

# INTERCHANGE

Society of Critical Care Anesthesiologists Newsletter Volume 34 | Issue 3 | September 2023

## PRESIDENT'S MESSAGE

Colleagues,

The goal of SOCCA is to offer numerous areas and opportunities for our members to engage and grow our Society, and our members have been very busy! The women in critical care group is open to all SOCCA members and has been very active in developing Fireside Chats and podcasts and discussing ways to improve mentorship and sponsorship within critical care. They are also working on a systematic review of women in critical care leadership. SOCCA has been developing an excellent collaboration with the Society for the Advancement of Transplant Anesthesia. I encourage all SOCCA members involved in transplantation to join this workgroup. There are possibilities to participate and attend SATA's regional meetings throughout the year. Stay tuned for more information about this. SOCCA has nominated Cortessa Russell, MD, to be the SOCCA liaison to the ASA Wellness Committee. Dr. Russell has a wellness leadership role at Columbia and has been involved in many aspects of CCM wellness during her career. The SOCCA education committee continues to plan next year's meeting with the IARS and developed the SOCCA Board Review course (September 28 and **October 5**). Also, join us for the SOCCA Early Career Intensivist's second Job Fair on **October 4**, where you will gain valuable insights on successfully navigating the



**Michael H. Wall,  
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*President, SOCCA*  
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evolving healthcare landscape. Remember, all work groups are open to all members, and we have plenty of things for folks to do!

**The 2024 Annual Meeting will be held in Seattle from May 17 to May 19, 2024.** SOCCA will continue collaborating with the IARS, Early-Stage Anesthesiology Scholars (eSAS), and others on the Annual Meeting Oversight Committee to plan the 2024 annual meeting. We will have extensive meeting

content devoted to critical care and more critical-care content at next year's meeting than ever.

A restructuring of administrative support for SOCCA to handle our substantial growth in membership and programs is currently under consideration. SOCCA maintains an unwavering commitment to promoting academic anesthesiology and critical care in academic and private practice. We are currently in the process of evaluating RFPs from several association management companies. The SOCCA Executive Committee and the Board of Directors are extensively involved with this, and we will keep all our members informed as things progress. Please let us know if you have any comments or suggestions as we move forward.

I hope everyone is having a great summer, and I look forward to seeing you in San Francisco in October and Seattle in May. 🏠



**SOCCA JOB FAIR:**  
**HOW TO NAVIGATE TODAY'S CHANGING LANDSCAPE**  
**October 4, 2023 | 6:00 PM ET**

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# SOCCA Nominations

The strength of SOCCA is the wealth of talent and energy of its members. One of the ways to serve the Society is through volunteer activities. The SOCCA Nominations Committee annually evaluates nominees and develops an election ballot for available Officer and Director positions. This election cycle we will be electing our Secretary (2-year term) and two members for the Board of Directors (3-year term). Further details about the governance structure of SOCCA are described in our Society Bylaws.

Information about additional opportunities to serve the organization, such as committee involvement, will be shared in future communications. This year, we will be looking for committee volunteers for our Communication, Education, Membership, and Research committees, as well as the recently created Clinical Practice committee.

Those interested in elected positions will be asked to submit a letter of interest, photograph, and curriculum vitae. The 2023 Call for Volunteers will open on November 1, 2023, and close on December 31, 2023. Criteria by which volunteer leaders are evaluated are available here: [VOLUNTEER LEADERSHIP SELECTION CRITERIA](#).

If you have questions about any of the opportunities available within SOCCA, please contact SOCCA Society Director [Vivian Abalama, IOM, CAE](#) who will ensure you are in touch with the appropriate SOCCA resource. 



**Miguel Cobas,  
MD, FCCM**  
*Immediate Past  
President, SOCCA*  
University of Miami  
Miami, FL



the  
**ANESTHESIOLOGY**<sup>®</sup>  
annual meeting  
American Society of Anesthesiologists<sup>®</sup>  
SAN FRANCISCO | OCTOBER 13-17, 2023  
#ANES23

**SOCCA Meet-Up  
in San Francisco**

  
**WHAT: Critical Care Anesthesia  
Meet-up | Sponsored by SOCCA**  
**WHEN: Sunday, October 15  
4:30-5:15pm**  
**WHERE: Exhibit Hall:  
Lounge B**

# COMMUNICATIONS COMMITTEE: CASE REPORT

## Successful Management of Right Ventricle Perforation Associated with a Protek Duo Cannula Placement

### INTRODUCTION:

Acute right ventricular failure (RVF) due to post-left ventricular assist device (LVAD) placement is challenging to treat with the management often limited to placement of either surgical or percutaneous mechanical circulatory devices. The Protek Duo® (LivaNova) is a percutaneous right ventricular support device (RVAD), which due to its relative ease of placement, has been a breakthrough in the management of post-LVAD implantation acute RVF.<sup>1</sup>

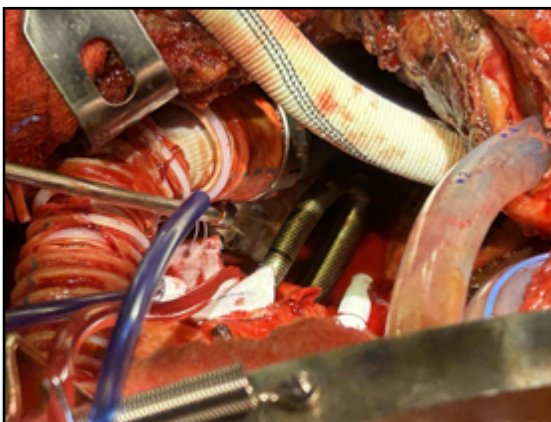
Cardiac perforation from placement of a Protek Duo cannula is a rare but potentially lethal complication. This case is the first to describe a patient who developed cardiac tamponade from a Protek Duo cannula perforation of the right ventricle. The report discusses preoperative and intraoperative management of this condition and relevant transesophageal echocardiography (TEE) imaging that aided in the diagnosis and surgical repair of the perforation.

### CASE SUMMARY:

A 76 year-old male with a history of heart failure with reduced ejection fraction secondary to ischemic cardiomyopathy was admitted for an elective surgical Heartmate III LVAD and Protek Duo cannula placement. A preoperative transthoracic echocardiogram (TTE) completed on hospital admission revealed an ejection fraction of 10% with a known left ventricular thrombus and preserved right ventricular function. The patient proceeded to the operating room (OR), and he underwent successful implantation of a HeartMate III, closure of a patent foramen ovale, and placement of a 29-French Protek Duo cannula. Intraoperative TEE revealed normal right ventricular function and a Protek Duo cannula positioned with the tip in the right pulmonary artery without any outflow obstruction. The chest remained open, and he was transferred to the cardiovascular intensive care unit (CVICU) in a hemodynamic stable condition.

On post-operative day (POD) 4, the patient went to the OR for a scheduled chest closure, and he returned to the CVICU in stable condition. Several hours later, the patient became acutely hypotensive, with an accompanying decrease in Protek Duo flows, increase in central venous pressure (CVP), and increase in chest tube output. The patient was emergently taken to the OR for chest exploration, with concerns for possible cardiac tamponade.

Utilizing both direct visualization (Figure 1) and intraoperative TEE imaging, a right ventricular perforation was identified, as the Protek Duo cannula had eroded through the right ventricle creating a linear perforation along the ventricular free wall. After successful surgical repair of the ventricular perforation, there was a subsequent decrease in Protek Duo flows to 0.5 L/min, an increase in the CVP to 20 mmHg, and right atrial distention was noted on TEE (Figure 2). After



**Figure 1:** Right ventricular perforation as found intraoperatively on POD 4 where the Protek Duo cannula had eroded through the right ventricle creating a linear perforation along the ventricular free wall

*continued on page 4*



**Jordan M. Stefko, MD**



**Michael Dougherty, DO**



**Danielle L. Holland, MD**

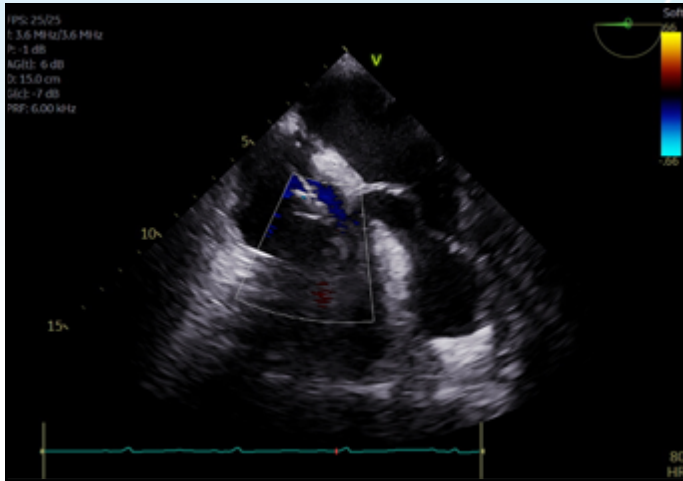


**Bridget Hughes, PA-C**



**Ron Leong, MD**

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**Figure 2:** Intraoperative TEE showing Protek Duo cannula placement as well as right atrial distention that was noted after repair of the right ventricular perforation


interrogation of both the Protek Duo inflow and outflow circuits and the oxygenator, the decision was made to replace the Protek Duo device.

After successful wean of the Protek Duo device, the patient returned to the OR on POD 10 for RVAD removal. The patient had an overall complex hospital course, and was discharged to inpatient rehabilitation on POD 128.

#### CASE DISCUSSION:

Ventricular perforation due to a mechanical device implantation is an uncommon but potentially life-threatening complication of cardiac surgery. Very few cases of ventricular perforation have been reported in the literature. Most cases of cardiac perforation are related to the placement of cardiac implantable electronic devices (CIEDs), with the incidence of cardiac perforation ranging from 0.1% to 0.8% for pacemakers and 0.6% to 5.2% for implantable cardiac defibrillators.<sup>2</sup> Cardiac perforation is classified as acute when it occurs within 24 hours of device implantation, subacute perforation occurring

between 1 day and 30 days, or chronic perforation occurring more than 30 days after implantation. Subacute ventricular perforation is rare, and affects 0.5% to 1.2% of patients with CIEDs.<sup>3</sup> In these cases, perforation most often occurs in the right ventricle apex or free wall of the right ventricular outflow track, where the wall is thinner than other structures of the heart.<sup>4</sup>

Although perforation has been reported with CIEDs, very little is known about the risk of myocardial perforation in patients with percutaneous mechanical circulatory devices. This is the first case to our knowledge regarding right ventricular free wall perforation in a patient with a recent Protek Duo cannula placement. In our case, the perforation occurred in the subacute setting on POD 4 after a successful and uneventful insertion several days prior. The patient showed signs of hemodynamic instability yet was taken to the OR promptly before he could clinically worsen. The clinical presentation of ventricular perforation varies from cardiac tamponade and hemodynamic instability to incidental discovery on imaging, where prompt recognition of this condition and emergent surgical intervention are crucial for patient survival.<sup>2,3</sup> 

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**MENTORING**



# SOCCA JOB FAIR:

## HOW TO NAVIGATE TODAY'S CHANGING LANDSCAPE

October 4, 2023 | 6:00 PM ET



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## SOCCA EARLY CAREER INTENSIVISTS

The SOCCA Early Career Intensivists working group provides new members and members who are early in their careers with the resources needed to ease the transition from trainee to practicing intensivist.

### 2023 MEETINGS

**October 4, 2023** | 6:00 pm ET

**SOCCA 2023 Job Fair** [Register in advance for this meeting](#)

**November 15, 2023** | 6:00 pm – 7:00 pm ET

Please join us for a discussion regarding contract negotiations featuring: **Gerald A. Maccioli, MD, MBA, FCCM, FASA**, Vice President, Medical Affairs, The Accreditation Commission for Health Care; Chief Medical Officer & Board Advisor, Quick'rCare; Chief Medical Officer, Care Angel; and Chief Medical Officer, Moterum

[Register here](#)



### RECORDED MEETINGS

**July 19, 2023**

6:00 pm – 7:00 pm ET

[Watch Recording](#)

**September 20, 2023**

6:00 pm – 7:00 pm ET

[Watch Recording](#)



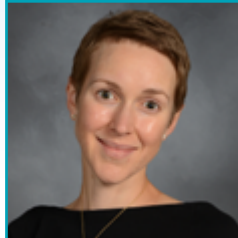
## EARLY CAREER INTENSIVISTS

# Bridging the Gap between Training and Practice for SOCCA Members

The transition between clinical training to independent practice is notoriously challenging. The goal of the SOCCA Early Career Intensivist (ECI) working group is to help support members through this progression. Founded in 2021, the ECI provides junior members with resources and content tailored to their concerns and interests. “The purpose of the group,” says Chair, Dr. Alisha Sachdev, “is to engage all SOCCA members in the first ten years of their careers with specific programming to meet their needs early on.”

Today, under the leadership of Dr. Sachdev and Dr. Christy Idichandy (Vice Chair) and Dr. Lauren Sutherland (Vice Chair), the ECI now hosts between 4 and 6 virtual events annually, as well as an in-person networking reception at the SOCCA annual meeting. Targeted content addresses effective mentorship, networking, and navigating the job market, among other topics. Prior webinars have explored “how to say no,” “work-life balance,” and “navigating a changing professional landscape.” According to Dr. Idichandy, ECI content is designed to help provide junior attendings with “mentorship and critical advice on growing [their] careers.”

Through its frequent and accessible programming, the Early Career Intensivist workgroup also strives to create and strengthen a sense of community among junior SOCCA members. In the words of Dr. Idichandy, “while [senior] mentorship is important and can help guide you in the right direction, sometimes talking to people in the same situation as you can be very comforting.” She notes that the Early Career Intensivist workgroup and programming offer “a great opportunity to meet colleagues in a similar career stage.” Dr. Sachdev echoes the welcoming nature of the ECI and frames it as a natural entryway into the SOCCA community. “We want all of our more junior members to feel like they are a part of the SOCCA family from the moment they join,” she says.



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Early Career Intensivist events also offer unique and valuable opportunities for junior SOCCA members to meet and ask questions of established and experienced intensivists. Nearly all ECI events feature “guest experts.” Prior panelists and discussants include Drs. Carlee Clarke, Michael O’Connor, Brigid Flynn, and Ashish Khanna, among others. “These events are a great place to get advice about how to start your academic or private practice career,” says Dr. Sutherland, who also notes that becoming involved in SOCCA may be intimidating to some junior members. “SOCCA may feel like a large community of well-known people who have accomplished so much,” she says. “We hope that our events can create a space to meet leadership, to have a more personal conversation with them, and to learn about how they got to where they are today.”

Recently, SOCCA board member Dr. Ashish Khanna was a featured guest at an Early Career Intensivists virtual networking event. In an online forum characterized by “lots of questions and discussion,” Dr. Khanna reports, “I really felt I could share my experiences and my leadership journey in various [professional] societies, as well as how to define a professional ‘niche.’” In his view, the Early Career Intensivist workgroup is a natural extension of the values that have shaped SOCCA for many years. According to Dr. Khanna, “SOCCA understands that trainees and junior faculty need opportunities to shine” within the organization and elsewhere. ECI offerings are one more platform through which SOCCA is helping to advance the careers of junior intensivists. Dr. Khanna notes that these efforts are particularly important given the rapid and exciting growth that SOCCA has seen in recent years, including from early career clinicians. “SOCCA’s growth from a few hundred to now over 1,100 members shows the high level of enthusiasm for our society,” he says. SOCCA is “full of opportunity,” and Early Career Intensivist


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## Early Career Intensivists *continued from page 6*

programming is one of many “first stepping stones” available to junior members.

Looking ahead to the remainder of 2023 and beyond, the Early Career Intensivist workgroup is expanding content to continue to support professional development and growth for members. In addition to creating opportunities for junior attendings to find mentors, the group hopes to create opportunities for these members to become mentors to medical students, residents and CCM fellows. Upcoming ECI events will also explore different facets of successful academic careers. In particular, Dr. Sutherland observes an opportunity to create programming for junior faculty who desire “academic but not necessarily research-based careers.” A September webinar, featuring Drs. Teresa Mulaikal and Arna Banerjee explored how to build a career in education. For members considering

academia or private practice, further scheduled programming in 2023 will address key strategies for successful contract negotiation and will feature former SOCCA President Dr. Gerald Maccioli. Finally, ECI leadership is working to strengthen connections to SOCCA programming for trainees. “We want to make sure that joining SOCCA becomes a normal next step after fellowship graduation,” says Dr. Sachdev. “We are always looking for people who want to get more involved!”

Information regarding future Early Career Intensivist events is available on the SOCCA website, along with previously recorded webinars. SOCCA members wishing to become involved in SOCCA Early Career Intensivist workgroup are invited to reach out to Society Director Vivian Abalama, IOM, CAE, at [vabalama@iars.org](mailto:vabalama@iars.org) for additional information. 



### JOB BOARD

**Read members-only job posts—including roles with:** Dartmouth Health, Lebanon, New Hampshire • University of Colorado School of Medicine, Denver, Colorado • Vanderbilt University Medical Center, Nashville, Tennessee • UMass Memorial Health, Worcester, MA • University of Louisville School of Medicine, Louisville, Kentucky.  
[Visit SOCCA's Job Board](#)

If you would like to post a job, please email a short description and/or PDF flyer including location, contact information, and closing date to SOCCA Society Director, Vivian Abalama, IOM, CAE at [vabalama@iars.org](mailto:vabalama@iars.org).

## ECMO EDUCATION FOR INTENSIVISTS

# Approaches and Potential Challenges

Since the 2009 H1N1 pandemic, there has been exponential growth in the use of extracorporeal membrane oxygenation (ECMO) for severe cardiopulmonary disease.<sup>1</sup> The increased utilization of ECMO has allowed the management of more complex and severe diseases, pushing the boundaries of critical care medicine (CCM) as a specialty. However, this increase in ECMO use means that more intensivists are likely to encounter and care for patients with ECMO, necessitating the evolution and standardization of specialized training in this field.

Despite the increase in the use of ECMO, there is significant variability in ECMO educational curricula and credentialing. A 2018 survey by Cook et al.<sup>2</sup> found that the majority of CCM fellowship program directors agreed that ECMO proficiency will be a growing part of CCM, but only 1 in 3 thought that their graduating fellows would be competent to do so. An even smaller number felt that their graduates would be able to cannulate for ECMO. Many CCM training programs face limitations in both ECMO case volume and the availability of expert educators in this highly specialized field, making the availability of internal ECMO education challenging.

The good news is that with the rapid growth of ECMO, there has also been an uptick in the available resources for ECMO education. Multiple online didactic courses are now available for a range of providers, and many professional societies offer a range of lectures, symposia, and simulation-based training courses for physicians who manage or plan to manage patients with ECMO. The Extracorporeal Life Support Organization (ELSO) offers an ECMO training course as well as Adult ECMO Certification. The American College of Chest Physicians and some large academic centers have created their own programs, aligned with the curriculum of the ELSO course. Many of these courses, however, are intended to target a broad audience including non-physicians, and to encompass all levels of training from novices to experienced providers. While this broad focus helps to improve overall access to ECMO education, a more targeted program specifically for intensivists is lacking. An intensivist-focused ECMO curriculum requires a greater depth of information required for the intricate decision-making demanded by critically ill patients, including a deep understanding of complex pathophysiology, nuanced patient assessment, and integration of ECMO into a larger treatment strategy.

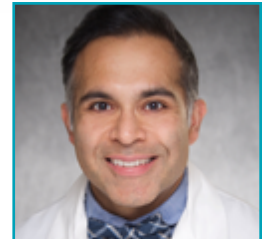
Another major hurdle is the lack of a standardized framework for intensivist ECMO education, with no agreement on the degree of education required to provide safe ECMO care nor the best way to evaluate competency.<sup>3</sup> Some centers offer dedicated non-ACGME-accredited ECMO fellowships either on a standing or ad-hoc basis, while other centers with higher ECMO volume consider critical care fellowship training to be adequate. This lack of standardization raises concerns about the consistency and depth of knowledge among intensivists currently managing ECMO, potentially impacting patient outcomes. As the field continues to evolve, establishing a consensus on the essential components of intensivist ECMO education is paramount to ensure optimal patient care and education to future trainees.

The Society of Critical Care Anesthesiologists is uniquely positioned to spearhead the development of a comprehensive educational framework and curriculum for ECMO within both the realms of critical care and perioperative medicine. A standardized ECMO curriculum targeted to physician intensivists could

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blend online and in-person learning to maximize accessibility and efficacy. Online components could provide learners with a foundational understanding of ECMO principles, including indications, contraindications, equipment utilization, and patient management strategies. Complementing this virtual component, immersive hands-on workshops with simulation for percutaneous ECMO cannulation and ECMO management would foster invaluable experiential learning in ECMO setup, monitoring, troubleshooting, and decision-making in a controlled environment.

The continued growth of ECMO has made it increasingly common in the intensive care unit. The creation of a standardized and readily accessible ECMO curriculum targeted to intensivists will help both experienced intensivists and trainees acquire the necessary skills and knowledge to manage these complex patients. By taking the lead in standardizing ECMO education, SOCCA in collaboration with

other societies can advance the fields of both anesthesiology and critical care medicine and ensure broad competency in this rapidly growing field. 

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[REGISTER HERE](#)



## SOCCA INTENSIVISTS IN PRIVATE PRACTICE

JOIN US FOR AN ONLINE MEETING  
**NOVEMBER 9 | 6:00 PM – 7:00 PM ET**

[REGISTER HERE](#)

SOCCA  
eLearning 

## SOCCA Critical Care Medicine 2023 Board Review Course

## EDUCATION COMMITTEE

# Ultrasound for Airway Management: Is it all Hocus POCUS?

Bedside point-of-care ultrasound (POCUS) has become ubiquitous in the critical care arena and is an essential tool for intensivists. POCUS has been used extensively to diagnose various cardiovascular and respiratory pathologies in critically ill patients and is now an integral part of various diagnostic algorithms in the intensive care unit (ICU). Yet, despite the proliferation of various portable and handheld devices, POCUS during emergency airway management in critically ill patients has never taken off.

The so-called “difficult airway” has traditionally described the anatomic difficulties associated with challenging visualization of the vocal cords and/or difficulty with placement of the endotracheal tube. With the almost universal adoption of video-laryngoscopy, however, such scenarios have become less commonplace. Nonetheless, complications associated with tracheal intubation in critically ill patients remain high. A recent international study found that 40.7% of critically ill patients undergoing tracheal intubation had a major adverse peri-intubation event, of which, cardiovascular instability was the predominant event<sup>1</sup>. Patients who experienced a major event also had a higher 28-day mortality. This highlights the significant risks associated with this commonly performed procedure, aligning with the concept of “physiologically difficult airway,” wherein the patients’ physiological state predisposes them to cardiorespiratory complications during tracheal intubation and/or initiation of positive pressure ventilation<sup>2</sup>.

Logically, hemodynamic optimization prior to and/or during tracheal intubation is essential but is often not considered or is inappropriate. Pre-emptive fluid administration is common prior to tracheal intubation, however, its role in improving outcomes is unclear. In a recent randomized controlled trial evaluating the impact of fluid bolus administration on peri-intubation hemodynamics, cardiovascular collapse was observed in about 20% of patients<sup>3</sup>. Similarly, the impact of pre-emptive administration of vasopressors is unclear. While there is no clear evidence that this strategy works, the Effect of a Fluid Bolus or a Low Dose Vasopressor Infusion on Cardiovascular Collapse Among Critically Ill Adults Undergoing Tracheal Intubation (FLUVA Trial) NCT05318066, is currently underway to better delineate the role of fluid loading versus early use of low dose vasopressors in decreasing the incidence of cardiovascular collapse during tracheal intubation. An individualized approach to using fluids, vasopressors, and/or inotropic administration to optimize peri-intubation hemodynamics is probably most appropriate, and we believe that POCUS is an important tool in our armament for this endeavor<sup>4</sup>.

A detailed description of the focused transthoracic exam is beyond the scope of this article. We prefer utilizing the rapid ultrasound in shock (RUSH) protocol to evaluate patients with peri-intubation hypotension rapidly and reliably<sup>5</sup>. Separating the evaluation into 3 components (the pump, the tank, and the pipes) allows for the assessment of multiple organ systems simultaneously to identify and differentiate the various shock states and to guide the next steps regarding optimization and management. Other resuscitative protocols are described in the literature as well, but one of the barriers to adoption is the perceived additional workload associated with the performance of POCUS in such time-limited circumstances.

*continued on page 11*



**Christopher Choi, MD**

*SOCCA Membership  
Committee, Subcommittee on  
Students, Residents, & Fellows*

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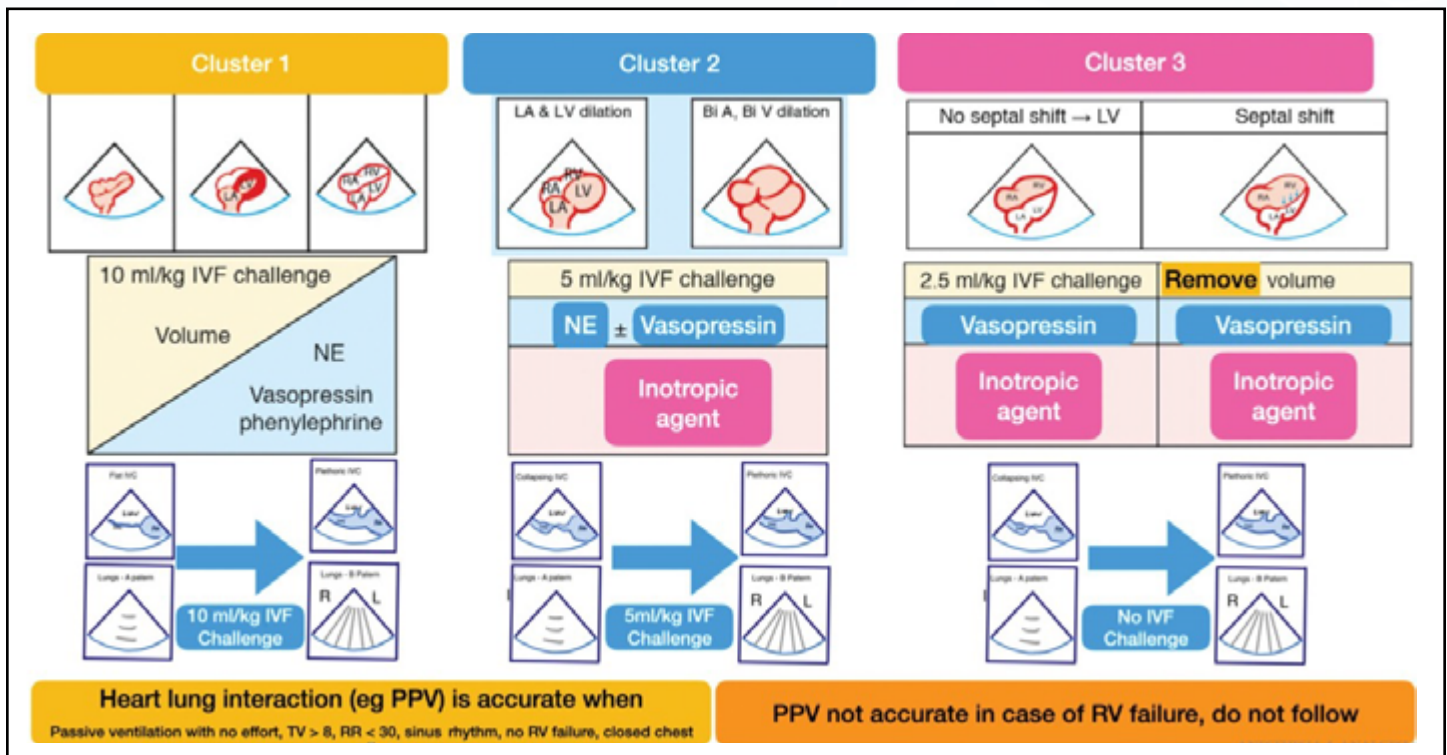
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Similarly, the logistics regarding the availability of the equipment and trained personnel is another deterrent. In addition, depending on the presence, type, and degree of pulmonary disease, parasternal and apical views may be difficult to obtain. In more pressing situations, and in situations when the subxiphoid window might be the only window readily available, a subxiphoid-only view assessment (EASy) provides sufficient information in most patients to narrow the differential diagnosis of hemodynamic instability and determine intravascular volume status—when paired with IVC assessment<sup>6</sup>. Recognizable phenotypes based on a qualitative assessment of right and left ventricular size and function, IVC size and variability over the respiratory cycle, and specific patterns of obstructive pathology, can help streamline training via visual patterns, which can be combined with pathology-specific interventions (See Figure 1).

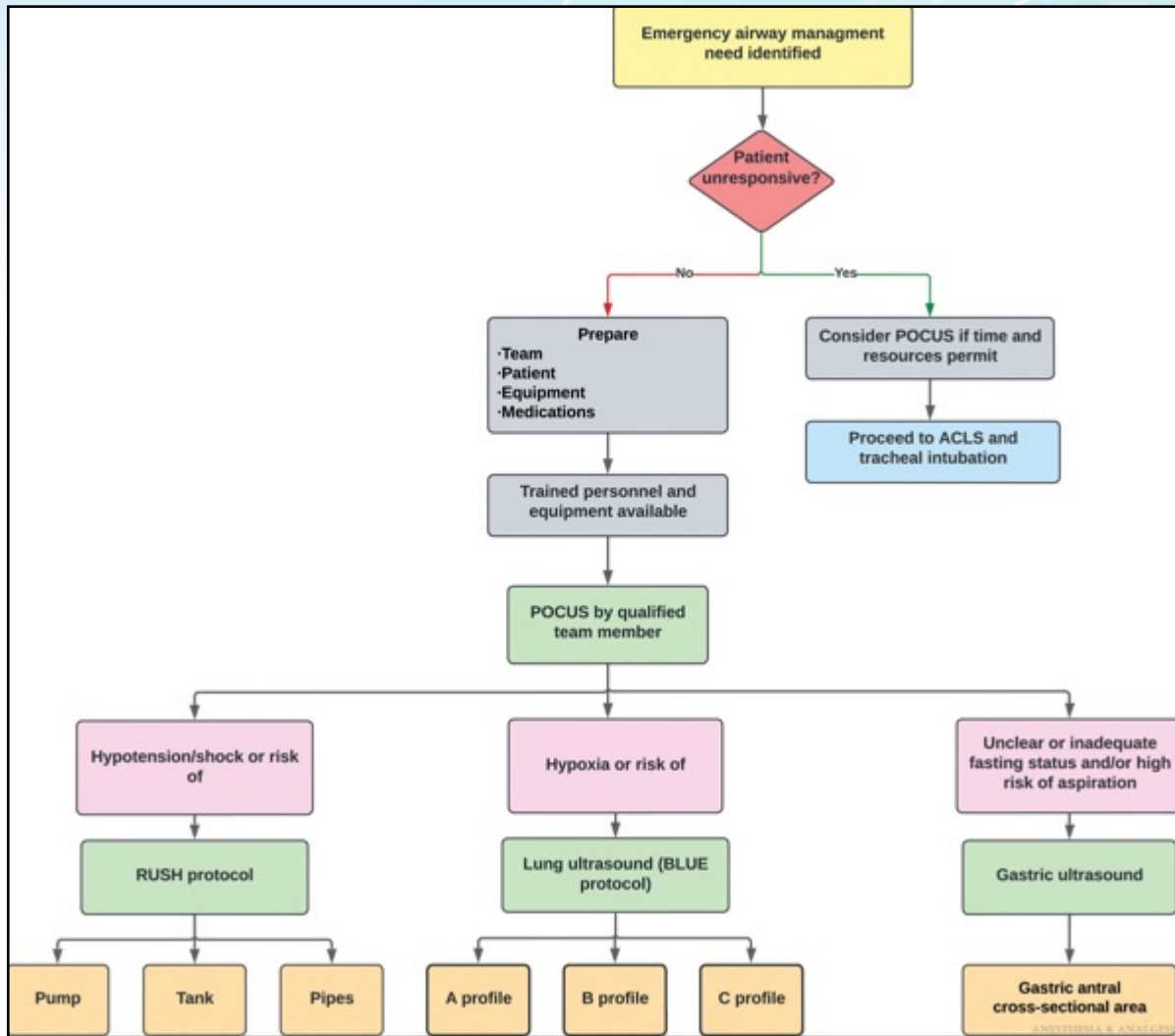


**Figure 1:** Echocardiographic assessment using subxiphoid-only phenotype-driven therapeutic management algorithms. BiA indicates biatrial; BiV, biventricular; IVC, inferior vena cava; IVF, intravenous fluid; IVS, interventricular septum; LA, left atrium; LV, left ventricle; LVH, left ventricular hypertrophy; NE, norepinephrine; PPV, pulse pressure variation; RA, right atrium; RR, respiratory rate; RV, right ventricle; TV, tidal volume. Figure reproduced with permission from Khorsand et al (2023), copyright Wolters Kluwer Health, Inc.

After training, clinicians can quickly recognize phenotypes associated with the risk of hemodynamic collapse prior to tracheal intubation due to either drug-induced vasodilation or myocardial depression and/ or initiation of positive-pressure ventilation. This recognition may ultimately lead to timely preemptive interventions. While operator competency remains an area of concern, a recently published case series demonstrated the feasibility of a resident-performed EASy exam during advanced life support (EASy-ALS)<sup>7</sup>. We believe that continuing development of POCUS training will further alleviate this concern in the future.

Recent guidelines for tracheal intubation of critically ill patients surprisingly do not mention the use of POCUS<sup>8,9</sup>. The Difficult Airway Society does recommend the use of POCUS during airway management, but for a separate indication; identification of the cricothyroid membrane in obese patients where it is unpalpable<sup>10</sup>. While waveform capnography remains the gold standard for confirming endotracheal tube placement, it is not always available outside the operating room, and in these situations, POCUS has been proposed as a replacement<sup>11</sup>. Routine integration of POCUS in emergency airway management outside the operating room may improve optimization and guide management, while potentially improving outcomes. Khorsand and colleagues have proposed an algorithm that can be utilized in such situations (Figure 2)<sup>4</sup>.

*continued on page 12*



**Figure 2:** Proposed algorithm for integrating point-of-care ultrasound in the workflow of managing a patient with a physiologically difficult airway. POCUS, point-of-care ultrasound; ACLS, advanced cardiac life support; RUSH, rapid ultrasound in shock; BLUE, bedside lung ultrasound in emergency. Figure reproduced with permission from Khorsand et al (2023), copyright Wolters Kluwer Health, Inc.

In conclusion, we believe we are in the early adoption phase of POCUS in airway management, and with continued advances in handheld devices and lowered cost barriers to entry, we have a unique opportunity to protocolize patient care for the better. 🏠

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## SOCCA — Perioperative Shock Management

Saturday | October 14, 2023 | 2:30 PM - 3:30 PM

Anesthesiology 2023 Annual Meeting | Room: South 215



Moderator  
**Kamrouz Ghadimi, MD, MHS**  
Duke University



**Ashish Khanna, MD, FCCP, FCCM**  
Wake Forest University  
**Vasopressors, Inotropes, & Inhaled Agents in Shock**



**Jacob Gutsche, MD**  
Penn Medicine  
**ECMO Use in Shock**



**Sara Nikravan, MD**  
University of Washington Medical Center  
**Ultrasonography for the Evaluation & Treatment of Shock**

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#ANES23



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## WOMEN IN CRITICAL CARE

QUALITY + COMPASSION + BENEVOLENCE

# Women in Critical Care Steering Committee Welcomes New Members



**Dr. Teresa Mulaikal, MD, FASE**, is a cardiothoracic and critical care anesthesiologist, practicing at Columbia University in New York. She also serves as the Core Residency Program Director, directing the education of 104 residents annually. In this role, she has been a part of the transformative journey of young physicians in training. She finds it both inspiring and challenging. She wishes to join Women in Critical Care (WICC) as she believes WICC is a group of talented clinicians and leaders who provide outstanding patient care, as well as promote the work of the wonderful women who surround them.

*“Our accomplishments are more rewarding and fulfilling when we succeed together.”*



**Tess Russell, MD**, Assistant Professor of Anesthesiology at Columbia University Vagelos College of Physicians and Surgeons, is a Texas transplant to New York City. She moved to New York in 2005 to complete Anesthesiology training, and in 2014, she left practice to pursue additional training in Critical Care Medicine at Mount Sinai Hospital. Currently at Columbia University, she serves as the co-director of the Physician Well-Being Initiative in the Department of Anesthesiology, the faculty well-being lead for Columbia University, and is the Medical Director of the Anesthesia Pre-operative Clinic. Her academic interests are

centered on physician flourishing. She was voted Physician of the Year at New-York Presbyterian Hospital in 2020, CTICU Attending of the Year, ICU Resident Teacher of the Year and Kathryn Cozine Resident Teacher of the Year. Dr. Russell lives in New York City with her husband and three children. She wishes to join Women in Critical Care (WICC) as she believes WICC is a team where women can celebrate and collaborate with each other.

*“The diversity, excellence and compassion of Women in Critical Care allows for true community formation.”* 



**Shahla Siddiqui, MD, MBBS, MSc, FCCM**

*Co-Chair, SOCCA Women in Critical Care Working Group*  
Assistant Professor,  
Department of Anesthesia, Critical Care and Pain Medicine  
Beth Israel Deaconess Medical Center  
Boston, MA



**May Hua, MD, MS**

*Co-Chair, SOCCA Women in Critical Care Working Group*  
Associate Professor of Anesthesiology  
Columbia University  
New York, NY

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**WHEN:** Sunday, October 15  
4:30-5:15pm

**WHERE:** Exhibit Hall:  
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## WOMEN IN CRITICAL CARE

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### Featuring Guest Speaker: **Dr. Lauren Hill**

Senior Vice President; Chief Operating Officer,  
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### Featuring Guest Speaker:

**Margaret Wood, MD, MB, ChB, FRCA** [WATCH RECORDING](#)

EM Papper Professor Emerita of Anesthesiology and Chair Emerita  
of Anesthesiology, Columbia University Irving Medical Center



### Featuring Guest Speaker:

**Rebecca Aslakson, MD, PhD, FAAHPM, FCCM**

Chair, Department of Anesthesiology, Larner College of Medicine  
University of Vermont [WATCH RECORDING](#)

## PODCASTS



SOCCA has collaborated with Stanford Continuing Medical Education for a Stanford Medcast Women in Critical Care podcast mini-series. The goal of the mini-series is to provide professional development content that puts a new lens on how Women in Critical Care define success and “having it all.” Listeners will hear from leaders in a wide range of fields, including organizational psychologists and experts in physician wellbeing. In these dynamic conversations, we hope to support and nourish the multiple roles that we play in our day-to-day lives.

#### EPISODE #66

“Psychosocial Challenges Facing Physicians” — [STREAM NOW](#)

#### EPISODE #65

“Stereotype Threats” — [STREAM NOW](#)

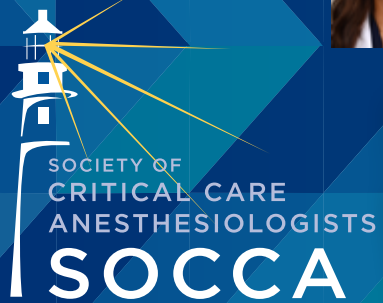
#### EPISODE #63

“The Wicked Problem of Physician Well-Being” — [STREAM NOW](#)

#### EPISODE #69

“Underestimation of Influence” — [STREAM NOW](#)





# SEPTEMBER IS Women in Medicine Month

SOCCA (the Society of Critical Care Anesthesiologists) would like to acknowledge the invaluable contributions of our female intensivists during this month and year-round.

Women face numerous challenges and perhaps even more in Critical Care.

SOCCA will continue to advocate for our female colleagues and support their salient roles in committees, educational panels and leadership positions throughout the society.

We look forward to increased female recruitment and participation in the field of Critical Care Anesthesiology.

Thanks for everything you do!

Warmly, **SOCCA Board of Directors**

SOCCA is dedicated to the support and development of anesthesiologists who care for critically ill patients of all types. SOCCA fosters the knowledge and practice of critical care medicine by anesthesiologists through education, research, advocacy, and community. To learn more about SOCCA, please visit: [socca.org](http://socca.org)

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AMA celebrates women physicians, residents and students throughout the month of September—and all year. [Click here](#) to learn more.

# SEPTEMBER IS Women in Medicine Month



## Now is Our Moment: A Call for Mentorship

### INTERVIEW SUBJECTS:



**Dr. Rebecca Aslakson, MSci, PhD, MD**, is a triple-boarded physician in Anesthesiology, Palliative Care Medicine, and Surgical Critical Care, and is the Chair of the Department of Anesthesiology at the Larner College of Medicine at the University of Vermont.

**Hannah Wunsch, MD, MsC** is an author, anesthesiologist, and intensivist in the Department of Anesthesiology, Weill Cornell Medical Center, New York.

I recently had several conversations with rising women medical students and residents wanting to know more about anesthesiology and critical care medicine as a career. Typically, in these situations, I think many of us feel compelled to give “the pitch” for why our lives are so great. And yes, recruitment into our subspecialty, particularly for women, is severely needed.

But we know that our specialty, compounded between anesthesiology and intensive care, is a profession at high risk for burnout and exhaustion. Aside from clinical responsibilities, women also contribute a significant time to “invisible work” – that is, work that requires time and effort but is not recognized by common metrics both professionally and in our personal lives. When these aspiring intensivists reach out to explore our career path, I sometimes walk away from these conversations unsatisfied. What is, or should be, our goal?

When reflecting on the questions these women ask, most of them aren’t asking for the generic answers of perioperative management of patient care in the operating room and intensive care unit, the fulfillment of treating complex physiology, etc. Those are easily demonstrated in the literature and with online searches. What these women want to know is not why we do it, but how we do it. It is incumbent upon us for the *successful* careers of future generations of women intensivists that we do not play Oz in the back room and simply put on a good show. We owe it to the next generation to pull the drapes back and reveal the inner workings of our lives.

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**Sarah Alber, MD**  
*SOCCA Women in Critical Care Working Group Assistant Professor of Anesthesiology Associate Program Director, Anesthesiology Critical Care Medicine Fellowship CU Anschutz Medical Campus Aurora, CO*



**Shahla Siddiqui, MD, MBBS, MSc, FCCM**  
*Co-Chair, SOCCA Women in Critical Care Working Group Assistant Professor, Department of Anesthesia, Critical Care and Pain Medicine Beth Israel Deaconess Medical Center Boston, MA*

Mentorship is essential for this mission; however, we are all susceptible to the lack of protected time and the limited number of experienced mentors. In fact, some studies suggest women carry a higher responsibility for mentorship, but without recognition in academic promotion or metrics for advancement (note again the invisible work), and without having mentors ourselves (<sup>2</sup>Shen MR, *et al.*). The Push-Pull Mentoring Model (<sup>1</sup>Silver, *et al.*) provides a bidirectional approach to mentorship, suggesting active participation by both the mentor and mentee contributing to a symbiotic relationship with academic and career productivity for both.

As this September recognizes Women in Medicine, let us alter our framework to become the *Lion, the Scarecrow, and the Tin Man* for our mentees, to help them navigate this career path and ultimately mentor them to become successful guides themselves. Below we asked expert women mentors in anesthesiology critical care medicine for suggestions on how we accomplish this mission:



**IN YOUR OPINION WHAT ARE THE QUALITIES THAT ENHANCE A GOOD MENTOR-MENTEE RELATIONSHIP?**

**Dr. Aslakson:** I think the most important quality in a good mentor-mentee relationship is earnest mutual respect and appreciation for each other. Along with that, good listening on both parts is key; with good listening to each other, the mentor can best understand the needs and goals of the mentee and the mentee can better process and utilize what advice the mentor has to give. As both mentor and mentee, my most rewarding relationships have been the ones where we honestly appreciate, respect, listen to, and enjoy each other as people and colleagues.

*“It is important to just be honest and, if needed, to set limits with mentees.”*

**IT IS NOT EASY TO FIND TIME AND PASSION FOR MENTORSHIP, HOW DO YOU STRETCH YOURSELF?**

**Dr. Aslakson:** Mentorship is not one-size-fits-all for every relationship, and that is a good thing. Sometimes you have more to give and other times you have less. It is important to just be honest and, if needed, to set limits with mentees. There are some mentees where we have a longitudinal, deep relationship that clearly has significant time invested on both sides. Then there are others where I might meet with them once or twice a year, and that is sufficient for both of us. Sometimes being able to offer only a little interaction, such as a single call or meeting, is still better than nothing and can start the person on the path to find a mentor who can make a more significant time investment. Also, clarity is a gift; if I recognize that I cannot be the mentor that a mentee would want, it is a gift to them to honestly say “no” and to help them find someone else. Knowing and respecting your own limits is important for self-care and it also is important for your mentees to see (and model).

**WHAT WOULD YOU TELL NEW MENTORS THAT YOU WISH YOU HAD KNOWN BEFORE YOU EMBARKED ON THESE RELATIONSHIPS?**

**Dr. Aslakson:** No one knows everything. Keep humble but also recognize that you have worked multiple years in the field, you have good experience, and you have good things that can help others. Also, a big part of being a good mentor is taking the time to listen; I feel like I have helped some of my mentees the most not through what I said but by giving them the space to talk through their thoughts and experiences. I have helped them the most by being someone with whom they can plan next steps forward. So never underestimate the incredible importance and value of being a sage, thoughtful, and wise listener for your mentees.

**WHAT ADVICE WOULD YOU GIVE TO MENTEES TO CONTRIBUTE TO THE MENTOR-MENTEE RELATIONSHIP, AND HOW CAN THIS PROMOTE ADVANTAGES FOR BOTH MENTEE AND MENTOR?**

**Dr. Aslakson:** I really like when my mentees approach our meetings with agendas; the day before we are meeting, they email me a tentative agenda for what they would like to discuss. It helps me to prepare so I am ready for the meeting. The agenda also enables the mentee to prioritize their goals and what they want out of our meeting. I find that having an agenda (it can be tight or loose) helps my mentee and I to be markedly more productive in our meetings.

**HOW DOES MENTORSHIP INTERSECT WITH INCREASING DIVERSITY AND INCLUSION?**

**Dr. Aslakson:** Mentorship is a major tool by which one can improve diversity and inclusion within a group. It is very hard to be what you do not see and thus, as individuals who are underrepresented in leadership rarely see people like them in leadership, they are consciously and unconsciously less likely to promote themselves as potential future leaders. Yet, with mentorship, you can actively short-circuit that negative pathway. By actively mentoring, sponsoring, and coaching

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individuals from underrepresented communities, you can help them to recognize their own potential, to more smartly leverage and work their way through the system, and to set themselves goals that they would not otherwise have thought possible.

**HOW CAN MENTORS BRIDGE SOCIAL CAPITAL AMONG SIMILAR GROUPS? BRIDGING SOCIAL CAPITAL DESCRIBES THE PROCESS OF UNITING INDIVIDUALS OF DIVERSE BACKGROUNDS TO ENCOURAGE COLLABORATION, UNDERSTANDING, AND THE EXCHANGE OF RESOURCES.**

**Dr. Aslakson:** The biggest thing is to connect your mentees across different domains. You likely exist in multiple domains in your career; for example, I am a critical care anesthesiologist and palliative care physician and researcher as well as the Chair of a Department of Anesthesiology. Thus, I have different “circles” of colleagues from critical care practice, critical care research, palliative care practice, palliative care research, administrative leadership, etc. I also have mentees in each of those different domains. One of the most helpful things that I can do is to bring together people across domains who might not have otherwise met but who could likely potentiate each other. Thus, I would encourage mentors to think about all of the different domains in their own career and to be open to thinking about how to connect people across them.

**HOW DOES MENTORSHIP INTERSECT WITH INCREASING DIVERSITY AND INCLUSION?**



**Dr. Wunsch:** Only through good mentorship can we increase diversity and foster inclusion. Mentorship is a way to show the next generation what successful, but also inclusive, working environments look like. While it may help to have mentors who themselves are diverse, I think mentors who may come from more traditional backgrounds can still help enormously to increase diversity and a sense of inclusion by the way they interact with others, and whether the environment in their lab, or research group, or more generally, feels welcoming, non-judgmental and supportive. It is also important to educate oneself about what the specific challenges are for different people. The topics addressed in discussions and the focus of the mentorship needs to be tailored to focus on whatever the specific challenges are for an individual, whether due to culture, or family background, or personality.



**IN YOUR OPINION WHAT ARE THE QUALITIES THAT ENHANCE A GOOD MENTOR MENTEE RELATIONSHIP?**

**Dr. Wunsch:** Trust is a big one. Both mentor and mentee have to trust each other. The mentor needs to know that the time and energy invested in a mentee are valued (and also respected) and that the mentee will make good use of the advice and support. The mentee needs to feel confident that the motivation of the mentor is one that is focused on excitement about seeing the mentee succeed, rather than about their own success or promotion. Both need to be committed to the relationship.

For a mentor, it’s important to let go and allow a mentee to make some mistakes along the way and then also help them build confidence in their own judgement. Otherwise, there can be too much reliance on the mentor for advice at every single step. However, I think it’s also important for a mentor to know when to step in and help a mentee avoid wasting time. Finally, I think a real key to the relationship is to recognize that ultimately each individual’s journey is about whatever makes them happy; this may not be the path the mentor is on, and it also may not be the path a mentor recommends.

**IT IS NOT EASY TO FIND TIME AND PASSION FOR MENTORSHIP, HOW DO YOU STRETCH YOURSELF?**

**Dr. Wunsch:** Mentorship is so important that it’s essential to find time for it. However, mentorship can take many forms, and sometimes it’s just a sporadic chat with someone at a conference, or a quick call a few times a year – these can be very rewarding relationships on both sides.

That said, for more traditional mentoring, which is a big-time commitment, I do think it’s important not to take on mentorship of too many people at once. While sporadic mentorship may be appropriate in some situations, in general, the mentor/mentee relationship requires a real commitment

*continued on page 21*

and availability. I also think it's a mistake to take on too much mentorship early in one's career. There are different phases in a career, and while peer mentorship can be great, it's hard to carve out time when you are yourself career-building.

*“A mentor can only provide useful support and advice if a mentee is honest about what they want to be doing and what they care about.”*

**WHAT WOULD YOU TELL NEW MENTORS YOU WISH YOU HAD KNOWN BEFORE EMBARKING ON THESE RELATIONSHIPS?**

**Dr. Wunsch:** Not every person looking for a mentor is someone you can mentor yourself. This may be because you are over-committed, their research interests or career focus don't align with yours, or because their personality is just not a good fit. I think it's much better to help guide such individuals to others and to recognize that you can't be a great mentor to all who need mentorship. That said, I've also been surprised as a mentee myself as to how meaningful and helpful even a single conversation with someone can be, often with people who are at different institutions or from different backgrounds. So, I also encourage people to be willing to meet, even if it's just for a chat. Those can sometimes be life-altering conversations.

**HOW CAN MENTORS BRIDGE SOCIAL CAPITAL AMONG SIMILAR GROUPS? BRIDGING SOCIAL CAPITAL DESCRIBES THE PROCESS OF UNITING INDIVIDUALS FROM DIVERSE BACKGROUNDS TO ENCOURAGE COLLABORATION, UNDERSTANDING, AND THE EXCHANGE OF RESOURCES.**

**Dr. Wunsch:** One way I try to facilitate this is by having a weekly “lab meeting.” I don't run a lab, but the idea is modeled on such meetings (I worked in a basic science lab as an undergraduate). To me, this is an opportunity for coming together as a group – ideally in person, although virtual can

work as well. And it's an opportunity to hear what others are working on, to exchange ideas, and to just force everyone to interact and share ideas. A lot of research (or clinical work) is spent off on one's own and so I think circumscribed discussion time is essential to help connect people. This is also true of more purely social events. I think it really helps people to come together socially as an opportunity to get to know each other, when there is a shared interest, such as a research area or clinical focus.

Something I noticed after COVID-19 was that more junior mentees didn't appreciate the value of attending conferences in person because they'd never had the opportunity! I encourage people to go to conferences as I think it is such a key way to forge relationships with like-minded individuals at other institutions and in other areas. So many of my main friendships and collaborations in my own work were formed standing in front of posters and at coffee breaks, and so I feel we need to really reinforce the importance of such interactions.

**WHAT ADVICE WOULD YOU GIVE TO MENTEES TO CONTRIBUTE TO THE MENTOR-MENTEE RELATIONSHIP, AND HOW CAN THIS PROMOTE ADVANTAGES FOR BOTH MENTEE AND MENTOR?**

**Dr. Wunsch:** Honesty is key. A mentor can only provide useful support and advice if a mentee is honest about what they want to be doing and what they care about. It's a danger that the mentee wants to say the right things to “please” the mentor. But this doesn't benefit anyone.

Related to that is the importance of the underlying tenet that people need to make choices and spend their time in ways that will make them happy. Both mentor and mentee must remember this. I think it's very important always to have frank conversations about individual goals and aspirations, mental health, and the importance of prioritizing family (and friends) in one's life. 🏠

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# SEPTEMBER IS Women in Medicine Month



## Maintaining Work-Life Balance as an Early-Career Intensivist

**HOW DO YOU BALANCE STARTING A CAREER WITH HAVING ENOUGH TIME FOR FAMILY OR OBLIGATIONS OUTSIDE WORK? DOES HAVING YOUNG CHILDREN MAKE IT DIFFICULT TO LAUNCH YOUR CAREER, OR CAN YOU REALLY DO IT ALL?**

**DR. SCHILLING:** I started my Anesthesia-career with a family of two—my husband and me. Within 3-6 months of starting my specialty, we were blessed with a puppy and our miracle baby girl. I will say “balance” is far from something that can be sustainable with just one recipe. Many of the things that worked for me a few years ago definitely do not work today. I think that making a 5-10 year “career goal” and a similar 5-10 year “life goal” is imperative. Then seeing how the two goals interact and what changes need to be made so that you can make both those goals attainable. For example, my 10-year “career goal” is to become a Critical Care Medicine Director. *How would that work with my daughter or if we wanted to further expand our family? What leadership positions would I have time to do now to set myself up for that career move?*

Another aspect of balance is establishing priorities; big and small. In going through a divorce, constantly working on my marriage has become a huge priority. In battling infertility, soaking in all the moments with my daughter has taken precedence over joining another committee or picking up *per diem* Anesthesia shifts. If you choose to focus the next 10 years on finding your spouse and traveling the world, then make peace with your choice and have grace and patience with yourself regarding the things that have moved lower on your priority list. It is okay to have seasons in your life; you dictate what those seasons will focus on.

Children are hard but it is not a “difficulty”. I always knew I wanted to have a child more than I wanted to pursue Medicine. I strongly believe that if you have a flexible and strong support system, you can do many things and do them well. If I go back to my prior example, I do not think I can jump into a Medical Director position at this moment, but there are other roles I feel comfortable taking on while still making it home for bath time and story time. A great mentor once told me to divide my life into buckets and decide which bucket I want to give to on a daily, weekly, or yearly basis. For me, that means I am wholly

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*“I think that making a 5-10 year “career goal” and a similar 5-10 year “life goal” is imperative”*

—Amanda Kore Schilling, DO

engrossed in work while I am at work and when I am at home, I am completely focused on being present for my husband, daughter, and dog. After my daughter’s bedtime, I can sit and do some learning modules, catch up on my emails, and plan my sister’s bridal shower.

**DR. SUTHERLAND:** It’s hard! I had my first child 6 weeks after becoming a new attending, so taking maternity leave was stressful. I was sure I would forget all my training while I was gone. Fortunately, that was not the case, and I felt very ready to come back to work. But having a family affects everyone differently. For me, I love my job, and this makes coming to work every day easier even though I miss my kids. But there are moments I miss at home because I’m at work, and there are events at work that I just can’t attend because of family obligations. I try to prioritize the important events, request time off early, and acknowledge that I just won’t be able to get as much done at home as I used to. There are many compromises while trying to “do it all”.

**DO YOU EVER FEEL LIKE PEOPLE TREAT YOU DIFFERENTLY AT WORK BECAUSE YOU HAVE A FAMILY OR OTHER NON-WORK OBLIGATIONS?**

**DR. SCHILLING:** My first job was at a private practice anesthesia group where many of my colleagues did not understand my requests for time off for IVF ultrasounds, etc. In trying to keep aspects of our fertility journey private, I was labeled as someone who never wanted to work. That label was a huge blow to my ego and was far from the physician I wanted to be perceived as. This was in part due to my naiveté in finding a flashy job and not taking the time to learn the demographics of my future partners. Currently, I am a part of a team of Intensivists who are all in similar stages of life. For a few months, two of us were nursing mothers, we would just alternate covering each other’s unit while the other one went to pump. Finding a supportive work environment was never something we are taught to seek. Do not let anyone tell you that you need to settle for a pay cut to find a job that supports you as an ambitious career woman, a new doctor-mom, or whatever you may define yourself as. You can have a job that values you financially, has a schedule that fits your family, and

cultivates a supportive working environment. Spend the time and search for your perfect position. Do not settle.

**DR. SUTHERLAND:** I purposely chose a workplace with a very supportive environment and many faculty members with families and young children. It’s the norm here to have life events that you need to get to outside of work. People are very understanding and flexible, and it makes the time I spend away from my family easier and more fulfilling.

**HOW DO YOU CHOOSE WHICH ASSIGNMENTS OR POSITION POSTINGS TO TAKE ON TO MAINTAIN A WORK-LIFE BALANCE?**

**DR. SCHILLING:** As far as daily assignments, being an anesthesiologist was hard. If you are in a position that allows you to pick your assignment for the day as a production-based anesthesiologist, then that could mean choosing between a good paycheck or making it for school pick-up. The nature of practicing in a hospital-based setting is comprised of add-on OR cases, emergencies or traumas, STAT C-sections, and the untimely call from labor and delivery for an epidural. Compared to that, transitioning into a full-time ICU role has given me a far more predictable schedule. I do not get to pick how many admits or consults I do in a day, and I work non-stop during my 7-day stretches in the unit, but when I am off, I am completely off. Granted, as you move up in your career, those 7-days of unplugged bliss start filling up with Zoom obligations, email responses, and random paperwork. However, if you understand those expectations, then you can work around them. YOU define your work-life balance. Now that I have created my 10-year “career goal,” I can triage what extracurricular assignments and tasks are manageable and work towards my goal. However, despite carefully choosing those extra projects, there are some weeks when I feel off balance. I consciously try to reset and implement subtle changes to improve my flow for the next week.

**DR. SUTHERLAND:** I’m a big planner, and I think this has been helpful in managing my work and home life. I purposely choose call weekends when we don’t have anything planned, and I put in early requests to be post-call or vacation days when I need to be at home. My husband and I share a Google calendar with our work and non-work schedules to make sure we have the necessary childcare. In terms of academic projects, I’m working to get better at saying no and only taking on projects that interest me and will help advance my career. But this is obviously easier said than done! I also have a strict rule that I don’t do work in the evenings or on weekends so I can spend time with my family. I try to use my time at work or on post-call and nonclinical days to be productive with academic projects.

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**DO YOU THINK WOMEN ARE UNEQUALLY AFFECTED BY THE ISSUE OF WORK-LIFE BALANCE?**

**DR. SCHILLING:** I think physiologically women have more to juggle with and I believe we were created with the capacity to handle it. I have a rockstar female co-intensivist, her background is Emergency Medicine. We laugh about how we can start dinner, put a load of laundry in, give the baby a snack, check back on dinner, finish feeding the baby, then move the clothes to the dryer, all within a few hours' time. We mimic our ICU workflow at home, and it works wonders. Meanwhile, if it were just left to our husbands, the house would fall apart on laundry day. The men-women, mommy-daddy dynamics will never change. It has been a constant learning process as I grow in my marriage and as our daughter's needs change so much on a week-by-week basis. However, as a female physician, I struggle with all the extra effort I need to put into just being a doctor. I was just asking one of my female colleagues if she feels just as exhausted in just showing up to play the same game that may have been built for our male colleagues. My male colleagues can run around the whole hospital and never have to stop and explain who they are, justify their credentials, or demand personal or professional respect. Meanwhile, if I am not completely ignored, I am either the janitor, transporter, or nurse's aide. I am never assumed to be the physician, whereas my male medical student or intern is always presumed to be my "senior." This is the aspect of our profession that has the potential to break me down, especially in an ICU where there are so many social interactions with staff, families, and patients. I come home exhausted just from trying to prove why I should have a seat at the table of a treatment team where I am the Attending Physician. This subliminal struggle is what throws off my work-balance and is a common plight of many of my female colleagues.

*"I purposely chose a workplace with a very supportive environment and many faculty members with families and young children."*

—Lauren Sutherland, MD

**DR. SUTHERLAND:** I do think there are a lot of physical hardships that women face with pregnancy, delivery, and breastfeeding that are unique and can be very physically and emotionally taxing. But every family has its own dynamic where home and work life are shared differently. I feel very



fortunate to have a husband who shares equally in childcare responsibilities, so this puts less of a burden on me to manage our home life. I also work longer hours which naturally shifts some responsibilities away from me and onto my husband, and this helps make our marriage and partnership feel more balanced.

If you take on a project that becomes more work than you can handle with your outside-of-work life, what can you do without burning any bridges?

**DR. SCHILLING:** I recently was on the receiving end of this exact situation. A project partner did the right thing for themselves in triaging their obligations and dropping the one project that was too much work for little yield—which happened to be my project. For that young woman, I wholeheartedly applaud her. However, I was not prepared to carry out the bulk of the project. If you are feeling overextended, I would advise you to be honest with the commitment and those involved, examine why it has now exceeded your expectations, ask for help, and attempt to delegate. If you have exhausted all options to cope, then ask someone else to take the lead and help ease your burden. When you bring up these difficult conversations, always end the communication in a positive and reassuring way that reinforces your gratitude for the opportunity and that through this experience you will better be able to assess future projects.

**DR. SUTHERLAND:** I think communication is incredibly important, both with your workplace and with your family and support system. It's essential to have support at home, whether that's from a partner, family, friends, or childcare providers, and I personally ask for help with childcare whenever I can. At work, if I'm feeling overwhelmed, I feel very comfortable talking to my bosses and colleagues to figure out the best way to manage work responsibilities. But

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that's not to say it's always easy! I've had to admit failure on projects in the past when I simply didn't have the time. This obviously can stir up a lot of difficult feelings, but in the end, one person can only do so much!

Do you have recommendations on what to do if you start to have trouble with work-life balance? What are some resources you can utilize?

**DR. SCHILLING:** I don't have a cookie-cutter recommendation, as I am far from a guru in this area.

But I will happily tell you what I have learned in my short time juggling multiple commitments. There is NOT one answer, and my answer may not fit your problem. I believe that one should have a system in place to outsource your frustrations and in turn, feel validated and supported. I recorded a podcast mini-series with Stanford Medcast for "Women in Critical Care" and in doing that, I learned that ALL female physicians struggle with balance. I felt validated in my journey when I heard one of my mentors describe how she had to learn to place boundaries to protect her home life. In another episode, I interviewed a Marriage and Family Therapist, Alaina Henry, MA, LCPC, NCC who also talked about the importance of boundaries but also gave great advice regarding how to cope with trauma and stress via Eye Movement Desensitization

and Reprocessing (EMDR). Putting effort into building that support system, utilizing your faith or beliefs, and taking time to rekindle your passions, are doable steps in your journey towards finding sustainable peace in your work and home life. Everyone struggles at some point or another, so be honest with yourself, give yourself grace, and don't give up on finding peace and happiness because it is obtainable. I think work-life balance may be a myth and maybe the entire concept should be redefined as peace in your work-life world.

**DR. SUTHERLAND:** I can't emphasize enough how important it is to have a reliable support system. I have a very supportive husband whose work hours are more flexible than mine, so he gets the kids to school in the morning and often picks them up when I'm on call. I also have extended family nearby that can help out in a pinch, and they love to come to spend time with us on weekends. As much as I personally hate asking for help, when I'm feeling overwhelmed, I know it's important for my mental health. The place where I work also has an office of work-life which offers some helpful resources. 🏠

[Stream the \*Stanford Medcast Women in Critical Care\* Mini-Series Podcasts](#)



We at SOCCA would like to invite you to join Women in Critical Care—our initiative to form a women's group within the ACCM community.

# SEPTEMBER IS Women in Medicine Month



## “SWAT” (Supporting Women Anesthesiologists to Thrive) Program

*Crafted by Women, Sponsored by Leadership*

### BACKGROUND

A diverse workforce has the potential to mitigate healthcare disparities, and improve patient satisfaction.<sup>1</sup> Diverse leadership offers key benefits as described by 14 members of Forbes Coaching Council in a recent publication.<sup>2</sup> They state that teams composed of members that are diverse in terms of gender, generational, cultural, sexual, or professional characteristics bring greater depth of experience and perspectives; this enables greater likelihood of seeing positive change and innovation. In times of uncertainty and rapid change, a diverse leadership team promotes unique and inclusive decision-making by increasing the ability to attract and retain top talent through fostering a sense of belonging, trust and psychological safety. According to a study by JAMA Network Open, just 15.3% of health system CEOs and 17.5% of board presidents were women in 2021.<sup>3</sup> The low representation may lead to the misconception that women are not equipped to lead. Nevertheless, a report by McKinsey & Company and Leanin.org found that women more often than men, provide emotional support to employees, take into account their personal well-being, and help them navigate work-life challenges. Women also intervene to prevent or deal with burnout more often than men.<sup>4</sup> This report also highlights that female leaders are more likely to face macroaggressions, such as being interrupted or spoken over, having their judgement questioned within their area of expertise, or having others comment on their emotional state. Moreover, women are consistently more burnt out than men. As a consequence, the growing gap in leadership leads to more women considering leaving the workforce. Alice Eagly and collaborators showed in a meta-analysis that women demonstrate a more dynamic transformational leadership style. There is also evidence that team collaboration is greatly improved by the presence of women in the group according to a 2010 study. Business coach Hira Ali describes internal and external barriers that make women and minorities more vulnerable at work. These internal factors are more common in women and minorities and include the inability to self-promote, perfectionism, imposter syndrome, and stereotype threat, among others.<sup>5</sup> Dr. Julie Silver describes external factors that impede women's advancement in academic medicine as structural gender bias by the employer, medical societies, and medical journals.<sup>6</sup>



**Silvia Perez-Protto,**  
MD, MS, MBA,  
FCCM  
Cleveland Clinic  
Cleveland, OH



**Pilar Castro,**  
MD, MEd  
Cleveland Clinic  
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**Christopher Troianos,**  
MD,  
FASE, FASA  
Cleveland Clinic  
Cleveland, OH

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*“The goal of the SWAT program is to facilitate professional development and promote the acquisition of leadership skills for women staff and trainees within Anesthesiology.”*

**“SWAT” PROGRAM (SUPPORTING WOMEN ANESTHESIOLOGISTS TO THRIVE)**

We embarked on a journey in 2018 to advocate for women and catalyze change for anesthesiologists at the Cleveland Clinic. First, we collected data provided by the Cleveland Clinic Women Professional Staff Association that showed a disparity between the prevalence of women in the workforce compared with the prevalence of women in leadership positions within the Anesthesiology Institute. Engagement of female anesthesiologists was consistently lower than men and burn-out was higher in women across the institute. We also identified a disparity in the prevalence of women trainees within the anesthesiology residency training program. We identified the need to foster professional development and leadership skills among women within the Anesthesiology Institute, creating a nurturing environment to help with engagement.

Dr. Pilar Castro and Dr. Silvia Perez-Protto attended the course entitled “Career Advancement and Leadership Skills for Women in Healthcare” led by Dr. Julie Silver at Harvard Medical School. They obtained the skills necessary to prepare a program proposal. After approval and sponsorship by Dr. Christopher Troianos, Anesthesiology Institute Chair, they founded the “SWAT Program” that has grown and thrived to its present state.

The goal of the SWAT program is to facilitate professional development and promote the acquisition of leadership skills for women staff and trainees within Anesthesiology. The goal was also to promote networking amongst women anesthesiologists and trainees with the aim of increasing the feeling of engagement and well-being at work. The program consists of an annual workshop and quarterly activities covering the topics that matter most to women. A survey is offered yearly at the end of the workshop as a needs assessment, while also exploring the barriers women encounter in their professional growth. This survey identifies the topics for the following year. The program offers annual

scholarships to attend the leadership course at Harvard for two women staff, with their commitment to plan the program the following year. The institute also offers administrative support to organize the events.

**The program metrics include:**

- Promote inclusion of women at Anesthesiology Institute leadership positions as measured by the number of women in leadership positions
- Improve faculty development for women as measured by the number of women faculty with academic rank at the Cleveland Clinic Lerner College of Medicine
- Engagement scores as measured by the Press Ganey survey offered by the Cleveland Clinic
- Burnout prevalence as measured by the Stanford survey offered by the Cleveland Clinic
- Anesthesiology women trainees as measured by the rate of women in anesthesiology residency and fellowships

The workshop and quarterly activities are open to all women staff and trainees, generating an inclusive and supportive environment, creating natural opportunities to establish mentoring relationships.

The program content has been tailored according to feedback from the annual survey. The first year it focused on internal work helping women to set goals, clarify values and articulate a purpose statement.

The following year it was focused on building leadership skills like negotiation, presentation, influence, and advocacy skills. Next, it was focused on self-awareness, dealing with microaggressions, and how to network effectively by creating social capital. During the Covid pandemic, we pivoted to virtual sessions offering tools focused on mindfulness. Then, we offered short sessions to help women put their new-found knowledge into action by developing their goals in an intentional way, working on how to communicate their vision, and leading with your strengths. The planning team decided that it was important to engage the department chairs in the workshops, so they are invited to attend the first portion of them. The topics of this new format workshop focused on how to build diverse leadership teams and gender pay gap. All the events have a didactic portion, skills practice session, and inspirational stories of women leaders in different areas. All the events include time for networking and relationship building.

**CHANGES SEEN**

In the first survey in 2018, women stated that one of the barriers for them to advance into leadership positions was the lack of awareness of open leadership positions. Moreover, women stated that many recruitment processes lacked female representation. Since 2019, the institute chair committed to

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Figure 1

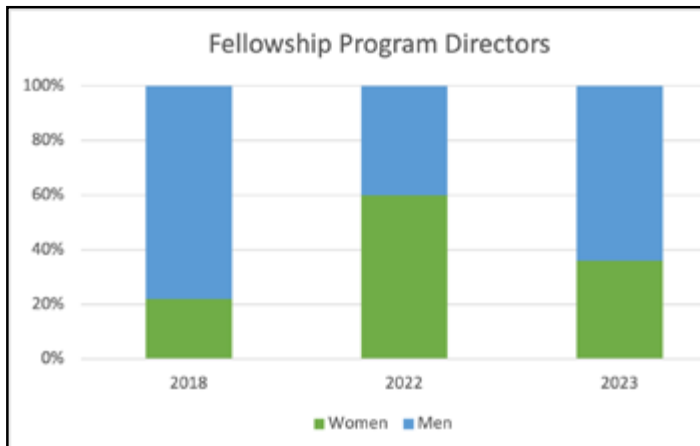


Figure 2



post all leadership positions in advance and to consistently include women in staff and trainee recruitment committees. Women representation in internal leadership positions—such as fellowship program directors, and quality officers—has increased. (Fig.1, 2) Even though we cannot attribute these changes solely to this work, we have seen a decrease in burnout prevalence and growth in women engagement, over time. (Figs. 3,4)

The recruitment of women in residency has shown an overall increase over time, noticing a huge drop during the pandemic. (Fig.5) We learned from the post-application survey that women did not choose Cleveland Clinic because they need to be in the vicinity of family, due to their families’ needs and spouse opportunities. Since then, we have organized a specific recruitment event for female applicants to our anesthesiology residency program, hosted by women staff and residents; there are breakout rooms to discuss work-life integration, diversity, leadership, career tracks and the SWAT program. Many of our residents share this event has been impactful in their decision to join the residency program.

Figure 3

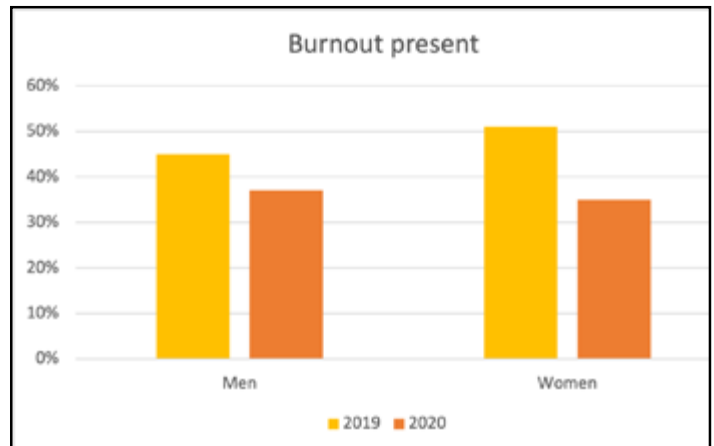


Figure 4

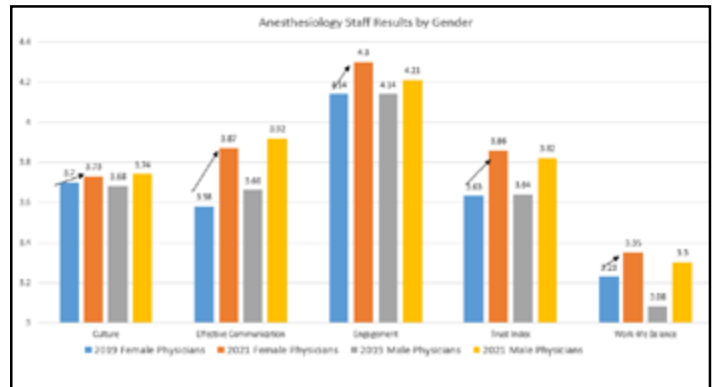
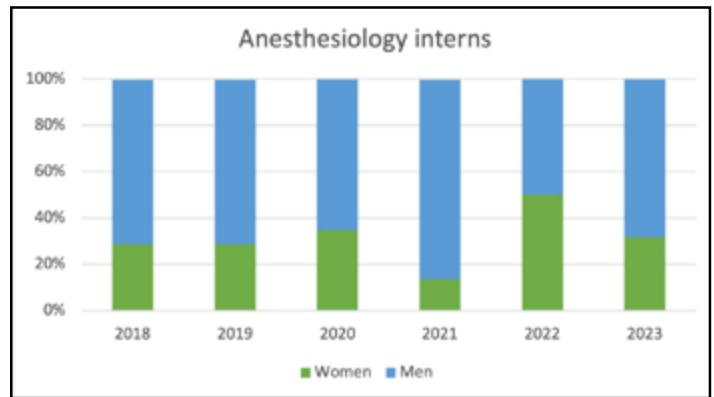


Figure 5



Women in academic ranks has also shown increased regular track appointments:

- Full professors from 1 to 4
- Associate professors from 3 to 6
- Assistant professors from 5 to 9

Unfortunately, we have not seen an increase in Department Chair representation, staying in the range of 10%. These appointments are done by Board of Governors searches.

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## CONCLUSIONS

The SWAT program has been successful because it was tailored by women anesthesiologists based on their needs, with strong leadership support and sponsorship. The leadership commitment is shown by changing practices that were adding bias to the internal selection process, and by encouraging women to apply for positions and academic promotions. An impactful piece written by Ngai and collaborators highlights the problems professional women face in the workplace and offers tangible actions to address them.<sup>7</sup> Many of the actionable solutions were implemented as a result of the evolving SWAT program like tracking diversity metrics for promotion and advancement, creating diverse selection committees, and transparency on the open leadership positions to offer equitable opportunities. Even though it is hard to say that engagement and the feeling of burnout has decreased because of the SWAT only, the program has created the opportunity to network, think, and grow together that trainees and faculty cherish. 🏠

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# SOCCA drip

**SOCCA Drip** offers member-generated content, spotlights member achievements, and delivers relevant news and updates from the broader critical care community—more frequently than ever before.

- Our newsletter, *SOCCA Interchange*, will continue to highlight features from our members and news from within the organization.
- To reflect these changes, SOCCA's Main Menu has changed to include "Drip" under "News" on the main menu.

- All back issues of *SOCCA Interchange* are available [here](#).
- To explore contribution opportunities or share relevant professional or programmatic accomplishments, please email SOCCA Society Director Vivian Abalama, IOM, CAE at [vabalama@iars.org](mailto:vabalama@iars.org)

# SEPTEMBER IS Women in Medicine Month



## An Important Step: Improving Gender Diversity in Leadership

In the last 50 years, the number of women graduating as physicians has increased; these trends have been noted in the United States, Europe, and as well as low-middle-income countries<sup>1</sup>. Emerging demographic trends in Critical Care Fellow recruitment from 2004-2017 highlighted the significant increase in female fellows from 29.5% in 2004 to 38.3% in 2014, ( $p < 0.001$ )<sup>2</sup>. Although the number of women graduating as physicians is increasing, those taking up critical care medicine and rising within organizations as leaders are painfully low.

[The Women in Intensive Care Study](#) published in 2018 was a survey of 84 critical care societies and showed that female representation on various CCM boards and councils ranged from 8 to 50%, depending on the geographic region; the highest representation was in the Society of Critical Care Medicine (SCCM) and was interprofessional. SCCM also had the highest proportion of female presidents between 2000-2017, whereas the European Society of Intensive Care Medicine (ESICM) had none. Similar results were seen in a [survey of Pulmonary Critical Care Medicine](#) leadership at academic centers, where a 2018 survey showed 29% of PCCM Program directors, 15% of PCCM Division Chiefs, and 15% of department of medicine chairs were women<sup>3</sup>. In pediatric critical care medicine, more women led fellowship programs, but less had representation in editorial leadership<sup>4</sup>, highlighting that this is a challenge for multiple sub-specialties and medicine as a profession.

Marian Wright Edelman rightfully said, “You can’t be what you can’t see,” and it is imperative that women have role models that we can be inspired by and emulate. The unconscious bias against women in leadership roles—“women aren’t natural leaders”—can be addressed by increasing the recruitment and visibility of women in executive roles.

[Women In Critical Care](#) (WICC) is committed to highlighting the impact of the gender gap and promoting efforts to reduce the gender gap in CCM leadership roles. I took the opportunity of asking Drs. Brian Bateman and Martin Angst, respectively Chair and Vice Chair at the Stanford University Department of Anesthesiology and Critical Care, why promoting gender diversity is important to their department and organization:

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**Shahla Siddiqui, MD, MBBS, MSc, FCCM**

*Co-Chair, SOCCA  
Women in Critical Care  
Working Group  
Assistant Professor,  
Department of Anes-  
thesia, Critical Care  
and Pain Medicine  
Beth Israel Deaconess  
Medical Center  
Boston, MA*



**Madiha Syed, MD**

*Chair, SOCCA  
Communications  
Committee  
Cleveland Clinic  
Cleveland, OH*

*“At Stanford, our department is committed to the inclusion of women in leadership roles. We recognize that our department thrives when its leadership mirrors the diversity of our faculty and trainees, encompassing aspects such as gender, race/ethnicity, and background. This diversity enriches our leadership team’s decision-making process, as it grants us insight into the unique challenges that certain groups may face.*

*Furthermore, it is important as it provides our junior faculty with role models and mentors who share similar life experiences and backgrounds. It is the combined skill set of a diverse leadership team that will propel our department’s vision to be a global leader in academic anesthesiology, improve patients’ experiences and outcomes, and transform healthcare through collaboration, discovery, and innovation.*

*Recently, we have made significant progress in diversifying our leadership team. Women have assumed various senior leadership positions, including several Vice Chairs and Division Chiefs. Nonetheless, our journey is ongoing. As we work to fill open leadership positions, we will conscientiously search for accomplished women leaders to assume these roles. Equally crucial, we will continue in our efforts to nurture and cultivate our female trainees and faculty, equipping them for future leadership roles that carry influence and impact.”*



**Brian Bateman, MD, MSc**  
Chair, Stanford University Department of Anesthesiology and Critical Care, Stanford, CA



**Martin Angst, MD**  
Vice Chair, Stanford University Department of Anesthesiology and Critical Care, Stanford, CA



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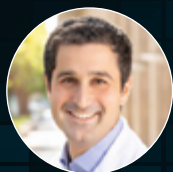


**HANNAH WUNSCH, MD, MSC**

Distinguished Professor of Anesthesiology  
& Critical Care Medicine & Vice Chair of Research  
Department of Anesthesiology, Weill Cornell Medical College

## The Liver Transplantation Patient and the Challenges Associated

### MODERATOR



**Vikram Fielding  
-Singh, MD, JD**  
Stanford University  
School of Medicine

### PANELISTS



**Amy Kloosterboer, MD**  
Stanford University  
School of Medicine  
Pre-Liver Transplantation  
Patient and the Challenges  
Associated



**Michael Lin, MD**  
UCLA Health  
Post-Liver Transplantation  
Patient and the Challenges  
Associated

## Enhancing Women Applicants for CCM Fellowships: Strategies for Success

Co-Sponsored by the Women in Critical Care Medicine

### MODERATOR



**Shahla Siddiqui, MD,  
MBBS, MSc, FCCM**  
Beth Israel Deaconess  
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### PANELISTS



**Vivek Moitra,  
MD, MHA**  
Columbia University



**Roshni Sreedharan,  
MD, FASA, FCCM**  
Cleveland Clinic



**Erin Hennessey, MD**  
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UT Health Houston,  
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### MODERATORS



**Shahla Siddiqui,  
MD, MBBS,  
MSc, FCCM**  
Beth Israel Deaconess  
Medical Center



**Matthew  
Warner, MD**  
Mayo Clinic  
Discussion | Q&A

### PANELISTS



**Emily Vail, MD, MSc**  
University of Pennsylvania  
Why I Chose to Incorporate  
Research into My Critical  
Care Practice



**Marcos Lopez, MD, MS**  
Vanderbilt University Med. Cntr.  
How I Use My Role as an Intensivist &  
Anesthesiologist to Fuel Translational  
Research & Collaboration



**Shahzad Shaefi, MD, MPH**  
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How to Achieve Sustainable  
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Membership in SOCCA is open to all anesthesiologists who have an interest in critical care medicine; nonanesthesiologist-physicians and scientists who are active in teaching or research relating to critical care medicine; residents and fellows in approved anesthesiology programs; and full-time medical students in an accredited school of medicine.

Renew or join today at [socca.org/socca-membership/](http://socca.org/socca-membership/)

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- Timely member news and information via SOCCA Drip
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