heated
- Expect and maintain Civility
- Maintain Composure and keep calm
- Work Hard
- Hold yourself and others accountable
- Apologize when appropriate
- Follow through

Setting up your organization for Civility

- I. Hire for civility
 1. Use structured interview
 2. Ask behavioral questions
 3. Check references well
2. Set Expectations
 1. Add it to mission/vision
3. Model excellent behavior all of the time
4. Consider Assessment and Coaching as needed
5. Recognize and Reinforce

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BRIGHAM AND
WOMEN'S HOSPITAL

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL



Suggested Readings

HANDOUT



Moving Beyond Anesthesiology

Joanne Conroy

Friday, November 5
11:05 AM - 11:35 AM

11/9/21



How to Win Friends and Influence Others as an Anesthesia Leader

Getting ready for your next step

Joanne M. Conroy, MD
CEO and President
Dartmouth-Hitchcock Health

1



Dale Carnegie Was a Very Smart Guy

- There are effective behaviors in prep for a new role...learn how to:
 - Get to yes;
 - Use praise effectively;
 - Manage your emotions;
 - Walk in their shoe and align incentives.



2



Techniques For Managing Communication

- Begin with praise and honest appreciation.
- Try honestly to see things from the other person's point of view;
- Be sympathetic with the other person's ideas and desires;
- Appeal to the nobler motives;



3



Techniques For Managing Communication

- The way to get the best of an argument is to deflect it;
- Show respect for the other person's opinions. Never say, "You're wrong";
- If you are wrong, admit it quickly and emphatically;



4



Everyone's Career Derailers

- Indecisiveness or lack of confidence
- Lack of awareness for self or others
- Egotistical, arrogant or self-promoting
- Unreliable or untrustworthy
- Critical or argumentative and not open to new ideas

5

Everyone has a few painful lessons...



6

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Moving to a new leadership role: The Why and the What

- Know why you want to make a career shift
- Understand your risk tolerance
- Reflect on what you do really well
 - DEIB
 - Faculty comp
 - OR throughput
 - Research development
 - Undergraduate and graduate medical education
 - Recruitment and practice development

7



Moving to a new leadership role: The Why and the What

- Create a resume that reflects your measurable accomplishments
- Measure your portfolio of people and budgetary responsibilities
- Consider what you have done outside the department across the institution or health system
- Consider what you have done outside of the organization where you have had a leadership responsibility

8



Opportunities

- Pros and Cons of working within your organization
 - Academic path
 - Operations path
- Working outside your organizations but not leaving
 - Outside societies
 - Politics
 - Consulting
- Leaving your organization for a new role
 - The increasing opportunities for physician leaders

9



The How: Playing Both the Inside and Outside Game

- Navigate the echelons of “power” with pragmatism and grace;
- Understand the subtleties of institutional dynamics;
- Build strategic relationships and coalitions
- Stand up for what is right;
- Play or at least appreciate the impact of the outside (public game) and inside (political game).

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HANDOUT



RRC Update

Aditee Ambardekar

Friday, November 5
12:45 PM - 1:05 PM

11/9/21



ACGME Review Committee Update to AAAC

November 5, 2021

Aditee Ambardekar, MD, MEd
Chair, Review Committee for Anesthesiology

1



Disclosure

- No disclosures to report

2



Session Objectives

- List names and composition of current Review Committee
- Share trends for core and subspecialty training programs
- Review changes to Program Requirements
- Provide updates on new ACGME initiatives

3



RC Members

• Aditee Ambardekar (PD)	• David Ninan (PD)
• Timothy Clapper (Public Member)*	• Andrew Rosenberg (Chair)*
• Alex Macario (PD)	• Mark Stafford-Smith (VC)
• Anne Marie McKenzie-Brown (VC)	• Santhanam Suresh (Chair)*
• Thomas McLoughlin (Chair)	• Manny Vallejo (DIO)
• Jill Mhyre (Chair)	• Johnny Wei (Resident)*

* Tenure ending in 2022

4



New Members - 2022

-  Tara Dhawan, MD (OHSU) – Resident Member
-  Adam Levine, MD (Icahn School of Medicine)
-  Vivek Moitra, MD (Columbia Univ Medical Center)
-  David Rodgers, EdD, EMT-P (Penn State Health)

5



Trends in Anesthesiology GME

6

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Trends in Core Anesthesiology Programs

Academic Year	# Approved Resident Positions	# Core Programs
2020-2021	7,640	161
2019-2020	7,531	160
2018-2019	7,299	153
2017-2018	7,171	153
2016-2017	6,994	147
5-Year Trend	↑ 9.2%	↑ 9.5%

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Core Anesthesiology Program Size – 2020-2021

Number of Filled Positions	Number of Programs
0 Residents	2
1-24 Residents	47
25-49 Residents	49
50-74 Residents	38
75-99 Residents	17
100+ Residents	8

Number of Filled Positions	
Range	0-117
Mode	56
Median	39
Mean	43

90.6% Fill

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Subspecialty Programs 2020-2021

Subspecialty	Number of Programs	Filled	Active Fellows
Adult Cardiothoracic	73	97.6%	249
Clinical Informatics	1	1.6%	1
Critical Care Medicine	64	82.9%	213
Regional Anesthesiology and Acute Pain Medicine	38	89.7%	87
Obstetric Anesthesiology	41	85.3%	58
Pain Medicine	111	99.3%	438
Pediatric Anesthesiology	60	83.1%	221

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Changes to Program Requirements

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Protected Time Program Director and Coordinator

- Task Force on Protected Time – October / November 2020
- Standardize Core Faculty, PD, and Coordinator time (RANGE)
- Program Requirements for Residency PD and coordinator **were not** in alignment with new guidance
- Program Requirements for Fellowship PD and coordinator **were** in alignment with new guidance

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Proposed Protected Time Program Director and Coordinator

II.A.2.a) At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program. Additional support for program leadership must be provided as specified below. This additional support may be for the program director only or divided among the program director and one or more associate (or assistant) program directors.

Number of Approved Resident Positions	Minimum Support Required (FTE) for the Program Director	Minimum Support Required (FTE) for Program Leadership
1-20	0.2	—
21-40	0.4	—
41-60	0.4	0.01 per approved resident position
100 or more	0.4	1.0

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Proposed Protected Time Program Director and Coordinator

Number of Approved Resident Positions	Minimum Protected Program of PDs
1-10	1.0
11-20	1.5
21-30	2.0
31-40	2.5
41-50	3.0
51-60	3.5
61-70	4.0
71-80	4.5
81-90	5.0
91-100	5.5
101-110	6.0
111-120	6.5
121-130	7.0
131-140	7.5
141-150	8.0
151-160	8.5
161-170	9.0
171-180	9.5
181-190	10.0
191-200	10.5
201-210	11.0
211-220	11.5
221-230	12.0
231-240	12.5
241-250	13.0
251-260	13.5
261-270	14.0
271-280	14.5
281-290	15.0
291-300	15.5
301-310	16.0
311-320	16.5
321-330	17.0
331-340	17.5
341-350	18.0
351-360	18.5
361-370	19.0
371-380	19.5
381-390	20.0
391-400	20.5
401-410	21.0
411-420	21.5
421-430	22.0
431-440	22.5
441-450	23.0
451-460	23.5
461-470	24.0
471-480	24.5
481-490	25.0
491-500	25.5
501-510	26.0
511-520	26.5
521-530	27.0
531-540	27.5
541-550	28.0
551-560	28.5
561-570	29.0
571-580	29.5
581-590	30.0
591-600	30.5
601-610	31.0
611-620	31.5
621-630	32.0
631-640	32.5
641-650	33.0
651-660	33.5
661-670	34.0
671-680	34.5
681-690	35.0
691-700	35.5
701-710	36.0
711-720	36.5
721-730	37.0
731-740	37.5
741-750	38.0
751-760	38.5
761-770	39.0
771-780	39.5
781-790	40.0
791-800	40.5
801-810	41.0
811-820	41.5
821-830	42.0
831-840	42.5
841-850	43.0
851-860	43.5
861-870	44.0
871-880	44.5
881-890	45.0
891-900	45.5
901-910	46.0
911-920	46.5
921-930	47.0
931-940	47.5
941-950	48.0
951-960	48.5
961-970	49.0
971-980	49.5
981-990	50.0
991-1000	50.5

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Protected Time Program Director and Coordinator



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Major Revisions

- Residency –Revision work begins 2024, effective July 1, 2026
- Fellowships –Revision work begins 2022, effective July 1, 2024

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ACGME Initiatives

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Milestones 2.0

- Anesthesiology (Residency) in effect July 1, 2021
- Adult Cardiothoracic – working through December
- Critical Care – working through Jan 2022
- Obstetrics – working through Feb 2022
- Pediatric – working through Feb 2022
- Pediatric Cardiac – working through Feb 2022
- Pain Medicine – Review and Comment Closed Oct 31

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Rural Track Program Designation

- Accreditation framework for programs that meet CMS definition of "rural track."
- DGME and IME financing available through partnerships with rural hospitals and sites
- Contact muap@acgme.org / 312.755.7458



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Equity Matters™

- To support the development of diverse physician workforce for diverse patient populations
- Continuous learning in DEI and anti-racism practices
- Curricular models and resources
- Collaborative learning communities
- Research and data
- diversity@acgme.org



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Medical, Parental, Caregiver Leave(s) of Absence

- Minimum of 6 weeks of leave at least once and at any time during an ACGME-accredited program
- Provide residents/fellows equivalent of 100% of salary for first 6 weeks of first approved leave
- At least one week of paid time off outside the first 6 weeks of first approved leave
- Continue health and disability insurance benefits for residents/fellows and eligible dependents during approved leave

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CONTACT ACGME Staff – they want to help!

Review Committee Staff Cheryl Gross: cgross@acgme.org Kerri Price: kprice@acgme.org Aimee Morales: amorales@acgme.org • Program requirements • Notification letters • Complement requests • Case Log <u>content</u>	ADS Staff ADS@acgme.org • ADS • Surveys • Case Log <u>technical support</u>
Field Activities Staff fieldrepresentatives@acgme.org • Site Visits • Self-Studies	

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Questions

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HANDOUT



Perfect Storm

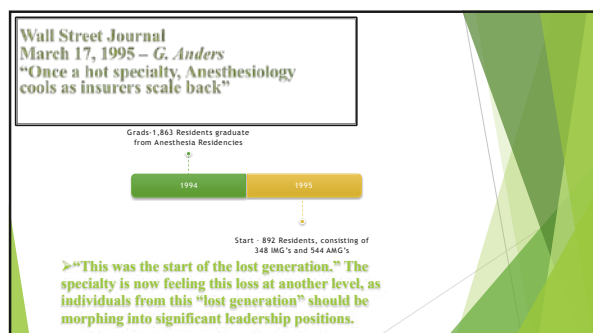
Charles Whitten

Friday, November 5

1:15 PM - 1:50 PM



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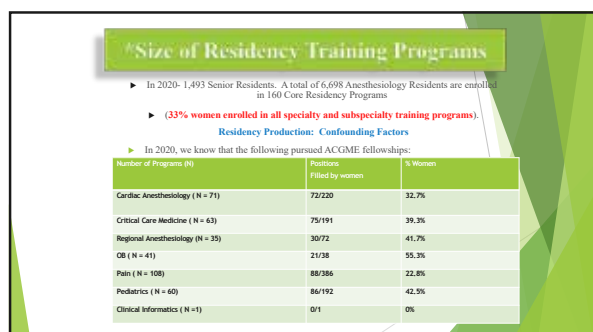


7

The Etiology of Perfect Storm Part II

➤ From my perspective Part II was defined by
increased requests for out of OR Services, in
addition to incorporation of historical private
practice groups under an academic umbrella.

8



9

SAAA YEARLY SURVEY DATA 2020

N = 68

10



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Unique Aspects of 2019-2020

- Data for July 1, 2019 - June 30, 2020 will be presented.
- Subsets of data defined as Pre-COVID (July 1, 2019 - February 29, 2020) will be compared and contrasted with During COVID data (March 1, 2020 - June 30, 2020)
- Subsets of data by size of faculty (N < 51; 52-98; 99+) will be presented.
- Data specific to AAs/CRNAs is available this year.

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2020 Department

Attending Physician FTEs	Mean	+/- SD	Median
ASA Unit production	49.9	26.2	45.8 (39.6)
Acute Pain (In-Patient)	2.8	3.97	2.0 (1.2)
Chronic Pain (Out-Patient)	4.1	2.62	3.6 (3.2)
ICU	5.3	4.83	3.9 (3.0)
Pre-Op Clinic	1.4	1.33	1.0 (1.0)
Other	2.2	5.45	0.0 (0.0)
OB	3.1	2.89	2.0 (2.0)
Total	68.8	35.3	59.5

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2020 Department (cont'd)

Academic Rank	Clinical Anesthesiology and Pain Faculty: Total Mean	25%	75%
Chair	1.0	1.0	1.0
Professor	10.5	3.0	14.0
Associate Professor	16.1	9.0	19.0
Assistant Professor	43.3	26.0	60.0
Instructor	5.1	0.0	4.0
Non-Academic Clinical	1.9	1.6	1.3
Total	77.9	51.0	103.0

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2020 Department (cont'd)

Academic Rank	Clinical Anesthesiology and Pain Faculty: Clinical FTE Mean	25%	75%
Chair	0.3	0.1	0.4
Professor	6.3	1.8	8.8
Associate Professor	11.6	5.5	15.4
Assistant Professor	34.1	20.1	46.0
Instructor	4.1	0.0	2.9
Non-Academic Clinical	1.3	0.0	1.0
Total	57.8	39.6	76.3

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2020 Department (cont'd)

Academic Rank	Clinical Pain Faculty: Total Mean	25%	75%
Chair	0.0	0.0	0.0
Professor	0.7	0.0	1.0
Associate Professor	1.4	0.0	2.0
Assistant Professor	3.7	2.0	5.0
Instructor	0.4	0.0	0.0
Non-Academic Clinical	0.0	0.0	0.0
Total	6.2	3.0	8.0

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National Clinical Coverage

	Mean	+/- SD	Median
How many OR's does your Department cover each day Monday- Friday?	47.2	21	43 (49)
• During COVID	32.5	20	29
How many Non-OR/Off Site locations does your Department cover each day Monday-Friday?	15.7	10.5	13 (12)
• During COVID	11.5	9.67	7.0
How many OB deliveries with anesthesia involvement does your Department have each year?	2,160	1,389	1,870 (1,666)
• During COVID	1,115	789	898

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National Clinical Coverage

How many faculty do you have on each of these services per day on average, Monday-Friday in the daytime?	Mean	+/-SD	Median
OR	33.4	15.8	29.3 (26.4)
OB	1.9	1.37	1.5 (1)
ICU	2.5	1.71	2.3 (2)
Acute Pain	1.6	1.1	1.0 (1)
Pain Clinic	3.6	2.56	3 (3)
Pre-Op Clinic	1.1	0.62	1.0 (1)
Total	44.1	19.3	42.8

National Clinical Coverage During COVID

How many faculty do you have on each of these services per day on average, Monday-Friday in the daytime?	Mean	+/-SD	Median
OR	26.6	15.2	22.0
OB	1.9	1.45	1.5
ICU	3.9	3.89	3.0
Acute Pain	1.5	0.91	1.0
Pain Clinic	3.2	2.39	3.0
Pre-Op Clinic	1.1	0.74	1.0
Total	38.2	18.5	34.0

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National Clinical Coverage by size <S1 (N = 15)			
	Mean	+/- SD	Median
How many OR's does your Department cover each day Monday- Friday?	26.5	8.4	25.0
• During COVID	17.5	10.2	19.0
How many Non-OR/Off Site locations does your Department cover each day Monday- Friday?	7.3	3.5	6.0
• During COVID	5.3	3.43	5.0
How many OB deliveries with anesthesia involvement did your Department have Pre-COVID?	1,737	1,056	1,334
• During COVID	948	827	779

National Clinical Coverage by size 99+ (N = 20)			
	Mean	+/- SD	Median
How many OR's does your Department cover each day Monday- Friday?	70.6	17.5	70.0
• During COVID	49.1	22.6	44.0
How many Non-OR/Off Site locations does your Department cover each day Monday- Friday?	25.1	12.33	22.0
• During COVID	18.9	12.04	18.0
How many OB deliveries with anesthesia involvement did your Department have Pre-COVID?	3,205	1,463	2,907
• During COVID	1,432	807	1,417

National Clinical Coverage by size S2-98 (N = 31)			
	Mean	+/- SD	Median
How many OR's does your Department cover each day Monday- Friday?	42.2	11.1	42.0
• During COVID	29.0	13.5	28.0
How many Non-OR/Off Site locations does your Department cover each day Monday- Friday?	13.6	6.01	14.0
• During COVID	9.6	6.48	7.0
How many OB deliveries with anesthesia involvement did your Department have Pre-COVID?	1,702	961	1,410
• During COVID	869	612	662

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Pre-COVID (N = 44)			
	Mean	+/-SD	Median
How many faculty do you have on each of these services per day on average, Monday- Friday in the daytime?	(17.1) (11.5)	(4.14) (4.36)	(16.0) (14.0)
OR	(1.4) (1.3)	(0.48) (0.59)	(1.0) (1.0)
OB	(1.2) (1.4)	(1.01) (1.41)	(1.0) (1.0)
ICU	(0.9) (0.8)	(0.29) (0.38)	(1.0) (1.0)
Acute Pain	(1.9) (1.7)	(0.93) (1.17)	(2.0) (2.0)
Pain Clinic	(0.6) (0.7)	(0.47) (0.59)	(1.0) (1.0)
Pre-Op Clinic	(23.0) (19.4)	(5.08) (5.19)	(21.5) (20.0)
Total	(41.1) (35.9)	(9.89) (12.06)	(40.5) (32.7)

During COVID (N = 32)			
	Mean	+/-SD	Median
How many faculty do you have on each of these services per day on average, Monday- Friday in the daytime?	(8.8) (7.9)	(15.1) (17.0)	(46.8) (35.5)
OR	(2.7) (2.8)	(1.51) (1.59)	(2.5) (2.5)
OB	(4.3) (8.2)	(1.4) (5.32)	(4.0) (4.8)
ICU	(2.2) (2.0)	(1.32) (0.97)	(2.0) (2.0)
Acute Pain	(5.4) (5.1)	(2.89) (3.16)	(4.6) (4.0)
Pain Clinic	(1.5) (1.5)	(0.62) (0.75)	(1.0) (1.0)
Pre-Op Clinic	(64.7) (55.4)	(15.1) (17.5)	(62.2) (50.0)
Total	(86.7) (88.4)	(15.1) (17.5)	(82.2) (50.0)

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OB Staffing		
	Nights (2019)	Weekends (2019)
Separately Assigned MD	65% (58%)	66% (58%)
Crossover Faculty from Main OR	26% (37%)	25% (34%)
Other	4% (3%)	3% (8%)
Call From Home	0% (0%)	1% (0%)

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Percentage of Anesthetizing Locations Staffed by MD ONLY						
%	Mean	+/- SD	90%	75%	50%	25%
< S1 (N = 13)	23.5%	30%	73%	55%	10%	0%
S2-98 (N = 29)	20.6%	22.7%	57%	42%	10%	2%
99+ (N = 19)	39.7%	36.1%	94%	76%	27%	6%

Percentage of Anesthetizing Locations Staffed by CRNAs or AAs						
%	Mean	+/- SD	90%	75%	50%	25%
< S1 (N = 13)	76.5%	30%	100%	100%	90%	45%
S2-98 (N = 29)	79.4%	22.7%	100%	99%	90%	59%
99+ (N = 19)	60.3%	36.1%	100%	94%	73%	24%

22

National Department Clinical Revenue		
	Mean	+/- SD
ASA Units	\$37,267,455	\$25,235,335
ICU Units	\$1,920,034	\$1,582,092
Pain Units	\$2,290,864	\$1,611,041
Other	\$1,042,355	\$951,834
Total	\$42,520,708	

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Number of Units Billed		
	Mean	+/- SD
ASA Units	845,950	354,957
ICU Work Units	30,677	24,560
Pain Work Units	26,978	19,120
Other	11,639	9,132

Number of Units Billed - Pre-COVID July 1, 2019 – February 29, 2020		
	Mean	+/- SD
ASA Units	609,883	273,521
ICU Work Units	20,050	15,590
Pain Work Units	20,601	14,822
Other	8,308	6,559

Number of Units Billed - During COVID March 1, 2020 – June 30, 2020		
	Mean	+/- SD
ASA Units	231,294	115,823
ICU Work Units	11,228	9,397
Pain Work Units	6,993	5,499
Other	3,360	2,626

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11/10/21

ASA Units	Mean	+/- SD	90%	75%	50%	25%
< 51 (N = 13)	487,436	202,097	850,815	613,509	487,972	299,973
52-98 (N = 29)	776,795	269,731	1,283,870	957,757	659,321	612,551
99+ (N = 19)	1,164,791	272,167	1,514,285	1,384,372	1,140,679	992,774

Units Billed

ICU wRVU	Mean	+/- SD	90%	75%	50%	25%
< 51 (N = 13)	12,073	15,772	-	23,641	3,979	965
52-98 (N = 29)	24,617	21,295	65,644	39,660	17,514	8,972
99+ (N = 19)	48,419	22,132	81,335	68,940	40,408	32,800

wRVU Billed

Pain wRVU	Mean	+/- SD	90%	75%	50%	25%
< 51 (N = 13)	12,469	9,687	-	14,994	10,483	7,209
52-98 (N = 29)	23,514	15,673	50,833	30,730	20,356	11,378
99+ (N = 19)	38,354	20,864	68,707	61,131	33,368	22,237

wRVU Billed

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Number of Units Billed/FTE	Mean	+/- SD	Median
ASA (Base and Time) units billed for anesthesia service	11,020	3,823	11,006
Work units in ICUs (wRVUs)	384	297	346
Units for Pain (wRVUs)	354	225	336
Any other billed services	157	123	154

**Number of Units Billed/FTE – Pre-COVID
July 1, 2019 – February 29, 2020**

	Mean	+/- SD	Median
ASA (Base and Time) units billed for anesthesia service	8,296	2,894	7,911
Work units in ICUs (wRVUs)	257	198	20
Units for Pain (wRVUs)	270	171	264
Any other billed services	112	87	117

**Number of Units Billed/FTE – During COVID
March 1, 2020 – June 30, 2020**

	Mean	+/- SD	Median
ASA (Base and Time) units billed for anesthesia service	3,163	1,181	3,040
Work units in ICUs (wRVUs)	138	104	125
Units for Pain (wRVUs)	89	61	71
Any other billed services	45	35	43

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Billing – Collection Mean Summary	Mean	+/- SD	Median
ASA (Base and Time) units billed for anesthesia service	37,267,455	25,235,335	30,341,255
Work units in ICUs (wRVUs)	1,920,034	1,582,092	1,916,272
Units for Pain (wRVUs)	2,290,864	1,611,041	1,872,620
Any other billed services	1,042,355	951,834	970,565

**Pre-COVID
July 1, 2019 – February 29, 2020**

	Mean	+/- SD	Median
ASA (Base and Time) units billed for anesthesia service	27,608,344	18,681,537	21,773,570
Work units in ICUs (wRVUs)	1,307,017	1,066,931	1,196,966
Units for Pain (wRVUs)	1,760,033	1,320,059	1,367,007
Any other billed services	737,525	700,049	656,899

**During COVID
March 1, 2020 – June 30, 2020**

	Mean	+/- SD	Median
ASA (Base and Time) units billed for anesthesia service	10,341,076	7,488,164	8,448,262
Work units in ICUs (wRVUs)	725,690	631,525	651,748
Units for Pain (wRVUs)	612,221	468,339	526,685
Any other billed services	296,657	279,911	295,285

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Billing collection per unit value	Mean	+/- SD	Median
ASA (Base and Time) units billed for anesthesia service	\$46.00 (\$48.49)	\$31.37	\$37.25 (\$38.44)
Work units in ICUs (wRVUs)	\$68.41 (\$72.45)	\$40.79	\$58.16 (\$57.75)
Units for Pain (wRVUs)	\$92.36 (\$87.90)	\$58.14	\$79.79 (\$79.08)
Any other billed services	\$77.90 (\$85.16)	\$58.14	\$79.81 (\$78.17)

**Pre-COVID Unit Value
July 1, 2019 – February 29, 2020**

	Mean	+/- SD	Median
ASA (Base and Time) units billed for anesthesia service	\$46.70	\$31.21	\$37.18
Work units in ICUs (wRVUs)	\$72.12	\$45.61	\$58.29
Units for Pain (wRVUs)	\$91.49	\$57.57	\$77.65
Any other billed services	\$78.69	\$59.77	\$76.81

**During COVID Unit Value
March 1, 2020 – June 30, 2020**

	Mean	+/- SD	Median
ASA (Base and Time) units billed for anesthesia service	\$47.36	\$33.00	\$36.59
Work units in ICUs (wRVUs)	\$72.81	\$46.83	\$58.88
Units for Pain (wRVUs)	\$98.30	\$65.16	\$82.73
Any other billed services	\$78.20	\$59.93	\$80.01

28

Average Collections	Mean	+/- SD	90%	75%	50%	25%
ASA Units	Mean	+/- SD	90%	75%	50%	25%
< 51 (N = 13)	\$31,855,551	\$28,519,953	\$81,589,186	\$67,467,491	\$13,730,141	\$10,850,212
52-98 (N = 29)	\$31,229,596	\$27,535,691	\$40,853,063	\$30,429,265	\$25,527,450	\$19,901,231
99+ (N = 19)	\$49,158,448	\$14,158,515	\$68,307,354	\$60,870,325	\$48,256,217	\$35,130,676

ICU wRVU

	Mean	+/- SD	90%	75%	50%	25%
< 51 (N = 13)	\$717,200	\$976,202	\$2,282,941	\$1,822,446	\$259,098	\$81,356
52-98 (N = 29)	\$1,512,761	\$1,358,553	\$3,667,767	\$2,071,595	\$1,271,096	\$382,546
99+ (N = 19)	\$3,065,538	\$1,451,701	\$5,417,187	\$3,938,465	\$2,608,835	\$1,958,219

Pain wRVU

	Mean	+/- SD	90%	75%	50%	25%
< 51 (N = 13)	\$1,227,817	\$854,062	\$2,892,673	\$1,602,141	\$1,123,935	\$708,183
52-98 (N = 29)	\$2,010,149	\$1,492,607	\$4,366,481	\$2,877,505	\$1,740,269	\$993,965
99+ (N = 19)	\$3,137,374	\$1,662,415	\$5,822,157	\$4,826,225	\$2,943,837	\$1,664,175

29

Average Unit Value Collected						
ASA Units	Mean	+/- SD	90%	75%	50%	25%
< 51 (N = 13)	\$61.75	\$52.35	\$166.77	\$125.27	\$33.18	\$27.15
52-98 (N = 29)	\$40.43	\$25.98	\$64.13	\$40.67	\$33.67	\$29.32
99+ (N = 19)	\$43.73	\$12.96	\$60.66	\$56.30	\$44.24	\$32.32

ICU wRVU	Mean	+/- SD	90%	75%	50%	25%
< 51 (N = 13)	\$84.97	\$57.98	-	\$141.38	\$76.12	\$40.42
52-98 (N = 29)	\$64.50	\$46.63	\$100.36	\$61.59	\$54.00	\$43.98
99+ (N = 19)	\$66.99	\$17.44	\$91.95	\$77.52	\$68.94	\$57.90

Pain wRVU	Mean	+/- SD	90%	75%	50%	25%
< 51 (N = 13)	\$121.44	\$89.57	-	\$199.45	\$104.83	\$58.51
52-98 (N = 29)	\$84.91	\$61.25	\$158.09	\$86.14	\$73.86	\$58.09
99+ (N = 19)	\$91.11	\$30.52	\$142.79	\$106.92	\$84.44	\$69.37

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11/10/21

National Collection / FTE - Mean		25%
2019		
ASA Units	\$ 549,522 (\$590,401)	\$ 328,416
ICU Units	\$ 24,074 (\$13,361)	\$ 7,563
Pain Units	\$ 30,760 (\$35,695)	\$ 15,183
Other	\$ 14,997 (\$17,295)	\$ 1,780

National Collection / FTE - Pre COVID		Mean	25%
July 1, 2019 – February 29, 2020			
ASA Units		\$ 392,729	\$ 217,643
ICU Units		\$ 16,925	\$ 5,797
Pain Units		\$ 23,322	\$ 10,325
Other		\$ 10,495	\$ 1,189

National Collection / FTE – During COVID		Mean	25%
March 1, 2020 – June 30, 2020			
ASA Units		\$ 151,670	\$ 79,832
ICU Units		\$ 9,048	\$ 2,754
Pain Units		\$ 8,039	\$ 3,884
Other		\$ 4,212	\$ 462

31

Total Support		25%	Median	75%
2019				
Total Support	\$ 9,996,186	\$ 20,483,435 (\$13,336,693)	\$ 28,604,756	
Total Support per FTE	\$ 173,998	\$ 300,950 (\$219,699)	\$ 385,535	

Mean National Institutional Support	
Total Support/FTE	
2020	\$ 307,359
2019	\$ 247,686
2018	\$ 224,091
2017	\$ 183,712
2016	\$ 190,584
2015	\$ 191,912
2014	\$ 196,441
2013	\$ 181,000

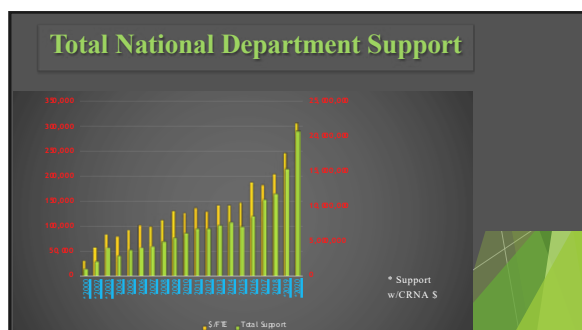
32

National Institutional Support						
	Mean	+/- SD	25%	Median	75%	
Institutional Support	\$ 20,783,747	\$ 14,527,351	\$ 9,996,186	\$ 20,483,435	\$ 28,604,756	
Institutional Support / FTE	\$ 307,359	\$ 204,354	\$ 173,998	\$ 300,950	\$ 385,535	

Institutional Support by size						
Dollars	Mean	+/- SD	90%	75%	50%	25%
<51 (N=13)	\$11,668,690	\$8,707,044	\$29,268,964	\$14,846,317	\$10,592,688	\$5,851,225
52-98 (N=30)	\$21,410,249	\$14,923,879	\$42,082,182	\$28,650,687	\$20,509,342	\$9,760,759
99+ (N=20)	\$25,768,781	\$14,737,991	\$43,411,551	\$33,177,506	\$23,728,761	\$15,628,545

National Institutional Support per FTE						
Dollars	Mean	+/- SD	90%	75%	50%	25%
<51 (N=13)	\$352,665	\$202,241	\$677,491	\$489,280	\$371,517	\$186,588
52-98 (N=30)	\$347,326	\$238,762	\$769,971	\$408,650	\$330,460	\$172,888
99+ (N=20)	\$217,960	\$105,303	\$373,679	\$311,513	\$214,922	\$109,440

33



34

CRNA/AA Economics			
Total Billable Hours per Year – CRNA/AA			
Hours per year	25%	Median	75%
	726	1,261	2,088

Average Cost per CRNA/AA, (Salary plus Benefits)			
Dollars per year	25%	Median	75%
	\$214,102	\$239,400	\$267,464

Average Cost per CRNA/AA, (Per ASA Unit)			
Dollars per unit	25%	Median	75%
	\$19.32	\$33.66	\$53.90

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Average Cost (Salary plus Benefits) per CRNA/AA, as of June 30, 2020						
Dollars	Mean	+/- SD	90%	75%	50%	25%
< 51 (N = 13)	\$187,683	\$66,505	\$247,440	\$232,411	\$206,000	\$171,250
52-98 (N = 29)	\$249,054	\$19,425	\$280,000	\$270,149	\$253,460	\$222,036
99+ (N = 19)	\$270,341	\$76,649	\$394,174	\$287,468	\$245,735	\$228,378

Dollars	Mean	+/- SD	90%	75%	50%	25%
< 51 (N = 13)	\$37.07	\$37.82	\$113.09	\$58.37	\$29.32	\$8.32
52-98 (N = 29)	\$39.22	\$34.93	\$72.84	\$54.46	\$33.81	\$14.34
99+ (N = 19)	\$37.76	\$19.25	\$69.46	\$56.71	\$32.60	\$26.55

What is the average total cost (salary plus benefits) per CRNA/AA per ASA Unit, as of June 30, 2020?

36

11/10/21

SAAA 2020 Total Compensation (Clinical Anesthesiology and Pain Faculty)			
Compensation	25%	Median (2019)	75%
Instructor	\$217,798	\$322,799 (\$328,750)	\$380,470
Assistant Professor	\$352,965	\$378,437 (\$375,500)	\$411,449
Associate Professor	\$388,389	\$413,341 (\$406,025)	\$447,259
Professor	\$407,062	\$429,247 (\$426,868)	\$466,850
Non-Academic Clinical	\$157,770	\$347,467 (\$340,364)	\$454,365
Chair	\$565,684	\$614,536 (\$626,093)	\$684,973

37

Additional Compensation						
	Fringe			Retirement		
	25%	Median	75%	25%	Median	75%
Instructor	\$0	\$12,722	\$43,219	\$0	\$0	\$0
Assistant Professor	\$14,837	\$53,578	\$71,773	\$0	\$0	\$22,742
Associate Professor	\$35,872	\$88,206	\$76,276	\$0	\$0	\$23,941
Professor	\$34,730	\$61,435	\$86,458	\$0	\$0	\$20,683
Non-Academic Clinical	\$0	\$0	\$12,510	\$0	\$0	\$0
Chair	\$37,013	\$76,324	\$110,730	\$0	\$0	\$28,150

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Average Fringe/Pension/Retirement			
	25%	Median	75%
Instructor	\$0	\$26,311	\$57,177
Assistant Professor	\$51,763	\$69,073	\$78,977
Associate Professor	\$54,751	\$71,895	\$84,855
Professor	\$59,256	\$75,167	\$88,285
Non-Academic Clinical	\$0	\$0	\$20,265
Chair	\$62,134	\$93,408	\$124,169

39

Pain Faculty Total Compensation			
Compensation	25%	Median	75%
Instructor	\$261,589	\$325,000	\$367,982
Assistant Professor	\$346,351	\$377,862	\$411,878
Associate Professor	\$381,410	\$416,223	\$496,222
Professor	\$355,180	\$417,516	\$499,655
Non-Academic Clinical	-	-	-
Chair	-	-	-

40

Pain Additional Compensation						
	Fringe			Retirement		
	25%	Median	75%	25%	Median	75%
Instructor	\$0	\$0	\$0	\$0	\$0	\$0
Assistant Professor	\$25,618	\$50,947	\$68,734	\$0	\$0	\$20,470
Associate Professor	\$0	\$40,108	\$71,397	\$0	\$0	\$0
Professor	\$0	\$0	\$63,295	\$0	\$0	\$0
Non-Academic Clinical	\$0	\$0	\$0	\$0	\$0	\$0
Chair	\$0	\$0	\$0	\$0	\$0	\$0

41

Pain Fringe/Pension/Retirement			
Compensation	25%	Median	75%
Instructor	\$0	\$0	\$0
Assistant Professor	\$43,140	\$61,171	\$76,511
Associate Professor	\$0	\$53,685	\$76,690
Professor	\$0	\$0	\$64,499
Non-Academic Clinical	\$0	\$0	\$0
Chair	\$0	\$0	\$0

42

11/10/21

Observations of 2020 Data

- ▶ Academic Anesthesiology was impacted by the pandemic!
- ▶ Overall, number of core residency programs and graduates has increased over the last five years.
- ▶ Greatest growth in the average Department was in the category of Faculty performing ASA Unit Production.
- ▶ OB Deliveries were down nationally. In contrast, a trend toward dedicated OB only coverage.

43

Summary of 2020 Submissions

In General, COVID:

- ▶ Decreased OR sites of service by 20% - 25%.
- ▶ Had the greatest impact on NORA sites within medium size Departments.
- ▶ Decreased OR Staffing by approximately 15% with the greatest impact on large Departments.
- ▶ Increased ICU Staffing with the greatest impact on large Departments.

44

Summary of 2020 Submissions

- ▶ Institutional support and Institutional support/FTE were at an all time high with the **largest** year over year change.
- ▶ Institutional Support/FTE was highest in the small Departments.
- ▶ ASA Units billed per FTE was down year over year
- ▶ Surprisingly, w/RVUs in the ICU were not increased to the extent I anticipated.
- ▶ National Collection per FTE for ASA units, ICU units, Pain units, and other were all decreased.

45

Summary of 2020 Submissions

- ▶ Collections per ASA unit were decreased
- ▶ Trend toward increasing total sites of coverage by CRNA/AA
- ▶ CRNA/AA cost per ASA unit and total cost of CRNA/AA was smallest in the small Departments.
- ▶ Faculty compensation is flat!!! **Don't be fooled.**

46

Questions?

Contact: Chardenay.Bagsby@utsouthwestern.edu
Charles.Whitten@utsouthwestern.edu

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HANDOUT

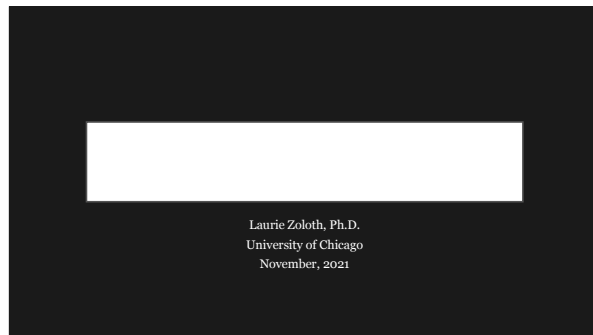


Ethics in a Pandemic

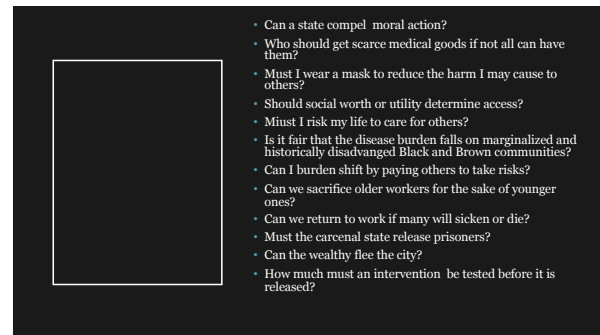
Laurie Zoloth

Friday, November 5
2:00 PM - 2:50 PM

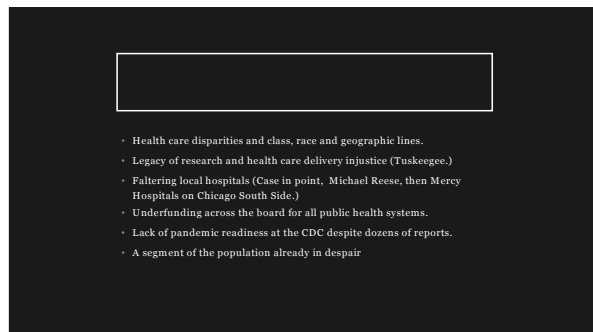
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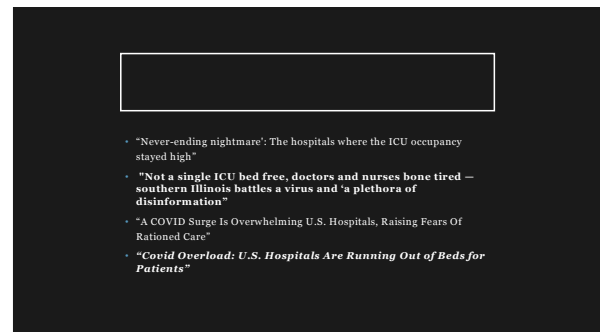
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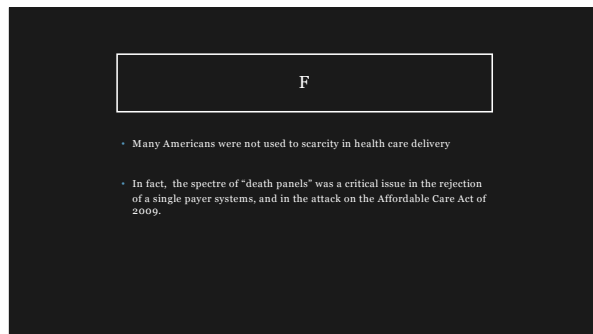
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3



4



5



6

- "As more Americans delve into the disturbing details of the nationalized health care plan that the current administration is rushing through Congress, our collective jaw is dropping, and we're saying not just no, but hell no!"

7

- "The Democrats promise that a government health care system will reduce the cost of health care, but as the economist Thomas Sowell has pointed out, government health care will not reduce the cost; it will simply refuse to pay the cost. And who will suffer the most when they ration care? The sick, the elderly, and the disabled, of course. The America I know and love is not one in which my parents or my baby with Down Syndrome will have to stand in front of Obama's 'death panel' so his bureaucrats can decide, based on a subjective judgment of their 'level of productivity in society,' whether they are worthy of health care.
- Such a system is downright evil."

8

B

- Health care insurance covered most interactions
- Drugs were in plentiful supply
- ICU beds were available
- Non-emergency surgery was a simple fact of scheduling it

- " still not the case for uninsured, or for many minorities populations, or for mental illness.

9

A

- Complex triage systems drawn up!
- News coverage of systems for triage!
- Charts and ranking systems based on QALYS

10

- Fair Allocation of Scarce Medical Resources in the Time of Covid-19

New England Journal of Medicine

List of authors: Ezekiel J. Emanuel, M.D., Ph.D.,

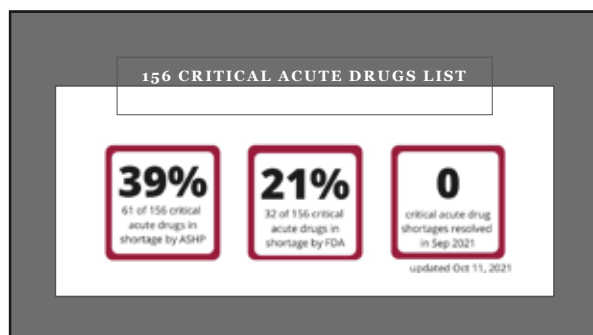
- Govind Persad, J.D., Ph.D.,
- Ross Upshur, M.D.,
- Beatriz Thome, M.D., M.P.H., Ph.D.,
- et al.

11

- Even a conservative estimate shows that the health needs created by the coronavirus pandemic go well beyond the capacity of U.S. hospitals.⁴ According to the American Hospital Association, there were 5198 community hospitals and 209 federal hospitals in the United States in 2018. In the community hospitals, there were 792,417 beds, with 3532 emergency departments and 96,500 ICU beds, of which 23,000 were neonatal and 5100 pediatric, leaving just under 68,400 ICU beds of all types for the adult population.⁴ Other estimates of ICU bed capacity, which try to account for purported undercounting in the American Hospital Association data, show a total of 85,000 adult ICU beds of all types. 🙄

12

11/10/21



19

FDA IS CALLING A RECENT DRUG SHORTAGE AN URGENT PUBLIC HEALTH CRISIS

20

Leading drugs for cardiovascular care; cancer treatment; and antibiotics.

Also short on common items- potassium chloride, certain types of saline units, etc.

21

As scarcity continues, and as supply chain problems deepen the crisis over drugs and test kits, and instruments.

As health care workers despair or quit

We need to look at allocation endemicity and whether it is acceptable.

22

A

"Leave aside the windblown avenues of an empty, joyless city, the generation-defining joblessness that has shifted so many from precarity to outright peril. To what extent did the market-drive, efficiency-obsessed culture of hospital administration contribute to the crisis?"

Siddhartha Mukherjee, "After the Storm," New Yorker, May 4, 2020

23

T

"According to new data published today by the AAMC (Association of American Medical Colleges), the United States could see an estimated **shortage of between 37,800 and 124,000 physicians by 2034**, including shortfalls in both primary and specialty care."

Jun 11, 2021"

24

11/10/21

A

- *Uneven distribution.* Some regions may face a mismatch of supply and demand (not enough PCPs practicing in rural or impoverished areas, for example).
- *Incomplete coverage.* With the uninsured rate now rising to 13% to 14% of the population, a significant number of people simply can't afford to access primary care.

25

- *Inconvenient hours.* In many markets, primary care still isn't available on evenings, nights, and weekends.
- *Inflexible care models.* Most markets still rely on PCPs to deliver primary care in a physician's office — even though physician assistants and nurse practitioners can deliver much primary care at a lower cost and equally high quality.

26

- *Payer aversion.* Some practices may limit the number of new patients they are willing to take on from Medicare, Medicaid, and other public programs because such patients are supposedly "unprofitable."
- *Inefficient use of physician labor.* Estimates of physician productivity suggest that 20% to 30% or more of a physician's available capacity is absorbed by clinical documentation, electronic medical record (EMR) inputs, and other compliance-related work.

27

EVEN BEFORE COVID-19

- Given the growing demand for healthcare services across a multitude of specialties, reports project that 1.2 million new registered nurses (RNs) will be needed by 2030 to address the current shortage.

28

- ***'Nursing Is in Crisis': Staff Shortages Put Patients at Risk***
- "When hospitals are understaffed, people die," one expert warned as the U.S. health systems reach a breaking point in the face of the Delta variant.

29

MAKING MORE SKILLED WORKERS

- Smaller medical schools?
- Cut backs in nursing schools?
- Artificial scarcity.

30

11/10/21

- In 2008, research in an Analysis in Brief (AIB) comparing the economic diversity of U.S. medical school matriculants with U.S. Census data found that "more than three-quarters of medical students came from families in the top two quintiles of family income." This AIB replicates that previous research and methodology to provide updated parental income data from 2007 through 2017.

31

- The AAMC explains that the percentage of medical students from families in the highest quintile of household income has not dropped below 48 percent since 1987—half of students come from the richest 20 percent of the population—while the percentage of students from the lowest quintile has never risen above 5.5 percent. Moreover, the percentage of entering medical students from families in the highest quintile of household income increased from 50.8 percent to 55.2 percent between 2000 and 2005.

32

A

- **"Hollowed-Out Public Health System Faces More Cuts Amid Virus"**
- The U.S. public health system has been starved for decades and lacks the resources necessary to confront the worst health crisis in a century."
- Kaiser Health News, July 1, 2020

33

- Even before the pandemic struck, local public health agencies had **lost almost a quarter** of their overall workforce since 2008 — a reduction of **almost 60,000 workers**, according to national associations of health officials. The agencies' main source of federal funding — the Centers for Disease Control and Prevention's **emergency preparedness budget** — had been **cut 40 percent since 2009**. The Trump administration had proposed slicing even deeper.

34

- According to public health expert David Himmelstein at CUNY's Hunter College, global consensus is that, at minimum, 6 percent of a nation's health spending should be devoted to public health efforts. The United States, he said, has never spent more than half that much.

35

G

- Public hospitals, and clinics, mental health and long-term care congregate settings
- But also public transport, surely buses and trains, but also airlines, courts, government offices, etc.

36

11/10/21

T

- Are of long duration
- Are not easily solved
- Will require massive federal spending
- A clarification of agency, expertise, and authority

37

THE WIDESPREAD COLLAPSE OF THE ACT OF CONSUMPTION

- "Across the country, Americans' expectations of speedy service and easy access to consumer products have been crushed like a Styrofoam container in a trash compactor. Time for some new, more realistic expectations."
- Washington Post, Oct. 18, 2021

38

T

- In the late 1990s, a shift in the idea of a public hospital as a source of community well-being, a place for equity and mercy.
- To a place that was a business that needed, if not to make a profit, at least to be able to provide competitive salaries for physicians and health care administrators.
- A shift to new management ideas that had been promoted in industrial production
 - just in time supply rationales
 - rewards for budget cuts

39

Ethan Porter

- "The consumer citizen is, firstly, a person who devotes much of his time to things besides citizenship. More specifically the consumer citizen is a person who spends a lot of his life shopping and making consumer decisions. Most people don't spend much time thinking about, say, monetary policy, but they make many choices every day about what to buy or not buy...As a result of this, people develop habits and techniques as consumers, and those habits and techniques shape the decisions they make".

40

H

- Scarcity in the case of a shared social good under conditions of social difficulty can be an event for a shared morality and create unity.
- But scarcity in the marketplace just creates competition.
- health care is just another product, and patients are consumers.
- *This is the American Idol Effect. And in a meta event, you get to vote among the voting shows for the best show.*

41

A

- "Mortality from deaths of despair far surpasses anything seen in America since the dawn of the 20th century. The recent increase has primarily been driven by an unprecedented epidemic of drug overdoses, but even excluding those deaths, the combined mortality rate from suicides and alcohol-related deaths is higher than at any point in more than 100 years. Suicides have not been so common since 1938, and one has to go back to the 1910s to find mortality from alcohol-related deaths as high as today's."

42

11/10/21

A

- After a decade in which expertise is degraded in favor of popularity
- "done enough research," "I have done research" "do the research"
- "The problem is that most people simply don't know how to do their own research, especially when it comes to understanding the complexities of medical science." CNN

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M



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C

- ***Congress Is Investigating McKinsey Over Its Role in the Opioid Crisis***
- By advising opioid makers and "the federal agency regulating their conduct," McKinsey "may have had a significant negative impact on Americans' health," the committee said.
- ***Opioid Manufacturer Purdue Pharma Pleads Guilty to Fraud and Kickback Conspiracies***
- "Purdue admitted that it marketed and sold its dangerous opioid products to healthcare providers, even though it had reason to believe those providers were diverting them to abusers." "The company lied to the Drug Enforcement Administration about steps it had taken to prevent such diversion, fraudulently increasing the amount of its products it was permitted to sell. Purdue also paid kickbacks to providers to encourage them to prescribe even more of its products."

47

OUR SITUATION IS APORETIC

- We live in a time of great uncertainty.

48

11/10/21

O

- Ethicists believe that we are "condemned to act," meaning that we have to make moral choices as moral agents in all that we do
- AND that it is this action that defines our characters as persons; and as nations.
- One cannot not act– this is what moral philosophy calls "our plight."

49

W

- Rights of the individual vs the collective
- Autonomy vs. heteronomy
- Justice under conditions of scarcity
- Role of personal responsibility
- Truth vs. a Noble Lie in policymaking
- Ownership of bodies and the question of embodiment
- The concept of the greater good
- What do our actions make of us? What virtues are important for civic life?

50

B

There is a throughline that runs through the pandemic.
It is the economic disparity of modernity and the market.
This is why it feels like the health care system is the Titanic and the virus is the iceberg and why the efforts by bioethicists to allocate deck chairs seems so futile.
The deep lack of trust between people and their doctors– the only scientists they may know– extends the catastrophe.

51

1. A

- Defense of scientific method
- Responsibility for being a scientist

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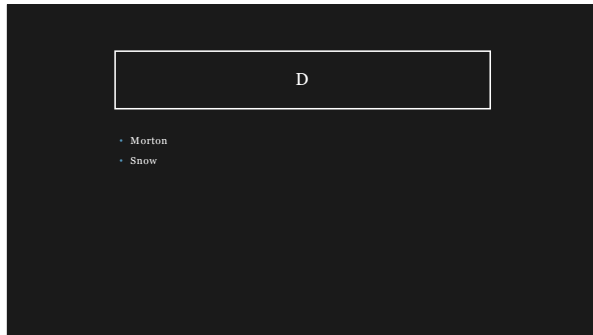
- Entrance into "the space of appearance" (Arendt)
- Willingness to stand up to irrational or ill-informed arguments

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- In the locations of responsibility, a duty emerges for leadership
- In your realm– medical education–
- Expanding the number of places even if it comes as a personal sacrifice

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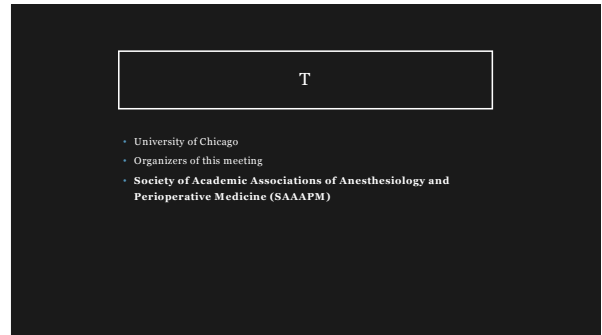
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D

- Morton
- Snow

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T

- University of Chicago
- Organizers of this meeting
- Society of Academic Associations of Anesthesiology and Perioperative Medicine (SAAAPM)

56

HANDOUT



Chair as Coach

Frank Rosinia

Friday, November 5
3:30 PM - 3:55 PM

11/10/21

Chair as Coach

Frank Rosinia, MD, MHCM
Professor & Chair
R. Brian Smith, MD Professorship in Anesthesiology
Department of Anesthesiology
Joe R. & Teresa Lozano Long School of Medicine



1

Outline

1. My journey on becoming an executive coach
2. What exactly is executive coaching
3. Why physicians benefit from executive coaching
4. How to manage an executive coaching engagement
5. Chair as Coach tips



2

Chair – the job.



The Chair is expected to lead the development of clinical, educational, and research activities, in accordance with the vision of the Medical School and its teaching hospital partners.

The Chair is responsible for maintaining the quality of the faculty by protecting their interests as individuals, professional scholars and educators and **for supporting their professional development.**



3

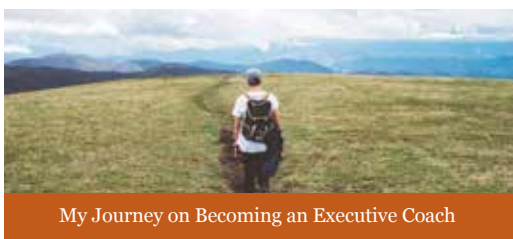
Primal Leadership¹ – coaching



The Coaching leadership style connects people's personal goals with the organization's goals. A leader using this style is empathic and encouraging and focuses on developing others for future success. This style centers on having in-depth conversations with employees that focus on long-term life goals and how these connect with the organization's mission. This style has a positive impact on your people, because it's motivating, and it establishes rapport and trust.



4



My Journey on Becoming an Executive Coach



5

PRE-Health Care Administrator

Physician Leadership Programs

- Graduate Schools – MBA, MMM, MHA, MHCM . . .
- Executive Education
- Mentorship
- ~~Executive Coaching~~



6

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Health Care Administrator

Leadership Programs

- **Executive Coaching!**
- Talent Plus and other assessments.
- Internal Organizational Development Programs
- Mentorship
- Graduate school & executive education



7

Post-Health Care Administrator

Physician Leadership Programs

- **Executive Coaching** & physician as coach
- Graduate Schools – MBA, MMM, MHA, MHCM . . .
- Mentorship
- Non-University leadership programs



8

My Journey - arrived



Michael Hein, MD MHCM is a former CEO of a large network of hospitals and health systems in the Midwest. Additionally, he was a Chief Medical Officer within the Catholic Health Initiatives system.

Currently, a full-time Executive Coach with **MEDI** Leadership.



9



What exactly is executive coaching



10

What exactly is executive coaching?

Coaching is a partnership of equals whose aim is to achieve an increased and sustainable effectiveness . . . The coach and client have the sole aim of closing the gaps between potential and performance.²

Jenny Rogers



11

What exactly is executive coaching?

Coaching is not about fixing people and problems; instead, it is developmental in nature and focused on adults who seek to make changes in their lives.³

Pamela McLean PhD



12

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What exactly is executive coaching?

Professional coaching plays an essential role in helping our leaders, both new and experienced, not only assimilate the shifting intellectual framework of governance but also grow in emotional capacity and resilience in order to thrive in an ever-changing team-based environment.⁴

Jeffery R. Balser MD PhD



13

Coaching

Mentorship	Coaching	Therapy
A person who has been in your shoes	Addresses short and long-term goals	Paid for by individual
Provides advice	Encourages self-improvement	Focuses on past
Non-supervised/unstructured	Positively focused way to explore opportunities	Often focused on trauma and seeking healing
Mentor and mentee are both volunteers	Action-oriented	Focuses on behavior change
Mentor senior to mentee	Helps individuals arrive at their own solutions	Inquiry based
	2-way communication	Long-term relationship
	Provides opportunities to expand knowledge	Process to create sustained change
		Can often take years to achieve results



14

What exactly is executive coaching?

The purpose of coaching is to help people change.⁵

Terry Bacon



15



Why physicians benefit from executive coaching



16

Why physicians benefit from executive coaching

*Physicians are provided intensive instruction on a wide variety of medical issues. What physicians are **not** provided much training on is how to deal with many of the exceptionally complex people issues they encounter.⁶*

Richard Horn, MD



17

Why physicians benefit from executive coaching

*The skills that make us excellent clinicians, such as . . . independent decision making, are essentially the **opposite** of those required for leading successful health care organizations.*

*Executives need to consider multiple perspectives, rely on collaboration and make decisions with a much longer-range view. These skills are **not** being taught in medical school.⁷*

Jane L. Thilo, MD, MS



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Why physicians benefit from executive coaching

The desirable skills of high performing executives such as **self-awareness, self-management, social awareness, and relationship management** are not readily acquired in courses or reading.

These skills are best learned with coaching, over time through practice.⁷

Jane L. Thilo, MD, MS



19

Case Report

Executive Coaching in an Academic Medical Center⁸

- The organizational strategy offered coaching *broadly* to institutional leaders
- 24 months of coaching for a physician leader was well chronicled by the physician client and the coach.
- Richard Kilburg, an outstanding coach, was used broadly by this health system to support many physician leaders.



20

Case Report

Executive Coaching in an Academic Medical Center⁸

Many individuals come to their leadership positions not only undereducated and underdeveloped in these areas but also in possession of a set of attitudes, values, beliefs, and biases that explicitly deny or denigrate the importance of them in human affairs. Such clients often experience precarious adjustments to their new positions and institutions until they actually learn that they cannot avoid politics, power, and influence.

Richard R. Kilburg PhD



21

Case Report Commentary

Executive Coaching in an Academic Medical Center⁹

Four coaching techniques are well demonstrated in this case report.

1. The timely echo – repeat what she needed to hear
2. The strong anchor – reminder of previous lessons learned
3. The vigilant mirror – feedback
4. The wise spark – encourage other pathways

Karol M Wasylyshyn



22

Case Report Commentary

Executive Coaching in an Academic Medical Center¹⁰

Going into my new role, I knew I needed to make important changes in the culture, and (my coach) helped me choose which changes and, more important, the pace of change. He also helped me craft and hone my voice and how I would lead.

Julie Ann Frieschlag, MD



23

Case Report Commentary

Executive Coaching in an Academic Medical Center¹¹

How would I have fared or how much easier would it have been if I had received feedback and direct input into my performance in real time? The answer is clear: Having an experienced and knowledgeable individual who truly understands what leadership entails to provide insight and feedback would have been an incredible boost to my performance.

Beverly S. Mitchell, MD



24

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Why physicians benefit from executive coaching

Common coaching topics from physician clients

- Leadership
- Change management on personal and team level
- Career development and planning
- Communication between peers, administration and staff

Deborah Munhoz, MS, PCC



25

Why physicians benefit from executive coaching

My experience - coaching topics from physician clients after 1-year

- Leadership
- Creating effective teams
- Dealing with administration, medical school & hospital
- Presence – how do people see me?
- Communication
- Self-awareness



26

100 Executives from *Fortune 1000* companies Improved after executive coaching⁶

Working relationships with direct reports – 77%	Teamwork – 67%
Working relationship with supervisors – 71%	Job Satisfaction – 61%
Working relationships with peers – 63%	Productivity – 61%



27

Physician Burnout⁸

Coaching presumes that the client already possesses strengths and skills to handle life's challenges but is not accessing them maximally.

A core coaching construct is amplifying a client's internal locus of control. Several studies note an inverse correlation between internal locus of control and burnout.

Helen Riess, MD



28

Why physicians benefit from executive coaching

Mayo Clinic Coaching Pilot¹³

- 88 clinically active physicians in the departments of Medicine, Family Medicine, and Pediatrics.
- 44 physicians in the control group
- 44 physicians in the intervention group received 6 months of coaching



29

Why physicians benefit from executive coaching

Mayo Clinic Coaching Pilot¹³

Coaching details

- Initial 1 hour session
- Followed by 5, 30-minute professional coaching sessions over 5 months.
- All coaching sessions conducted by phone
- Cost \$1400 per physician



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Why physicians benefit from executive coaching

Mayo Clinic Coaching Pilot¹³

Outcome

The prevalence of symptoms of burnout at 5 months decreased by 17.1% in the intervention group and increased by 4.9% in the control group (P Value <.0001).



31

Why physicians benefit from executive coaching

Mayo Clinic Coaching Pilot¹³

Outcome

Participants randomized to the intervention group also had a significant improvement in overall quality of life compared with those in the control group (P Value <.005) and an increase in resilience.

No change in job satisfaction or measures of engagement and meaning at work.



32



How to manage an executive coaching engagement



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Cost

It depends!

- Internal resources from your HR Department may be available. In fact, you may already be paying for this with your Dean's tax.
- Coaching, without assessments (E.g., 360 evaluation)
 - ~\$350 / hour is common from single practitioners
 - ~\$12,000 for 1-year
- Coaching company \$8,000 for 6 months, typically includes other assessments.



34

Coaching frequency

It depends!

- Monthly sessions are common and work well.
- Coach availability for ad hoc issues that arise is desirable.



35

Choosing a coach⁷

1. **Chemistry** – The ethereal quality that is hard to describe, but you usually know it when it is present. A sense of safety and trustworthiness are essential.
2. **Background and Experience** – A coach does not have to have equivalent or more experience than the client. A coach is not a consultant. Experience in health care is preferable.
3. **Formal Training** – Where did they train and are they certified by the International Coaching Federation.



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Who is a candidate for executive coaching?



37

Who is a candidate for executive coaching?¹⁴

- Individuals transitioning to more complex and highly ranked jobs
- Emergent leaders with great potential
- Able leaders with performance anxiety or who are prone to conflict
- Highly capable underperformers
- Newly appointed leaders or managers



38

Who is a NOT a candidate for coaching?¹⁴



Dysfunctional individuals on the way out.



39

Who is a candidate for executive coaching?

- | | |
|--|--|
| <p>● NOT COACHABLE at Present</p> <p>Client exhibits identifiable psychological issues or narcissistic personality</p> | <p>● VERY LOW Coachability</p> <p>Client resists or defies feedback and is not committed or invested</p> |
| <p>● FAIR Coachability</p> <p>Client is complacent or unmotivated to change</p> | <p>● GOOD Coachability</p> <p>Client experiences a wake-up call as a result of an assessment and is open to the process</p> |
| <p>● VERY GOOD Coachability</p> <p>Client exhibits an earnest desire to improve and is committed to the process</p> | <p>● EXCELLENT Coachability</p> <p>Client has an intrinsic need to grow and engages in self-reflective practices</p> <p><small>(Many factors, Adaptive Coaching)</small></p> |



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Hudson Institute Coaching Methodology



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Harvest your professional development rewards

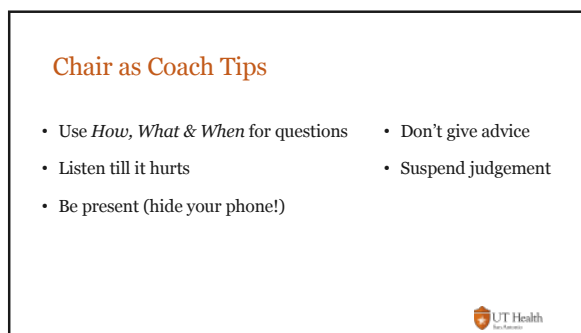


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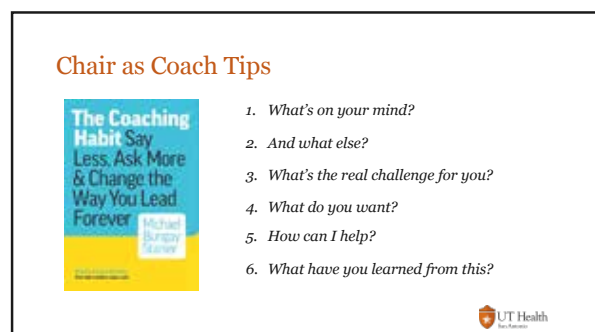
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HANDOUT



Faculty Development

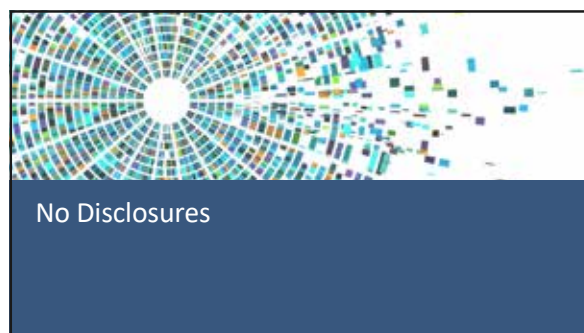
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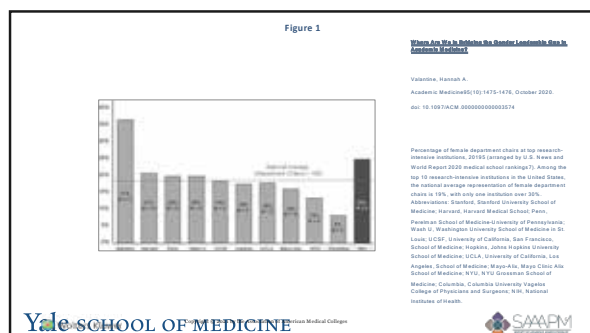


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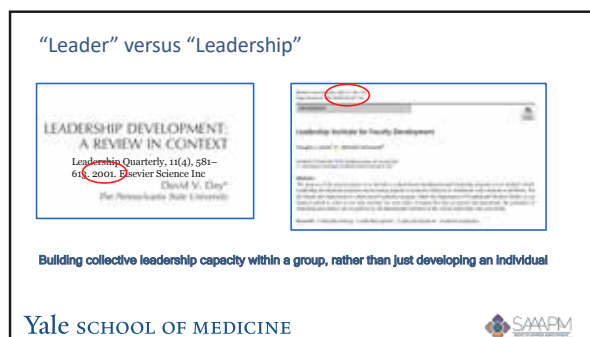
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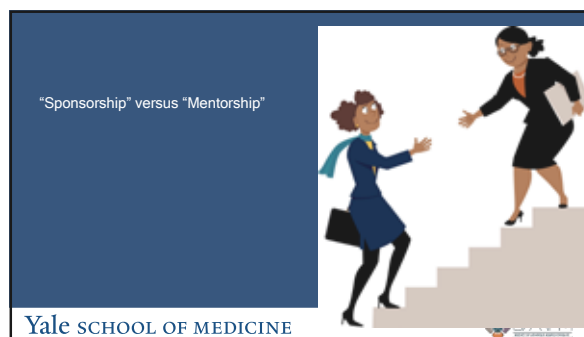
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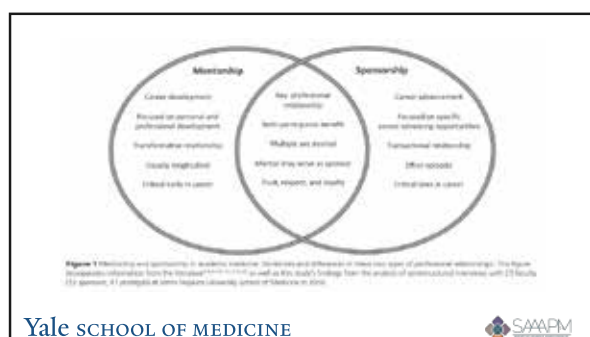
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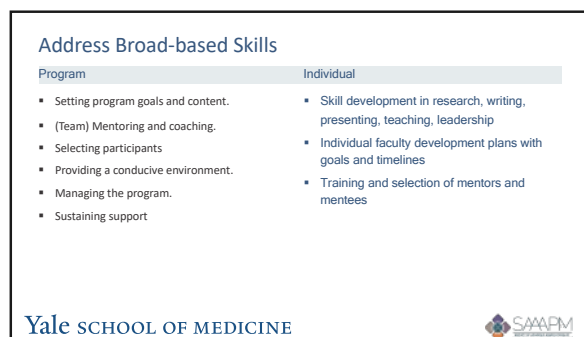
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- meta-analytic investigation: 335 leadership training evaluation studies.
- defined as programs that have been systematically designed to enhance leader knowledge, skills, abilities, and other relevant components

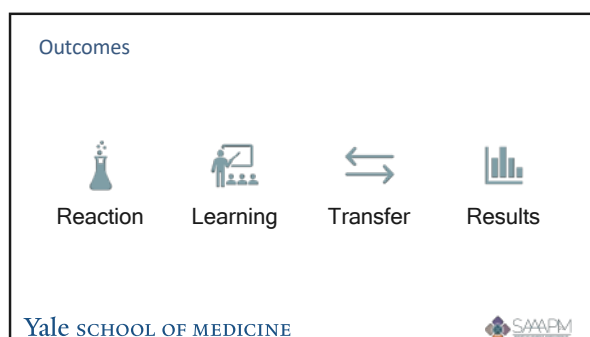
Journal of Applied Psychology
Leadership Training Design, Delivery, and Implementation: A Meta-Analysis
 Christine B. Lawrence, David J. Brown, Stephanie A. Brown, John A. Bragg, and Michael S. Eby
 Online First Publication: July 17, 2017. <https://doi.org/10.1037/apo0000185>

Abstract
 Lawrence, C. B., Brown, D. J., Brown, S. A., Bragg, J. A., & Eby, M. S. (2017). Leadership training design, delivery, and implementation: A meta-analysis. *Journal of Applied Psychology*. Advance online publication. <https://doi.org/10.1037/apo0000185>

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19



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Summary

- Leadership training is effective at improving affective, cognitive, and skill-based outcomes, corroborating prior meta-analytic findings
 - leadership training is specifically effective in improving reactions ($d = .63$), learning ($d = .73$), transfer ($d = .82$), and results ($d = .72$)
 - the trickle-up effect (i.e., leadership improvements aggregate up to the organizational-level) is stronger than the trickle-down effect (i.e., leadership improvements flow down to subordinates).
- This study is the first to demonstrate that leadership training improves trainee reactions, in contrast to the idea often perpetuated in the popular press that individuals generally dislike training

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SAAPM

21

Training Design Characteristics

Take-Home Messages

- Conduct a needs-analysis
- Conflicting results for mandatory versus voluntary
- Temporally spaced programs are better for transfer of learning
 - Those spaced weekly rather than daily had larger effects on results
- Higher level leaders seemed to benefit least
 - May need specially targeted programs
- Internal or externally administered more effective than self-directed
- Multiple delivery methods are best
- Feedback helps (not clear that 360 further enhances)
- On-site appears to be at least as good as off-site if not better
- Longer training programs may be better (no specifics on optimal time).

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Study Characteristics

- 17-year follow-up (National Faculty Survey)
 - Random sample, 25 medical schools, overrepresentation of people from underrepresented racial and ethnic groups
 - N=1270, 56% response rate
- Compared White, URM, Non-URM Faculty
- Outcomes:
 - Academic productivity
 - Advancement
 - Retention
 - Satisfaction
 - Compensation

HHS Public Access
 Author manuscript
 Available from September 1, 2018 at <https://pubmed.ncbi.nlm.nih.gov/30111441/>
 See this full-text PDF: <https://doi.org/10.1101/381111>
 Race/Ethnicity and Success in Academic Medicine: Findings from a Longitudinal Multi-Institutional Study

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23

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Key Findings

- Faculty from URM had:
 - lower rates of peer-reviewed publications (relative number 0.64, 95% CI: 0.51, 0.79),
 - promotion to professor (OR, 0.53; CI: 0.30, 0.93),
 - retention in academic medicine (OR, 0.49; CI: 0.32, 0.75) than White faculty.
- No differences were identified in federal grant acquisition, senior leadership roles, career satisfaction, and compensation

HHS Public Access
Author manuscript
published in the open access journal
Health Affairs (Millwood)
DOI: 10.1371/journal.pone.0240000
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JAMA Network Open
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Race/Ethnicity and Success in Academic Medicine: Findings From a Longitudinal Multi-institutional Study

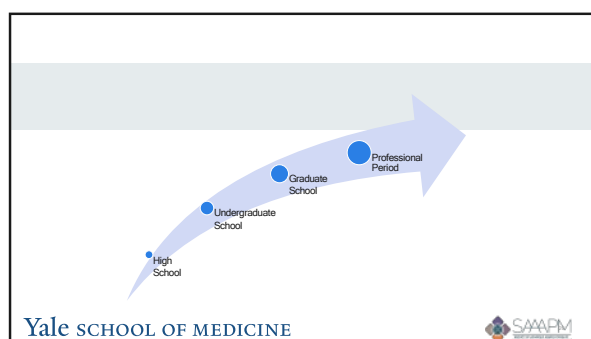
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24

Create a Pipeline

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Yale UNIVERSITY
College of Medicine

ACADEMICS

MD Program
Graduate School
Postdoctoral Fellow
Post Doctoral Program
Resident in Health & Leadership

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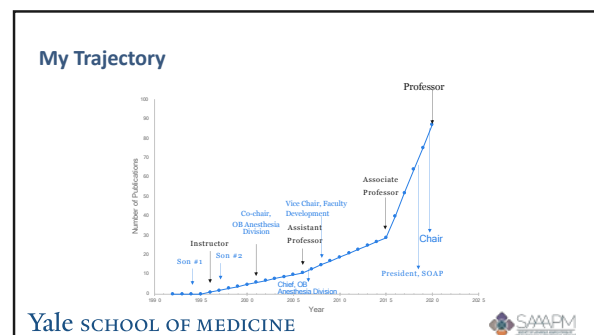
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Factor in Pace

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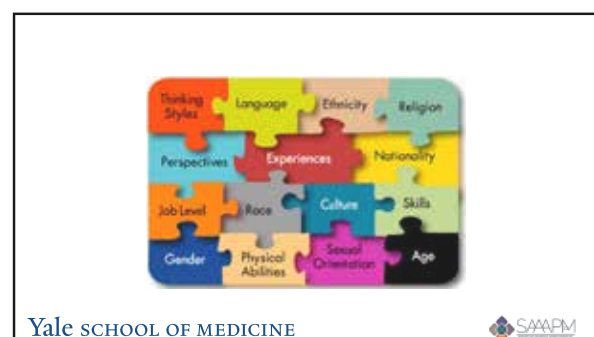
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Summary:

- Leader versus Leadership—it doesn't help to just train an individual you have to train the community. (change the culture, don't just appoint a leader)
- Mentorship versus Sponsorship- all need opportunities, not just instructions
- Grow a pipeline—Start early
- Ensure that individuals have the necessary skills (do no one a favor if you appoint someone who is not qualified)
- Knit DEI into the fabric of everything that you do.

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Lisa Leffert, MD
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 Tel: 617-877-8393

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HANDOUT



ABA Update & ABA Exams Update

Robert Gaiser

Friday, November 5
10:00 AM - 10:20 AM

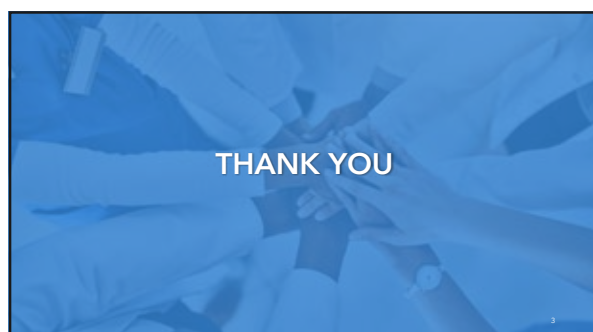
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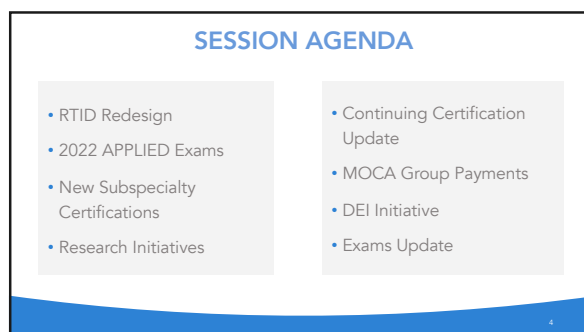
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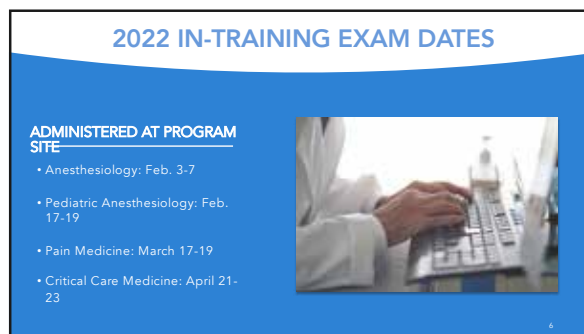
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2022 APPLIED EXAMS

- SIX EXAM WEEKS
- RETURN TO RALEIGH
- HELD AT THE AIME CENTER

- Virtual exams were an emergency measure to accommodate 2020 displaced candidates and the 2021 cohort
- Anticipate returning to in-person exams in Raleigh in February 2022 with risk-mitigating measures in place; better positioned to deliver fair and standardized exams in-person
- 2022 candidates will be first to experience The AIME Center – our newly expanded assessment center
- Will be able accommodate more candidates each exam week, making it less likely candidates will have to wait for a desired exam week

7

2022-2023 OSCE CHANGES

FIRST CHANGE	SECOND CHANGE
Application of Ultrasonography (Point-of-care Ultrasound) - Heart (2022) - Lung (2023)	Interpretation of Echocardiograms & Surface Ultrasound of Lung - Transthoracic echocardiography images (2022) - Lung and diaphragm ultrasound images (2023)

These changes were set to take effect in 2021, but were postponed to 2022 or 2023 because of disruptions to training

8

NEUROCRITICAL CARE (NCC) EXAM

- NCC specialty is devoted to the comprehensive, multisystem care of critically ill patients with neurological diseases and conditions
- First exam was administered Oct. 4-8 by the American Board of Psychiatry and Neurology to eligible diplomates of the American Boards of Anesthesiology, Emergency Medicine and Surgery
- NCC Exam will be given in 2021 and 2022, and then even-numbered years after that

9

ADULT CARDIAC ANESTHESIOLOGY (ACA) EXAM

Diplomates in this specialty will pursue ACA certification to demonstrate their expertise in the imaging, diagnosis, physiology, pharmacology and management of care for adults whose cardiac disease requires leading-edge techniques, interventions and the latest treatment technology

- New subspecialty certification
- First exam in 2023
- ACA Examination Committee appointed
- Exam development process now underway

10

EXTRA BREAK TIME FOR NURSING MOTHERS

Effective Jan. 1, 2022

- IN-TRAINING EXAMS:** Nursing mothers may request a 45-minute break for the In-Training Exams in Anesthesiology, Critical Care, Pain Medicine or Pediatric Anesthesiology
- ABA WRITTEN EXAMS:** Nursing mothers may request a 45-minute break in addition to the standard 20-minute break for the ADVANCED Exam, BASIC Exam, Critical Care Medicine Exam, Pain Medicine Exam, Part I Exam and Pediatric Anesthesiology Exam
- APPLIED EXAM:** Nursing mothers may request an additional 45-minutes of break time be added to the standard 15-minute break between APPLIED Exam components

11

CONTINUING CERTIFICATION

BUILDING THE NEXT ITERATION

- DIPLOMATE EXPERIENCE
- INCORPORATE INTEGRATED LEARNING
- DEVELOP NEW ASSESSMENT PLATFORMS
- ENHANCE QI/REGISTRY INTERFACE

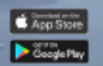
- Purpose of the program is to promote lifelong learning, improve public health and enhance outcomes
- Multi-phased initiative underway to develop an interactive, diplomate-centered program that incorporates AI and other technologies to promote learning
- Offer credit for participating in on-the-job learning (Point-of-care learning)
- Diplomates can earn CME credit for MOCA Minute participation

12

11/10/21

PHASE 1: ABA GO

- New user experience
- Redesigned physician portal and integrated mobile app
- Features and tools designed to not only deliver data but elevate the experience of board certification
- 98 percent of users have opted-in to CME for MOCA Minute as part of ASA collaboration (Earn up to 10 CMEs/year)
- Diplomates are engaging three times more in 2021 than in 2020 and are accessing more web pages
- 17,000 mobile app downloads



13

ABA PREPAY

FOR GROUP PAYMENTS

- Launched Oct. 1
- Pay for your faculty's annual continuing certification fee at prepay.theaba.org
- Encourages participation in lifelong learning and self-assessment activities
- Provides way for institutions to support their physicians in MOCA



PREPAY.THEABA.ORG

14

14

DIVERSITY, EQUITY & INCLUSION (DEI)

- We are committed to addressing DEI issues, particularly those relating to our organization and assessments
- Objective is to ensure that ABA governance, assessment and human resource policies and practices contribute to a diverse and inclusive specialty
- Began collecting physician race/ethnicity data July 1 as part of a broader analysis of our certification programs
- Working with a DEI consultant to guide this work

15

15



THE AMERICAN BOARD OF ANESTHESIOLOGY
Advancing the Highest Standards of the Practice of Anesthesiology

EXAM UPDATE

16

ITE PERFORMANCE

BY TRAINING LEVEL & EXAM YEAR

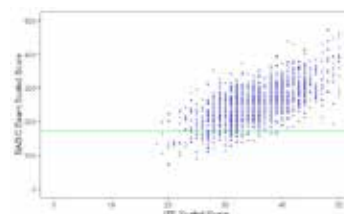


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17

RELATION OF SCORES

2021 ITE TO 2021 JUNE BASIC EXAM



The correlation between the 2021 ITE scaled scores and 2021 June BASIC Exam scaled scores is 0.644, $p < 0.001$.

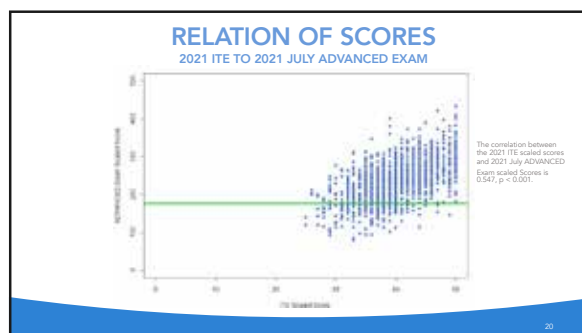
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18

11/10/21

RELATION OF SCORES 2021 ITE TO 2021 JUNE BASIC EXAM				
Scaled Score	Percentile Rank in CA1	N	2021 June BASIC Scaled Score Mean (S.D.)	BASIC Pass Rate
≤25	≤5	75	180(45)	57%
26-30	6-20	311	214(42)	84%
31-35	25-49	574	237(40)	94%
36-40	56-80	586	262(41)	98%
41-45	84-95	244	295(45)	100%
≥46	≥96	87	339(57)	100%

19



20

RELATION OF SCORES 2021 ITE TO 2021 JULY ADVANCED EXAM				
Scaled Score	Percentile Rank in CA3	N	2021 July ADVANCED Scaled Score Mean (S.D.)	ADVANCED Pass Rate
≤25	≤1	2	129(14)	0%
26-30	1-3	46	174(43)	52%
31-35	5-17	247	202(42)	72%
36-40	23-51	601	223(43)	87%
41-45	59-82	486	250(41)	96%
≥46	≥86	267	286(47)	99%

21

2021 JUNE BASIC EXAM RESULTS

- Key validation eliminated eight items in two forms
- Mean Scaled Score: 250.3
- Reliability: 0.85
- Pass rate breakdown:
 - First time-takers' pass rate: 93.6%
 - Second time-takers' pass rate: 81.8%
 - Third time-takers' pass rate: 66.7%

1,906
residents examined

93.1%
of residents passed

22

2021 JULY ADVANCED EXAM RESULTS

- Candidates were assigned to examine on Friday or Saturday
- Key validation eliminated 15 items in two forms
- Mean Scaled Score: 234.1
- Reliability: 0.75

1,807
candidates examined

87.1%
of candidates passed

23

VIRTUAL APPLIED EXAM

SPRING 2021

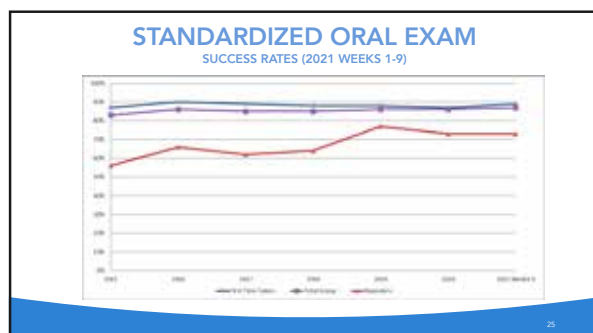
- 1,651 candidates examined over nine weeks
- Not perfect, but professional and high quality
- Most candidates were satisfied
- 95 percent said we prepared them well for the virtual experience

FALL 2021

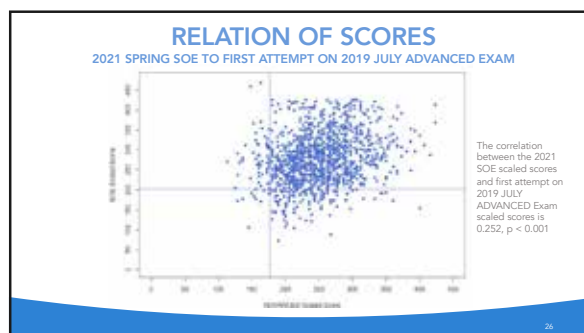
- More than 1,600 candidates scheduled from July to November
- Applying lessons learned in spring administration
- By Nov. 18, we will have examined all 2020 displaced candidates and the 2021 cohort

24

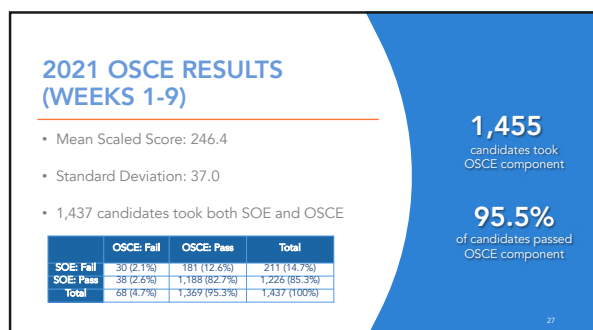
11/10/21



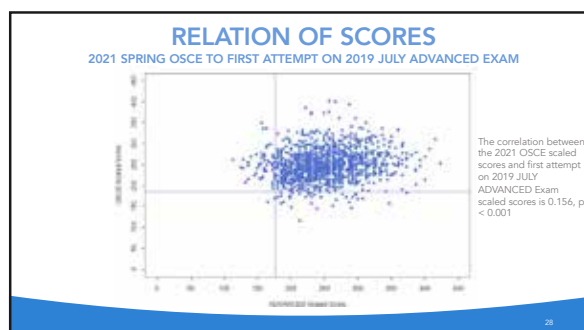
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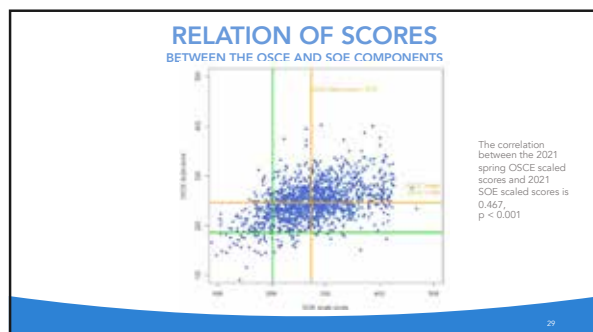
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ABA
THE AMERICAN BOARD OF
ANESTHESIOLOGY

CONTACT INFO

coms@theaba.org

(866) 999-7501

www.theaba.org

4200 Six Forks Rd., Suite 1100
Raleigh, NC 27609

30

30

HANDOUT



ABA Update & ABA Exams Update

Mark Keegan

Friday, November 5
10:00 AM - 10:20 AM

EXAM UPDATE

Mark T. Keegan
Chair, ABA Assessments Committee

ITE PERFORMANCE

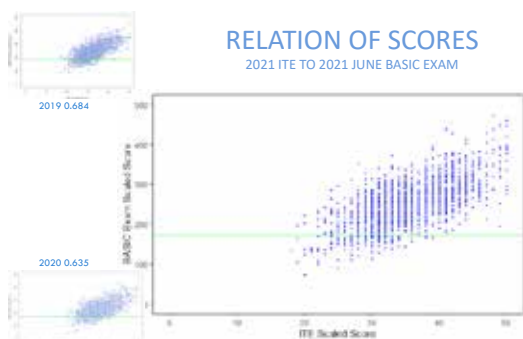
BY TRAINING LEVEL & EXAM YEAR



2

RELATION OF SCORES

2021 ITE TO 2021 JUNE BASIC EXAM



3

RELATION OF SCORES

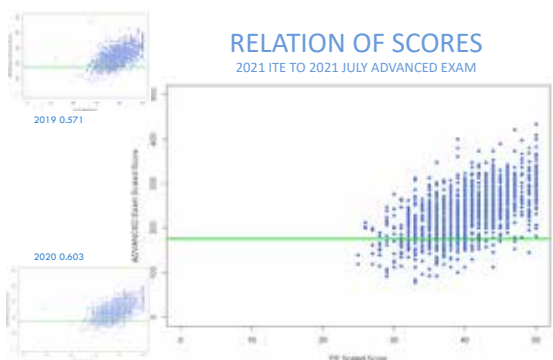
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4

RELATION OF SCORES

2021 ITE TO 2021 JULY ADVANCED EXAM



5

RELATION OF SCORES

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1,906
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93.1%
of residents passed

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2021 JULY ADVANCED EXAM RESULTS

- Candidates were assigned to examine on Friday or Saturday
- Key validation eliminated 15 items in two forms
- Mean Scaled Score: 234.1
- Reliability: 0.75

1,807
candidates examined

87.1%
of candidates passed

8

VIRTUAL APPLIED EXAM

SPRING 2021

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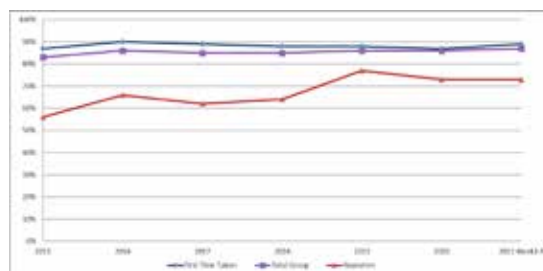
FALL 2021

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9

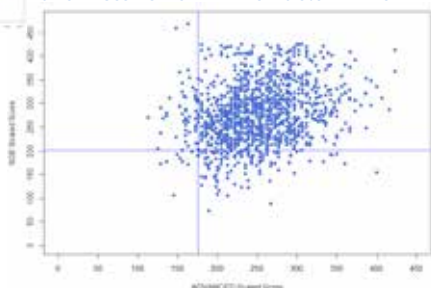
STANDARDIZED ORAL EXAM SUCCESS RATES (2021 WEEKS 1-9)



10

RELATION OF SCORES

2021 SPRING SOE TO FIRST ATTEMPT ON 2019 JULY ADVANCED EXAM



The correlation between the 2021 SOE scaled scores and first attempt on 2019 JULY ADVANCED Exam scaled scores is 0.252, $p < 0.001$

11

2021 OSCE RESULTS (WEEKS 1-9)

- Mean Scaled Score: 246.4
- Standard Deviation: 37.0
- 1,437 candidates took both SOE and OSCE

	OSCE: Fail	OSCE: Pass	Total
SOE: Fail	30 (2.1%)	181 (12.4%)	211 (14.7%)
SOE: Pass	36 (2.6%)	1,188 (82.9%)	1,226 (85.3%)
Total	66 (4.7%)	1,369 (95.3%)	1,437 (100%)

1,455
candidates took OSCE
component

95.5%
of candidates passed
OSCE component

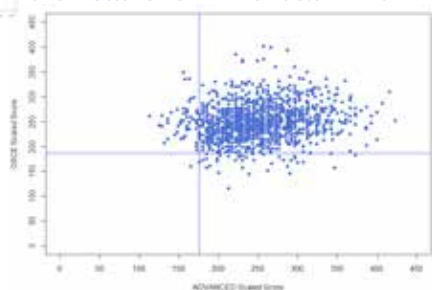
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2019 OSCE to first attempt on 2018 July ADVANCED Exam
0.190

RELATION OF SCORES

2021 SPRING OSCE TO FIRST ATTEMPT ON 2019 JULY ADVANCED EXAM

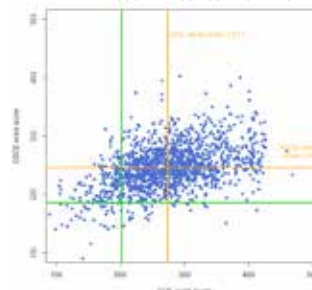


The correlation between the 2021 OSCE scaled scores and first attempt on 2019 JULY ADVANCED Exam scaled scores is 0.156, $p < 0.001$

13

RELATION OF SCORES

BETWEEN THE OSCE AND SOE COMPONENTS



The correlation between the 2021 spring OSCE scaled scores and 2021 SOE scaled scores is 0.467, $p < 0.001$

14



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4200 Six Forks Rd., Suite 1100
Raleigh, NC 27609

15

The Assistant/Associate PD: Structures and Approaches

Kaitlyn Mitchell

Friday, November 5
10:45 AM - 10:55 AM

11/10/21



The Assistant/Associate PD: Structures and Approaches

Kaitlyn Mitchell
Assistant Program Director
Assistant Professor
University of Rochester
Kaitlyn_Mitchell@URMC.Rochester.edu

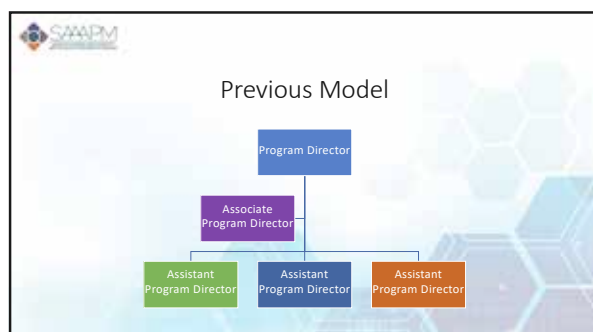
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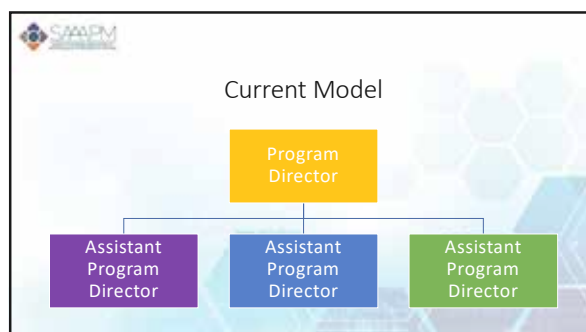
Learning Objectives

- Describe different approaches to the assistant and associate program director (APD) role in anesthesia residency.
- Explain why different approaches may be more or less successful in your program.

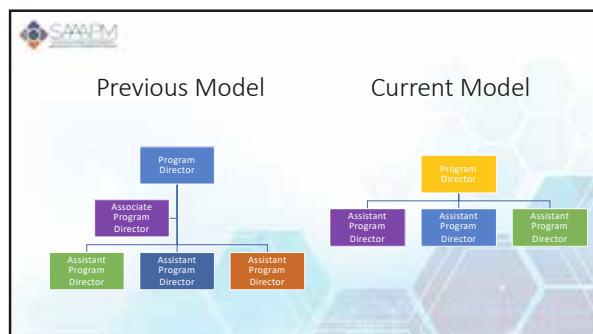
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Thank you

Kaitlyn Mitchell
Assistant Program Director
Assistant Professor
University of Rochester
Kaitlyn_Mitchell@URMC.Rochester.edu

6

HANDOUT



11 Years as an APD – Joys and Regrets

Susan Martinelli

Friday, November 5
11:00 AM - 11:10 AM

10/20/2021



11 Years as an APD—Joys and Regrets

Susie Martinelli, MD FASA
University of North Carolina Chapel Hill
November 5, 2021

1

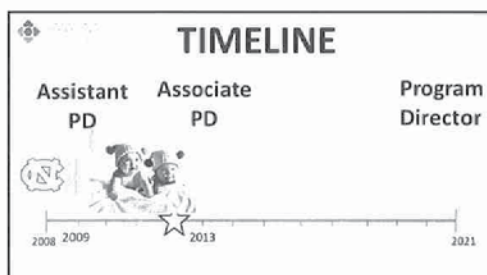


Susan M Martinelli, MD FASA
Program Director and Professor of Anesthesiology
University of North Carolina at Chapel Hill

I have no financial relationships with commercial interests to disclose

My presentation does not include discussion of off-label or investigational use.

2



3

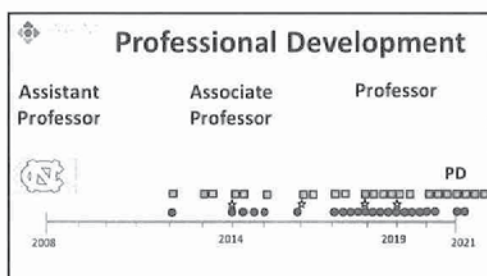


PROS

- Professional development
- ACGME/ABA changes
- Experience
- Networking



4



5



ACGME/ABA CHANGES





6

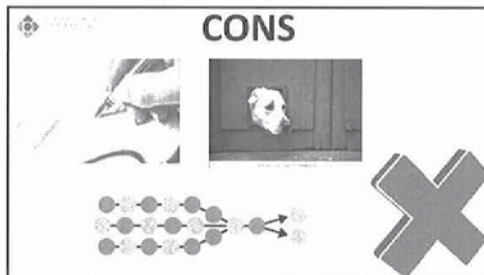
10/20/2021



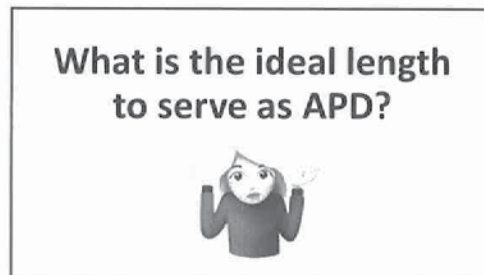
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8



9



10

Tips for the APD to PD Transition in 2021

Emily Peoples

Friday, November 5
11:15 AM - 11:25 AM



Tips for the APD to PD Transition in 2021

Emily E. Peoples, MD

Program Director
University of Michigan
Department of Anesthesiology



I have no relevant financial disclosures.



Learning Objectives

- Describe successful strategies for the APD to PD transition.
- Explain the practical aspects of the transition from associate program director to program director.



My Progression to PD



Internship as a Mini Residency Program

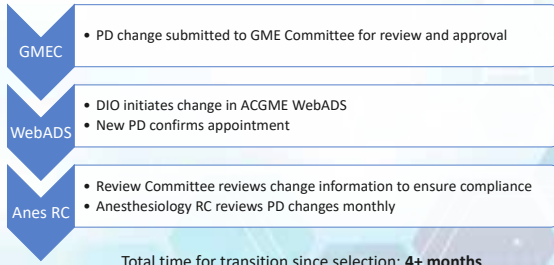


Progression to APD





Practical Steps to PD Change



Selected as New PD! Now What?

- Fill your newly designated admin time with meetings
 - Regular meetings with stakeholders
 - Chair
 - Former PD / Vice Chair for Education and APDs
 - Administrative team
 - Chief residents
 - Operational leadership
 - Education road show – update meetings from education leads
 - Establish meeting with DIO
- Plan for change management
 - Resident town halls
 - Administrative team meetings



Selected as New PD! Now What?

- Prepare to be tested
- Network with PDs and former PDs
- Prepare to be viewed differently by residents
- Explore executive coaching



Selected as New PD! Now What?



Set Boundaries



Save Space for Fulfilling Projects



Enjoy the Ride



Thank you

Program Director Emeritus - How and When to Make the Transition

Manuel Pardo

Friday, November 5
11:30 AM - 11:40 AM

10/31/21



Program Director Emeritus - When and How to Make the Transition

Manuel Pardo, Jr. MD, FASA
Professor and Vice Chair for Education
University of California, San Francisco
Department of Anesthesia and Perioperative Care

1

I have no relevant financial disclosures.

2



Transition Planning for the PD

1. How long should I serve as the PD?
2. When should I step down?
3. How to transition smoothly?
4. What to do after you're no longer PD?

6

1. How long should I serve as the PD?

7



ACGME Core Program Requirements

II.A.1.c) The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)

8



Minimum Time as Anesthesia PD?

Description	Time
Recruitment (Match Day) to CA-1 start	1.25 years
Recruitment (Match Day) to completion CA-3	4.25 years

9

10/31/21

Average Time of PD Tenure

Specialty	Median	Mean
Anesthesiology	5.7 years	6.7 years
Average for all specialties		6.8 years
Allergy and Immunology	6.7 years	10.4 years
IR - Integrated	1.2 years	1.2 years

Source: ACGME Data Resource Book 2020-2021, pp 137-142

10

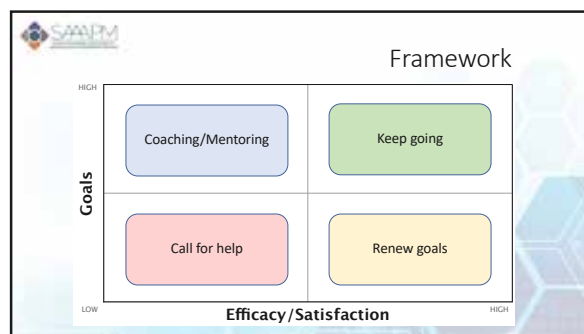
Maximum Time as Anesthesia PD?

Approaches	Pros	Cons
Unlimited, open-ended tenure	Stability, experience gain	Potential successors, accountability
Term limits	Fresh perspective	Forced change (for better or worse), uncertainty, "lame duck" phase
Terms, renewable	Mix of above	Mix of above

11

2. When should I step down?

12



13



14

Maslach Burnout Inventory (subset)

Question area	Example
Emotional exhaustion	I feel emotionally drained by my work
Depersonalization	I feel I have become more callous towards people
Personal accomplishment	I feel I am positively influencing people's life through my work
Burnout – 20% of PD's	

De Oliveira et al. J Clin Anes 2011.

15

10/31/21

SAAPM

"High likelihood of stepping down in 1-2y" = 22%

Factors unchanged compared to not likely to step down group	Factors associated with high likelihood of stepping down
Age, gender	Job-related stressors
Years as PD, self-efficacy	
Personal/professional balance	
Salary dissatisfaction	

De Oliveira et al. J Clin Anes 2011.

16

SAAPM

COVID-19 Pandemic

Job-Related Stressors

ACGME issues
Compliance issues
Resident recruitment
Substance abuse
Dispute with Chair
Resident dismissal

De Oliveira et al. J Clin Anes 2011.

17

3. How to transition smoothly?

21

SAAPM

Timing of PD Transition - Short

Prior	July 24	September 1
One APD New Chair Sep 1 No search	Announce current PD will step down	New PD Starts

22

SAAPM

Timing of PD Transition - Long

Jun 30	July	Nov	July 1
Current PD announce will step down in 1 year	Chair forms search committee	New PD named by 1 st interview	New PD starts

23

SAAPM

Timing of PD Transition

	Pros	Cons
Short time interval	No uncertainty	Search process short Short prep time for new PD
Long time interval	More thorough search Handoff potentially better	Uncertainty about leadership "Lame duck" period

24

10/31/21

4. What to do after you're no longer PD?

25

Support Your Successor

Informal	Formal
Intermittent meetings	Vice Chair Education
	Clinical Competency Committee
	Program Evaluation Committee

26

Leadership Roles for Former PD

Department	Institution
Faculty Recruitment	Associate Dean for GME (DIO)
Vice Chair Education	Assistant/Associate Dean Education
Vice Chair (Other)	National
Chair	ACGME

27

Mistakes Made; Lessons Learned as a Program Director

Helen Bean

Friday, November 5
1:05 PM - 1:15 PM

11/10/21



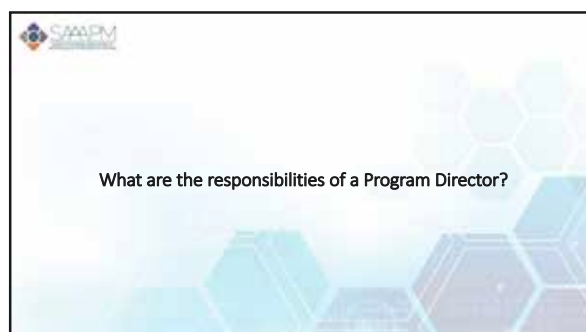
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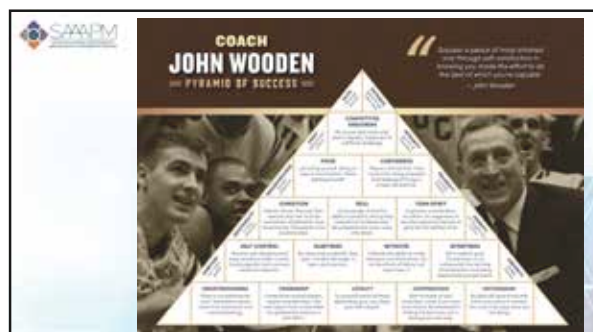
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11/10/21



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Thinking about becoming a Program Director?

1. Know the breadth and depth of your bench
2. Align to a career in service
3. Trust others
4. Assign responsibility and ask for help
5. Have fun with each season
6. Have personal and professional goals
7. PD wellness
8. Set realistic expectations

9



10

Standard Work: Anes Program Calendar

Month	Key Dates	Activities
January	1/15	Program Review Meeting
February	2/15	Program Review Meeting
March	3/15	Program Review Meeting
April	4/15	Program Review Meeting
May	5/15	Program Review Meeting
June	6/15	Program Review Meeting
July	7/15	Program Review Meeting
August	8/15	Program Review Meeting
September	9/15	Program Review Meeting
October	10/15	Program Review Meeting
November	11/15	Program Review Meeting
December	12/15	Program Review Meeting

11

Transition Process: Suggestions

- Standard work in place
- Stagger APDs
 - Terms
- Regular meetings several months prior to transition w/ outgoing PD and the Program Coordinator
- Private office
- Meeting with HR representative

12

11/10/21



13

Mistakes Made; Lessons Learned as a Program Director

Laura Pinault

Friday, November 5
1:15 PM - 1:25 PM

11/10/21



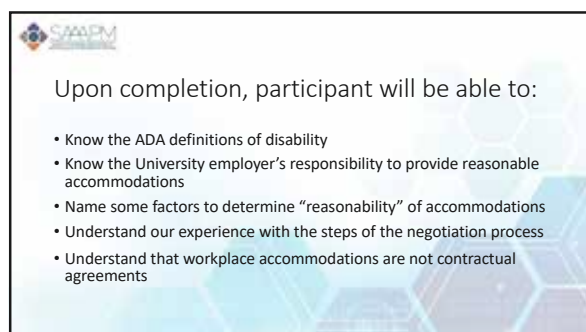
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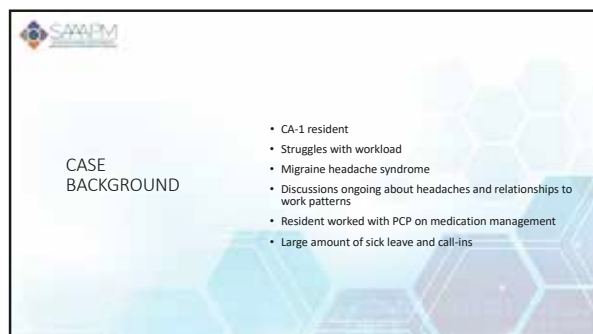
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11/10/21



Accommodations Request Form

- Requests could be made through supervisor or directly by employee
- Suggested accommodations initially were solicited from employee directly on this form
- Asked about:
 - Description of impairment
 - How it affects ability to perform essential job functions
 - To list accommodations requested to perform essential functions

7



ADA Language on Accommodation

- Section 504 of the Rehabilitation Act of 1973, Title II of the Americans With Disabilities Act of 1990, and the Americans with Disabilities Act Amendments Act of 2008, **collectively referred to in this policy as "ADA,"** protect against disability-based discrimination
- The University **must provide reasonable accommodations** to qualified individuals with a disability who are applicants for employment, active employees, and beneficiaries of University programs, services, and activities

Administrative Policies and Procedures Manual - Policy 0120: Reasonable Accommodations for Employees, Job Applicants, and Participants with Disabilities

8

Further Definitions of Disability

"Individual with a Disability" A person who has: • a medical condition or a physical or mental impairment that • substantially limits <i>one or more</i> major life activities OR • has a record of such impairment OR • is regarded as having such impairment	"Qualified Individual with a Disability" Defined as an individual who possesses the requisite: • skills, education, experience, knowledge, and other job requirements AND • who can, <i>with or without</i> a reasonable accommodation, perform the <i>essential functions</i> of the job
--	---

"Essential functions" = the fundamental (as opposed to marginal) duties of the job the individual holds

9



So, what might be "reasonable" accommodation?

- The University must make reasonable accommodations to accommodate qualified individuals with a disability unless the accommodations would create an *"undue hardship."*
 - Whether an accommodation constitutes an undue hardship will be determined on a case-by-case basis.
- Examples given, including but not limited to:
 - Modifying a job so they could perform essential functions
 - Using part-time or modified work schedules

10



So, what might be "reasonable" accommodation?

- The factors and information that will be used to determine if an accommodation is necessary and reasonable include, but are not limited to, whether:
 - The task for which the accommodation is sought is necessary for performing the essential functions of the employee's position.
 - The employee is otherwise qualified to perform the essential job functions and duties.
 - The accommodation will allow the employee to effectively perform the essential functions of the employee's position.
 - There is another more cost-effective option that would allow the individual to perform the essential functions of the job.

11



THE NEGOTIATION PROCESS

1. What were "ground rules" of internal discussions?
2. Forwarded initial document by ADA Coordinator
3. Meeting set among myself, Chairman, DIO, ADA Coordinator and resident
4. Discussed requested accommodations as a group and proposed any changes via email drafts

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Accommodations Requested

- Modification of work schedule to accommodate sufficient recovery from headaches post-call
- Agreement was to maintain a call schedule with one of two weekly options:
 - Thursday night call, Friday post-call, Saturday recovery, and Sunday 12 hour weekend call –OR–
 - Friday night call, Saturday post-call, Sunday recovery
- No other weekday calls and eliminated 24 hour weekend call options
- Per our handbook, we require all residents to work 24 hour weekend call burden/month; split into two 12 hour shifts for this resident

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Challenges: What did we Learn

- We should **not** consider “fairness” to other residents when modifying the schedule for the one needing accommodations
- The Accommodations Agreement is **not** a contract; it could be revised at any time with negotiation between employee and employer
- Would elimination of overnight call ever be “reasonable” in context of a training program?

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HANDOUT



From the Chair's Perspective

Jeffrey Berger

Friday, November 5
1:35 PM - 1:50 PM

11/10/21



Negotiating with the Chair



Jeffrey Berger, MD, MBA
Seymour Alpert Professor and Chair
Department of Anesthesiology and Critical Care Medicine

1



Objectives & Disclosures

1. Teach basic negotiation preparation
2. Advise PD on potential chair considerations for negotiation

• I disclose an advisory role with Thalamus and Dilon Technologies and I am eligible to receive royalties from Oakstone and McGraw Hill Publishers.

2



Basics



- What type of negotiation is this?
- Preparation
 - What is important to you?
 - What is important to the chair?
 - Prioritize each list
 - Target? Reservation price?
 - BATNA?
 - Opening move?



3



What is important to you?

- Remuneration?
- Time
 - Yourself
 - Others
- Personnel
 - Administrative
 - Assistant Directors
- Space
 - Office
 - Didactic
 - Simulation

4



What is important to you?

- Other?
 - Fixed time (vs. flexible)
 - Venue: home office?
 - Additional time when compromised by service, interviews, other
 - Development (yourself and team):
 - Key meeting attendance
 - Leadership course
 - Resources (ie. Laptop, etc)
 - Budgetary oversight with GME funds flow transparency
 - Marketing
 - Web-based resources
 - Recruitment software

5



What is important to Chair?

1. Reputation: external
 - Strong programs
 - Important research
 - Clinical excellence
2. Reputation: internal (respected)
 - Fairness (ie. Compensation, time, DEI)
 - Commitment
 - Communication and transparency
3. HR – staffing
4. Budget – positive margin
5. Academic Medical Center global priorities

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Prioritize each list



- What is important to you is not necessarily important to your chair.
- Variance in prioritization affords opportunities to “expand the pie” whereby you support high priority items for your chair and your chair supports high priority items for you. Each party concedes low priority items in this scenario, maximizing satisfaction for both parties



7

Target, Reservation Price, BATNA



- Target: the goal outcome your are trying to reach
- Reservation price: the offer, below which you walk away from negotiation
- BATNA: Best alternative to the negotiated agreement
- Opening move ???
 - Opening move request ABOVE target – give yourself “room to negotiate”

8

When to negotiate?



TIPS

- Fully staffed (August – October)
- Pre-budget season
- Strong BATNA
- Chair needs your help
- Limited authority to make decisions (without speaking with family)

9

HANDOUT



From the Chair's Perspective

Cynthia Lien

Friday, November 5
1:50 PM - 2:05 PM

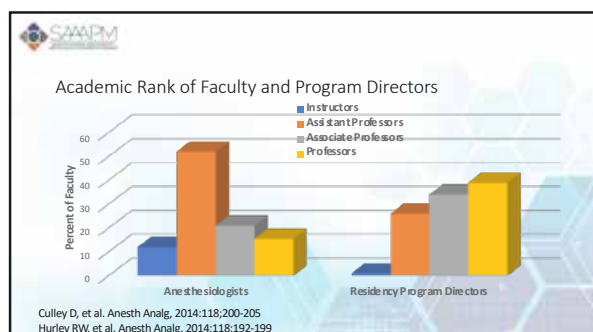
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There will never be enough time



7

Career Goals Evolve

What do you want to accomplish?

- Be a Program Director
- Become a Chair
- Become a Dean
- Become a Medical Director
- Practice Clinical Medicine
- Engage in Science: Clinical, Education, Data-Based
- Grow from the collegiality in an Academic Department

8



Tips for Success:

- Ask for support
- Build a network
- When appropriate (possible), ask to do things
- Develop scholarship
- Find the joy in your work



9

Requirements for Success:

- Understand of the rules
- Find mentors
- Seek support
 - Time
 - Money
 - Emotional
- Be a mentor



10



11



Think Positively



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HANDOUT



From the Chair's Perspective

Stephanie Jones

Friday, November 5
2:05 PM - 2:20 PM



A Chair's perspective

Stephanie B Jones, MD
Professor and Chair
Albany Medical College

November 5, 2021

What have I learned?

- Pre-chair (APD, PD, Vice-Chair)
 - Ask for what you want
 - Identify solutions as well as problems
 - Communication
 - Understand the org chart



PD life...



- Seek opportunities
 - Outside dept
 - Outside education
 - Outside comfort zone



What have I learned?

- Pre-chair (APD, PD, Vice-Chair)
 - Ask for what you want
 - Identify solutions as well as problems
 - Communication
 - Understand the org chart
 - Coaching is valuable





What have I learned?

- Chair
 - Communication and transparency
 - Buy some time
 - Trust yet verify
 - Understand the org chart
 - Boots on the ground
 - Coaching is valuable



Evaluation vs Feedback

Keith Baker

Friday, November 5
2:30 PM - 2:45 PM



Evaluation AND Feedback

Words with Meanings

SAAAPM
November 5, 2021
Virtual

Keith Baker, MD PhD
Vice Chair for Education
Dept. of Anesthesia, Critical Care and Pain Medicine
Massachusetts General Hospital
Boston, MA USA

I have **no disclosures** to make & **no conflicts** of interest to reveal

Caveats:

I will **leave out much** material germane to feedback

I will **simplify** the results of studies

Objectives:

Attendees will be able to:

- Define and differentially use the terms Evaluation and Feedback
- Describe how evaluation can interfere with motivation to learn and how task-relevant feedback can help.
- Discuss how Evaluation and Feedback form a Gordian Knot
- Describe one way to cut the Gordian Knot of Evaluation and Feedback

Evaluation & Feedback

A judgment
(BORM, ABA, ACGME,
the Public)

Information delivered with
the sole aim of **improving**
performance

Evaluation & Feedback

“...is the systematic collection
of information for the purpose
of making decisions”

...is used for growth and
professional development

Evaluation & Feedback

We need both:

Evaluation

Assure the public that we are graduating competent anesthesiologists
Assure the State Medical Boards that we are
Assure the American Board of Anesthesiology that we are....
= Standard monitoring

Feedback

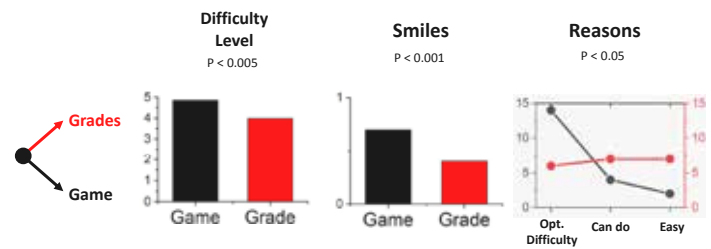
We want our trainees to improve each day throughout training and
subsequently throughout their careers. Feedback is a tool to achieve
this goal of improvement.
= Growth

Evaluation *per se* does not lead to growth or improvement. Indeed, some studies have found that evaluation, in the form of **grades**, reduce interest and performance compared to comments or feedback.



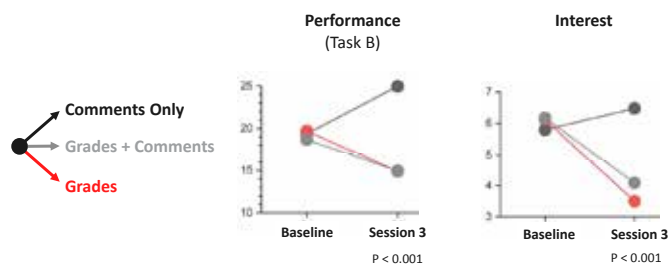
Free Choice Paradigm with Kids

Anagrams: Easy ↔ Difficult



Farther, S. Child Dev. 49, 788 (1978) 6th Graders, Randomized, N = 40, USA

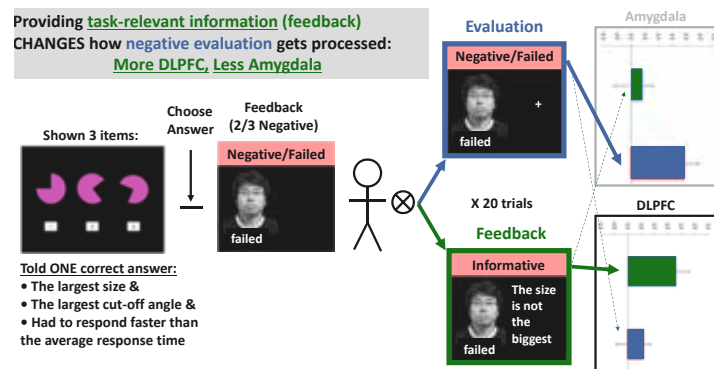
Effects of **Grades** and/or **Comments** on Performance and Interest with Kids



Butler, R. Br. J. Educ. Psych. 58, 1 (1988) 5th & 6th Graders, Randomized, N = 132, High performers, Israel

The response to **Evaluation** and **Feedback** can be VERY different

Inclusion of **task-relevant information** reduces the emotional reaction to negative or critical feedback.



Voo et al. Front. Hum. Neurosci. 9, Article 378. (2015)

Task Feedback vs. Task Evaluation

“...providing **task-relevant information** (*feedback by the definition from slide 4*) could facilitate implicit down-regulation of negative emotions following failure”

Task-relevant information elicits *greater neural activity in the dorsolateral prefrontal cortex* (DLPFC) which affords *cognitive control* (*executive control*) of *negative emotions* when participants experience failure.

Task feedback vs. Trait feedback

“Your **choice was correct**” → “You are **clever**”

Using a challenging rule-switching task:

Motivation scores were higher after task-feedback vs. trait-feedback ($p = 0.01$)
Stress scores were lower after task-feedback vs. trait-feedback ($p = 0.001$)
Accuracy improvement scores were higher after task-feedback vs. trait-feedback ($p = 0.032$)
More participants were positive after task-feedback (75%) than after trait-feedback (30%)

Voo et al. Front. Hum. Neurosci. 9, Article 378. (2015)

1 Jppelgren and Bengtsson. PLoS One. Jun 23;10(6):e0129714 (2015) PMID: 26102501. 20 healthy young Swedish adults (mean age 24)

The Gordian Knot

The **Gordian Knot** is often used as a **metaphor** for an intractable problem (untying an impossibly tangled knot) - *Wikipedia*

The Gordian Knot metaphor pertains to **evaluation and feedback** since they are so **highly intertwined**. One way to deal with this is to “cut the Gordian Knot” thereby separating evaluation and feedback.

Jordon M.J., Acad. Med. 72, 876 (1997)

One Approach to cutting the Gordian Knot



1 iaddawi-Konefka, Acad. Med. 96 1425 (2021)
earner-Engaged Analysis of Feedback



Thanks for your attention

khbaker@partners.org

Situational Judgement

Ilana Fromer

Friday, November 5
2:45 PM - 3:00 PM

11/10/21

Situational Judgement Tests

Ilana Fromer, MD, Joss Thomas, MD, Mojca Remskar, MD, PhD



1

SJTs

- Why
- What they are
- The evidence behind them
- How we have been using them
- Future applications
- Questions



2

Why SJTs?

- Despite the importance of measuring noncognitive competencies related to professionalism, few tools have been developed to measure noncognitive competencies in residency
- Many programs heavily rely on USMLE test scores, LORs, previous academic achievement, and MSPE.
- These assessments primarily predict performance on future tests and give little information about the qualities of each candidate that are likely predictive of a competent clinical anesthesiologist



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Why SJTs?

- Broad consensus regarding the need to assess professionalism and interpersonal skills in residency applicants
 - Professionalism includes traits such as ethical principles, accountability, self-awareness, effective interactions with patients and coworkers, and a drive for continuous self-improvement.



4

Why SJTs

- The importance of assessing professionalism and interpersonal skills in physicians is reinforced by their inclusion in physician assessment frameworks
 - AAMC's Core Entrustable Professional Activities for Entering Residency
 - ACGME's educational milestones in the Next Accreditation System .



5

What are SJTs?

- SJTs are a measurement method that can be used to measure a wide variety of psychological constructs
- Present respondents with a job-relevant situation or scenario and ask them to choose the best way of responding.
- The method of scenario presentation varies
 - Both written and video-based formats.
- SJTs are a popular measurement method in employment and organizational settings due to their high criterion-related validities, positive applicant reactions, and small subgroup differences relative to more cognitively loaded measures



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The Evidence

- Evidence suggests SJTs are useful predictors of short- and long-term outcomes in physicians.
 - Lievens et al. found that an interpersonally-oriented SJT used for medical school selection predicted medical school GPA, internship performance, and job performance over a 7-year period
 - Other studies have demonstrated that interpersonally-oriented SJTs predict diverse training outcomes
 - in-training performance, end-of-training performance, supervisory ratings of performance, and OSCEs.



7

The Evidence

- Cullen et al. (2020) developed and validated an SJT to measure seven dimensions of professionalism and interpersonal skill
- Found that their SJT predicted overall ACGME milestone performance and performance on an independent measure of professionalism (MPA) created for the study
- In addition, the SJT score contributed incremental validity over USMLE scores in predicting overall ACGME milestone performance one year later and MPA performance three months later.



8

The Evidence

- In preliminary analyses, this SJT has also proven useful in predicting the need for remediation.
- In a multi-institutional, multispecialty study Cullen et al. (2021) found that a 1 standard deviation increase on the SJT reduces the probability of a resident experiencing any professionalism issues by 39% at mid-year.
- Similarly, a 1 standard deviation increase on the SJT reduces the probability of a resident needing active remediation at mid-year by 51%.



9

How we are using SJTs

- Every interviewed applicant (120) completes SJT on interview day
- We then weighted SJT results as a component of rank list (33%)
- Matched applicants and program received full SJT report for debrief



10

Future plans

- If we find significant differences between residents who performed well on the SJT and those who were average, we may consider increasing the weight of the SJT in our process.
 - This may be helpful especially in the current environment with the USMLE moving toward a P/F reporting system
- Annual debrief with individual resident on SJT results and incorporation into overall residency evaluation/milestones



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Future plans

- Residents in the cohort will be exposed to SJTs every year of the residency to assess incremental improvements in the evaluation of parameters not tested in the AKTs and Part I and Part II ABA examinations.
- We further intend to follow the 10 matched residents for their performance on Milestones throughout the 4 years of residency to determine how residents' performance correlates with SJT scores



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Potential Problems

- Cultural and socioeconomic bias
 - Western standards, non-native English speakers



13

References

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- F. Lievens, H. Peeters, and E. Schollaert, "Situational judgment tests: A review of recent research," *Personnel Review*, vol. 37, no. 4, pp. 426–441, 2008
- M. A. Sorrel, J. Olea, F. J. Abad, J. de la Torre, D. Aguado, and F. Lievens, "Validity and Reliability of Situational Judgement Test Scores," *Organizational Research Methods*, vol. 19, no. 3, pp. 506–532, Jul. 2016
- Michael J. Cullen, Charlene Zhang, Brittany Marcus-Blank, Jonathan P. Brame, Ezgi Tiriyaki, Mojca Konia, Matthew A. Hunt, Michael S. Lee, Ann Van Heest, Robert Englander, Paul R. Sackett & John S. Andrews (2020) Improving Our Ability to Predict Resident Applicant Performance: Validity Evidence for a Situational Judgment Test, *Teaching and Learning in Medicine*, 32:5, 508-521,



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Thank You!



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HANDOUT



EPAs

Pedro Tanaka

Friday, November 5
3:00 PM - 3:15 PM

Entrustable Professional Activities (EPA) from theory to practice

Pedro Tanaka, MD, PhD (Medicine), MACM, PhD (Education)
Clinical Professor

Stanford University School of Medicine
Department of Anesthesiology, Perioperative and Pain Medicine

@pedro_tanaka | ptanaka@stanford.edu



Outline

Introduction

Statement of Purpose / Research Questions

Methodology

Results

Discussion



Core Components and Theories of CBME

CBME CORE COMPONENTS				
Frameworks: Competencies	Sequential Progression	Tailored Learning Experiences	Competency-focused Instruction	Programmatic Assessment
THEORIES				
-Social accountability -Backwards design	-Dreyfus model -Entrustment and supervision -Surface & deep learning	-Situating learning -Deliberate practice -SRL -Professional identity development	-Zone proximal development -Constrictive friction -Learner centered -Cognitive apprenticeship	-Programmatic Assessment -Formative assessment

©2020ACME

Van Meir et al. Acad Med. 2019 Jun;94(7):1002-1008



Outline

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Statement of Purposes

Develop and Validate	Create	Examine
Develop and validate EPAs for clinical anesthesia year 1 (CA-1) (post graduate year 2 (PGY2)) residents in Anesthesia Residency Programs in the United States;	Create an EPA-aligned workplace-based assessment tool for the specialty of anesthesiology;	Examine validity of the tool using Messick's unified validity framework (1995) (content, response process, and consequences).



Research Questions

1. What are sources of validity evidence in the development of EPAs?
2. How reliable (internal consistency) is this new workplace-based assessment tool?
3. What are sources of validity evidence for the EPA-aligned workplace-based assessment tool?
4. How do anesthesia attendings make entrustment decisions for residents (Content, Response Process, Internal Structure, Relations to other variables, and Consequences) ?
5. How does the assessment tool support feedback for learning (consequences)?



Outline

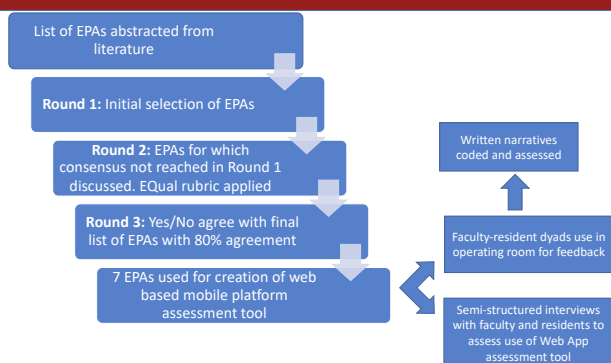
Introduction

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EPA Web App



Outline

Introduction

Statement of Purpose / Research Questions

Methodology

Results

Discussion



Data summary

Delphi: 3 Rounds with 14 experts. Start with 111 possible EPAs. Equal rubric (40 EPAs). Listed 14 curricular EPAs for CA1. Study 7 EPAs.

Reliability: Cohort of 31 residents generated 1,116 observations. 186 observations for each EPA.

Utility: Semi-structured interviews with 14 faculty and 16 residents. Generated 396 excerpts in 4 domains (12 themes)

Complexity of entrustment decisions: Semi-structured interviews with 14 faculty and 1,116 comments from the Web App. Generated 1,163 excerpts in 7 domains.

Feedback quantitative: Analysis of 1,116 comments regarding orientation and relevance

Feedback Qualitative: Analysis of 1,116 comments generated 1,599 sub-competency specific responses



EPAs selected for the study

Perform preoperative assessment of ASA 1 or 2 patient undergoing a minor surgical procedure
Perform preoperative assessment of ASA 3 or 4 patient undergoing a minor surgical procedure
Basic airway management
Perform an anesthesia induction of an ASA 1 or 2 patient without a difficult airway for a minor surgical procedure
Provide intraoperative care of ASA 1 or 2 patient undergoing a minor surgical procedure
Emergence of an ASA 1 or 2 patient with a normal airway after undergoing a minor surgical procedure



D-study showing changes in projections in reliability estimates

EPA	Observations	G Coefficient	Phi Coefficient
1	24	0.418	0.402
2	24	0.684	0.664
3	24	0.480	0.468
6	24	0.598	0.598



Consolidated Framework for Implementation Research

Intervention Characteristics	Characteristic of Individuals	Outer Setting	Inner Setting
- Evidence strength and quality - Adaptability - Complexity	- Personal use - Other Personal Attributes - Knowledge and Beliefs - Self-efficacy	- Learner Needs - Constructive Feedback - Quality of Narrative Comments	Implementation



Theoretical Domains Framework

Knowledge

Skills

Beliefs about capabilities

Reinforcement

Environmental context and resources

Intention

Memory, attention, and decision processes



Distribution of the orientation and relevance of narrative comments

raw number of comments and (%) of all 1116 comments

Orientation / Relevance	Very Irrelevant	Irrelevant	Relevant	Very Relevant
Very Critical	1 (0.1)	2 (0.2)	7 (0.6)	3 (0.3)
Critical	4 (0.4)	45 (4.0)	359 (32.2)	120 (10.7)
Modest Praise	24 (2.2)	54 (4.8)	292 (26.2)	146 (13.1)
High Praise	0 (0)	4 (0.4)	25 (2.3)	30 (2.7)



Core Competency Subcompetency	n	%
Patient Care		
Pre-Anesthetic Evaluation	159	9.9
Peri-Operative Care and Management	185	11.6
Application and Interpretation of Monitors	53	3.3
Intra-Operative Care	622	38.9
Airway Management	257	16.1
Situational Awareness and Crisis Management	53	3.3
Medical Knowledge		
Clinical Reasoning	17	1.1
Practice-Based Learning and Improvement		
Evidence-Based and Informed Practice	42	2.7
Reflective Practice and Commitment to Personal Growth	58	3.6
Professionalism		
Professional Behavior and Ethical Principles	17	1.1
Accountability/Conscientiousness	47	2.9
Interpersonal and Communication Skills		
Patient- and Family-Centered Communication	31	1.9
Interprofessional and Team Communication	58	3.6
Total	1599	100

Mapping of written in feedback comments to the ACGME competencies



Outline

Introduction

Statement of Purpose / Research Questions

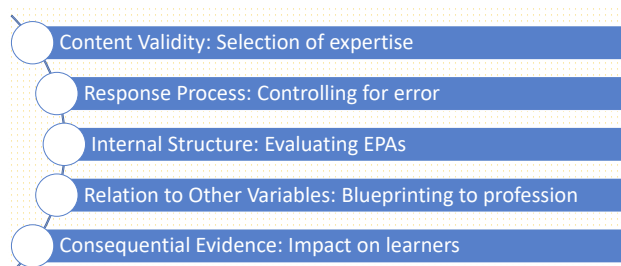
Methodology

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EPA construct validity



Reliability

- Two EPAs (Perform preoperative assessment of ASA 3 or 4 patient; and Emergence of an ASA 1 or 2 patient with a normal airway) were more effective in discriminating differences in resident performance. Both can be used for both formative and summative assessment.
- Two other EPAs (Perform preoperative assessment of ASA 1 or 2 patient and Basic airway management) were less effective in reflecting nuances in resident performance.



Utility of the Web App

- Provided a tool for discussion
- Incorporated as part of the usual workflow
- Substitute for an already existing form of evaluation
- Clinical demands and competing priorities
- Another task in an already busy environment
- Provided opportunity for reflection
- New to the culture



Complexity of Entrustment Decisions



Accelerate Entrustment

Conceptual knowledge of the task and environment
The conversation about planning care
Discussion on decision making process



Detract Entrustment

Previous negative interaction
Production pressure



Feedback

- Narrative comments were overall split between modest praise and critical, and the majority were relevant (specific and actionable).
- Five of the six ACGME competencies were represented in these comments.
- Feedback is reconceptualized.
- Recognize many of the milestones described in sub-competencies.



Conclusion

This study sought to look for robust validity evidence in using EPAs through a Web App as part of the developmental process and reinforce the concept of assessment as learning. The results explored the validity of the EPA construct, the reliability and utility of the Web App, how faculty made entrustment decisions while supervising residents in the operating room, and the quality of feedback. The process described in this study presents a road map for other graduate medical education programs interested in incorporating EPAs as part of an assessment program.



HANDOUT



Development of Milestones 2.0

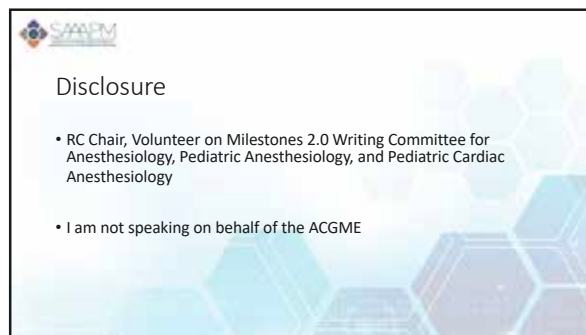
Aditee Ambardekar

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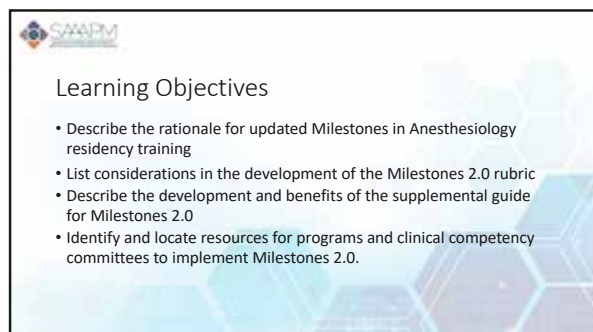
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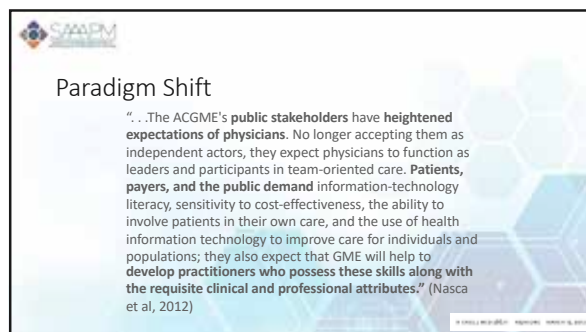
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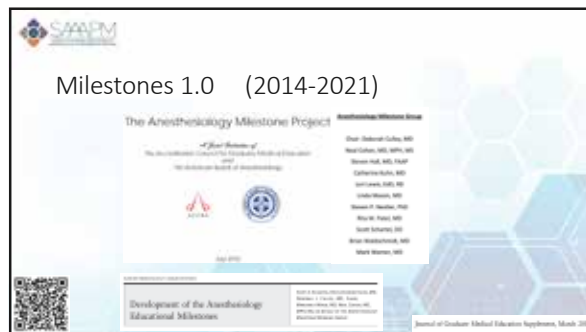
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Milestones 1.0 (2014-2021)

- Commitment to balance comprehensiveness with practicality
- Variability between specialties challenged assessment development
- Straightlining
 - guidance material related reporting level based on time in training
 - Programs wary to show slow progression amongst trainees
- Non-PC/MK as harmonized milestones across specialties

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Milestones 2.0 (July 2021)

- July 2019 ACGME-sponsored survey work for PDs/PCs
 - Too many milestones
 - Too many items within milestones
 - Complex/conflicting language
 - Absence of critical skills
- POCUS, EMR, situational awareness, clinical reasoning
- Preamble re-written
- Consistent language
- Limited developmental trajectories

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Milestones 2.0 (July 2021)

	Minuteman 1.0	Minuteman 2.0
Company	1.0	1.0
Platoon	2.0	0.1
Machine gunner	0	0
Reconnaissance	0	1
Intelligence and communications skills	0	1
Personal load-bearing air equipment	4	0
Armored-vehicle practice	0	0
Total	5.0	2.1

Notable Changes

- MK2—Clinical Reasoning
- PC6—POCUS
- PC7 –Situational Awareness
- PC11 –Pain

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Milestones 2.0 (July 2021)

- Harmonized Milestones (SBP, PBLI, Communication, Professionalism)
- Qualitative analysis of Milestones 1.0
- Interdisciplinary and consensus-generating activities
- Standardized baseline with ability to modify for specialty-specific considerations

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Supplemental Guide

- To reduce ambiguity in interpretation and application of milestones
- To enable curricular mapping with relevant and understandable examples
- Resources for curriculum and assessment
- Living, dynamic document within the program for iterative enhancements in clinical/didactic curriculum

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Implementation of Milestones 2.0

Carol Diachun

Friday, November 5
4:15 PM - 4:30 PM

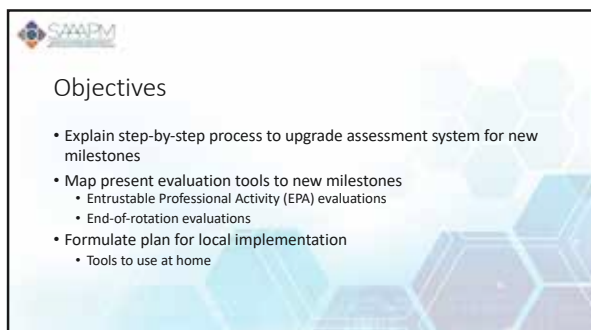
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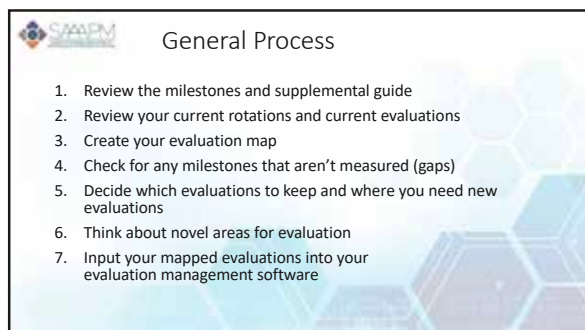
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Clinical Care or Simulation	
- Contribution to QI or Safety Activities - Review of personal outcomes - Personal wellness - Population health - Accountability - Professionalism lapses - Teaching others	- Crisis management - Clinical reasoning - Evidence-based medicine - Giving and receiving feedback

13

Objective Structured Clinical Exam (OSCE)		
- Contribution to QI or Safety Activities - Review of personal outcomes - Personal wellness - Population health - Accountability - Professionalism lapses - Teaching others	- Crisis management - Clinical reasoning - Evidence-based medicine - Giving and receiving feedback	- Adverse event disclosure - Patient conflict (2) - Staff conflict - Ethical Issues (2)

14

Mapping Rotation & Other Evals	

15

Milestone Mapping of Evaluations	

16

Milestone Mapping of Evaluations	

17

Implementing Milestones 2.0	

18

1. Review the milestones and supplemental guide
2. Review your current rotations and current evaluations
3. Create your evaluation map
4. Check for any milestones that aren't measured (gaps)
5. Decide which evaluations to keep and where you need new evaluations
6. Think about novel areas for evaluation
7. Input your mapped evaluations into your evaluation management software

11/10/21



Slide 19 features a header with the SAAAPM logo in the top left corner. The main title "Resources" is centered at the top. On the left side, there is a large QR code with a black border, and below it, a black button with a white smartphone icon and the text "SCAN ME". To the right of the QR code, a bulleted list contains the text "• Link to Mapping Template". The background is a light blue and white hexagonal pattern.

19



20

Lessons Learned from a Quickly Adaptable Process: What Will We Keep Moving Forward

Chris Spofford

Friday, November 5
10:05 AM - 10:20 AM

11/10/21



Lessons Learned from a Quickly Adaptable Process: What Will We Keep Moving Forward?

Chris Spofford, MD, PhD, FASA
Associate Professor
Director, Regional Anesthesia and Acute Pain Fellowship
Director, Froedtert Hospital Simulation Center
Editor-In-Chief, Anesthesia Toolbox
Medical College of Wisconsin
Milwaukee, WI

1



Disclosures

- I have no financial disclosures

2



Objectives

- Describe two methods for teaching fellows during the COVID-19 pandemic
- Discuss the benefits of frequent, short learning sessions for fellows during the COVID-19 pandemic
- Delineate those teaching methodologies that were successful during the pandemic for long term education going forward

3



Scope of the problem for fellow level education

- Burnout, fatigue, fear
- Limits to number of learners for classic in-person teaching
- Concerns about how ABA exams would be administered and when
- Rapid learning of online platforms for meetings (zoom, webex, etc)
- Massive shifts in daily work (changes in OR schedules, PPE, supplies, etc)
- Teams doing alternative jobs (covering ICU, helping in ED, etc)
- Early retirement and infection leading to reduced workforce

4



Solution #1: Cooperative learning platforms

- Anesthesia Toolbox online learning platform with fellow level curriculum
- ASRA sponsored learning sessions



5



Solution #2: Drip learning

- Question of the Day
 - Currently in use nationally for regional anesthesia fellowship programs
- Images of the day
 - TEE
 - USGRA
 - Monitors (reflect OSCE component)



6

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Solution #3: National Lecture Series

- Anesthesia Toolbox daily series (Drs. Leila Zuo and Glenn Woodworth at OHSU)
 - Daily lectures for residents
 - Oral Board practice sessions

7

Solution #4: Simulations

- Mini simulation scenarios using modified fidelity
 - Let's assume you have this EKG....what would you do next?
- Subset of oral boards practice sessions
 - Monitor interpretation
 - Critical events training *in-situ*



8

Solution #5: rotating stations

- Fellows engage in a variety of teaching sessions (medical students, residents)
- Instead of one large session, we created the same platform but using smaller breakout rooms to keep with mandate of 6-10 people or less.
 - Round robin
 - Teachers can follow the students so they get all material (less boring, less repetitive)
 - Teachers can teach the same session so they gain expertise (repetitive practice leading to mastery)

9

What didn't work?

- Classic in room large teaching sessions
 - Grand rounds, journal clubs, business meetings—virtual
 - Hands-on workshops in classic sense

10

Summary

- Anesthesiologists are known to be highly adaptable, resourceful, with strong ability to persevere.
 - Covid-19 Pandemic stretched us all
 - Covid-19 Pandemic helped us learn what was possible
 - Covid-19 Pandemic helped us discover what worked for both faculty and learners.
- What worked for you? What didn't work for you?

11

Thank you!

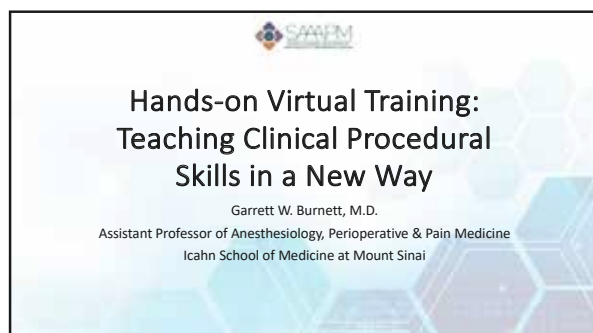
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Hands-on Virtual Training: Teaching Clinical Procedural Skills in a New Way

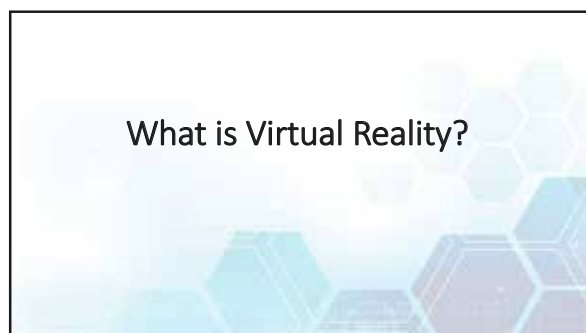
Garrett Burnett

Friday, November 5
10:20 AM - 10:35 AM

11/10/21



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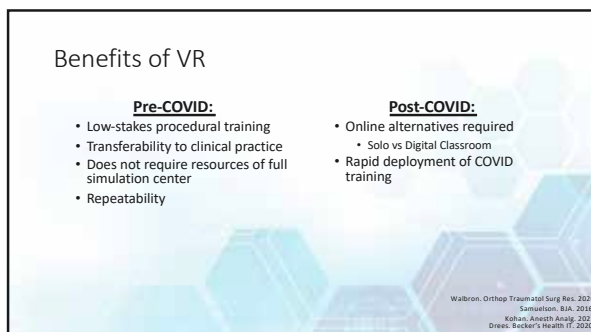
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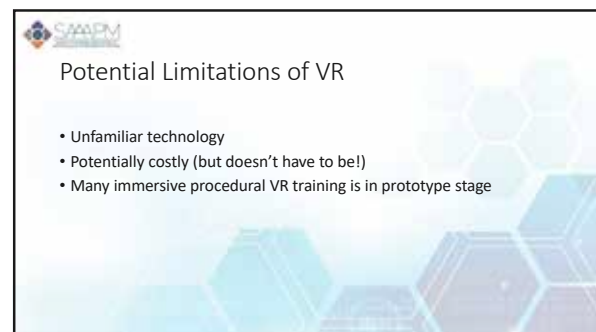
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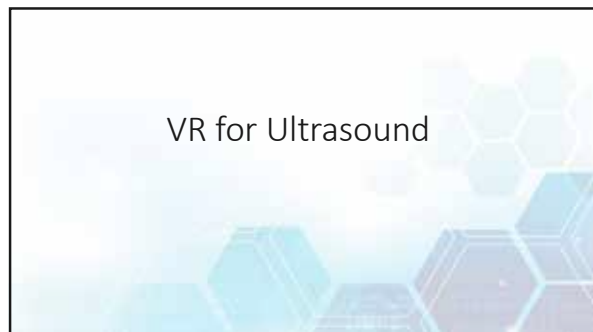
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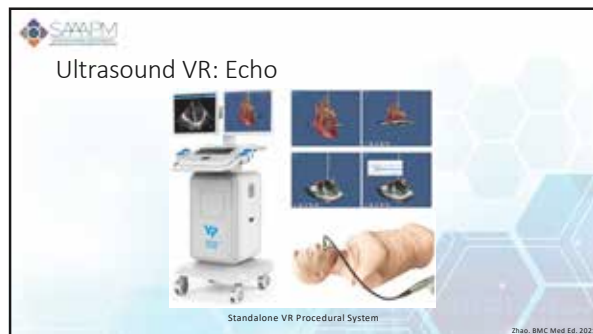
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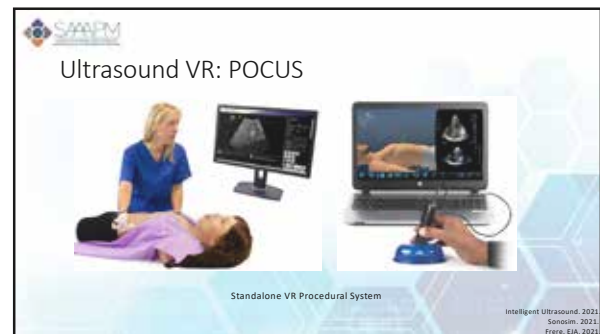
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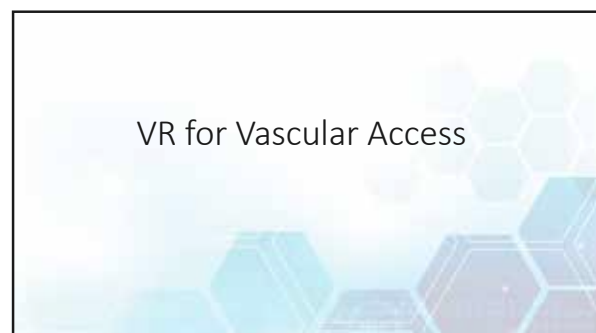


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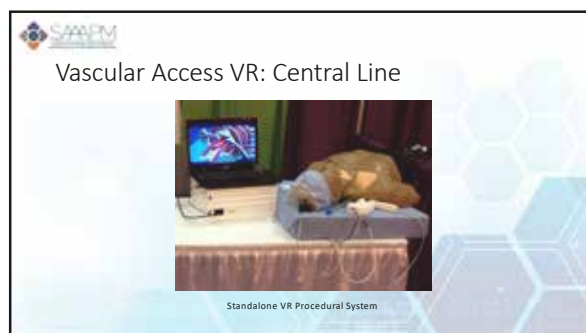


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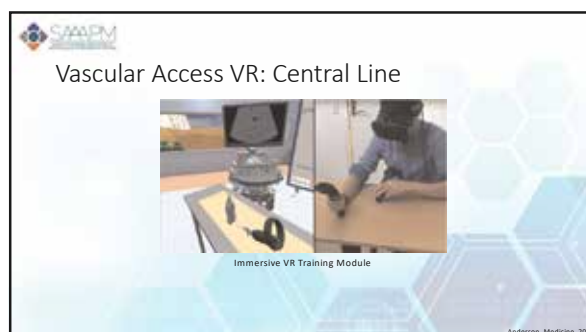
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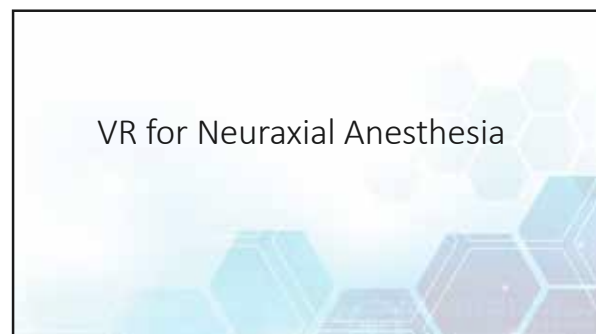
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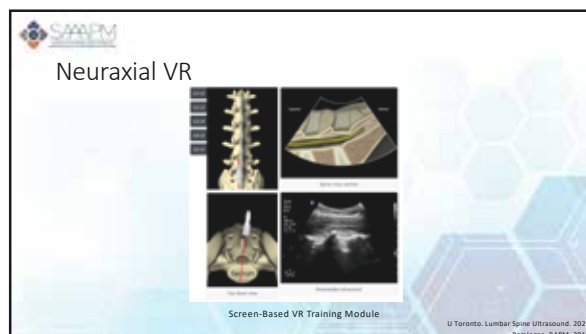
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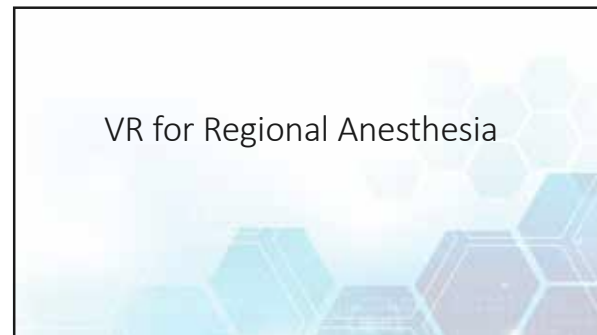


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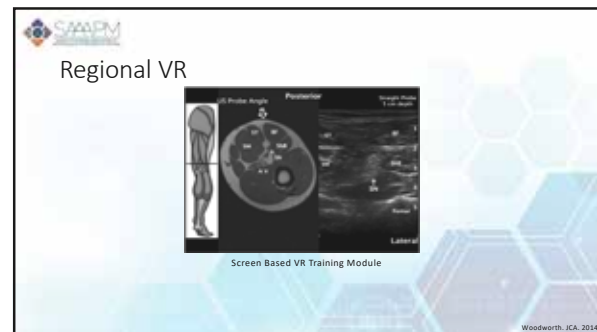
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Conclusion

- Standalone VR for procedural training is robust, but expensive
- Educational VR modules can increase knowledge, but lack procedural skills transfer
 - Skills transfer requires physical practice
- Prototype → commercialization is required for this technology
- Potential POV learning for procedures?

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References

- [illegible]

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Protected Time for All Anesthesia Subspecialties: Administrative or Scholarly Use

Rachel Kacmar

Friday, November 5
10:45 AM - 11:00 AM

11/10/21

**Protected Time for All
Anesthesiology Subspecialties:
Administrative or Scholarly Use**

Rachel M. Kacmar, MD
Associate Professor of Anesthesiology
Anesthesiology Residency Program Director
Chair, Academic Time Committee, Dept. of Anesthesiology
University of Colorado School of Medicine

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Disclosures

- No financial or industry disclosures or conflicts of interest

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2

Learning Objectives

- Describe the reasons to support protected time for Anesthesiology Fellowship Program Directors (PDs)
- List ACGME requirements for Anesthesiology PDs
- Explain strategies to document “productivity” for PD activities and use of protected time

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3

**Extrapolating from Anesthesiology Residency PDs –
In 2017 a PD was:**

- Average age: 52 years
- Average time since appointment: 3.6 years
- PD with senior academic rank (Associate/ Full Professor): 53%

Kenevan et. al. JEPM 2018. Purushothaman R, et al. Acad Radiol 2021.

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4

**Program Director
Turnover**

Contemporary Challenges for Fellowship Training in Adult Cardiothoracic Anesthesiology: Perspectives From Program Directors Across the United States

Michelle Capdeville, MD¹, Jonathan Sweeney, MD², Patrick A. Ford, MD, FACC, FASE³, Roger W. Ford, MD⁴, David G. Long, MD⁵, Robert C. Kohn, MD⁶, David W. Fierman, MD⁷, Jonathan Green, MD, FACC⁸, Robert C. Pinnock, MD, FACC, FASE, FRCPC, FRCGS⁹, John C. E. Apantaku, MD, FACC, FASE¹⁰

Period	Programs	Total New PD	Percent New PD	Active Fellows	New Programs	Total Anesth	Percent Anesth
2016-20	76	12	15.8%	228	1	-11	11.7%
2016-19	80	13	16.3%	215	5	-30	14.2%
2017-18	86	7	8.0%	207	9	-7	32.8%
2018-17	86	36	41.9%	199	8	-13	18.2%
2013-16	62	7	11.3%	182	1	-6	9.9%
2014-15	61	11	18.0%	173	1	-30	35.4%
2013-14	60	6	10.0%	167	2	-4	6.7%
2012-13	56	9	16.1%	148	3	-9	9.4%
2011-12	56	9	16.1%	133	4	0	0%
2010-11	52	8	15.4%	144	5	-3	5.6%
2009-10	47	6	12.8%	139	9	-3	6.4%
2008-09	44	9	20.5%	106	13	0	0%
2007-08	33	3	9.1%	99	27	0	0%
2006-07	4	0	0%	15	4	0	0%

Capdeville M, et al. J Cardio Vasc Anes 2020.

5

Why is protected time important?

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Program Coordinator

5.C.1. There must be a program coordinator. ⁽¹⁾⁽ⁱⁱ⁾ Different language for one-year Fellowship Common Program Requirements. There must be administrative support for program coordination.

5.C.2. Requirement 5.C.2 below was deleted from the one-year Fellowship Common Program Requirements. The program coordinator must be provided with support adequate for administration of the program based upon its size and configuration. ⁽¹⁾⁽ⁱⁱⁱ⁾

The program coordinator is a **member of the leadership team** and is **critical to the success of the program**. As such, the program coordinator **must possess skills in leadership and personnel management**. Program coordinators are expected to **develop unique knowledge of the ACGME and Program Requirements, policies, and procedures**. Program coordinators **assist the program director** in accreditation efforts, educational programming, and support of fellows.

Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and assist them in opportunities for both professional and personal growth. Programs with fewer fellows may consider program coordinators to be the program director or assistant program director.

Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and assist them in opportunities for both professional and personal growth. Programs with fewer fellows may consider program coordinators to be the program director or assistant program director.

Feist TB, et al. JGME 2019. Ewen AM, et al. JGME 2019. www.acgme.org 2020. @rkacsMD

Considering Program Coordinators

7

PC support and retention = $\uparrow$ time for PDs

- High degree of PC turnover
- High degree of PC burnout (even before COVID)

Including PCs in wellness initiatives and providing adequate support should help control some of the administrative burden for Program Directors.

Feist TB, et al. JGME 2019. Ewen AM, et al. JGME 2019. www.acgme.org 2020. @rkacsMD

8

Program Director Promotion

The review for promotion to Associate Professor shall be in accordance with the following guidelines:

Meritorious performance in all:	Excellence in one:
- Teaching	- Teaching
- Scholarly activity	- Research
- Service/clinical activity	- Clinical activity

The review for promotion to Professor shall be in accordance with the following guidelines:

Meritorious in:	Excellence in two:	Excellence in:
- Teaching	- Teaching	- Scholarly activity
- Service/clinical activity	- Research	
	- Clinical activity	

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9

Program Director Promotion con't

Professors in the regular faculty series should have the terminal degree appropriate to their field or its equivalent. They must demonstrate continued achievement in their areas of expertise; that is, they must have a record, since receiving tenure or promotion to associate professor, that indicates substantial, significant and continued growth, development and accomplishment in teaching, scholarship and other applicable areas.

Success takes TIME

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Specialty-Specific Program Requirements: Support for Program Director
Effective as of July 1, 2021
Common Program Requirements are in bold

CORE Residency Program Director

Anesthesiology 5.A.2. At a minimum, the program director must be provided with the salary support required to devote 20 percent FTE of non-clinical time to the administration of the program. ⁽¹⁾⁽ⁱⁱ⁾

5.A.2.a) Additional support must be provided based on the program size as follows: ⁽¹⁾⁽ⁱⁱⁱ⁾

Number of approved resident positions	Minimum FTE
1-20	0.2
>20	0.4

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Specialty-Specific Program Requirements: Support for Program Director
Effective as of July 1, 2021
Common Program Requirements are in bold

Fellowship* Program Director

Adult Cardiology 5.A.2. The program director must be provided with support adequate for administration of the program based upon its size and configuration. ⁽¹⁾⁽ⁱⁱ⁾

Anesthesiology 5.A.2.a) At a minimum, the program director must be provided with the salary support required to devote 10 percent Medicine FTE of non-clinical time to the administration of the program. Additional support must be provided based on program size as follows: ⁽¹⁾⁽ⁱⁱⁱ⁾

Number of Approved Fellow Positions	Minimum FTE
1-2	0.1
3	0.125
4	0.15
5	0.175
>5	0.2

*ACGME Accredited Programs
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What about other specialties?

- Orthopedic Surgery Fellowships
 - 1-4 fellows → 0.1 FTE for PD
 - ≥ 5 fellows → 0.2 FTE for PD
- Psychiatry Fellowships
 - 1-2 fellows → 0.25 FTE for PD
 - ≥ 3 fellows → 0.375 FTE for PD
- Surgical Critical Care
 - 1-4 fellows → 0.1 FTE for PD
 - 5-9 fellows → 0.15 FTE for PD
 - ≥ 10 fellows → 0.2 FTE for PD
- Obstetrics/ Gyn Fellowships
 - Minimum of 0.2 FTE for PD
- Radiology Fellowships
 - 1-4 fellows → 0.1 FTE for PD
 - 5-7 fellows → 0.2 FTE for PD
 - ≥ 8 fellows → 0.3 FTE for PD

****Varying requirements for # and aggregate protected time for Associate Fellowship PDs**

<https://www.acgme.org/>

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14

Time = Money

What is the value of 0.1 FTE protected time?

Conservatively ...
~ \$33,000

15

Preaching to the Choir...Fellowship PDs are BUSY

- Administrative tasks
 - Fellowship interviews
 - Fellow semi-annual reviews
 - Clinical Competence Committee
 - Annual Program Evaluation
 - Program Evaluation Committee
 - PLAs, Rotation Goals/ Objectives
 - **And more!**
- Educational/ Scholarly activities
 - Fellow didactics
 - Fellow project/ research mentorship
 - Personal research
 - Book chapters and peer reviewed publications
 - Editorial activities
 - Hospital/ Institutional roles
 - National subspecialty society service
 - National speaking engagements
 - **And more!**

How do you justify protected time to your Chair (and Department colleagues)?

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16



17

How do we compare to others?

Academic Productivity of Directors of ACGME-Accredited Residency Programs in Surgery and Anesthesiology

Deborah J. Culley, MD,* Brenda G. Fahy, MD,† Zhongcong Xia, MD, PhD,† Robert Leikowski, MD,* Sandra Buerter, MD, PhD,* Xiaoxia Liu, MS,* Neal H. Cohen, MD,‡ and Gregory Crosby, MD¶

Table 2. Publication Comparison

Variable	Anesthesiology (N = 127)	Surgery (N = 127)	P
Publications, median (IQR)	6.0 (2.0-14.0)	29.8 (11.0-55.0)	<0.001
Editorial publications, median (IQR)	0.0 (0.0-1.0)	1.0 (0.0-3.0)	<0.001
Peer-reviewed publications, median (IQR)	3.0 (0.0-8.0)	6.0 (2.0-12.0)	<0.001

Culley DJ, et al. Anesth Analg 2014; Fahy BG, et al. Crit Care Med 2016.

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Academic Productivity of Accreditation Council for Graduate Medical Education-Accredited Critical Care Fellowship Program Directors*

*Based on data from the American Society of Anesthesiologists (ASA) database, 2014-2016. Data were analyzed by the ASA's Office of Research and Statistics.

Metric	Anesthesiology n=18	Perfusion n=18	Surgery n=18	Intensivist n=18	P-value	Statistical Significance (p < 0.05)
Total publications (all types), median (IQR)	40 (15-80)	70 (25-81)	88 (17-96)	59 (8-82)	0.03	Anesthesiology < Surgery (p < 0.05)
Peer-reviewed publications, median (IQR)	21 (5-30)	7 (0-18)	14 (5-27)	7 (0-11)	<0.001	Anesthesiology < Surgery (p < 0.001) Perfusion < Surgery (p < 0.001)
First author publications, median (IQR)	11 (4-18)	3 (0-7)	4 (2-9)	7 (0-11)	0.007	Anesthesiology < Surgery (p < 0.001)
Last author publications, median (IQR)	1 (0-7)	3 (0-8)	4 (2-9)	4 (1-8)	0.046	Anesthesiology < Surgery (p < 0.05)

Culley DJ, et al. Anesth Analg 2014; Fahy BG, et al. Crit Care Med 2016.

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Objective evaluation of academic productivity

- Activities are assigned relative weighted scores
 - Education
 - Service/ Admin
 - QI
 - Research/ Scholarship

Activity	Weighted Score	Score
Education	1.0	1.0
Service/ Admin	0.5	0.5
QI	0.5	0.5
Research/ Scholarship	2.0	2.0

Isaak BS, et al. Anesth Analg 2021; Sakai T, et al. Brit J Anesth 2013.

20

Take Home Points

- The ACGME now **mandates** protected time for **all** Anesthesiology Fellowship Program Directors
- This time represents a significant financial investment by Departments to support the administrative, educational and scholarly activities of Program Directors
- Objective systems can help document non-clinical contributions of Program Directors and other Core faculty to Department Chairs, Institutional and Hospital Leadership

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21

Techniques to Manage and Focus Energy of PD on Building and Shaping a Successful Fellowship Program

Justin Lockman

Friday, November 5
11:00 AM - 11:15 AM

11/10/21

FOCUSING PROGRAM DIRECTOR ENERGY... OPTIMIZING RESULTS

Justin L. Lockman, MD, MEd
Associate Chair, Education
Anesthesiology and Critical Care Medicine
AASPD November 2021




1

DISCLOSURES

- No relevant financial disclosures
- Current PAPDA president
- Current SPA Board of Directors member



2

DISCLAIMERS

- I'm not very good at being vulnerable
 - Even worse with strangers
- I'm not perfect at doing the things I will talk about here



3

OBJECTIVES

- By the end of this discussion, the learner will be able to:
 - Discuss causes of stress for program directors
 - Create a resilient system to decrease stress
 - Learn about an empty inbox and how it can change your life



4

BEING A PROGRAM DIRECTOR...




5

BEING A PROGRAM DIRECTOR...

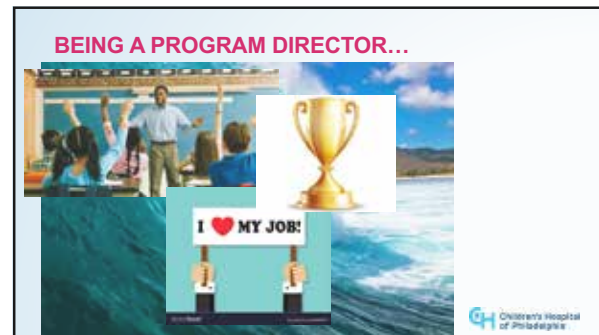



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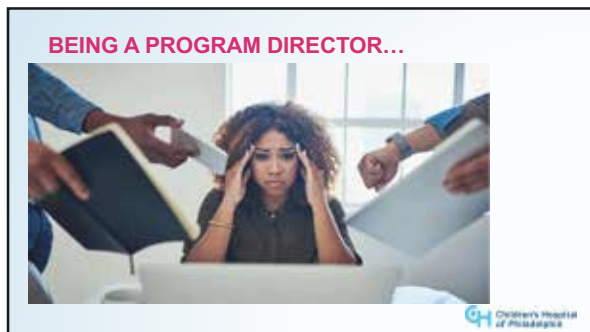
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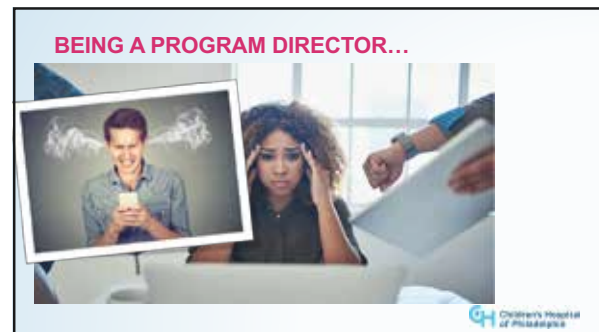
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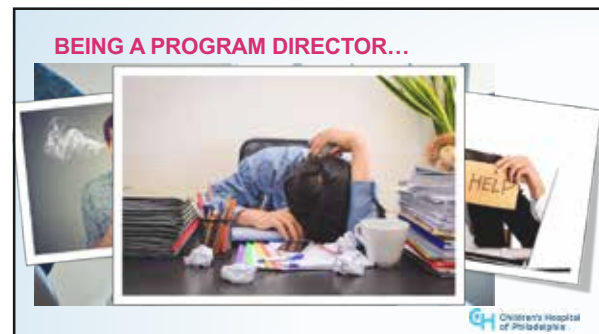
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CAUSES OF STRESS

- Alphabet soup
 - ACGME, ABA, GMCE, ECFMG, JCAHO, NRMP, ERAS...



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13

CAUSES OF STRESS

- Alphabet soup
 - ACGME, ABA, GMCE, ECFMG, JCAHO, NRMP, ERAS...
- Constant emergencies



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CAUSES OF STRESS

- Alphabet soup
 - ACGME, ABA, GMCE, ECFMG, JCAHO, NRMP, ERAS...
- Constant emergencies



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CAUSES OF STRESS

- Alphabet soup
 - ACGME, ABA, GMCE, ECFMG, JCAHO, NRMP, ERAS...
- Constant emergencies
- Human Resources issues



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CAUSES OF STRESS

- Alphabet soup
 - ACGME, ABA, GMCE, ECFMG, JCAHO, NRMP, ERAS...
- Constant emergencies
- Human Resources issues
- Not to mention.... My own life, family, career, worries

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AND OF COURSE... RECRUITMENT / ONBOARDING / OFFBOARDING

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I QUICKLY REALIZED
NOT ONLY WAS I
NOT THRIVING,



19

I QUICKLY REALIZED
NOT ONLY WAS I
NOT THRIVING,
I WAS AT RISK FOR
TOTAL CAREER FAILURE



20

AND THOSE FIRES I WAS PUTTING OUT...



21

SO... WHAT TO DO?

- Think strategically
- Create a resilient system
- Design your ideal team
- Find/use administrative support
- Clear your inbox
- Celebrate small moments of joy



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THINK STRATEGICALLY

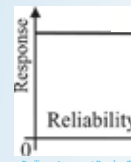
- Given infinite tasks and finite time... What *should* I be spending my time on?

- Triage
- Impact
- Focus is critical
 - Concept of deep work



23

CREATE A RESILIENT SYSTEM



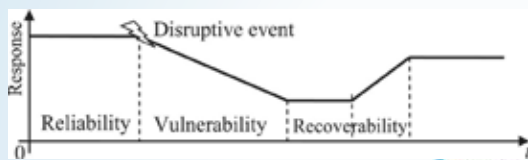
Resilience Assessment Based on Time-Dependent System Reliability Analysis
[Journal of Mechanical Design](#), July 2016, 138(7)



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CREATE A RESILIENT SYSTEM



Resilience Assessment Based on Time-Dependent System Reliability Analysis
Journal of Mechanical Design, July 2016, 138(1)



25

CREATE A RESILIENT SYSTEM

- Disruptive events are the NORM
 - Unpredictability is the one predictable thing!



26

CREATE A RESILIENT SYSTEM

- Disruptive events are the NORM
 - Unpredictability is the one predictable thing!
- **Every time you solve a problem,
solve it forever (if you can)!**



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CREATE A RESILIENT SYSTEM

Examples:

- Fellow jeopardy system
- ACGME WebADS updates
- Interview day nonclinical time

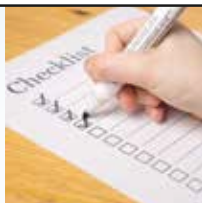


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CREATE A RESILIENT SYSTEM

Will your program keep running if you don't show up?

- Do not rely on an individuals
- Build (and share) checklists



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DESIGN YOUR IDEAL TEAM

- Associate/Assistant Program Director(s)
- Rotation Directors
- Recruitment Chair
- Didactic Course Director
- Mentorship leader
- Onboarding Chair



- Find the right people, give them clear instructions, let them build their own teams, and trust them (with oversight)
- Be ready to step in if you need to, but don't step on toes



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FIND AND USE ADMINISTRATIVE SUPPORT

- We like to do things ourselves
- Program coordinator likely looking for ways to support you better
 - Regular meetings key
 - Clear and written instructions about what to do/how/style
 - Annual checklist
- When people grab you in the hallway with a problem... tell them to send you an email with their proposed solution and then set up a meeting to discuss



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CLEAR YOUR INBOX (AND YOUR BRAIN)

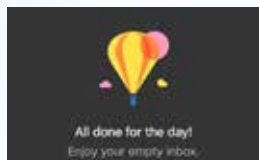
- Your brain is great at having ideas, terrible at storing them
 - Fear of dropping the ball creates stress and anxiety
 - Create an AIRTIGHT system to eliminate this risk



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CLEAR YOUR INBOX (AND YOUR BRAIN)

- Use inbox as an inbox – triage to other folders
 - Including: Brain dump into your computer
 - Respond only if < 2 min
- My folders:
 - Inbox
 - Urgent To do
 - To do
 - Waiting for
 - Archive
 - Trash



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CLEAR YOUR INBOX (AND YOUR BRAIN)

- Before going home, check "Urgent To Do" Folder
- When time to focus, check "To Do" folder
- When asking others to help/do something, copy yourself and put that in the "Waiting For" folder
 - Periodically check in with people
 - Never use brain power to remember these things



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CELEBRATE SMALL MOMENTS OF JOY

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CELEBRATE SMALL MOMENTS OF JOY

36

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CELEBRATE SMALL MOMENTS OF JOY



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CELEBRATE SMALL MOMENTS OF JOY



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ACKNOWLEDGMENTS

- Getting Things Done (Allen) is a great book about empty inboxes and organizational systems
- I have benefitted along the way from great mentorship, great teammates, and great administrative support

Children's Hospital of Philadelphia

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THANK YOU FOR LISTENING!



Children's Hospital of Philadelphia

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Maternity and Paternity Leave: How Do Institutions React and Accommodate New Parents

Corinna Yu

Friday, November 5
11:25 AM - 11:40 AM

10/26/21



DEPARTMENT OF ANESTHESIA 11/5/2021

Parental Leave During Anesthesiology Fellowship

Corinna J. Yu, MD, FASA
Assistant Professor of Clinical Anesthesia

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Disclosure

None.



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Special Thanks

Frank Rigueiro
Indiana University School of Medicine
MD Candidate Class of 2023




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Outline

- Background on Parental Leave
- Overview of Legal Regulations & Policies
- Challenges to Parental Leave in Anesthesiology Fellowships
- Discussion



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Background on Parental Leave

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Is paid leave available for both parents of infants?



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Population Health Benefits

1952: International Labor Organization (United Nations) recommended 14 weeks paid maternity leave

2000: Increased recommendation to 18 weeks

Most developed economies offer 18 weeks to 1 year of leave at 70%-100% pay

The US ranks last in government-mandated paid leave for new parents



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Decrease Infant Mortality

10-week extension of paid leave predicted to reduce infant mortality rates by 2.5%-3.4%, with 3.7%-4.6% mortality reduction for post-neonatal mortality, and 3.3%-3.5% in child mortality



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Increase Breastfeeding

Canada: six-month extension of paid parental leave led to 40% increase in exclusive breastfeeding at six months

US: American mothers returning to work in 6 weeks are 40% less likely to exclusively breastfeed than those planning to take 12 weeks of leave



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Breastfeeding Benefits Mother & Baby

Mother: Not breastfeeding is associated with increased maternal risk of breast cancer, ovarian cancer, hypertension, diabetes, heart disease

Baby: Breastfed children perform better on intelligence tests and have a lower risk of sudden infant death syndrome, asthma, obesity, diabetes, ear and GI infections, and severe lower respiratory disease (health benefits persist beyond the duration of breastfeeding)

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Overview of Legal Regulations & Policies

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Organizations and Policies Governing Parental Leave in Graduate Medical Education

- US Legal Code
- State Legal Code
- Centers for Medicare and Medicaid Services, HHS
- Health Resources and Services Administration, HHS
- Veterans Health Administration, Dept of Veteran Affairs
- National Institutes of Health
- Accreditation Council for Graduate Medical Education
- Institutional GME
- American Board of Medical Specialties
- Specialty-Specific board

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US Family and Medical Leave Act of 1993

"to entitle employees to take reasonable leave for medical reasons, for the birth or adoption of a child, and for the care of a child, spouse, or parent who has a serious health condition"

"to promote the goal of equal employment opportunity for women and men, pursuant to such clause"

"an employee shall be entitled to a total of 12 administrative workweeks of leave during any 12-month period"

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"to promote the goal of equal employment opportunity for women and men, pursuant to such clause"

"an employee shall be entitled to a total of 12 administrative workweeks of leave during any 12-month period"

IF THEY WORKED FOR 12 MONTHS

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US Family and Medical Leave Act of 1993

"to entitle employees to take reasonable leave for medical reasons, for the birth or adoption of a child, and for the care of a child, spouse, or parent who has a serious health condition"

"to promote the goal of equal employment opportunity for women and men, pursuant to such clause"

"an employee shall be entitled to a total of 12 administrative workweeks of leave during any 12-month period"

NOT PAID

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States With Paid Family & Medical Leave (PFML)

- New Jersey (6 weeks partial paid)
- District of Columbia (8 weeks)
- California (12 weeks)
- Massachusetts (12 weeks)
- New York (12 weeks)
- Oregon (12 weeks)
- Rhode Island (4-13 weeks)
- Washington (12 weeks)
- Connecticut (2022)
- Colorado (2024)

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Centers for Medicare and Medicaid Services

Federal Register Vol 75 No 226

The Affordable Care Act clarified that "hospitals may count residents' vacation, sick leave, and other approved leave time toward the hospitals' direct GME FTE resident count, **so long as the leave does not prolong the total time** the resident participates in his or her approved program."

The hospital to which the resident is assigned during the leave counts the FTE time for direct GME and IME **regardless** of which hospital pays the resident salary and benefits. If the rotation is not specified, the hospitals allocate the leave proportionately to the overall schedule.

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Health Resources and Services Administration

"The cost of fringe benefits in the form of regular compensation paid to employees during periods of authorized absences from the job, such as for annual leave, family-related leave, sick leave, holidays, court leave, military leave, administrative leave, and other similar benefits, are allowable if all of the following criteria are met:

- (1) They are provided under **established written leave policies**;
- (2) The costs are equitably allocated to all related activities, including Federal awards; and,
- (3) The accounting basis (cash or accrual) selected for costing each type of leave is consistently followed by the non-Federal entity or specified grouping of employees."

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Veterans Health Administration

The cost of annual leave is included in the per diem rate of residents

The VA must not be billed for days residents are on leave

Sick leave can be used for family leave, limit 15 days per resident

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National Institutes of Health

National Research Service Awards:

60 calendar days (8 work weeks) of parental leave per year for the adoption or the birth of a child (either parent)

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ACGME Fellowship Common Program Requirements

VI.C.2. There are circumstances in which fellows may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave. Each program must allow an appropriate length of absence for fellows unable to perform their patient care responsibilities. (Core)

Background and Intent: Fellows may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.

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Local GME

Does your institution have a formal written GME policy on parental leave?

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December 11, 2018

Childbearing and Family Leave Policies for Resident Physicians at Top Training Institutions

1010 Reynolds Ave, PO Box 16000, Indianapolis, IN 46116-0000
1010 Reynolds Ave, PO Box 16000, Indianapolis, IN 46116-0000
1010 Reynolds Ave, PO Box 16000, Indianapolis, IN 46116-0000

7 of 15 institutions had an institutional GME policy providing paid designated childbearing leave (mean 5.7 weeks, range 2-8 weeks)

Mean duration of maternity leave was 6.6 weeks (range, 2-10 weeks)

7 of 15 institutions had leave for non-birth parents (mean 3.9 weeks, range 1-8 weeks)

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Parental leave policies in graduate medical education: A systematic review

Systematic review: 28 studies addressed existence of parental leave policies in GME

1986-1992: 2 studies report 22-66% of surveyed programs had formal maternity leave policies (no mention of paternity leave)

1995-2016: 9 studies reporting maternity or family leave policies, in a 1991 study of Boston-area hospital program directors there were 82% with written maternity leave policy, 75% reporting implementation of policy, with 6 studies describing paternity leave policies

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Formal Maternity Leave

Pediatric residency program directors: 90% formal maternity leave policies

Radiology residency program directors: 88% formal maternity leave policies

Female urologists: 42% formal maternity leave policy at their institutions

General surgery: 67% formal maternity leave policies

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Formal Paternity Leave

OB-Gyn: 69% policies for paternity leave



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Local GME

Does your institution have a formal written GME policy on parental leave?

If so, can interested residents find it easily online?



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Searching For "Family-Friendly" Fellowships

140 compiled locations for ACGME-approved anesthesiology fellowships

- 60 pediatric anesthesiology
- 74 adult cardiothoracic anesthesiology
- 63 critical care medicine
- 39 regional anesthesiology and acute pain medicine
- 41 obstetric anesthesiology
- 111 chronic pain medicine
- 1 clinical informatics

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Anesthesiology Fellowships With Online GME Policies

- 99 programs with policies easily accessible online
- 41 programs unable to find parental leave policies online
 - 6 programs required a log-in for access

Anesthesiology Fellowships Publishing Parental Leave Policies



29% Policy Accessible Online
71% No Policy Online

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American Board of Medical Specialties



American Board of Medical Specialties
Higher standards. Better care.®

American Board of Medical Specialties Policy on Parental, Caregiver and Medical Leave During Training
Effective July 1, 2021

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ABMS

"This policy applies only to Member Boards with training programs of 2 or more years duration."

"Member Boards that are exempt from this policy are encouraged to consider accommodations for parental, caregiver and medical leave consistent with the spirit of this policy."

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ABMS

- Written and accessible policy on training requirements for certification.
- Incorporate time away for parental leave in addition to vacation.
- Allow minimum 6 weeks time away for parental/medical leave.
- Add to existing allowances for time away or average time over the course of the training program.
- Clearly state when parental leave requires an extension of training.
- Establish guidelines for candidates requesting parental leave.
- Limit the maximum amount of time away from any single year.
- Make reasonable testing accommodations for those that extend training.

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ABA: CA1-CA3 40-day allowance for FMLA

Qualifying Circumstances for Extended Leave (up to 40 additional day/eight weeks)
This policy is designed to align with circumstances covered by the Family and Medical Leave Act (FMLA), which allows for reasonable unpaid leave for certain family and medical reasons. These reasons may include:

- The birth and care of a newborn, adopted or foster child
- The care of an immediate family member (child, spouse or parent) with a serious health condition
- The resident's own serious health condition

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ASA Statement on Personal 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. 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."

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ASA Statement on Lactation-NEW!

1. Offer reasonable break time and location for expressing breast milk
2. Offer lactation room close to clinical responsibilities, if possible, with phone and computer to continue communication re: clinical care
3. Allocate personnel and resources for lactation session breaks
4. Wearable breast pumps are acceptable in the clinical setting or the OR
5. Provide education to create supportive work culture for individuals who are breast pumping

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ABA THE AMERICAN BOARD OF ANESTHESIOLOGY

EXTRA BREAK TIME FOR NURSING MOTHER
Effective July 1, 2022



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Specialty Board

Other certifications outside of the ABA

ex: National Board of Echocardiography

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Challenges to Parental Leave in Anesthesiology Fellowships

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Perception of Mothers & Fathers



Journal of the American College of Surgeons
Volume 122, Issue 6, June 2016, Pages 1086-1096

New England medical society article:
Pregnancy and Parenthood among Surgery Residents: Results of the First Nationwide Survey of General Surgery Residency Program Directors

Presented at the 2016 American Society of Anesthesiologists (ASA) National Meeting, October 1-5, 2016, San Francisco, CA

Authors: [List of authors]

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Maternity VS. Paternity



General surgery program directors, 70% male

67% reported maternity leave policy (58% with 6 weeks duration)

48% reported paternity leave policy (45% with 1 week duration)

58% reported availability of lactation facilities

61% reported becoming a parent negatively affects female trainees' work, including placing an increased burden on fellow residents (33%)

Children decreased female trainees' well-being more often than male trainees (32% vs. 9%)

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Bias?

"General surgery residents with children during training did not have significantly different total case numbers, in-service scores, or written/oral board pass rates than those without children"



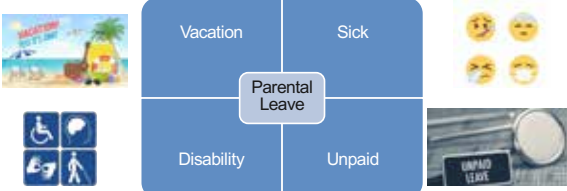
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Where does the time come from?



PC: Google Images

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Where does the money come from?

Centers for Medicare and Medicaid Services under Department of Health and Human Services: leave counts toward hospitals direct/indirect GME costs if leave does not extend training

Veterans Health Administration: max 15 days of reimbursed sick leave during VHA assignment

Health Resources and Services Administration: funding of family-related leaves if provided under written policies, equitably allocated among sources of funding

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Family planning and choosing a fellowship

40% of residents and fellows at 269 programs across 3 sites of Mayo School of GME planned to have children during training.

"Pregnancy and childbirth altered trainee choice of GME program, date of completion, career plans and/or pursuit of additional degrees more often for women than for men"

89% of fathers rated paternity leave as an important benefit

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Reasons trainees don't use parental leave

1. The sense of being a burden to colleagues
2. Anticipation of a heavier workload later
3. Delayed program completion
4. Not needing the time
5. Not being the primary caregiver

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Education & Board Certification?

Maximum limit of absence from training?

Timing of specialty board certification?

Case-log quotas?

Decreased opportunity to observe readiness for practice?

Equity concerns?

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Clinical Coverage

Certain subspecialties may rely on fellows for clinical coverage, such as overnight in-house ICU call or pediatric OR cases

When a fellow takes parental leave:

Do other fellows take on their work?

Do attendings take on their work?

Is there a way to make up the work later?

What about work-hour regulations?

How does it affect work culture and environment?

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If a fellow takes parental leave during fellowship and needs/wants to extend their fellowship:

Are there limited opportunities for certain required rotations?
Does that delay the available start date for the next fellow?
Will more fellows overlap than usual?
Is there enough clinical material for an extra fellow or does it dilute the educational experience for the others?
Does an off-cycle start date affect the candidate pool for the position?



If a resident takes parental leave during anesthesiology core residency, and needs to extend their time, how does this affect their opportunities for fellowship?

Will they be able to find part-time work and have health insurance until the next year's cycle?

Will they be able to find a fellowship off-cycle?

Will this disproportionately affect child-bearing women?

Will this pressure men to not take parental leave?



Competency-based training with criteria including milestones achievements, targeted (focused) assessments, learning analytics

Accommodate lactation

Flexible scheduling of work hours

Part-time options

Sympathetic colleagues

Formal policies for pregnancy and parental leave

Childcare benefits

Flexible start dates for physicians who extend training

Allow 6 weeks away from training while preserving 2 weeks vacation without extension

Documentation



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Thank you for attending

Q & A

[illegible]

17 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4118118/> 2018-11-24;PMID: 29726626

18 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4118118/> 2018-11-24;PMID: 29726626

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34 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4118118/> 2018-11-24;PMID: 29726626



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Mental Health and Burn Out: Resources and Responsibilities

Allison Dalton

Friday, November 5
11:40 AM - 11:55 AM

Allison Dalton, MD

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- Define burnout and recognize its impact on physicians
- Identify risks for burnout and depression
- Assess high priority well-being interventions
- Develop a database of available well-being resources

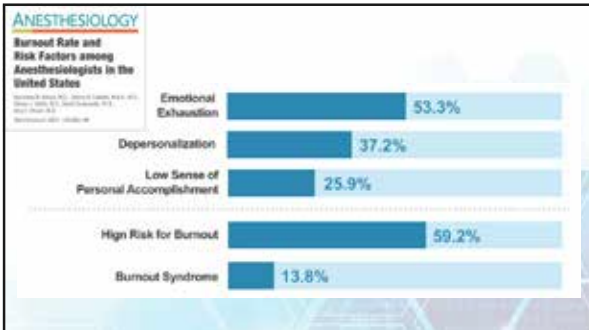
I have no relevant disclosures

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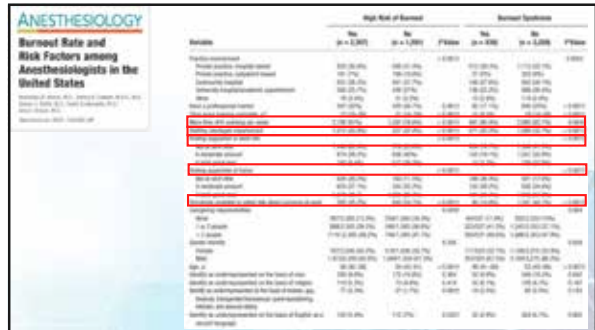
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²Christina Maslach, 1986

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The Prevalence of Burnout and Depression and Their Association with Adherence to Safety and Practice Standards: A Survey of United States Anesthesiology Trainees

Journal of the American Society of Anesthesiologists, 2015

Table 1. Prevalence of Burnout and Depression by Age Group and Gender

Age Group	Gender	Burnout (%)	Depression (%)
25-34	Male	15.2	12.1
	Female	18.7	14.3
35-44	Male	22.5	18.9
	Female	25.1	21.4
45-54	Male	28.3	24.7
	Female	31.2	27.5
55-64	Male	35.6	31.2
	Female	38.4	34.1
65-74	Male	42.1	38.5
	Female	45.3	41.2
75-84	Male	48.7	44.6
	Female	51.2	47.1
85-94	Male	55.4	50.3
	Female	58.1	53.2
95-104	Male	62.3	57.8
	Female	65.1	60.4
105-114	Male	68.5	64.2
	Female	71.2	67.1
115-124	Male	75.1	70.5
	Female	78.3	73.2
125-134	Male	82.4	77.1
	Female	85.2	80.3
135-144	Male	88.7	83.5
	Female	91.1	86.2
145-154	Male	92.3	88.1
	Female	95.1	90.4
155-164	Male	96.5	92.3
	Female	98.2	94.1
165-174	Male	99.1	95.2
	Female	100.0	96.5
175-184	Male	100.0	98.1
	Female	100.0	99.3
185-194	Male	100.0	100.0
	Female	100.0	100.0
195-204	Male	100.0	100.0
	Female	100.0	100.0
205-214	Male	100.0	100.0
	Female	100.0	100.0
215-224	Male	100.0	100.0
	Female	100.0	100.0
225-234	Male	100.0	100.0
	Female	100.0	100.0
235-244	Male	100.0	100.0
	Female	100.0	100.0
245-254	Male	100.0	100.0
	Female	100.0	100.0
255-264	Male	100.0	100.0
	Female	100.0	100.0
265-274	Male	100.0	100.0
	Female	100.0	100.0
275-284	Male	100.0	100.0
	Female	100.0	100.0
285-294	Male	100.0	100.0
	Female	100.0	100.0
295-304	Male	100.0	100.0
	Female	100.0	100.0
305-314	Male	100.0	100.0
	Female	100.0	100.0
315-324	Male	100.0	100.0
	Female	100.0	100.0
325-334	Male	100.0	100.0
	Female	100.0	100.0
335-344	Male	100.0	100.0
	Female	100.0	100.0
345-354	Male	100.0	100.0
	Female	100.0	100.0
355-364	Male	100.0	100.0
	Female	100.0	100.0
365-374	Male	100.0	100.0
	Female	100.0	100.0
375-384	Male	100.0	100.0
	Female	100.0	100.0
385-394	Male	100.0	100.0
	Female	100.0	100.0
395-404	Male	100.0	100.0
	Female	100.0	100.0
405-414	Male	100.0	100.0
	Female	100.0	100.0
415-424	Male	100.0	100.0
	Female	100.0	100.0
425-434	Male	100.0	100.0
	Female	100.0	100.0
435-444	Male	100.0	100.0
	Female	100.0	100.0
445-454	Male	100.0	100.0
	Female	100.0	100.0
455-464	Male	100.0	100.0
	Female	100.0	100.0
465-474	Male	100.0	100.0
	Female	100.0	100.0
475-484	Male	100.0	100.0
	Female	100.0	100.0
485-494	Male	100.0	100.0
	Female	100.0	100.0
495-504	Male	100.0	100.0
	Female	100.0	100.0
505-514	Male	100.0	100.0
	Female	100.0	100.0
515-524	Male	100.0	100.0
	Female	100.0	100.0
525-534	Male	100.0	100.0
	Female	100.0	100.0
535-544	Male	100.0	100.0
	Female	100.0	100.0
545-554	Male	100.0	100.0
	Female	100.0	100.0
555-564	Male	100.0	100.0
	Female	100.0	100.0
565-574	Male	100.0	100.0
	Female	100.0	100.0
575-584	Male	100.0	100.0
	Female	100.0	100.0
585-594	Male	100.0	100.0
	Female	100.0	100.0
595-604	Male	100.0	100.0
	Female	100.0	100.0
605-614	Male	100.0	100.0
	Female	100.0	100.0
615-624	Male	100.0	100.0
	Female	100.0	100.0
625-634	Male	100.0	100.0
	Female	100.0	100.0
635-644	Male	100.0	100.0
	Female	100.0	100.0
645-654	Male	100.0	100.0
	Female	100.0	100.0
655-664	Male	100.0	100.0
	Female	100.0	100.0
665-674	Male	100.0	100.0
	Female	100.0	100.0
675-684	Male	100.0	100.0
	Female	100.0	100.0
685-694	Male	100.0	100.0
	Female	100.0	100.0
695-704	Male	100.0	100.0
	Female	100.0	100.0
705-714	Male	100.0	100.0
	Female	100.0	100.0
715-724	Male	100.0	100.0
	Female	100.0	100.0
725-734	Male	100.0	100.0
	Female	100.0	100.0
735-744	Male	100.0	100.0
	Female	100.0	100.0
745-754	Male	100.0	100.0
	Female	100.0	100.0
755-764	Male	100.0	100.0
	Female	100.0	100.0
765-774	Male	100.0	100.0
	Female	100.0	100.0
775-784	Male	100.0	100.0
	Female	100.0	100.0
785-794	Male	100.0	100.0
	Female	100.0	100.0
795-804	Male	100.0	100.0
	Female	100.0	100.0
805-814	Male	100.0	100.0
	Female	100.0	100.0
815-824	Male	100.0	100.0
	Female	100.0	100.0
825-834	Male	100.0	100.0
	Female	100.0	100.0
835-844	Male	100.0	100.0
	Female	100.0	100.0
845-854	Male	100.0	100.0
	Female	100.0	100.0
855-864	Male	100.0	100.0
	Female	100.0	100.0
865-874	Male	100.0	100.0
	Female	100.0	100.0
875-884	Male	100.0	100.0
	Female	100.0	100.0
885-894	Male	100.0	100.0
	Female	100.0	100.0
895-904	Male	100.0	100.0
	Female	100.0	100.0
905-914	Male	100.0	100.0
	Female	100.0	100.0
915-924	Male	100.0	100.0
	Female	100.0	100.0
925-934	Male	100.0	100.0
	Female	100.0	100.0
935-944	Male	100.0	100.0
	Female	100.0	100.0
945-954	Male	100.0	100.0
	Female	100.0	100.0
955-964	Male	100.0	100.0
	Female	100.0	100.0
965-974	Male	100.0	100.0
	Female	100.0	100.0
975-984	Male	100.0	100.0
	Female	100.0	100.0
985-994	Male	100.0	100.0
	Female	100.0	100.0
995-1004	Male	100.0	100.0
	Female	100.0	100.0
1005-1014	Male	100.0	100.0
	Female	100.0	100.0
1015-1024	Male	100.0	100.0
	Female	100.0	100.0
1025-1034	Male	100.0	100.0
	Female	100.0	100.0
1035-1044	Male	100.0	100.0
	Female	100.0	100.0
1045-1054	Male	100.0	100.0
	Female	100.0	100.0
1055-1064	Male	100.0	100.0
	Female	100.0	100.0
1065-1074	Male	100.0	100.0
	Female	100.0	100.0
1075-1084	Male	100.0	100.0
	Female	100.0	100.0
1085-1094	Male	100.0	100.0
	Female	100.0	100.0
1095-1104	Male	100.0	100.0
	Female	100.0	100.0
1105-1114	Male	100.0	100.0
	Female	100.0	100.0
1115-1124	Male	100.0	100.0
	Female	100.0	100.0
1125-1134	Male	100.0	100.0
	Female	100.0	100.0
1135-1144	Male	100.0	100.0
	Female	100.0	100.0
1145-1154	Male	100.0	100.0
	Female	100.0	100.0
1155-1164	Male	100.0	100.0
	Female	100.0	100.0
1165-1174	Male	100.0	100.0
	Female	100.0	100.0
1175-1184	Male	100.0	100.0
	Female	100.0	100.0
1185-1194	Male	100.0	100.0
	Female	100.0	100.0
1195-1204	Male	100.0	100.0
	Female	100.0	100.0
1205-1214	Male	100.0	100.0
	Female	100.0	100.0
1215-1224	Male	100.0	100.0
	Female	100.0	100.0
1225-1234	Male	100.0	100.0
	Female	100.0	100.0
1235-1244	Male	100.0	100.0
	Female	100.0	100.0
1245-1254	Male	100.0	100.0
	Female	100.0	100.0
1255-1264	Male	100.0	100.0
	Female	100.0	100.0
1265-1274	Male	100.0	100.0
	Female	100.0	100.0
1275-1284	Male	100.0	100.0
	Female	100.0	100.0
1285-1294	Male	100.0	100.0
	Female	100.0	100.0
1295-1304	Male	100.0	100.0
	Female	100.0	100.0
1305-1314	Male	100.0	100.0
	Female	100.0	100.0
1315-1324	Male	100.0	100.0
	Female	100.0	100.0
1325-1334	Male	100.0	100.0
	Female	100.0	100.0
1335-1344	Male	100.0	100.0
	Female	100.0	100.0
1345-1354	Male	100.0	100.0
	Female	100.0	100.0
1355-1364	Male	100.0	100.0
	Female	100.0	100.0
1365-1374	Male	100.0	100.0
	Female	100.0	100.0
1375-1384	Male	100.0	100.0
	Female	100.0	100.0
1385-1394	Male	100.0	100.0
	Female	100.0	100.0
1395-1404	Male	100.0	100.0
	Female	100.0	100.0

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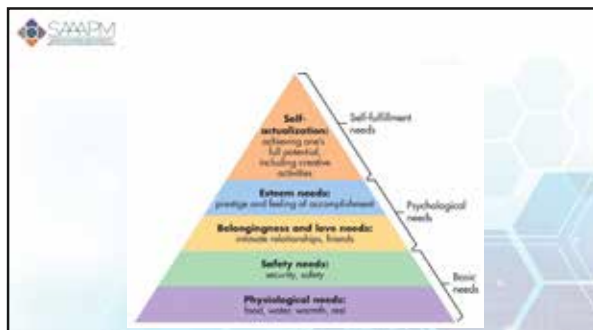
Identifying Resources & Building a Program

13

Building a Well-Being Program

- Creating a culture
 - Admitting that we are not always going to be ok
 - Encourage asking for help
- Program cannot be a narrow, one-size-fits all
 - Assessment of the program – wants and needs of individuals to be served by the program
- Multidimensional
 - Personal
 - Organizational components

14



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Time Banking



17

Time Banking

Impact	Pre, mean (SD)*	Post, mean (SD)*	P value
Control over time and resources	2.64 (0.12)	2.77 (0.11)	.158
Support for a culture of flexibility	2.99 (0.14)	3.23 (0.12)	.020
Support from colleagues for flexibility	3.67 (0.16)	3.61 (0.12)	.699
Wellness	1.89 (0.12)	2.13 (0.13)	.013
Understanding of professional development opportunities	2.96 (0.13)	3.24 (0.13)	.036
Institutional satisfaction	3.05 (0.12)	3.30 (0.10)	.020

Abbreviation: SD indicates standard deviation.

*All scales range in value from 1 (low) to 5 (high).

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Program Development

"Wellness is defined as a dynamic and ongoing process involving self-awareness and healthy choices resulting in a successful, balanced lifestyle"

Eckleberry-Hunt, J GME, 2009

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Peer Support



Figure 3. The Scott Three-Tiered Interventional Model of Second Victim Support. Adapted from Scott et al. (2018).

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Developing Peer Support

Five STEPS to Build a Peer Support Program

1. Assess the Need for Peer Support in Your Organization
2. Develop a Peer Support Program
3. Implement the Peer Support Program
4. Evaluate the Peer Support Program
5. Sustain the Peer Support Program

<https://edhub.ama-assn.org/steps-forward/module/2767766>

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Additional Resources from National/International Organizations

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Accreditation Council for Graduate Medical Education

ACGME AWARE

Now AWARE program available! The Impact of Resilience on Resident Well-Being during Pandemic. Listen to the entire Podcast Series on Spotify, Apple Podcasts, and YouTube.

Download the Web-Being App from the App Store or Google Play.

View the Digitized and Web-Being 360 Developmental Video Workshop.

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National Academy of Medicine

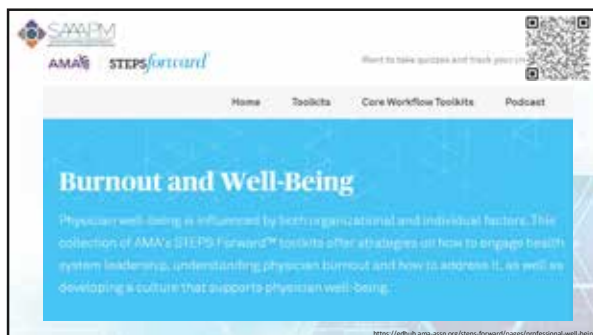
Action Collaborative on Clinician Well-Being and Resilience

Resources from the Clinician Well-Being Collaborative

More Resources

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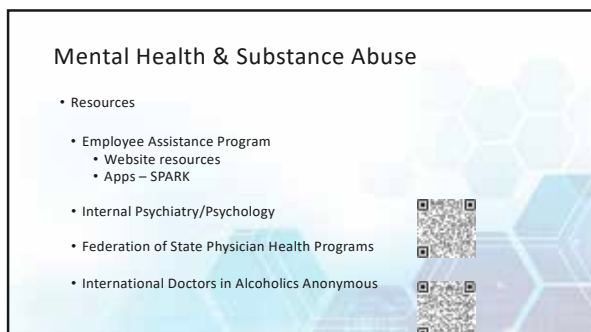
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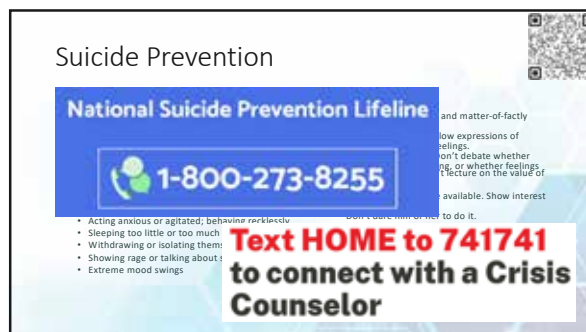
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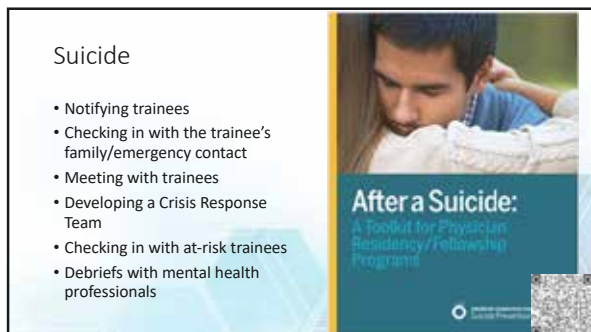
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Private Practice vs Academics: How to Succeed in Each

Magdalena Anitescu
Tjorvi E. Perry

Friday, November 5
1:30 PM - 2:15 PM

11/10/21

Private Practice vs Academics: How To Succeed in Each

Tjorvi E Perry, MD MMSc, Associate Professor, University of Minnesota
Magdalena Anitescu, MD, PhD, Professor, University of Chicago



1

Tjorvi E Perry

Sponsored Funding from Edwards LifeSciences: Early identification of right ventricular dysfunction and failure in cardiothoracic and liver surgical patients
UpToDate: Anesthetic management for enhanced recovery after cardiac surgery (ERACS)

Magdalena Anitescu

Consultant: Boston Scientific and Abbott
Fellowship Grants: Abbott, Medtronic, Boston Scientific
Sponsored Research: Abbott, Medtronic, NIH
Citizenship: Member at large, NANS and INS Board of directors, Past President WIN, Chair APPD, AASPD



2

Our Stories...



Tjorvi E Perry, MD, MMSc
 Associate Professor and
 Chief of Cardiothoracic
 Anesthesiology
 University of Minnesota
 Medical Center



Magdalena Anitescu, MD, PhD
 Professor and
 Chief of Pain Medicine
 University of Chicago



3

Academic Practice

- Tripartite mission: clinical, education, research + citizenship
- Clinical excellence
- Expertise in education
- How to succeed in research
- Get involved
- What to tell your fellows about world outside academic bubble
- Challenges



4

Private Practice

- Primary mission-clinical excellence
- Is there room for education?
- Can you do research?
- Getting involved in specialty/subspecialty
- Rotating residents/fellows
- Challenges



5

Topics for Discussion

Job Security **Interviewing**
Mentoring **Compensation**
Quality Work **Lifestyle**



6

How Well Do We Know our Fellows?

Doyle Lim

Ellen Choi

Jody Leng

Friday, November 5

1:30 PM - 2:15 PM

11/10/21



How Well Do We Know Our Fellows?

ELLEN CHOI, MD
JODY CIMBALO LENG, MD, MS
DOYLE LIM, MD, MMM

1

Disclosure

- ▶ No financial disclosures



2

Objectives

- Evaluate our own awareness of our fellows' experiences and challenges
- Learn tangible tools that PDs can use to get to know their fellows better
- Discuss ways to incorporate wellbeing discussions and lessons into fellowship didactics



3

Ground Rules

- ▶ Please use the chat and PollEV
- ▶ Video optional

@ Request at PollEv.com/6eyl6e725

"How Well Do We Know Our Fellows?" Poll #1

- ▶ Getting to Know Our Fellows
- ▶ Communication
- ▶ Wellbeing



4

Normal (pre-Covid) Considerations

- ▶ 12 month program
- ▶ Relocation
- ▶ Job search
- ▶ ABA APPLIED examination
- ▶ (Lack of) Social support system
- ▶ Size of fellowship and faculty
 - ▶ Smaller programs: more opportunities for repeated interactions
 - ▶ Larger programs: larger internal and external networks

@ Request at PollEv.com/6eyl6e725

"How Well Do We Know Our Fellows?" Poll #1



5

WHY should we get to know our fellows?

- GREATER ENGAGEMENT
- STRONGER RELATIONSHIP BUILDING
- MORE ADAPTABILITY
- LEADERSHIP OPPORTUNITIES
- REDUCED STRESS



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WHEN should we get to know our fellows?

Before they arrive: Post-match Email, onboarding

When they arrive: Welcome and Program Overview Expectations

Through the year: Fulfillment of expectations Adaptability

Respond at [Poll.ee.com/doi/teim725](https://poll.ee.com/doi/teim725)
 "How Well Do We Know Our Fellows?" Poll #1



7

Respond at [Poll.ee.com/doi/teim725](https://poll.ee.com/doi/teim725)
 "How Well Do We Know Our Fellows?" Poll #1



8

How do WE get to know our fellows?

- ▶ Pre-arrival bios
- ▶ Welcome and occasional Happy Hours
- ▶ Group wellness sessions
- ▶ Check-ins
- ▶ Fellow or departmental retreat
- ▶ Group exercise
- ▶ Commensality groups
- ▶ Stanford Well-Being Toolkit



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Communication

10

Communication

Respond at [Poll.ee.com/doi/teim725](https://poll.ee.com/doi/teim725)
 Poll #2 - Communication - "How Well Do We Know Our Fellows?"



11

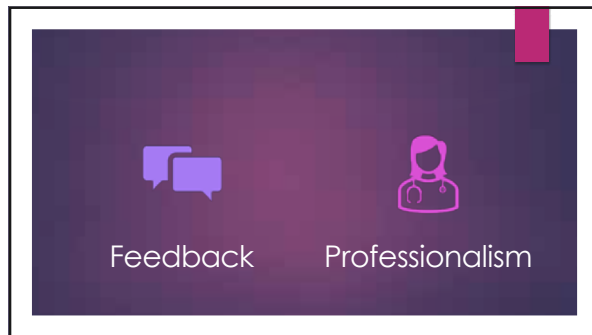
Social Media, Virtual Meetings and Texting

- Pre-op discussions
- Text vs Email
- Trainee text group
- Sharing information
- Zoom lectures



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11/10/21



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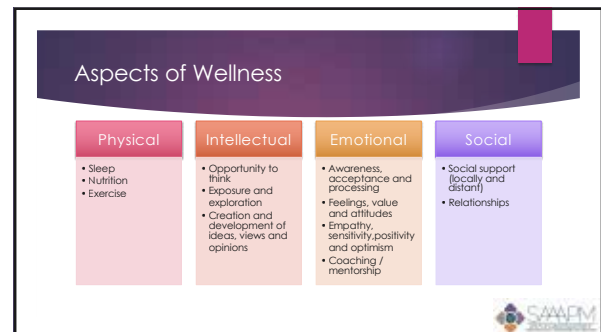
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Aspects of Wellness

Spiritual	Vocational	Financial	Environmental
- Religion - Personal values and beliefs - Sense of connection - Compassion	- Positive impact and purpose - Engagement - Feedback - Personal satisfaction and fulfillment	- Income and budget - Saving and retirement planning - Credit and debt management	- Safe and stimulating, pleasant surroundings - Work - Home - Nature



19

Resource Management



TIME



ENERGY



20

Wellbeing

Respond at PollEv.com/doiylim725

Poll #3 - Wellbeing - "How Well Do We Know Our Fellows?"



21

Questions and Discussion



22

thank you!

- ▶ Ellen Choi - echoi@dacc.uchicago.edu
- ▶ Jody Cimbalo Leng - cimbalo@stanford.edu
- ▶ Doyle Lim - doyle.lim@nemours.org



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How Well Do We Know Our Fellows? Tools and references

Use any of these tools and resources to help you introduce the topic of wellness and departmental support to your fellows

[Stanford Well-Being toolkit](#) - links to self assessment tools (for you and your fellows), wellbeing videos and webinars

[Commensality groups](#) - randomized trials suggest that meeting regularly in small groups to discuss specific aspects of wellness increases professional fulfillment in physicians

Wellbeing resource link - example on [Stanford Anesthesiology frequently used website](#), we added a “[GET HELP](#)” link in the top left corner with easy access to 24/7 mental health resources and other national support groups

[Crisis Management Plan](#) - spend a didactic session filling these out for yourself and your fellows, so they have time to think about their support resources before they experience a crisis

Suggested 4-step feedback tool:

- 1) Establish that you'd like to give feedback (ideally at a time when emotions are stable)
- 2) “I noticed”
- 3) “I’m concerned”
- 4) “What are your thoughts?”

Sample Housestaff Resources poster -->

Create and distribute a list of potential needs for trainees, such as mental health services, peer support, coaching, safe rides home, or who to contact in case of harassment or mistreatment



Sample wellness curriculum (bold items are ACGME requirements) - bottom sections are options the trainees can choose to include throughout the year

RAAPM fellow wellness curriculum

Session 1	Session 2	Session 3	Session 4
Introduction to Mindfulness	Setting healthy boundaries/overcome self-doubt	Physician depression, anxiety, and suicide	
Building your support network	Communication and Conflict Management	Substance use disorder recognition and education	
How/where to seek appropriate care for mental health			
Fatigue and sleep hygiene. Nutritional strategies to maximize performance and manage stress/energy	How to provide/seek feedback	Financial planning	Address Burnout, Stress, Peer Support, and Self-Compassion
Social media guidelines	Addressing microaggressions	Relationship health	Back slide (to find)

References

COVID specific

[Medical Student Education in the Time of COVID-19](#). Rose S.

JAMA editorial from late March 2020 discussing the medical student clerkship learning environment during COVID.

[Residency in a pandemic: How COVID-19 is affecting trainees](#). Murphy B.

AMA editorial from April 2020 discussing exhaustion, education, and the need for supervision and support during COVID.

[“We Signed Up for This!” — Student and Trainee Responses to the Covid-19 Pandemic](#).

Gallagher TH, et al.

NEJM editorial from June 2020 on medical student and trainee experiences during COVID-19. Interesting commentary from surveys including feelings of underutilization, dilemmas about balancing the need for procedure numbers with increased risk and being nonessential personnel, perceived risk to non-medical roommates.

[Addressing the Covid-19 Burden on Medical Education and Training: The Role of Telemedicine and Tele-Education During and Beyond the Pandemic](#). Sharma D, et al.

Lit review from November 2020 of medical student education during COVID-19. Interesting breakdown of students with various backgrounds and the challenges they may have faced, such as financial needs from family, subpar internet access or caregiving responsibilities.

Wellbeing specific

[Mayo Clinic Strategies To Reduce Burnout: 12 Actions to Create the Ideal Workplace](#).

Swensen S, Shanafelt T.

Collection of evidence driven methods for promoting wellbeing and “esprit de corps” among physicians in the workplace.

[10 Bold Steps to Prevent Burnout in General Internal Medicine](#). Linzer M, et al.

Steps include institutional support of wellbeing, improving work conditions with float pools and standardization of roles, career development opportunities and prioritization of physician self care.

[Charge nurse facilitated clinical debriefing in the emergency department](#). Rose S, et al.

Provides a debriefing tool for an organized approach to addressing emergencies or other situations. The basic assumption provided: “We believe that everyone participating in patient care is intelligent, capable, cares about doing their best and wants to improve.”

[An Evidence-based, Longitudinal Curriculum for Resident Physician Wellness: The 2017 Resident Wellness Consensus Summit](#). Arnold J, et al.

Provides a 17-module physician wellness curriculum for emergency medicine physicians, easily applicable to anesthesiologists.

[Dimensions of Wellness: Change your habits, change your life](#). Stoewen DL.

Although there are many attempts to break down the concept of wellness, they generally fall into the same aspects as described by Stoewen, among many others.

Social media specific

[Use of Smart Phones and Social Media in Medical Education: Trends, Advantages, Challenges and Barriers.](#) *Latif MZ et al.*

Results: "The use of personal smartphones for teaching and learning among medical community is highly prevalent and increasing day by day. Medical students use the mobile application for online textbooks (70%), medical podcasts (60%), medical calculator (75%), online lecture (50%) and notes taking (45%)."

[Social Media and Medical Education in the Context of the COVID-19 Pandemic: Scoping Review.](#) *Katz et al.*

Lit review of medical research involving social media platforms, concludes social media has "unique capabilities" for formal and informal medical education, especially during pandemic times.

[Are We Witnessing a Paradigm Shift?: A Systematic Review of Social Media in Residency.](#) *Economides et al.*

Lit review of medical research, discusses pros/cons of social media use in medical education, including potential detrimental impact on professionalism, augmentation of education, use in recruitment, use as a screening tool for applicants, and use as a platform for scholarship.

[Promote Education, Research, and Networking in Cardiac Anesthesia with Journal of Cardiothoracic and Vascular Anesthesia Social Media.](#) *Huang J et al.*

Editorial discussing the benefits of enhanced social media presence by Journal of Cardiothoracic and Vascular Anesthesia, including increased impact and promotion of articles.

[Professionalism and social media in pediatric anesthesia.](#) *David Greaney et al.*

Editorial discussing etiquette regarding use of social media with or about patients and families, including privacy concerns.

[Social media for the regional anesthesiologist: can we use it in place of medical journals?](#)

Tran BW et al.

Editorial discussing social media use in the regional anesthesia and acute pain medicine community. Concludes "mindful dialog, promotion of academic journals, and professional etiquette will help maintain a collegial environment."

[Dissemination of medical publications on social media - is it the new standard?](#)

Johannsson H, Selak T.

Discusses posting papers on social media as both an opportunity for rapid dissemination of knowledge and a risk of circulation of non-peer reviewed work.

[Gender differences in professional social media use among anaesthesia researchers.](#)

Demailly Z, et al.

Evaluates publications and determines female researchers in anesthesiology are less visible on social media.

[Healthcare practitioners' views of social media as an educational resource.](#) *Pizzuti et al.*

Survey of >1500 US healthcare workers, most of whom believed social media platforms could be an effective tool for medical education.

[Starting a fellowship wellness program or activity?](#)

Reach out to the moderators for further discussion: *Ellen Choi* (echoi@dacc.uchicago.edu)

Jody Leng (cimbalo@stanford.edu), *Doyle Lim* (Doyle.Lim@nemours.org)

Fellows Recruitment: What Does the Future Hold?

Edward Mariano
John Eck

Friday, November 5
1:30 PM - 2:15 PM

11/10/21

Fellowship Recruitment: What Does the Future Hold?

John B. Eck, MD
Duke University School of Medicine

Edward R. Mariano, MD, MAS, FASA
Stanford University School of Medicine

1

Disclosures

- None.

2

It's tough to make
predictions, especially
about the future.

King Burt

3



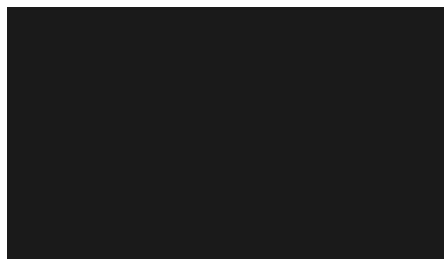
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In Person or Virtual Events



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The Video Tour



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Questions for Discussion

- Who is doing something similar?
- Who screens applications? PD, APD, core faculty, or administrative staff?
- How many interviewers? Does virtual vs. in-person make a difference?
- What objective data are programs interested in or using? If using exam scores, which ones (e.g., USMLE, ITE, ABA basic)?
- Who uses the standardized letter of evaluation (new AASPD version)?

7

Multi-institutional Collaborations: How Effective is it?

Erin Hennessey
Lindsey Loveland Baptist
Rebecca Dale

Friday, November 5
1:30 PM - 2:15 PM

11/10/21

Multi-institutional Collaborations: How Effective is it? A call for Anesthesia Fellowship Subspecialty Learning Exchange Platforms



Thank you for joining our session. Please join the Jamboard by using the QR code above.



Erin Hennessey, MD, MEHP
Associate Professor
Stanford University



Lindsey Loveland Baptist, MD, FASA
Associate Professor
University of Pennsylvania



Rebecca Dale, DO
Assistant Professor
University of Washington

1

Financial Disclosure

We do not have relevant financial relationships with commercial interests that pertain to the content of our presentation

2

Learning Objectives

1. Describe an example of an effective multi-institutional learning exchange program for fellowship programs
2. List key components of a multi-institutional collaboration that would benefit their training program
3. Describe positive outcomes for fellows and faculty that participate in a multi-institutional learning exchange program
4. Use resources from the session to start a multi-institutional collaboration program for their subspecialty

3

Workshop Overview

8 min LARGE GROUP PRESENTATION PLEX as an example with Dr. Dale	25 min LARGE GROUP: Introductions and Brainstorm on Jamboard	5 min KEY POINTS and SUMMARY Optional: Post workshop survey
--	--	--

We will be using Jamboard for this Session!



4

“Everyone knows more than you about something” – Adam Grant

How can interinstitutional didactics enrich your fellowship?

- > Case: The Pain Learning EXchange (PLEX)
 - Developed in response to COVID-19 lockdown
 - Flexed up and down in response to clinical activity
 - Takes advantage of medicine's newly found comfort with tele-technology



McPherson et al. Inter-Institutional Pain Learning EXchange (PLEX): Virtual Opportunities for Learning and Collaboration in Chronic Pain Fellowships During the COVID-19 Pandemic and Beyond. Pain Med. PMID:3393617

5

Pain Learning EXchange (PLEX)

What is it?

- > A simple semi-asynchronous lecture, Q&A and ever-expanding library
- > Given monthly by rotating participating programs
- > Lecture recorded and uploaded onto YouTube
- > Live Q&A held on 2nd Monday of the month

McPherson et al. Inter-Institutional Pain Learning EXchange (PLEX): Virtual Opportunities for Learning and Collaboration in Chronic Pain Fellowships During the COVID-19 Pandemic and Beyond. Pain Med. PMID:3393617

6

11/10/21

PLEX: Goals and Objectives

- > Offer networking opportunities for both fellows and faculty
- > Share ideas and practice styles across institutions
- > Expand the education of our fellows
- > Advance the careers of associate and assistant professors in the education tract
- > Have fun and experiment with Tele-learning, it is the wave of the future

7

PLEX: What it looks like

Name	Status	Date
Introduction to PLEX	Completed	11/10/21
PLEX Fundamentals	In Progress	11/10/21
PLEX Advanced Topics	Upcoming	11/11/21
PLEX Case Studies	Upcoming	11/12/21
PLEX Guest Lectures	Upcoming	11/13/21
PLEX Q&A Session	Upcoming	11/14/21

8

PLEX Library

Title	Author	Date
Introduction to PLEX	John Doe	11/10/21
PLEX Fundamentals	Jane Smith	11/10/21
PLEX Advanced Topics	John Doe	11/11/21
PLEX Case Studies	Jane Smith	11/12/21
PLEX Guest Lectures	John Doe	11/13/21
PLEX Q&A Session	Jane Smith	11/14/21

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PLEX Schedule

Topic	Date	Time
Introduction to PLEX	11/10/21	10:00 AM
PLEX Fundamentals	11/10/21	11:00 AM
PLEX Advanced Topics	11/11/21	10:00 AM
PLEX Case Studies	11/12/21	10:00 AM
PLEX Guest Lectures	11/13/21	10:00 AM
PLEX Q&A Session	11/14/21	10:00 AM

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PLEX: The good

Is it effective?

- > Does it meet its learning objectives?
- > Initial surveys sent out to assess collaboration, education and networking indicate it is very well received
 - Based on IDEA Partnership Success Rating Scale

Mohrland et al. Inter-Institutional Pain Learning Exchange (PLEX): Virtual Opportunities for Learning and Collaboration in Chronic Pain Fellowships During the COVID-19 Pandemic and Beyond; Pain Med. 2020;20(10):2000-2007

11

PLEX: Goals and Objectives

- > Offer networking opportunities for both fellows and faculty
- > Share ideas and practice styles across institutions
- > Expand the education of our fellows
- > Advance the careers of associate and assistant professors in the education tract
- > Have fun and experiment with Tele-learning, it is the wave of the future

12

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PLEX: The bad and the ugly

3 main barriers

- > Time Zone and live scheduling
- > Zoom fatigue
- > Administrative support

13

PLEX: learn more about it

- > [SEA Podcast](#): Innovations in Anesthesia Education: Episode 8: Pain Learning Exchange (PLEX)
- > Twitter account: @didacticPLEX

14

**CCLEX, OBLEX, CTLEX: Is it right for your specialty?**

- > Does your fellowship/specialty have something similar already?
- > Would your specialty be interested in developing a multi-institutional program?
- > Could your programs overcome the barriers?

TIME FOR THE BREAKOUT - Please join the breakout session of most interest to you. Please link to the jamboard to find the frame that corresponds to your breakout group.



15

**Summary and Take Homes**

1. Multi-institutional collaborations for fellowship training programs can be effective for fellows and faculty when tailored to the needs of the specialty
2. Cross-specialty networking and administrative support from national society groups can ease some of the barriers to initiating this platform
3. Key components of the program that were noted to be beneficial to your group is a great place to start
4. Learning exchange programs can take your program above and beyond the minimal didactic requirements set forth by ACGME and offer a component of networking and sense of community beyond your own institution

16

Please consider taking our post-workshop survey

Questions?
erinkh@stanford.edu
lovelandbl@chop.edu
rdale@uw.edu

Thank you for your active participation in this workshop!



17

Updates from the Subspecialties: Regional Anesthesiology and Acute Pain Medicine

Edward Mariano

Friday, November 5
3:00 PM - 3:07 PM

11/10/21

Updates from Regional Anesthesiology and Acute Pain Medicine

Edward R. Mariano, MD, MAS, FASA
Professor of Anesthesiology, Perioperative & Pain Medicine
Stanford University School of Medicine
Chief, Anesthesiology and Perioperative Care
Veterans Affairs Palo Alto Health Care System



1

Disclosures

- None.

2

History article

History and evolution of regional anesthesiology and acute pain medicine fellowship training

David Michael Shapiro, MD, Mary J Hargett, MD, Sandra Kopp, MD, Joseph M Neis, MD, Edward R Mariano, MD, Gregory Liguori, MD
RAAPM 2020;45:311-314

Table 1: Early official RA/PPM fellowships by decade

1960s	1970s
Brigham and Women's Hospital	Duke University
Hospital for Special Surgery	University of Illinois
Mayo Clinic Rochester	University of Texas Health Science Center at Houston
Virginia Mason Medical Center	Yale University

Table 2: Evolution of anesthesiology training over time

Year of training	1	2	3	4	5
1960	1 year	2 years	3 years	4 years	5 years
1970	1 year	2 years	3 years	4 years	5 years
1980	1 year	2 years	3 years	4 years	5 years
1990	1 year	2 years	3 years	4 years	5 years
2000	1 year	2 years	3 years	4 years	5 years
2010	1 year	2 years	3 years	4 years	5 years
2020	1 year	2 years	3 years	4 years	5 years

3

The road to accreditation for fellowship training in regional anesthesiology and acute pain medicine

Edward R. Mariano, MD and Richard W. Browne, MD

- 2013 (May): Fellowship Directors agreed to pursue ACGME accreditation
- 2013 (Dec): Letter submitted to Dr. Nasca (CEO)
- 2014 (Sept): ACGME approval to develop subspecialty program in RAAPM
- 2015-16: Development and revision of program requirements
- 2016: ACGME opened applications for RAAPM
- 2017-18: Milestones development

4

Today (2021)

- >90 RAAPM fellowships in US and Canada
- >200 positions available in the US and Canada

<https://www.asra.com/the-asra-family/trainees/fellowship-directory>

5

ACGME-Approved Programs (39)

+4 from November 2020

Accreditation Council for Graduate Medical Education (ACGME) - Public

List of Programs by Specialty

List of programs within a particular specialty for current students and those newly approved programs with future effective dates (See specialty page for details).

Specialty: (Include Programs with a Pivotal Accredited status to report)

Programs approved and active (as of 10/1/2021) 39

View Programs

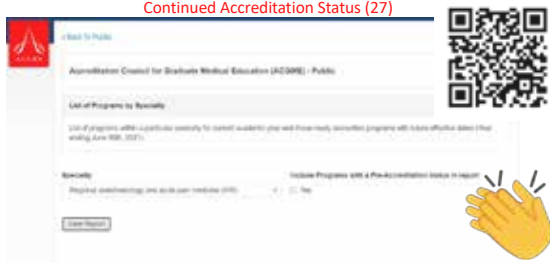
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11/10/21

@EMARIANOMD

ACGME-Approved Programs (39)

Continued Accreditation Status (27)

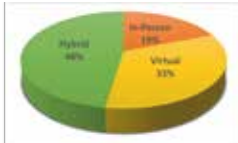


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@EMARIANOMD

Fellowship Directors Group

- Started in 2002 and has remained informal
- Twice-yearly meetings (ASA and ASRA Spring)
- Initiatives:
 - Development of Fellowship Training Guidelines
 - Knowledge/Practice Sharing
 - Common Application
 - ACGME Accreditation
 - Interviews for 2021-22 (n=21)



8

@EMARIANOMD

“Regional anesthesia is a vital skill for any anesthesiologist and ultrasound-guided techniques have enhanced our ability to achieve effective and consistent blocks. It is important that we ensure our graduating residents have the requisite skills to perform basic regional techniques in a safe and effective manner in order to disseminate the benefits of regional anesthesia to the broader surgical population.”



McCortney & Mariano, RAPM 2016

9

@EMARIANOMD

Non-Fellowship regional anesthesia training and assessment: an international Delphi study on a consensus curriculum



Anesthetical region	Number of blocks (Median 2020)
Regional blocks for shoulder and upper arm surgery	10-20 (10-15)
Regional blocks for elbow, forearm, wrist and hand surgery	10-20 (10-15)
Regional blocks for hip and upper leg surgery	10-20 (10-15)
Regional blocks for knee, lower leg, ankle and foot surgery	10-20 (10-15)
Thoracic/Thorax blocks	10-20 (10-15)
Abdominal/Abdominal blocks	10-20 (10-15)
Genitourinary/Genitourinary blocks	10-20 (10-15)
Neurological/Neurological blocks	10-20 (10-15)
Other/Other blocks	10-20 (10-15)

Chuan, et al. RAPM 2021

10

@EMARIANOMD

7 Principles of Perioperative Pain Management

1. Conduct a preoperative evaluation to identify assessment of needs of all patients, including assessment of comorbidities, history of previous pain, assessment of chronic pain, and assessment of previous pain management plans.
2. Use a validated pain assessment tool to track responses to postoperative pain treatments and adjust treatment plans accordingly.
3. Offer multimodal analgesia, for the use of a variety of analgesic medications and techniques combined with non-pharmacological interventions, for the treatment of postoperative pain in adults.
4. Provide patient and family education, including patient education on the patient (and/or responsible caregiver) to having their pain assessed and treated appropriately, and document the plan and goals for postoperative pain management.
5. Provide education to all patients (and/or responsible caregiver) on the pain management plan, including ongoing education and the goal of reliable pain reporting of analgesic after hospital discharge.
6. Adjust the pain management plan based on assessment of pain in the patient and/or responsible caregiver.



Chuan, et al. RAPM 2021

11

@EMARIANOMD

2021 ASA-hosted Pain Summit involving 13 other surgical and medical organizations



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Updates from the Subspecialties: Critical Care Medicine

Erin Hennessey

Friday, November 5
3:07 PM - 3:14 PM

Updates from the Subspecialties: Pain Medicine

Magdalena Anitescu

Friday, November 5
3:14 PM - 3:21 PM

11/10/21

THE UNIVERSITY OF CHICAGO MEDICINE

Updates on Pain Medicine 2022

Magdalena Anitescu, MD, PhD
Professor of Anesthesia and Pain Medicine
Program Director, Pain Medicine
Department of Anesthesia and Critical Care
University of Chicago Medicine

1

Pain Medicine Programs-2022-23

- Total for 2022 programs: 110, 1 withdrawn programs
- Participating (certified) in match: 109, 99% participation
- Filled: 98 (89.9%), Unfilled: 10 (10.1%)



THE UNIVERSITY OF CHICAGO MEDICINE

2

Pain Medicine Positions-2022-23

- Total for 2022 positions: 378 positions
- Filled: 362 (95.8%), unfilled 16 (4.2%)



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3

Applicants

- Applicants for 2022 : 428
- Matched: 362 (84.5%)
- Not matched: 66 (15.4%)

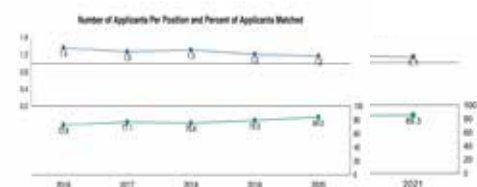


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Positions and applicants

- Stable from 2018:
– 1.13 applicants per position



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The applicants

Year	Program	Positions	Filled	% not matched	%US Grad	% FMG	Osteopaths	US International
2014	82	261	256	36	73	8	9	10
2015	84	286	286	27	69	9	14	7
2016	90	305	303	37	71	10	14	5
2017	93	316	309	23	70	9	15	6
2018	98	335	331	24	61	8	14	7
2019	103	359	345	21	65	11	16	8
2020	104	367	361	15	69	4	17	10
2021	102	349	337	15	64	5	19	11
2022	109	372	362	15	64	6	21	8

THE UNIVERSITY OF CHICAGO MEDICINE

Presentation Title Here | 6

6

11/10/21

Activities in last year

- Trimestrial meetings for the APPD board and monthly for AASPD board
- Emails to programs from APPD to discourage out of match activities
- Bi-annual virtual meeting with all PD to keep all engaged and bring problems to discuss
- Web based educational endeavors for fellows and residents: hot topics, AAPM, NANS, INS webinars
- Virtual interviews continue
- Residents activities: in person and virtual meet and greet with PD, engage medical students
- Slowly open up for in person meetings



Presentation Title Here | 7

7

To start a possible reversed process



- Social distance, masks and virtual meetings



Presentation Title Here | 8

8

To a masked new reality



Presentation Title Here | 9

9

What continues

- Encourage programs to keep in match
- Virtual interview for foreseeable future
- Ensure competence upon graduation: PD review case log
- Supportive and networking for job finding
- Expand fellowship education on telemedicine.



Presentation Title Here | 10

10

ACGME vs NRMP

- ACGME: 111 programs
- NRMP: 109 programs,
- % programs in match: 98%



Presentation Title Here | 11

11

Pain Medicine Fellowship-2019 Program Requirements

- Multidisciplinary fellowship
- Base specialties
 - Anesthesiology
 - Physical Medicine and Rehabilitation
 - Neurology
 - Psychiatry
- Other specialties can apply: ED, pediatrics, radiology, etc
- 1 Fellowship Program per institution no longer required



Presentation Title Here | 12

12

11/10/21

CONCLUSIONS

- Consistent, high competitive fellowship 15% applicants not matching
 - Steady state of the match, now the 9th year.
 - Advantages/Disadvantages
 - Applicants:
 - Apply/interview widely,
 - Fear of no match
 - Virtual interviews
 - Extracurricular activities to serve the application best possible
 - Program directors
 - Many applications/Time consuming
 - No objective data
 - Short Time of the interview
 - Virtual at times difficult
 - Programs
 - Potential more
 - Quality of Education
 - Institutional resources
 - Few programs created since new req.
- Building a community of pain PD with similar aspirations for their incoming trainees

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THANK YOU
FOR
LISTENING!



14

Updates from the Subspecialties: Pediatric Anesthesiology

Justin Lockman

Friday, November 5
3:21 PM - 3:28 PM

11/10/21



Pediatric Anesthesiology

Justin L. Lockman, MD, MSED
 PAPDA President
 LockmanJ@CHOP.edu

November 2021
 Virtual SAAAPM Meeting

1

Disclosures



- None

2

Objectives



- By the end of this discussion, the learner will be able to:
 - Understand important fellowship issues for pediatric anesthesiology
 - Review Pediatric Anesthesia Match data for 2021 Match
 - Discuss the Society for Pediatric Anesthesia GME Task Force

3

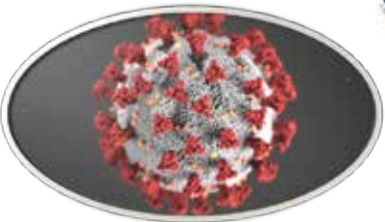
PAPDA Board of Directors



- President – Justin Lockman (CHOP) 
- President-elect – Concetta Lupa (UNC) 
- Secretary/Treasurer – Doyle Lim (Nemours/A.I. DuPont) 
- At-Large Members – Jennifer Lau (CHLA) 
 William Waldrop (TCH) 
 Joseph Sisk (OU) 
- Past-President – Franklyn Cladis (Pittsburgh) 

4

Pediatric Anesthesiology: Past year

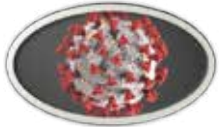



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Pediatric Anesthesiology: Past year



- Virtual lectures?
- Hybrid conferences?
- Boot camps?
- Recruitment?
- Graduation?
- Wellness?



6

11/10/21

Pediatric Anesthesiology: Past year



- National pediatric anesthesia fellow journal club
 - Launched Spring 2021
 - Will continue!

7

Pediatric Anesthesiology: Past year



- Program Director professional development
 - Combined journal club with PDs and fellows annually (started 2021)
 - Enhanced communication through WhatsApp group/chat
 - Quarterly PD virtual happy hours – now discontinued
 - Was planning a live workshop for this meeting; defer to 2022

8

A small sample of publications...



9

Pediatric Anesthesiology: Past year



- National Pediatric Anesthesia Fellow Graduate Survey
 - Completed June 2021
 - Included:
 - Demographic data
 - Career plans
 - Scholarly activity
 - Thoughts about ABA exam timing
 - Match input

10

Pediatric Anesthesiology: Past year



- Pediatric Cardiac Anesthesia
 - ACGME accreditation process in development
 - PAPDA membership extended to peds cardiac PDs

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Pediatric Anesthesia 2022 Match



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11/10/21

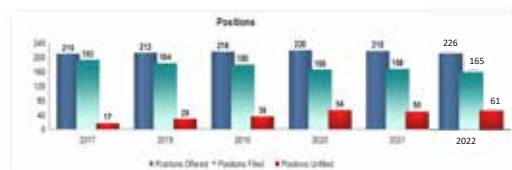
Pediatric Anesthesia 2022 Match



- ERAS opens in December; interviews start in April
 - Agreed upon match exceptions (but not binding):
 - International (non LCME-medical school) graduates, separately funded
 - Military applicants, separately funded
 - Advanced fellowship positions (with at least 24-month contract signed with offer letter)
- SF match?

13

ERAS & Match Data



Positions increasing due to BOTH new and expanding programs
~120 positions in 2010

Source: NRMP.org

14

ERAS & Match Data

Ideal Ratio > 1

Fellowship Start Year	2015	2016	2017	2018	2019	2020	2021	2022
Applicant/Position Ratio	1.12	1.1	0.98	0.89	0.85	0.81	0.81	0.74
Match Acceptance	86%	86%	93%	97%	98%	93%	94%	99%

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Unconscious Bias Training



- For:
 - Application screeners
 - Interviewers
 - Faculty
 - Fellows
- One source of free (and high quality) education*: <http://kirwaninstitute.osu.edu/implicit-bias-training/>

*not officially endorsed by PAPDA



16

Standard Letter of Evaluation (SLOE)



- PAPDA working on this for year
- Need YOUR support to convince AACPD to start using it!



17

Society for Pediatric Anesthesia GME Task Force



- Multi-year process looking at current and future training requirements, market forces, sub-specialty training, curriculum design, and more
- Developed concrete recommendations for change (approval votes to occur this month)
- Look for publication of these results in the next few months

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11/10/21

Questions?



LockmanJ@CHOP.edu

Thank you!

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Updates from the Subspecialties: ACTA

Douglas Shook

Friday, November 5
3:28 PM - 3:35 PM

11/10/21

ACTA UPDATE

Douglas C. Shook, MD, FASE
Chief, Division of Cardiac Anesthesia
Department of Anesthesiology
Brigham and Women's Hospital

1

DISCLOSURES

Edwards Lifesciences – Education, Consultant
Baylis - Education

2

GREATEST STRENGTH



3

MATCH UPDATE 99% OF POSITIONS



4

PROGRAM DATA FROM SF MATCH

	June 2013	June 2014	June 2015	June 2016	June 2017	June 2018	June 2019	June 2020	June 2021
# of Participating Programs	54	55	57	60	64	64	66	70	71
Positions Offered	168	174	183	199	207	212	224	239	247
Positions Filled	166	172	182	199	202	211	222	238	245
Unfilled Positions	2	2	1	0	5	1	2	1	2

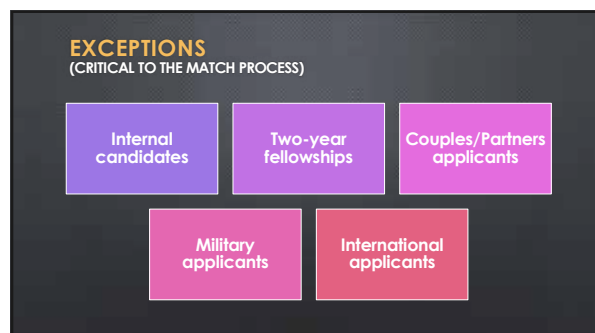
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APPLICANT DATA FROM SF MATCH

	June 2013	June 2014	June 2015	June 2016	June 2017	June 2018	June 2019	June 2020	June 2021
Applicant registrations	267	268	268	331	316	354	333	363	361
# Applicant Rank Lists Submitted	230	213	211	258	258	276	292	330	279
Matched Total	166	172	182	199	202	211	222	238	245
Unmatched Total	64	41	29	59	56	65	50	60	34
Applicant Matching % (Overall)	72%	81%	86%	77%	78%	76%	76%	72%	87%

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11/10/21

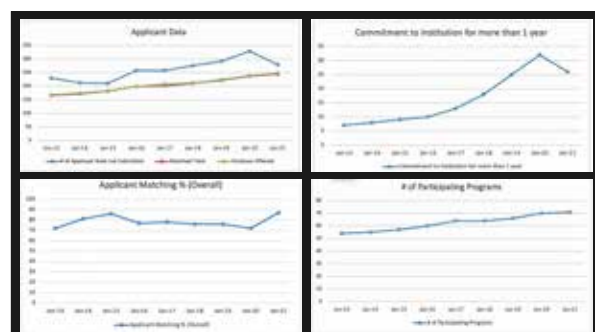


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EXCEPTIONS FROM SF MATCH

	June 2013	June 2014	June 2015	June 2016	June 2017	June 2018	June 2019	June 2020	June 2021
Internal candidate	31	46	21	21	27	23	33	33	30
Two year commitment	7	8	9	10	13	18	25	32	29
Active military	3	1	0	0	1	2	2	1	1
Spouse/partner	1	0	1	0	0	0	1	0	2
Residency outside US	0	1	0	1	2	1	1	1	2

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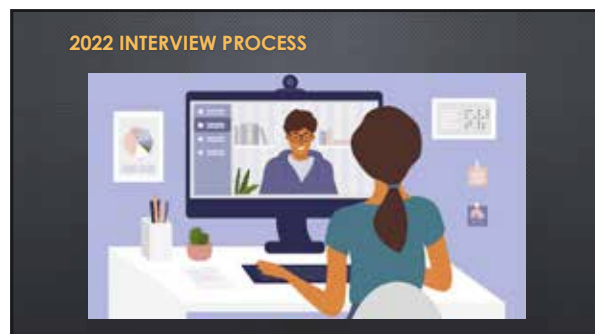


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APPLICANT TIMELINE

November 8, 2022	Applicant registration begins.
March 2, 2022	Target Date for applicants to complete the requirements for application distribution.
June 2, 2022	ALL rank lists must be submitted.
June 9, 2022	Match results are made available.
June 10, 2022	Unmatched position posted.
July 2023	ACTA training begins.

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11

INITIATIVES 2021-2022

- DATA ON APPLICANTS
- VIRTUAL INTERVIEW PROCESS
- 2-YEAR APPLICANTS
- EDUCATION
- ABA CERTIFICATION

	June 2019	June 2020	June 2021
Applicant registrations	333	363	361
# Applicant Rank Lists Submitted	292	330	279

12

11/10/21

INITIATIVES 2021-2022

- DATA ON APPLICANTS
- VIRTUAL INTERVIEW PROCESS
- 2-YEAR APPLICANTS
- EDUCATION
- ABA CERTIFICATION



13

INITIATIVES 2021-2022

- DATA ON APPLICANTS
- VIRTUAL INTERVIEW PROCESS
- 2-YEAR APPLICANTS
- EDUCATION
- ABA CERTIFICATION



14

INITIATIVES 2021-2022

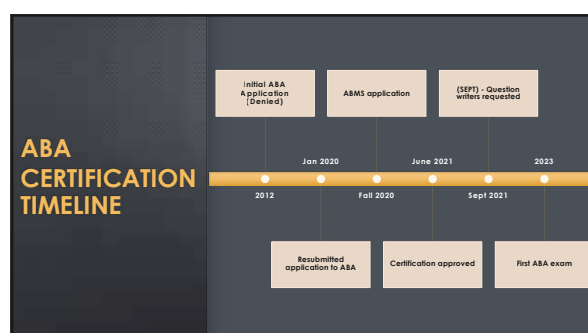


ABA APPROVED TO OFFER
SUBSPECIALTY CERTIFICATE IN ADULT
CARDIAC ANESTHESIOLOGY

- NBE only exam
- Top 10 cardiac hospitals have fellowships
- Match data helpful

ABA CERTIFICATION

15



16

THANK YOU!



dshook@bwh.harvard.edu @DouglasShookMD

17

Updates from the Subspecialties: OB Anesthesia

Andrea Traynor

Friday, November 5
3:35 PM - 3:42 PM

HANDOUT



Developing an Online Presence

Rena Gresh

Friday, November 5
11:00 AM - 11:15 AM

HANDOUT



Test Taking

Rachel Moquin

Friday, November 5
11:15 AM - 11:30 AM

11/10/21



SNAP Talk: Diagnosing Exam Breakdowns--Questions to ask to inform action plans

Rachel Moquin, EdD
Director of Learning and Development
Department of Anesthesiology

1

Opening, Introductions

- Introduction
- Opening Reflection:
 - Stop and jot: Describe yourself as a test-taker.

2

Exam Failure

KEY IDEA: It is unclear if performance on exams correlates with performance in practice

HOWEVER: Passing exams is a necessary component of Board Certification and is often a key measure in determining resident competence during training (AKTs, ITEs, etc.) *for now

SO: It is important to appropriately support residents experiencing exam struggles



3

We Often Sound Like...

These responses are intended to be helpful, but do not allow us to identify potential root causes of struggle and are not tailored to individual needs to address the root causes.

- “Make a study plan.”
- “Use a different resource.”
- “What’s your learning style? Use a resource that fits that.”
- “Plan to study more this time.”
- “Go through the question bank again.”

4

What Could Go Wrong: Test-taking Skills

- Approach to individual questions
- Approach to exam as a whole
- Navigating questions they don’t know
- Navigating questions they are unsure about
- Annotation strategies
- Time management during exam/pacing
- Focus/stamina during lengthy exams

5

What To Ask, What To Do

- Key Questions
- Recommendations

6

11/10/21

What Could Go Wrong: Disconnect Between Study and Practice

The Forgetting Curve

80% remembered after 10 minutes, but 10% after 1 hour, and 10% after 1 day.



7

What To Ask, What To Do

- Key Questions
- Recommendations

8

What Could Go Wrong: Test Anxiety

- Can occur in weeks leading up to exam or only on the day of
- Impacts memory, focus, **self-efficacy**
- Both mental and physical manifestations
- Compounded after failure



9

What To Ask, What To Do

- Key Questions
- Recommendations

10

What Could Go Wrong: Inefficient/Ineffective Study Habits

- Access to quality resources
- Use of resources
- Variety of resources accessed
- Variety of input types represented
- Timing of resource use (i.e. how are their resources working together-- **are they** working together?)

11

What To Ask, What To Do

- Key Questions
- Recommendations

12

11/10/21

What Could Go Wrong: Time Management/Self Management Strategies

- Organization
- Systems/routines
- Self-awareness
- Self-management
- Realistic expectations
- Balance of work/personal



13

What To Ask, What To Do

- Key Questions
- Recommendations

14

HANDOUT



“2021 Pronouns” – Not What I Learned in 6th Grade Grammar!

Callie Keller

Friday, November 5
11:30 AM - 11:45 AM

11/10/21



2021 PRONOUNS: NOT WHAT I LEARNED IN 6TH GRADE GRAMMAR

Callie Keller
University of Virginia Anesthesiology
Education Programs Administrator

1

DISCLOSURES

- > I am NOT an expert in this field
- > I still stick my foot in my mouth often without intention
- > I believe that educating oneself is the first step in changing ingrained behaviors and speech patterns




2

WHY ARE PRONOUNS IMPORTANT

- ❖ Using the proper pronouns is a sign of respect for another person
- ❖ Pronouns are an important social dynamic in how one identifies in their environment
- ❖ Addressing someone by their preferred pronouns shows that you are an inclusive and accepting individual – even trying shows effort!
- ❖ Traditional She/Her & He/Him pronouns reflect a binary gender society
- ❖ Gender today exists on a much broader spectrum, so our use of pronouns needs to reflect the many diverse ways individuals can choose to identify
- ❖ Creating an Inclusive Environment and Community

3

GENDER PRONOUNS: TRADITIONAL AND NEUTRAL

Subjective	Objective	Possessive adjective	Possessive pronoun	Reflexive	Pronunciation
She	Her	Her	Hers	Herself	pronounced as it looks
He	Him	His	His	Himself	pronounced as it looks
It	It	Its	Its	Itself	pronounced as it looks
Us/We	Us	Our	Ours	Ourselves	pronounced: see, here, hah, hares, hahself
Us	Us	Our	Ours	Ourselves	pronounced: see, here, here, here, here, here
It	It	Its	Its	Itself	pronounced: A, M, see, see, see, see
Her	Her	Hers	Hers	Herself	pronounced as it looks
They	Them	Their	Theirs	Themselves	pronounced as it looks

4

LET'S PRACTICE....

❖ Hi, my name is Callie, my pronouns are she/her/hers, and I'm the Education Programs Administrator at UVA! **YOU TRY...**

❖ Ever in doubt – just address someone by their name and if you don't know it, you can use they/their in the singular form as a gender neutral pronoun.

EXAMPLE:

They/Them/Their/Theirs
They go to the store. I bought them a soda. That's their soda. That's theirs.

YOU TRY...

(Fred/Wilma) is our new intern and _(they)_ think _(they)_ want to specialize in Cardiac Anesthesia, but it's just _their_ first month, so there is a high probability that _they_ will change their mind!



5

WHAT YOU CAN DO TODAY

- ❖ Share your pronouns in your email signature, Zoom name, and introductions
- ❖ When introducing yourself to someone, use your chosen name and pronouns
- ❖ Provide opportunities for your trainees to share their pronouns
- ❖ It's always safe to use someone's name if you are unsure of what pronouns they use
- ❖ Apologize if you misgender someone, at least you tried
- ❖ Practice using nonbinary pronouns in your daily conversations so it becomes part of your normal speech

6

11/10/21

REFERENCES

1. <http://showyourlovetoday.com/>
2. University of Virginia Multicultural Student Services/LGBTQ Center;
<http://LGBTQ.Virginia.edu>
3. www.forge-forward.org

**KINDNESS MATTERS in ALL Forms**

7

8

HANDOUT



Documentation in Case of Litigation

Carolyn Iezzi

Friday, November 5
11:45 AM - 12:00 PM

11/10/21

How to Document in case of Litigation

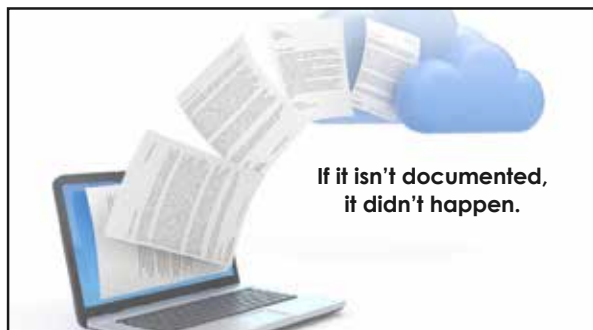
Presented by: Carolyn Iezzi

1

Conflict of Interest Disclosure

- ▶ **Speaker:** Carolyn Iezzi
- ▶ **Disclosure to the Learner:**
 - ▶ Not a documentation expert: Giving examples and experiences I have had in my 8 years as a Program Coordinator and what I have learned
 - ▶ Still learning different avenues, etc. with documentation
 - ▶ Technology for Documentation is ever changing

2



3

Why Documentation is Important

- Ensures all parties have a clear understanding of expectations, policies, procedures
- Outlines how to address any issues and expectations moving forward
- Provides Evidence of knowledge of expectations and opportunities given to correct issues

4

Documentation of Policies, Procedures and Expectations during Training

Key Reminders:

- If it isn't written down, they don't know
- Have all policies, procedures and expectations clearly stated in a Program Manual, updated regularly.
- Have both Program Director and Trainee sign acknowledgement of review of Manual, initials on each page
- Provide Policies and Procedures in an electronic file that can be accessed 24/7 (prevents the "I forgot/I couldn't find" excuse)

5

Get Everyone on Board

Challenges: Many Faculty/Staff fear putting things in writing

Reasons:

- Fear of repercussions/ broken working relationship
- Not enough training on how to document and why it's important
- Doubt in their observation
- Assumption that it was a one time thing/bad day for the trainee

6

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Solutions:

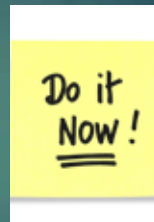
- Provide training for faculty/staff on importance of documentation
- stress the importance of trainees needing feedback (good or bad) and why
- explain how documentation doesn't have to be negative, show how it can be positive and constructive
- train faculty and staff how to give constructive criticism and how to properly document
- Remind faculty/staff the expectation of working at a teaching institution, feedback and documentation is expected
- Note:** expectations, policies and procedures should also be given to faculty/staff
- send when hired and yearly reminder



7

Document it Immediately

- ensures nothing is forgotten
- ensures proper time frames/documentation is as accurate as possible



8

Types of Documentation and Sources to get the Job Done



9

DocuSign

Reason to use it:

- legally binding in most cases
- DocuSign confirms it is in full compliance with the privacy and security requirements of HIPAA and its service meets HHS standards for digital signatures.

What to use it for:

- offer letters
- contracts
- program manuals
- evaluation reviews



10

Use your calendar

- one-off conversations (can be important later on)
- appointments (exams, Dr., wellness, etc.)
- all off days and reasoning
- deadlines (prevents the "I forgot/I didn't know" excuse)



11

Take Note

When to use it

- meetings
- conversations



12

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"Per our Conversation"

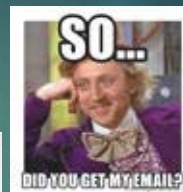
No, you're NOT a Karen!



1. Allows both parties to agree on what was discussed
2. Prevents confusion of expectations
3. Provides a detailed review of what was discussed
4. Always
5. save to files

13

Read Receipt



- documentation individual has read/acknowledged the email and it's contents
- nudge the recipient to respond
- if not read, possibility of direct disregard, other action needs to be taken

14

Electronic Files



- Provides HouseStaff access to their files 24/7, meeting ACGME requirements
- Provides all evaluations, milestones, documentation within reach to program and trainees
- Allows more documentation compared to paper files
- Easier to save items

Notes: Make sure trainee is marked as "Read Only" to prevent editing of documents

15

Three's Company



16

Why three?

- prevents he said she said
- allows meeting minutes/notes to be taken for documentation
- provides professional feedback/discussions

Note: Try having an agenda sent out for every meeting. Allows both parties to know what will be discussed and prevents the meeting from going off the topic

-also allows both parties to contribute to meeting discussion

Follow-up with an email detailing meeting discussion, minutes and outcome

Goal: Be specific in expectations and communication, be detailed, take notes

17

ZOOM Recording



- great feature for meetings
- prevents any confusion/argument of what was discussed

Note: be mindful of what is discussed/said "other people are listening"

18

11/10/21

Screen Shot



Ways of Communications have changed within programs and texting is now a regular form of communication within programs.

-always screenshot discussions, reminders, etc. and save to their files

19

Who to consult when issues arise

- ACGME
- DIO
- Choir
- Chiefs
- ABA
- Institution Legal/ Team
- HR
- Clinical Competency Committee

Note: still make sure to have everything in writing, meeting minutes should be taken on all meetings, per our conversation e-mail follow-ups with phone conversations

20

In Summary



21

Utilizing a Learning Management System to Support Anesthesiology Education: Recommendations and Best Practices

Ashley Grantham

Friday, November 5
12:00 PM - 12:15 PM

11/10/21



Utilizing a learning management system to support anesthesiology education: Recommendations and best practices

Ashley Grantham, PhD, MA
Duke Anesthesiology

1



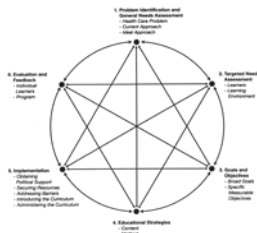
Learning objectives

- At the end of this session, participants will be able to:
 - List possible uses for a learning management system (LMS) to support anesthesiology education
 - Describe best practices for implementing a LMS in an anesthesiology department

2

Six-step approach to curriculum development

1. Problem identification and general needs assessment
2. Targeted needs assessment
3. Goals and objectives
4. Educational strategies
5. Implementation
6. Evaluation and feedback



(Thomas et al, 2016)

3



What is an LMS?

"Comprehensive, integrated software that supports the development, delivery, assessment, and administration of courses in traditional face-to-face, blended, or online learning environments"

(Wright et al, 2014)

4



Needs assessment



Wanted a Duke-supported and/or low-cost tool



Needed easy to use options for faculty and learners



Needed an interactive platform that could be used for various levels of learners

5



Implementation

- Created Sakai sandboxes (educator + faculty pilot user)
- Established partnership with Duke Learning Innovations (DLI)
- Agreed on pilot projects and timelines
- Established project teams
 - Education specialist
 - DLI instructional technology staff
 - Fellowship program coordinators
 - Faculty education leaders

6

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Projects to date

- Medical student education
 - ANES 440-C (Clinical Anesthesiology)
- Fellowship education
 - ACTA
- Continuing education
 - Morpheus Perioperative online programs
- Faculty development

7

E-learning examples

8

Projects in progress

- Medical student education
 - CTICU rotation
- Fellowship education
 - TEE training
 - Critical care fellowship
- Scoping continuing education project focused on nutrition

9

Recommendations and best practices

- Develop curriculum first, then determine opportunities for online instruction
- Let learning needs, not technology, drive the process
- Examine existing resources at your institution, partnering when necessary
- Identify faculty who are interested in learning new skills or innovative instructional methods

10

Recommendations and best practices

- Identify areas that might benefit from online education resources
 - High priority topics and/or programs
 - Areas that would benefit from additional organization and/or structure
 - Areas where your institution or program shines
- Utilize LMS to reduce administrative burden
- Involve coordinators in trainings and consultations with learning technology staff
 - Great way to learn new skills!

11

References

- Thomas, P. A., Kern, D. E., Hughes, M. T., & Chen, B. Y. (Eds.). (2016). Curriculum development for medical education: A six-step approach. JHU Press
- Wright, C. R., Lopes, V., Montgomerie, C., Reju, S., & Schmoller, S. (2014, April 21). *Selecting a Learning Management System: Advice from an Academic Perspective*. EDUCAUSE. <https://er.educause.edu/articles/2014/4/selecting-a-learning-management-system-advice-from-an-academic-perspective>

12

HANDOUT



Process Improvement

Lucine Torosian

Friday, November 5
12:15 PM - 12:30 PM

HANDOUT



Positive Communication

Lara Zisblatt

Friday, November 5
12:30 PM - 12:45 PM

HANDOUT



Diversity, Equity, and Inclusion

Rena Gresh
Vu Willey

Friday, November 5
3:20 PM – 4:00 PM





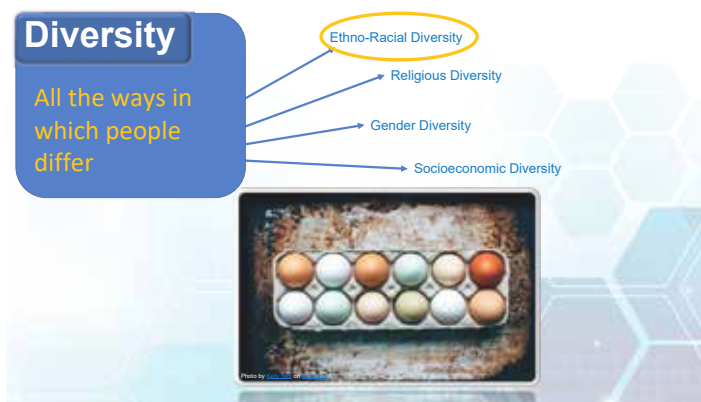
D.E.I. & YOU

AAPAE Roundtable
November 5, 2021

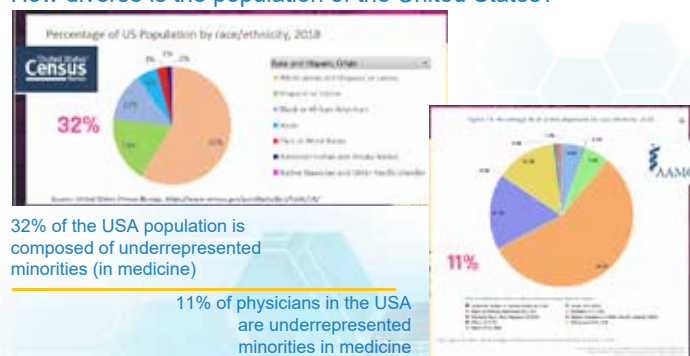
Vu Willey, MS
Diversity Co-lead
Anesthesiology
Office of Health Equity
& Inclusion Trainer
University of Michigan

Rena Gresh,
Anesthesiology
Residency Program
Coordinator
University of Rochester

Are you biased? We are...



How diverse is the population of the United States?



Why do we care?



How diverse is your group of residents/fellows? Select the percentage of trainees that are UnderRepresented Minorities in Medicine (URM).

A	B	C	D	E	F
more than 31%	21-30%	11-20%	1-10%	0%	No idea!

Powered by Dell Everywhere

Start the presentation by asking students: "Do you want to be a leader? What do you think a leader should do?"

How diverse is your faculty? Select the percentage of faculty that are UnderRepresented Minorities in Medicine (URM).

more than 31%	21-30%	11-20%	1-10%	0%	No idea!
------------------	--------	--------	-------	----	----------

Powered by Dail Everywhere

Start the conversation with the content. The system should respond, "What the hell is this?" Get help at policy.comcast.net

© When poll is active, respond at pollev.com/urmcaneesthesia
 @ Text **URMCANESTHESIA** to 22333 once to join

How diverse is your personal network?

Most of my friends/acquaintances look like me.	About 50% of my friends/acquaintances look like me.	Hardly any of my friends/acquaintances look like me.	I intentionally diversify my friend base.	No ideal
--	---	--	---	----------

Powered by Poll Everywhere

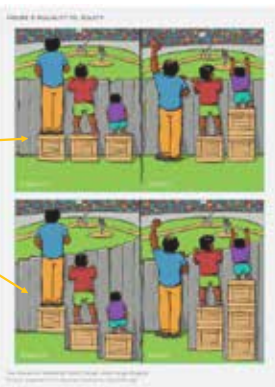
Start the presentation on the screen. To access chart software, click the chart icon. Get help at pubs.cwi.nl

Equity

Not to be confused with Equality...

Equality: Boxes are of equal size, but do not consider characteristics of each individual

Equality: Boxes are of equal size, but do not consider the environment of each individual



Inclusion

A variety of people have power, a voice, and decision-making authority.

- ## 1. Implicit/Unconscious Bias
- Refers to the *unconscious, unintentional* assumptions we make about others.



THE 5DS of Bystander Intervention



Delay without action is Denial

Let's Learn From Each Other!

Please share what your institution does to be inclusive...

Recruitment
Training
Anything Else?



Tell us what you've done or can do...

Identify your own biases
Advocate by speaking up
Connecting resources
Checking in on learners and building community
???



Take a PAUSE
A quick way to check your reaction

- 1 • Look inward, why am I reacting this way?
- 2 • Own your own reactions, interpretations and judgments
- 3 • Are there other reasonable explanations?
- 4 • After doing your own work, how else can you help?
- 5 • Speak up!

Additional Resources:

21-Day Racial Equity Habit Building Challenge: https://www.debbivirvine.com/21-day-challenge-archive2021/7b0c1d-1wAR1+SUBNq8K_CcW2mws9hVz9scTh6GUPvZlCctQ2N8AAmaza58M83IE#read
Code for America: <https://www.codeforamerica.org/about-us/diversity-equity-inclusion/>
Diversity and Inclusion Definitions through HUD: https://www.hud.gov/program_offices/administration/admbout/diversity_inclusion/definitions
Project Implicit: <https://implicit.harvard.edu/implicit/takeatest.html>
Ideal: <https://ideal.com/diversity-equity-inclusion/>
Journal for Graduate Medical Education, "It Takes a Village: Guidance on Mentoring Black Residents and Fellows": <https://doi.org/10.4300/JGME-D-20-01090.1>
Mapping Inequality: <https://dsl.richmond.edu/panorama/#maps>
New England Journal of Medicine, "Race and Medicine": <https://www.nejm.org/race-and-medicine>
Quartz, "Map" What Story Does Your Neighborhoods Life Expectancy Tell?: <https://qz.com/1462111/map-what-story-does-your-neighborhoods-life-expectancy-tell/>
Racial Equity Toolkit: <https://www.racialequitytools.org/resources/act/communicating/implicit-bias>
Society for Education in Anesthesia, "Diversity and Inclusion Educational Aids": <https://sea.memberclicks.net/diversity-and-inclusion-educational-aids>

Video Materials:

IHI: What is Bias, and What Can Medical Professionals Do to Address It? https://www.youtube.com/watch?v=F_gFRP-Y0lw
Implicit Bias: Peanut Butter, Jelly and Racism <https://youtu.be/1jVh2uWSJF4>
Unconscious Bias- Leadership and Management <https://youtu.be/dtoCjg8shZE>

HANDOUT



New Coordinators

Malin Cannon
Stephanie Harris

Friday, November 5
3:20 PM – 4:00 PM

	ACGME & GME Timeline July 1- June 30												
	Anesthesia Residency Program												
	YEAR						YEAR						
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	
WebADS	Prepare WebADS updates and submit to ACGME (Citation Responses, Updated CV, Major Program Changes, Faculty and Resident Scholarly Activities)												
Milestones					Submit Milestone Reports to ACGME				Submit Milestone Reports to ACGME				
Clinical Competency Committee				Send Gradebook and Summary Evaluations Reports to mentors. Meet, Review, Finalize in New Innovations				Send gradebook and summary evaluations reports to mentors. Meet, Review, Finalize in New Innovations					
Case Logs Reporting	Save case logs. Active case logs by deadline.		Monitor case log minimum reports monthly. Send summary reports to residents.										
Semi-Annual Evaluations					Residents complete self-evaluation		Period 1 Evaluations. Document summary report and meet with residents				Period 2 Evaluations. Document summary report and meet with residents		
ACGME Survey for Faculty and Residents						Reporting Window. ACGME delivers confidential survey. Must be distributed by coordinator through WebADS			Survey results released through WebADS				
Summative Evaluations												Completed at the end of training	
Program Evaluation Committee / Annual Program Evaluation	Update APE		Annual Program Report due to GME										Schedule meeting, send out program surveys, and gather documents.
Clinical and Educational Work Hours	Ongoing: monthly reports to GMEC												
CLER	Approx. every 18 months.												
ABA EXAMS (ITE, Basic, Advanced)					CA-2 Basic Exam Retake	ITE Registration		In-Training Exam	CA-1 Basic Exam Registration, CA-3 Advanced Exam Registration		CA-1 Basic Exam		
ABA Record of Training Information Database (RTID)	Training Reports due 7/31					Training Reports due 1/31							
Resident Assignments	Program specific assignment deadlines												
Recruitment		Plan Residency Interviews, open house	ERAS opens						Ranklist deadline: Match week/SOAP: Match day.		Orientation		
Important Residency Conferences/ Events				ASA - ANESTHESIOLOGY Annual Meeting	SAAAPM/ AAPAE Conference			ACGME Annual Conf					

Source: http://med.stanford.edu/gme/gme_community.html#acgme

HANDOUT



Diversity and Inclusion in Graduate Medical Education Anesthesiology

William McDade

Saturday, November 6
10:05 AM - 10:35 AM

HANDOUT



The RADAR Initiative

Matthew Wixson

Saturday, November 6

10:35 AM - 10:55 AM

11/10/21



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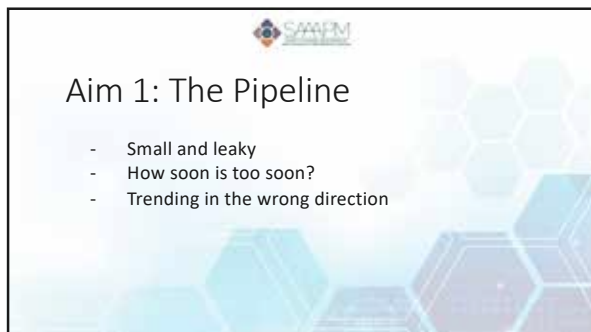
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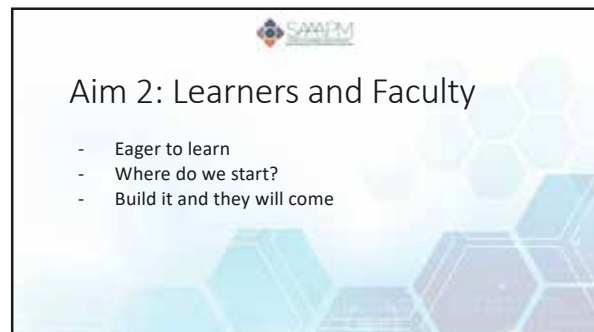
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6

11/10/21



Aim 3: Senior Leaders

- Best practices
- Collaboration, not competition
- Setting the tone

7



www.radaranesthesia.org

8



9



Next Steps

- Collaboration is key to success
- RADAR Partners
- National Grand Rounds

10



Join the RADAR Movement

- radaranesthesia@umich.edu
- mwixson@med.umich.edu

11

HANDOUT



DEI Efforts in Anesthesia

Meghan Lane-Fall

Saturday, November 6

10:55 AM - 11:15 AM



DEI efforts in anesthesia: applying what we know to achieve the change we seek

Meghan Lane-Fall, MD, MSHP, FCCM

Vice Chair of Inclusion, Diversity and Equity and
David E. Longnecker Associate Professor of Anesthesiology and Critical Care
University of Pennsylvania Perelman School of Medicine

SAAAPM Meeting | November 2021

Disclosures



- ▶ No financial conflicts of interest
- ▶ Grant funding:
 - NIH (NHLBI, NIA, NICHD, OD)
 - AHRQ
 - PCORI
- ▶ APSF Vice President
- ▶ Boards of Directors, APSF & FAER

Grounding assumptions

- ▶ Diversity, equity, and inclusion are desirable in academic medicine



social justice



excellence

Grounding assumptions

- ▶ Diversity, equity, and inclusion are desirable in academic medicine
- ▶ We are not yet where we want to be with DEI



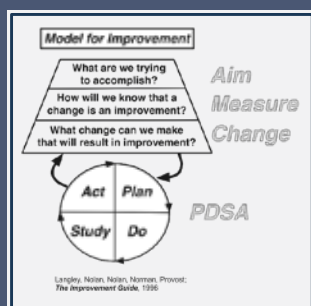
DE&I efforts are
fundamentally about
behavior change

*We know how
to change behavior
in health & healthcare*

*quality
improvement*



A tried-and-true quality improvement approach:
The Model for Improvement



DE&I is very ordinary in some ways

Organizational change in DE&I requires:



will to change

"The starting point is really to acknowledge that there is an issue, and [the need to] just have a dialogue about race."

Rohini Anand, Leading Diversity at Work podcast

DE&I is very ordinary in some ways

Organizational change in DE&I requires:



resources

"I think sometimes we don't treat the diversity office like a business unit, and business units need budgets to function."

Stephanie Creary, Leading Diversity at Work podcast

DE&I is very ordinary in some ways

Organizational change in DE&I requires:

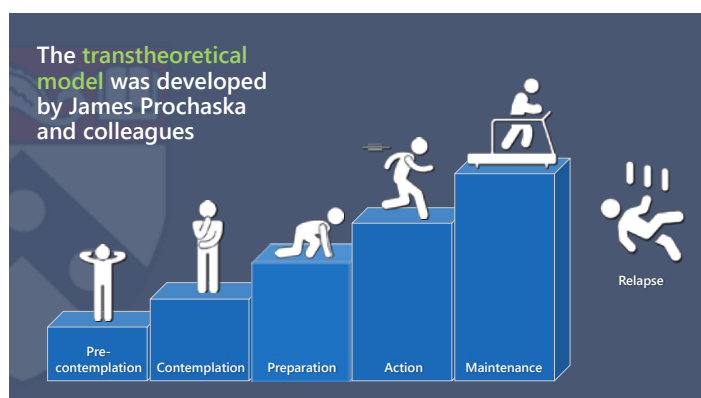
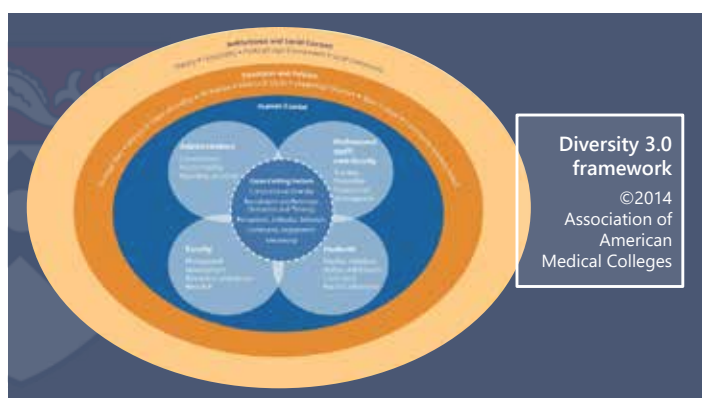
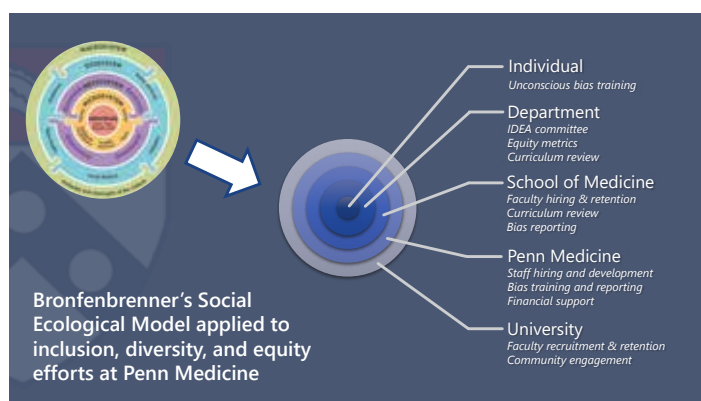
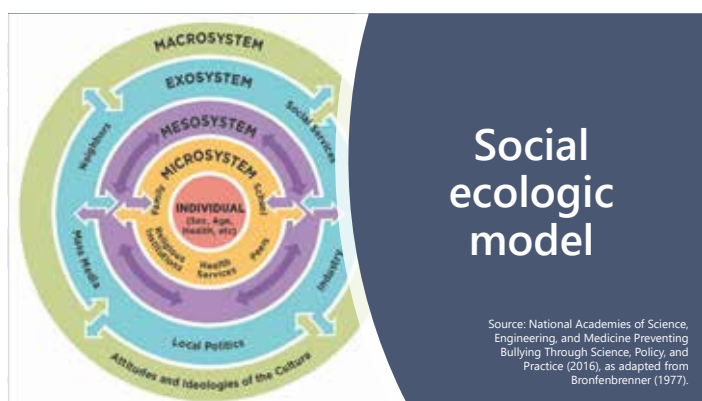
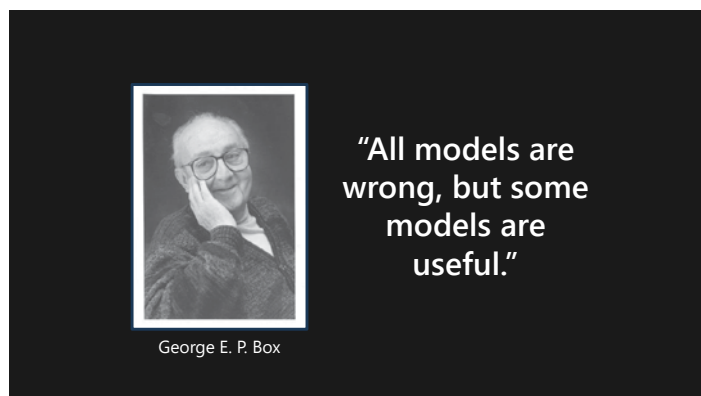


expertise

Requisite diversity leadership skills:

- Interpersonal skills
- Technical knowledge
- Strategic vision
- Change management expertise

Diversity and Inclusion in Academic Medicine: a Strategic Planning Guide. AAMC, 2014.

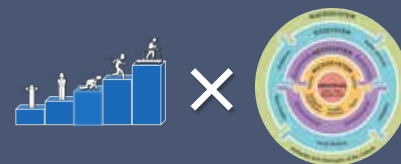


TTM stage-matched interventions are more effective

Prochaska JM, Prochaska JO, Levesque DA. A transtheoretical approach to changing organizations. *Adm Pol Ment Hlth* 2001; 28(4).

- ▶ Precontemplation
 - Consciousness raising
 - Environmental re-evaluation
- ▶ Contemplation
 - Self re-evaluation
- ▶ Preparation
 - Self liberation
- ▶ Action & Maintenance
 - Helping relationship
 - Stimulus control

The transtheoretical model can be applied to organizations



Transtheoretical model stages of change					
	Pre-contemplation	Contemplation	Preparation	Action	Maintenance
Individual	- Consciousness raising - Dramatic relief - Environmental re-evaluation	Self re-evaluation	Self liberation	- Contingency management - Helping relationship - Counter conditioning - Stimulus control	
Organization		- Dramatic relief - Self re-evaluation - Thinking about commitment	Teams	- Consciousness raising - Commitment - Counter conditioning	- Stimulus control - Helping relationship - Reinforcement management

Adapted from: Prochaska JM, Prochaska JO, Levesque DA. A transtheoretical approach to changing organizations. *Adm Pol Ment Hlth* 2001; 28(4).



Lane-Fall MB, Gordon EKB, Valentine EA, Black SA, Kapur PA, Fleisher LA. Fostering belonging in academic anaesthesiology. *Br J Anaesthesia* 2020; 124(3):E155-E159.

Pitfalls to avoid



- ▶ Unproductive behaviors
 - Performative allyship
 - "Oppression Olympics"
- ▶ Overreliance on marginalized groups
 - Tokenism and ghettoization
 - Minority tax
 - Lived experience ≠ expertise
- ▶ Minimizing the work
 - Gaslighting
 - Normalcy bias
 - System justification¹

1. Jost JT and Banaji MR. The role of stereotyping in system-justification and the production of false consciousness. *British Journal of Social Psychology* 1994;33(1):1-27.

Takeaway points



- ▶ We know how to change behavior in health and healthcare
 - Quality improvement approaches
 - Social science-informed approaches
- ▶ Strategic planning (or another deliberate process) is needed to articulate goals and objectives in DE&I
- ▶ History, language, social weight increase the complexity of DE&I efforts



HANDOUT



D&I Interventions for Improvement

Felipe Perez

Saturday, November 6
11:15 AM - 11:30 AM



D&I Interventions for Improvement



Felipe Perez, MD FAAP | November 6, 2021



Financial Disclosure

- No financial disclosures
- Assistant Dean for Diversity at School of Medicine
- Co-Chair of Stanford Anesthesiology Diversity Council



7 Step Guide to Bring About Change

- Step 1: Committee Formation
- Step 2: Mission Statement
- Step 3: Recruit
- Step 4: Start to sponsor
- Step 5: Create anti-racism changes
- Step 6: Inclusion
- Step 7: Retain and promote

© 2021 AMERICAN SOCIETY OF ANESTHESIOLOGISTS

3



Case Study: Stanford Anesthesiology Department



4



Timeline



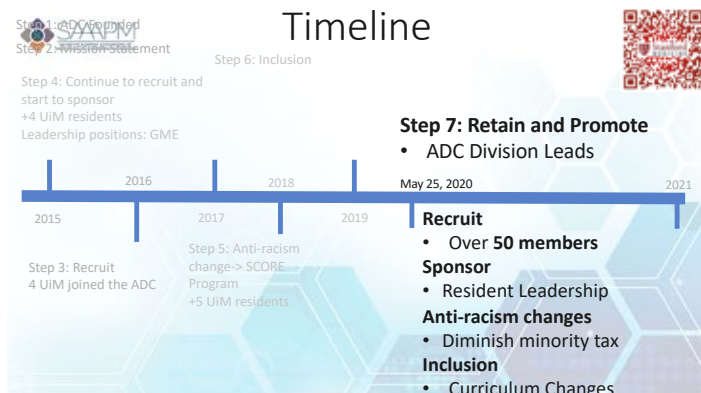
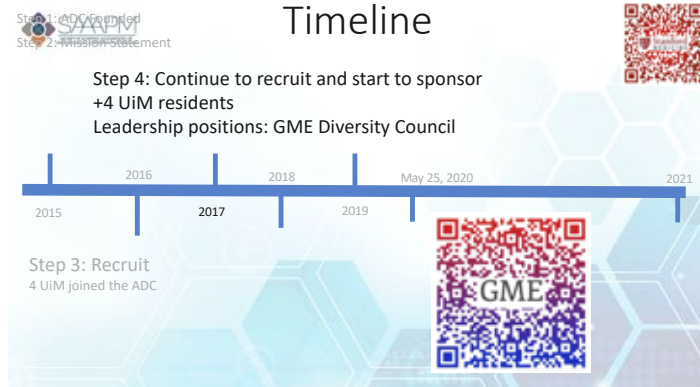
- Step 1: ADC Founded
- 2 faculty, 1 resident



- Step 1: Create a Committee
- Step 2: Create a Mission

ADC Mission:

The Stanford Anesthesiology Diversity Council's (ADC) mission is to **recruit, support, retain, and promote** diversity within the Department of Anesthesiology, Perioperative, and Pain Medicine.





7 Step Guide to Bring About Change

- Step 1: Committee Formation
- Step 2: Mission Statement
- Step 3: Recruit
- Step 4: Start to sponsor
- Step 5: Create anti-racism changes
- Step 6: Inclusion
- Step 7: Retain and promote



Nationally

- JEDI Collaborative of Anesthesiology DEI Officers



Meghan Lane-Fall
Associate Professor UPenn
<http://www.lanefall.info/>



For JEDI Officers to Register



Jennifer Lucero
VC Chair DEI UCLA
Associate Dean for Admissions, DGSOM



Infrastructure



Department ADC



Visiting Clerkship



GME Council



Resident Leadership



Twitter



High School Outreach



Infrastructure



JEDI Collaborative

HANDOUT



ASA Update

Randall Clark

Saturday, November 6

12:30 PM - 12:50 PM

HANDOUT



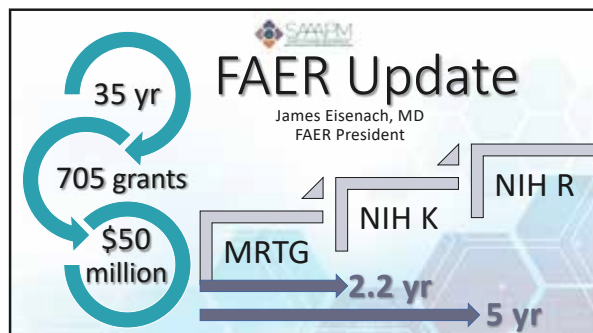
FAER Update

Jim Eisenach

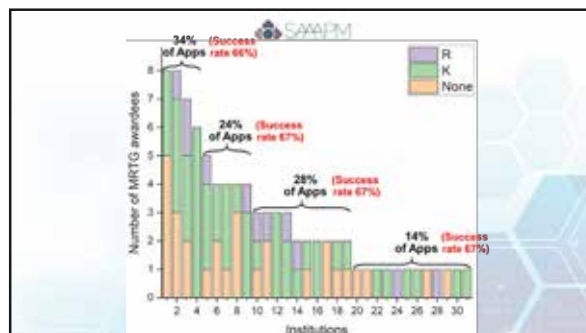
Saturday, November 6

12:50 PM - 1:00 PM

11/10/21



1



2

Mission
Developing the next generation of physician-investigators

Vision
A nurturing community of anesthesiologists advancing health through research

FAER
Foundation for Anesthesiologist Education and Research

3

Increased awareness

Sustainable growth

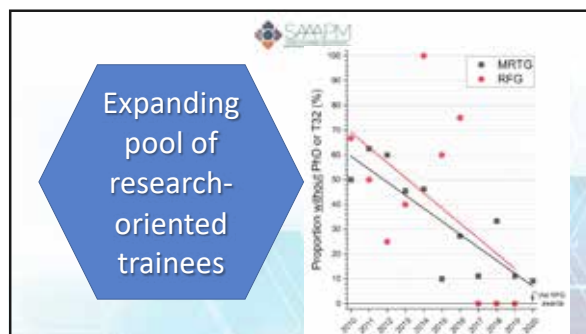
4

2018: ↑ size of MRTG by 40% (cost: \$750,000)

2022: ↑ # of MRTGs by 3 & added 2 partnered MRTGs (cost: \$1,180,000)

Community of early investigators and their supporters

5



6

11/10/21



7

HANDOUT



Effective Interviewing Techniques

Jane Risen

Saturday, November 6
1:00 PM - 1:40 PM



Effective Interview Techniques

Jane Risen
Professor of Behavioral Science
University of Chicago, Booth School of Business
November 5th, 2021

Our Goal is to Interview with Equity

1) Understand how bias can (unintentionally) creep into interviews

- Discrimination, stereotypes, prejudice, and implicit bias

2) Prevent bias from creeping into interviews

- Mindset, debiasing, and “decoupling”

Subject Line: Prospective Doctoral Student Next Monday

Dear Professor [surname of professor inserted here],

I am writing you because I am a prospective doctoral student with considerable interest in your research. My plan is to apply to doctoral programs this coming Fall, and I am eager to learn as much as I can about research opportunities in the meantime.

I will be on campus next Monday, and although I know it is short notice, I was wondering if you might have 10 minutes when you would be willing to meet with me to briefly talk about your work and any possible opportunities for me to get involved in your research. Any time that would be convenient for you would be fine with me, as meeting with you is my first priority during this campus visit.

Thank you in advance for your consideration.

White, Black, Hispanic, Indian, Chinese (male or female)

Sincerely,

[Student's full name inserted here]

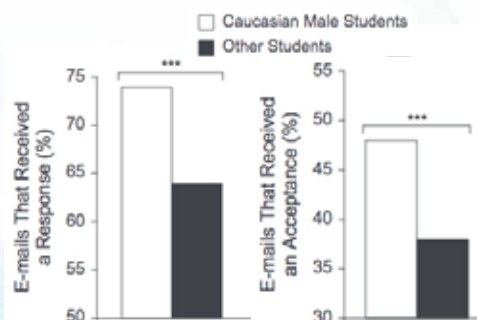
What Happens Before? A Field Experiment Exploring How Pay and Representation Differentially Shape Bias on the Pathway into Organizations

Katherine L. Milkman
Modupe Akinola
Dolly Chugh

Journal of Applied Psychology 2015

- Audit study in academia of over 6500 professors at top US Universities from 89 disciplines and 259 institutions
- Fictional prospective students wanting to discuss research opportunities before applying to doctoral programs
- Names were randomly assigned to signal gender and race (white, black, Latinx, Indian, Chinese) otherwise no change in message
- Faculty were significantly more responsive to white males request for future mentoring than to all other categories of students
- Particularly in higher paying disciplines and private institutions

Professors Respond (Milkman et al., 2012; 2015)



Psychological Sources of Bias

- **Discrimination – Behavior.** Differential actions that limit the social, political, or economic opportunities of members of particular groups.

1) “Belief-based/statistical discrimination” – based on a stereotype

- **Stereotypes – Beliefs.** Traits that are attributed to people based on group membership.

2) “Taste-based discrimination” – based on prejudice

- **Prejudice – Attitude.** Negative attitudes about certain groups and their members.

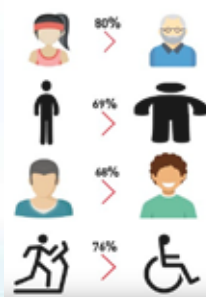
Potential Pitfalls in Evaluation

- Research suggests that both prejudice and stereotyping can shift standards in evaluation without people realizing that they are doing so.
 - Majority men tend to be judged on their potential, whereas other groups tend to be judged on what they have already accomplished.
 - For majority group members, one strength is often generalized into a global positive rating, but for underrepresented group members, one weakness is often generalized into an overall negative rating.
 - Requirements are often applied rigorously to underrepresented groups, but leniently applied for majority men.
 - Letters of recommendation for female applicants are more likely to include "doubt raisers" or "hedges" compared to letters for men. Women also receive less "standout" adjectives (e.g., brilliant).
 - Evaluators follow (biased) intuitions when evaluating candidates and then shift what they believe to be the most important criteria after the fact to match the criteria showcased by a majority group member.

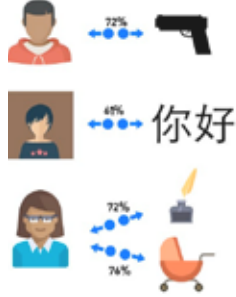
Implicit Bias

- Implicit bias: bias in favor of or against one group compared with another that occurs **automatically** (without requiring awareness, intent, cognitive resources)
 - Implicit **attitudes** and **stereotypes**
- Implicit Association Test (IAT)
 - <https://implicit.harvard.edu/implicit/>
 - What does your score mean?
 
- The score reflects the categories that "go together" in your mind. If *Black* and *Bad* are associated in your mind, then you will be quicker to respond when Black faces and bad words are paired together than when Black faces and good words are paired together.

Implicit Attitudes



Implicit Stereotypes



Implicit Bias Predicts...

- Own behavior in socially sensitive situations
 - Meta-analyses: r between .15 and .25 (Greenwald et al., 2009 and Oswald et al., 2011)
 - Callback rates for job applicants of different groups (Agerstrom & Rooth, 2011; Rooth, 2007)
 - The extent to which people engage in awkward or exclusionary non-verbal behavior in conversations with members of different groups (McConnel & Leibold, 2001)
- Biased outcomes in the environment
 - Countries with stronger male-science IAT had greater gender achievement gaps in 8th grade science and math scores (Nosek et al., 2009)
 - U.S. cities with higher levels of racial bias on the IAT have greater racial disparities in shootings by police (Hehman et al., 2017)
 - U.S. counties with higher levels of racial bias had greater Black-White gaps in infant health outcomes (Orchard & Price, 2017)
- Other's behavior
 - Minority employees perform worse when they are randomly assigned to work with biased managers (Glover et al., 2017)

Psychological Sources of Bias

- Discrimination – Behavior.** Differential actions that limit the social, political, or economic opportunities of members of particular groups.
 - "Belief-based/statistical discrimination" – based on a stereotype
 - Stereotypes – Beliefs.** Traits that are attributed to people based on group membership.
 - "Taste-based discrimination" – based on prejudice
 - Prejudice – Attitude.** Negative attitudes about certain groups and their members.
- Ingroup Favoritism (vs. Outgroup Hostility)**

Ingroup Favoritism (vs. Outgroup Hostility)

"Ultimately, many forms of discrimination and bias may develop not because outgroups are hated, but because positive emotions such as admiration, sympathy, and trust are reserved for the ingroup and withheld from outgroups" (Brewer, 1999, p. 438).

- Liking similar others still causes discrimination!
 - Study of hiring at elite professional service firms found that similarity ("fit") in terms of lifestyle markers (leisure pursuits, experiences, self-presentation style) was cited as the top criterion for hiring at the interview stage (Rivera, 2012)



- **Bad News:** People have biases. They sometimes don't even realize they have them. Biases can affect behavior.
- **Good News:** The vast majority of people try to overcome their biases and their stereotypical preconceptions to treat everyone fairly.

We have the goal of preventing bias from affecting behavior. How?

- **Mindset** – thinking about our biases in productive ways
- **Debiasing** – eliminating the biases in our mind
- ***Decoupling*** - breaking the link between biases in our mind and behaviors we engage in

Start with the right mindset

- **Be humble**
 - If you think you are objective, you are more likely to not be
- **Be mindful**
 - Biases more likely to creep in when we can't be deliberative
 - Slow down, pause, reflect
- **Adopt a learning orientation**
 - If you recognize that there is always more to learn and discover, then you'll stay on the look-out for more opportunities to interrupt bias
- **Remind yourself about your internal motivations to be fair and equitable**
 - You're here because you want to conduct an effective and equitable interview

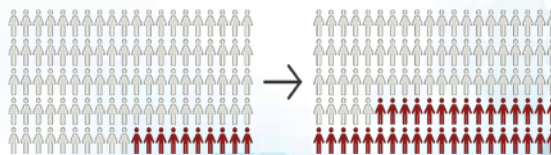
Debiasing

- **Intentional, meaningful, long-term exposure to counter-stereotypical and counter-attitudinal exemplars**
 - Choose diverse and inclusive environments where you interact with lots of people who are different from you in lots of different roles
 - Curate diverse and inclusive representations in the media you consume
 - TV, movies, books, music...
 - Engage in a self-audit to determine how you may be letting implicit attitudes or stereotypes affect you

Decoupling

- Breaking the link between bias and behavior
- "Take the bias out of the process rather than trying to take it out of the people."

When leading orchestras started using blind auditions...



...the percentage of women in orchestras rose from 10% to 35%

Decoupling

- Breaking the link between bias and behavior
- “Take the bias out of the process rather than trying to take it out of the people.”

- ✓ Pre-determined job criteria
- ✓ Standardized evaluation forms
- ✓ Structured interviews
- ✓ Diverse search committees

Preparing for the interview

- Remember: the candidate is interviewing you just as you are interviewing them
- Be inclusive - think about all of the signals you give. You want to create identity safety (not identity threat)
- Focus interviews on collecting information, not making the decision
- Create standard materials and ensure everyone receives the same treatment
 - Review your personal and group website
 - Create a welcome packet
 - Provide a list of everyone with whom they will interview in advance
- Prepare structured interview questions asking everyone the same core questions that are directly related to performance on the job

Decoupling Interviews for Medical Residents

#1: Use pre-determined criteria (and be accountable to it)

- Make sure they are clear and concrete
- DON'T USE “FIT” AS AN ABSTRACT CONCEPT
 - Evaluating “fit” ends up being “Does this person’s experiences, interests, and style seem similar to me and to others I know in my field/department/hospital?”
 - Evaluating fit reproduces the people we already have
- DEFINE what it means to “fit” in your residency program and evaluate those criteria instead
 - Curious/inquisitive
 - Hard-working

Decoupling Interviews for Medical Residents

#2: Use standardized evaluation forms

Please rate the candidate on each of the following:

	excellent	good	neutral	fair	poor	unable to judge
Potential for (diversity of) scholarly impact						
Potential for (diversity of) research productivity						
Potential for (diversity of) research funding						
Potential for (diversity of) collaboration						
Potential for (diversity of) outreach efforts to diverse groups						
Fits with department's priorities						
Ability to make positive contribution to department's climate						
Potential (demonstrated ability) to attract and supervise graduate students						
Potential (demonstrated ability) to teach and supervise undergraduate students						
Potential (demonstrated ability) to be a conscientious scholarly community member						

Candidate's Name: _____

Please indicate which of the following are true for you (check all that apply):

☐ Read candidate's CV	☐ Met with candidate
☐ Read candidate's scholarship	☐ Attended lunch or dinner with candidate
☐ Read candidate's letters of recommendation	☐ Other (please explain): _____
☐ Attended candidate's job talk	

Please comment on the candidate's scholarship as reflected in the job talk: _____

Decoupling Interviews for Medical Residents

#2: Use standardized evaluation forms

- Make sure that the traits you evaluate are not stereotypically associated with some groups more than others (Gaucher et al., 2011)
 - e.g., Women are stereotyped as more cooperative/understanding/committed than men. Men are stereotyped as more competitive/confident/driven than women.
- If your form only asks you to evaluate applicants for how confident and driven they are, that could favor men.
- Instead, consider a balance of desirable traits or neutral traits

Decoupling Interviews for Medical Residents

#3: Use structured interviews

“The use of unstructured interviews despite structured interviews being more predictive of future job performance] has been one of the most persistent gaps between research and practice” (Wolgast et al, 2018).

Decoupling Interviews for Medical Residents

#3: Use structured interviews

- Structured interviews predict job performance better than unstructured interviews (Macan, 2009)
 - Interviewers open themselves up to various forms of bias when they ask questions that come to mind in the interview.
 - Instead, plan to ask the same set of questions for all applicants in the same order.
 - You can add follow-up questions / transitions to make it more natural

Decoupling Interviews for Medical Residents

#3: Use structured interviews

Some Example Qs:

- How are your past experiences relevant for the current position?
- What actions do you take when working in a team to ensure consistent communication?
- What skills would you need to develop for this job?
- How do you function under stress?

Decoupling Interviews for Medical Residents

#3: Use structured interviews

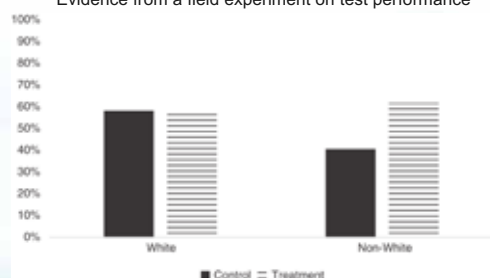
- Make sure that the questions you ask are geared towards people from all groups. Consider how they can reduce threat.
 - e.g., For many underrepresented groups, goals are not just personal, but tied to their community. Give applicants space to reflect on all of their goals.

"Unscripted interactions, particularly those occurring between a candidate from a minority group and an interviewer from a majority group, were shown to cause discomfort and anxiety, which can lead to discriminatory behavior on the part of the majority member and heightened awareness of the racial aspects of the interaction for the minority candidate" (O'Meara et al, 2020)

The power of a question...

- Leveling the playing field (2017): A field study manipulated the language before a police force exam to help minorities feel less anxious and consider why being on the police force would be meaningful to them and their community:
 - First, we removed any language that was unnecessary and may have caused anxiety. Specifically, this meant removing a sentence that read: **'Please note there is no appeals process for this stage.'**
 - Second, we changed the language to be more positive and to prime success and belonging. In practice, this meant beginning the email with **'Congratulations! You successfully completed the Behaviour Style Questionnaire'** and ending it with **'Good luck!'**
 - Finally, we added the following sentence: **'Before you start the test, I'd like you to take some time to think about why you want to be a police constable. For example, what is it about being a police constable that means the most to you and your community?'**

Levelling the playing field in police recruitment: Evidence from a field experiment on test performance



Levelling the playing field in police recruitment: Evidence from a field experiment on test performance, Volume 95, Issue 4, Pages: 843-856, First published: 02 August 2017, DOI: 10.1111/japm.12345

Decoupling Interviews for Medical Residents

#3: Use structured interviews

Some Example Qs:

- How are your past experiences relevant for the current position?
- What actions do you take when working in a team to ensure consistent communication?
- What skills would you need to develop for this job?
- How do you function under stress?
- **Why do you want to go into anesthesiology? What is it about being an anesthesiologist that means the most to you and your community?**

Decoupling Interviews for Medical Residents

#4: Use a diverse search committee

- Encourage those with different backgrounds and identities to serve on the search and interview committee.

(ALT #4) Gather Diverse Perspectives

- If interviewing as part of a relatively homogenous committee, you can implement diverse perspectives by having current residents, students, colleagues, or staff members also look at application materials.

Final tips to consider

- Hire in batches if possible
 - More likely to consider diversity when hiring several people at a time than when hiring one at a time (Chang et al., 2020)
 - Easier to assess performance comparatively (Bohnet et al., 2015)
- Create a finalist pool that includes multiple people from underrepresented backgrounds
 - Having more than one woman or minority in the finalist pool appears to increase the likelihood of hiring a woman or minority — beyond the increase you'd expect simply due to probability. (Johnson et al., 2016)
- Consider how to assure that your group decision making process is informed by all group members
 - You may want to have the more junior people share their views first.
 - You may want to explicitly state that you're looking for people to share different views from what has already been shared.
 - You may want to explicitly ask people to share any unique knowledge that they have.

We have the goal of preventing bias from affecting behavior. How?

1) Mindset

- Be humble, be mindful, adopt a learning orientation, remind yourself about your internal motivation to be equitable

2) Debiasing

- Choose diverse and inclusive environments to interact in, curate your media consumption to be diverse and inclusive, engage in a "self-audit"



3)*Decoupling*

- e.g., hiring: Use pre-determined search criteria, standardized evaluation forms, structured interviews, and a diverse search committee

Thank you!

Jane.Risen@ChicagoBooth.edu

HANDOUT



Assessing Resident Applicants with Meaningful Metrics

Maya Hammoud

Saturday, November 6
1:40 PM - 2:00 PM

HANDOUT

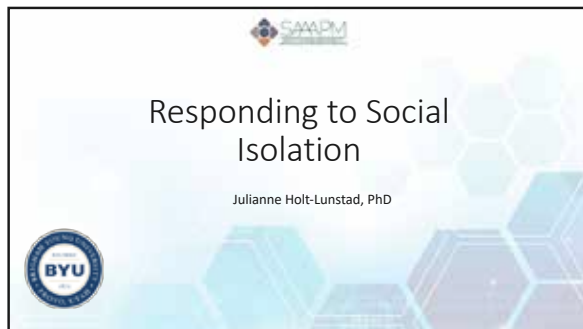


Responding to Social Isolation

Julianne Holt-Lunstad

Saturday, November 6
2:45 PM - 3:25 PM

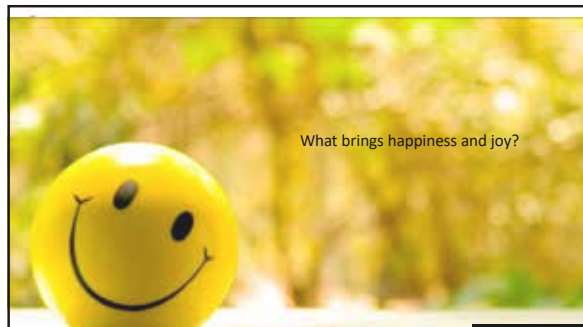
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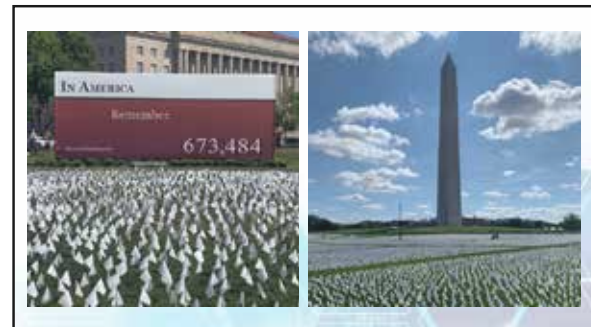
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6

11/3/21



What will “social distancing” and other restrictions do to us?

What is known about the short term and long-term effects of Isolation & Loneliness?

Who's most at risk?

How might this influence public health, and society long term?

7

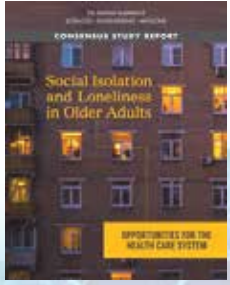
Social Isolation and Loneliness were public health concerns before the Pandemic

8



“Social Isolation is a major public health concern”

The National Academies of
SCIENCES
ENGINEERING
MEDICINE



9



OUTLINE

-  Define the issue
-  State of our Knowledge
-  Gaps
-  Translation

10



- **Homebound:** never or rarely leaving the home over the past month
- **Social Isolation:** is objectively being alone, having few relationships, or infrequent social contact.
- **Loneliness:** is subjectively feeling alone. The discrepancy between one's desired level of connection and one's actual level.

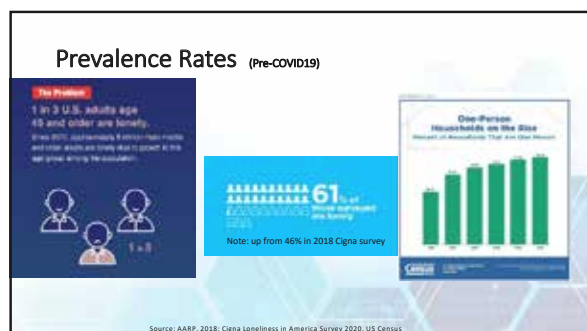
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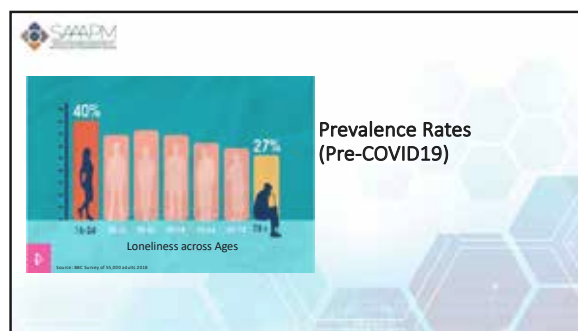
What is the size of the problem?

12

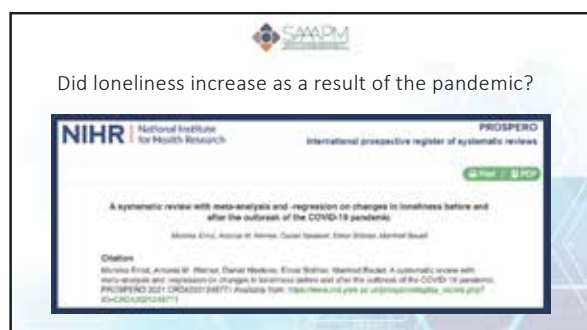
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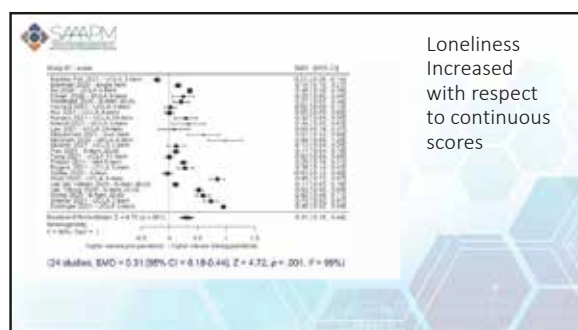
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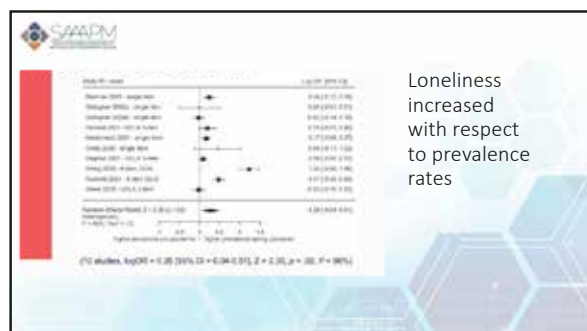
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11/3/21

HOW SERIOUS IS THE PROBLEM?

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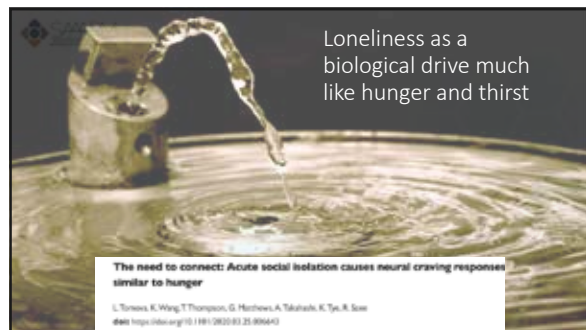
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Humans are social species

- Most vulnerable at birth
- Infants and children in custodial care that lack human contact fail to thrive and often die.

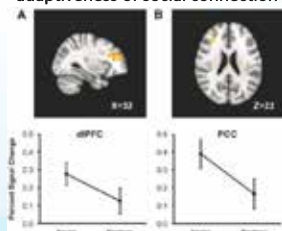
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Loneliness as a biological drive much like hunger and thirst



22

Neuroscience supports a biological adaptiveness of social connection



Source: Coan et al *Social Cognitive and Affective Neuroscience*, 2017

23

Isolation used as Punishment



24

11/3/21



25



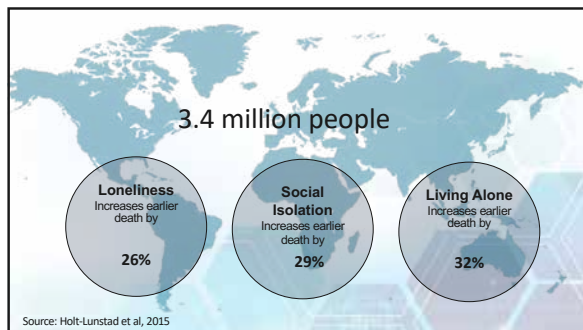
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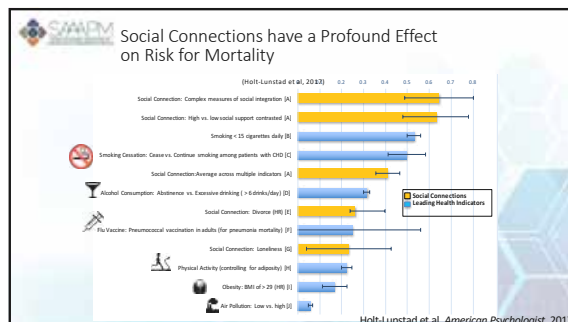


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11/3/21

Putting the effects in context

31



32

GAPS in Existing Data

Fewer prospective studies . . .

- Examine younger ages/developmental course
- Are from developing countries
- Examine cultural/ethnic/economic differences
- Include indicators of relationship quality
- Assess multiple components, and even fewer examine their synergistic effects

33

What are the effects beyond premature mortality?

34

The influence of Social Isolation on Health and Economy

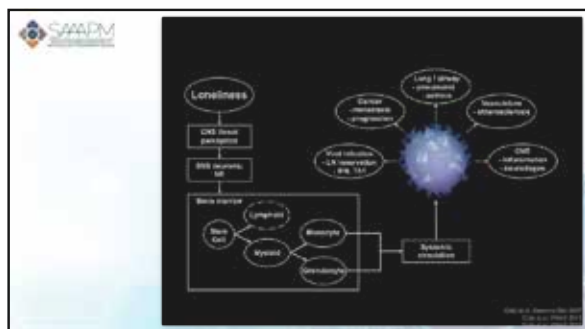


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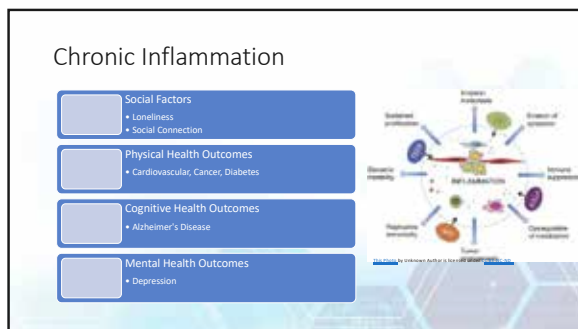


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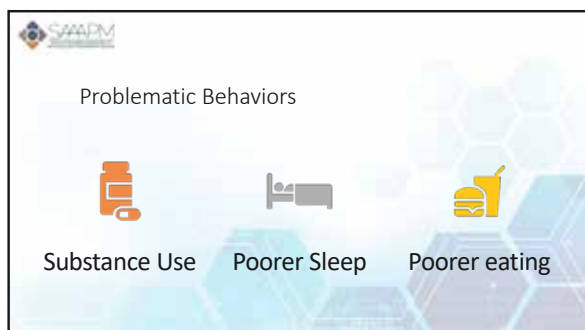
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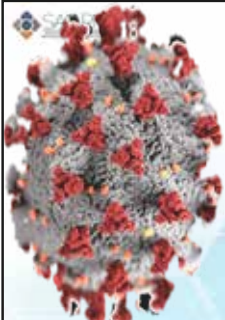


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11/3/21



Additional Health Implications of Social Isolation for the Current Pandemic

- Susceptibility to the virus
 - EHR data on mental health and Covid19 infection, hospitalization, & mortality (Wang et al, *World Psychiatry*, 2020; Tachet et al, *Lancet Psychiatry*, 2020)
- Short term effects on biological responses that may precipitate or exacerbate other health conditions

43



GAP: How long does it take for health effects to appear?

It isn't clear the time course from short term biological markers to disease onset

Pandemic provides an opportunity to examine and address this gap

44

THE PROBLEM IS URGENT
THE PROBLEM IS SERIOUS

45



Loneliness is a biological cue like thirst:
Unique Challenges to Reducing Isolation and Loneliness



46



GAPs: Tech Based Solutions

- Evidence is primarily based on in person contact
- Complex data
- Preliminary data suggest caution
- Barriers to reaching those most in need
- Evaluation of effectiveness

47

Solutions to Reduce Risk

48

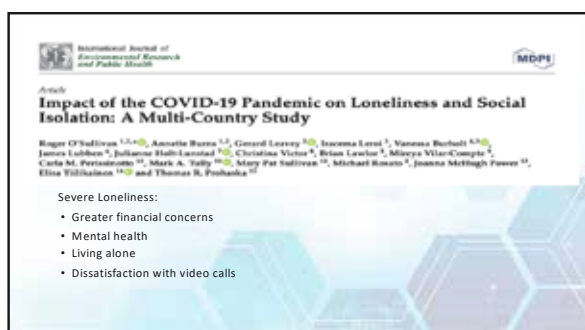
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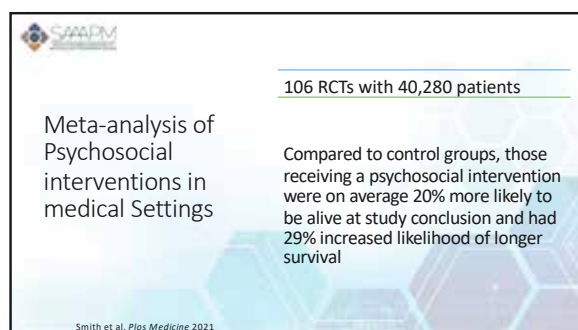
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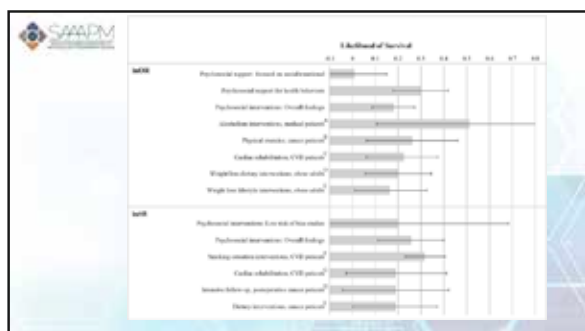
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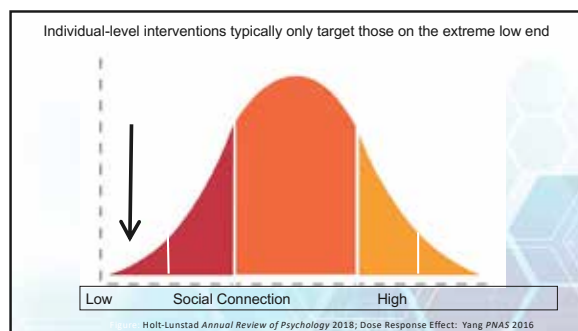
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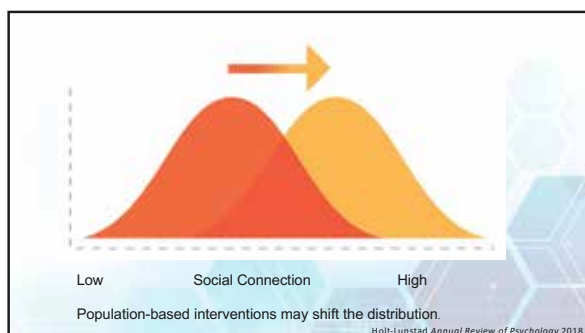


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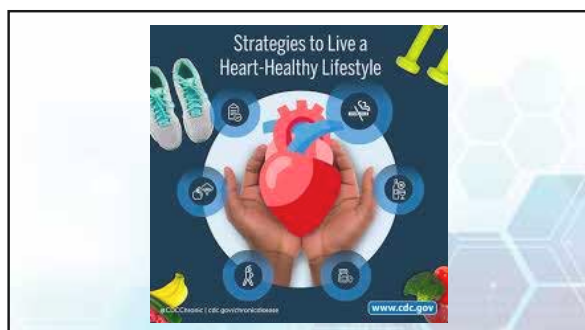
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56



57

Social contact is part of almost every aspect of life

- Almost every aspect has been altered due to pandemic
- Will changes be sustained?
- Built Environment
- Policy

Public Health Policy (Holt-Lunstad, Health Affairs, 2020)

SWAPM

58

What can you do for your patients?

Lend a listening **EAR**

- **Educate** yourself and your patients
- **Assess** the risk level of your patients
- **Respond** refer patients to local sources, tailored to their needs, reassess

59

ACL National Resource Center

COMMIT TO Connect

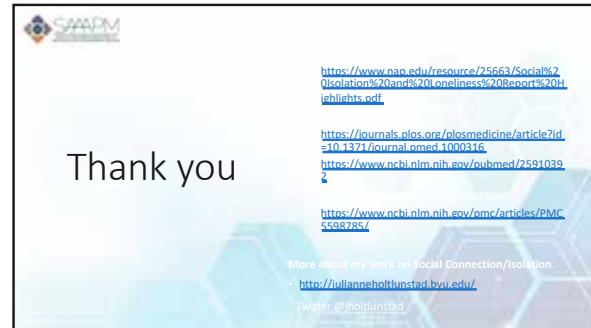
Commit to Connect

60

11/3/21



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HANDOUT



Digital Learning: Challenges and Opportunities

Faye Haggar

Saturday, November 6
3:25 PM - 4:05 PM