virginia society of anesthesiologists

UPDATE

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FALL 2020: **WOMEN & DIVERSITY IN MEDICINE**

Volume 28, Number 4 • Fall 2020

President's Message

We're Not as Diverse as I Thought

By Jeffrey Green, MD, FASA
VSA President

Dr. Jeffrey A. Green
VSA President

When I first started residency in anesthesiology, I thought it was a pretty diverse medical specialty. I was one of only a couple of white males in my residency class. There was also nearly 50% female representation.

I assumed this was the norm for anesthesiology. This was quite a change from the surgery residency program where I started my training which was almost entirely white males. Once I finished residency training, I realized that there was a significant lack of diversity in the field.

Some may view anesthesiology as a diverse specialty, but the data demonstrate otherwise. According to data from the American Association of Medical Colleges, anesthesiology ranks near the middle in diversity among specialties. We are not nearly as well represented by females as allergy, obstetrics, or pediatrics. Minorities are underrepresented in anesthesiology compared to primary care.

We do know that women and minorities are underrepresented in medicine overall compared to the U.S. population, but it is difficult to tease out specialty specific data since the tracking of this data is based on voluntary self-report.

One survey of the ASA House of Delegates from 2017 found that the proportion of women and minorities in ASA leadership roles was significantly lower than the general medical workforce (A&A:124(5), May 2017). Given that

Continued on page 4

Feature Article

On the Challenges and the Importance of Her Science

By Nadia Lunardi, MD, PhD
Department of Anesthesiology
University of Virginia

No matter whether your focus is on clinical or basic science research, whether you are a male or a female, science is hard. Increasing clinical productivity pressure, a hyper-competitive funding environment and growing requirements to publish mechanistic studies that combine a number of approaches are among the universal challenges that come to mind.

However, female scientists may face some additional, unique obstacles. Over the years, I found I had to work a bit harder than my male colleagues to get the same recognition, to exert extra assertiveness for my research to be taken seriously and to wait a little longer before sponsorship opportunities were offered to me. I have been blessed to work alongside exceptional male mentors. However, in my discussions with female colleagues, a lack of female mentorship and a prevalence of male mentors who may not always be attuned to the specific difficulties encountered by female scientists have often been cited as an important issue.

For me, the most testing task has been balancing family life with a career in research. As a post-doc, I would frequently stay in the lab past midnight to complete experiments. I could work on Saturdays and Sundays to meet a deadline. Thinking about my future, I thought I could have it all. Fast forward several years, I am fortunate to have an amazing, energetic five-year-old daughter, a supportive husband, and to be the Principal Investigator of a basic science Anesthesiology lab.

I want to be there to see my little one grow, to play an active part in raising her,

Continued on page 3

Inside This Edition:

WOMEN AND DIVERSITY IN MEDICINE

ASA Statement on Racism

ASA abhors racism. We stand with our colleagues in organized medicine and the broader health care community who assert that racism undermines public health. It cannot be ignored and must be addressed for the safety, fairness, justice and health of everyone. We hope for calm, peace, and reconciliation throughout the nation.

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Administrative Office

VSA
2209 Dickens Road
Richmond, VA 23230-2005
Phone: (804) 565-6356
Fax: (804) 282-0090
vsa@societyhq.com • www.vsahq.org

Stewart Hinckley
Executive Director
stewart@societyhq.com

Andrew Mann
Association Executive
andrew@societyhq.com

Newsletter Editors

Editor
Brooke Trainer, MD
brooke@vsahq.org

Resident Editor
Daniel H. Gouger, MD
Daniel.Gouger@vcuhealth.org

The ***VSA Update*** newsletter is the publication of the Virginia Society of Anesthesiologists, Inc. It is published quarterly. In January, a special annual legislative issue is published. The VSA encourages physicians to submit announcements of changes in professional status including name changes, mergers, retirements, and additions to their groups, as well as notices of illness or death. Anecdotes of experiences with carriers, hospital administration, patient complaints, or risk management issues may be useful to share with your colleagues. Editorial comment in italics may, on occasion, accompany articles. Letters to the editor, news and comments are welcome and should be directed to: Brooke Trainer, MD • brooke@vsahq.org.

and I wish my daughter to care enough to be around when my husband and I will be old and sick. Does this mean I do not care enough about my research career?

There is nothing I have worked harder on in the last several months than getting the lab's next manuscript accepted for publication. Besides health for my family, there is nothing I desire more than to secure my next NIH R01 funding. I still believe I can have it all, but I realize now I cannot have it all at the same time.

It was tough for me to take care of a newborn and manage the preliminary experiments for my next grant. It was exhausting to wake up at night to feed my baby and to be in my office the next morning so I could get that paper out. Women in science are asked to do it all at the same time. They are expected to publish papers, present their findings at conferences, and secure funding, while taking care of their children, being a wife to their husbands and attend to other family responsibilities.

Research shows this is the most commonly cited reason for why female researchers - and women in medicine overall - abandon their careers. Having to choose between family and science is a difficult position that no female researcher should be put.

In my experience, the absence of pathways that allow women to stay on a track of career advancement while maintaining a satisfactory work-life balance remains a critical barrier to the advancement of women in science. At a departmental level, on-site childcare that accommodates early, long working hours and child illness, as well as flexibility in regards to working through pregnancy and choosing accommodating shifts are often missing. At an institutional level, flexible academic advancement options, with part-time opportunities, time out for raising a family, a smooth re-entry into duty, and extended timelines to reach the criteria for promotion and tenure are oftentimes not available.

As Dr. Angell pointed out eloquently in her 1981 editorial commentary in the *New England Journal of Medicine*, "female physicians who work flexible times in order to raise their children are performing a highly useful function for society [therefore] choosing flexible work pathways should be not only possible, but respectable".

Dr. Nadia Lunardi

My observations over the years have led me to the conclusion that the best teams are the most diverse teams. I hold this to be true in any field, from finance to law, to business and certainly when it comes to science. The best teams I've been a part of were groups made up of PD.s, MDs, MD-PhDs, males, females, individuals with a background in medicine, and individuals with absolutely no background in medicine.

These are the best teams because each one of their members can tap into their unique background and come up with solutions, approaches, alternatives that are creative and unique. In much the same way, female scientists and clinicians are unique in their approaches, and often bring different attitudes and perspectives, distinctive tactics to problem-solving and unique solutions to the research and care team.

Overwhelming research demonstrates that this diversity of approaches sharpens a team's performance, and promotes innovation and higher success rates. Thus, rather than forcing women to fit into pre-molded requirements for success and pushing them to the fringes, why not embrace their uniqueness by creating flexible pathways that allow them to bring that uniqueness to the team?

There is no doubt that women should be given the same exact opportunities to pursue and succeed in science as anybody else. Besides what is fair - if nothing else from a purely business standpoint - creating a team enriched with representatives of different genders is a smart business decision.

Science is hard, but also thought provoking, enlightening, refreshing, and invigorating. I hope my daughter will look back at me thirty years from now, recognize my challenges of balancing time spent with her and in the lab, reflect on the progress made towards achieving gender equality in science, and be proud of her mom.

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Save The Dates

ASA Annual Meeting

October 2-5, 2020

Virtual meeting! Attend from anywhere. See asahq.org for registration information.

VSA Fall Meeting

October 7, 2020

7:00 - 8:00 pm

Watch vsahq.org for more details.

AVAA/USSA Annual Meeting

October 2, 2020

8:00 am - 4:00 pm

Held virtually in conjunction with ANESTHESIOLOGY 2020. CME opportunities for all participants. Members of USSA and AVAA will be free. Registration details at asashq.org.

President's Message, *from page 1*

it is important to have diverse leadership to reduce workforce disparities by encouraging more minority representation, it is not surprising that the anesthesia workforce is not as diverse as it needs to be.

The Virginia Society of Anesthesiologists only collects data on gender. The U.S. population is 50.8% female and the general physician workforce is 38% female. The VSA membership is about 30% female. Although I don't have the data to analyze, I believe the VSA is comprised of less than the 32% minorities that make up the U.S. population and the 8.9% of the general medical workforce. We clearly could be doing better.

Although I believe there are more women and minorities in the VSA now compared to the past, we are not reducing the gap enough and must do more to keep up with our rapidly changing cultural demographics.

So how do we promote diversity and inclusion in our specialty? Given the increased attention and awareness related to this issue currently, now is a great time to increase our effort in this endeavor.

I think there are three key steps to improving our diversity. First, we should actively promote diversity and inclusion in the VSA leadership. I am pleased to report our efforts in the regard have been admirable, with female representation greater than 50% and with minority representation of approximately 25% of the Board of Directors.

This is the right direction to make sure that the decision making body of the organization has composition that more closely resembles the population at large. It is hopeful that these leaders will continue to serve as role models and mentors to our next generation of anesthesiologists and we will see our diversity increase, with more diverse populations assuming leadership positions.

Second, the VSA leadership should have education and information for its Board members who are volunteers representing all regions of the Commonwealth. However, it's not enough to just have cultural competency training for the Board. We can also learn from the diversity of backgrounds and experiences among our varied Board members.

I am looking forward to engaging with my fellow Board members in a thoughtful and meaningful discussion about promoting diversity and inclusion in the VSA. It is imperative that we create a sustained and intentional program to promote heterogeneity in anesthesiology.

Finally, the VSA leadership must promote diversity to the membership. It is the membership who interact with students and trainees who are the future of our specialty. Members should seek out variety in the future anesthesiologists who will join our ranks.

We also should encourage our members, particularly those representing minority groups, to volunteer for leadership roles, committees, and other opportunities in VSA and ASA. The ASA Committee on Professional Diversity is a stellar example of how the active role of leadership can broaden the appeal of anesthesiology and embrace our differences. Since created, this committee has had tremendous success in growing the diversity of the ASA leadership.

In the not too distant future, there will no longer be a group that identifies as the majority in the U.S. Our demographics are changing. Anesthesiology and the VSA must change as well to grow into the specialty of the future that is representative and inclusive of all people and that demonstrates our differences, not just our similarities, as physician anesthesiologists.

Support Health Care Workers by Reducing Burnout

By Sen. Tim Kaine

In November 2019, Dr. Lorna Breen—a Charlottesville native and medical director of New York-Presbyterian Allen Hospital's emergency department—coauthored an article in the American Journal of Emergency Medicine titled "Clinician Burnout and its Association with Team-Based Care in the Emergency Department." Her article began:

Recent work has noted the alarming prevalence of clinician burnout among providers, particularly among acute care physicians. Burnout is characterized by emotional exhaustion, physical fatigue, and cognitive weariness, which may lead to feelings of depersonalization and reduced accomplishment.

Less than six months later, Dr. Breen was dead, likely a victim of the very burnout she drew attention to, among other factors. Her emergency department was overrun by coronavirus in March and April, receiving three times its normal patient load.

"People I work with are so confused by all the mixed messages and constantly changing instructions," Dr. Breen said before she contracted the virus herself.

By the time she recovered and returned to work in early April, the situation had become even grimmer. Nearly a quarter of COVID patients admitted to her hospital died. She told a friend, "I couldn't help anyone. I couldn't do anything. I just wanted to help people and I couldn't do anything."

On April 26, after an 11-day stay in a psychiatric hospital, Dr. Breen died by suicide.

Dr. Breen's suffering wasn't an outlier. As many as 45 to 55 percent of healthcare workers have suffered from burnout, and physicians have the highest rate of death by suicide of any profession in this country—double that of the general population. Worse, some surveys suggest burnout is 20 to 60 percent more prevalent among female physicians than male ones.

To reduce burnout and prevent suicide and behavioral health conditions among healthcare professionals, I've introduced the Dr. Lorna Breen Health Care Provider Protection Act. This bill would establish grants to train healthcare students, residents, and professionals on strategies to prevent burnout. It would also establish a national education and awareness campaign to encourage healthcare professionals to seek support and treatment for mental and behavioral health concerns.

The bill also addresses the unique mental health challenges that the pandemic presents. It would establish a comprehensive study on healthcare worker burnout, including the impact of the COVID-19 pandemic on such professionals' health. In addition, the bill would prioritize COVID-19 hotspots in disseminating grants for employee education, peer-support programming, and mental and behavioral health treatment.

Three weeks before she died, Dr. Breen texted her Bible study group, "I'm drowning right now." Since March, so many Americans expressed a desire to support physicians on the front lines of the pandemic. We can support them by passing the Dr. Lorna Breen Health Care Provider Protection Act to provide them the resources and culture they need to not feel like they're drowning.

Mitigate Unconscious Bias to Increase Diversity & Inclusion in Our Specialty

By Brooke Trainer, MD, FASA
Editor, VSA UPDATE

"Diversity is being invited to the party. Inclusion is being asked to dance."
—Verna Myers, diversity advocate.


Dr. Brooke Albright-Trainer

Diversity and Inclusion (D&I) in our political organization is especially important in order for our specialty of Anesthesiology to thrive.

This past July 2020, the ASA Joint Committee Roundtable had a conversation on D&I where they discussed the need to foster a culture which welcomes diverse perspectives. It is necessary to stimulate a discussion at the highest level of our organization, even if it means confronting awkward topics and having uncomfortable conversations. As an organization, we need to be actively discussing this at the Board of Directors and Executive Committee levels to find gaps and learn where to dedicate resources for improvement.

This issue of the VSA Update is themed "Women and Diversity in Medicine". For the past several months, the VSA editorial team has been recruiting members to submit articles on this topic. We hope to stimulate a meaningful discussion of these important topics among our organization. Healthcare organizations, like the VSA, need to be deliberate in their efforts to improve diversity in their membership and active in their outreach to improve inclusivity. The problem does not improve if we chose to ignore, or worse, deny it.

Fostering a culture of diversity and inclusivity in healthcare professional organizations is important for many reasons, and thus should be a priority. First and foremost, there is compelling evidence that increasing diversity in the healthcare workforce improves healthcare delivery, especially to underrepresented populations.

Second, diversity in the U.S. population is increasing and is reflected in the patients whom we treat. Unfortunately, this diversity is not always represented by the demographic characteristics of healthcare professionals themselves. Last but not least, this mismatch can lead to unintended healthcare inequities due to cognitive and unconscious biases.

Unconscious bias describes associations or attitudes that reflexively alter our perceptions, thereby affecting behavior, interactions, and decision-making. The ability to rapidly categorize every person we encounter is thought to be an evolutionary development to ensure survival; early ancestors needed to decide quickly whether a person, animal, or situation they encountered was likely to be friendly or dangerous.

Today, these tendencies may lead to more harm than good. Cultural stereotypes, stigmas, and prejudice may influence the way information about an individual is perceived, leading to unintended disparities that have real consequences in patient-clinician interactions, hiring, promotion, and opportunities for growth.

All of us are guilty of unconscious bias. Evolution has wired our brains with it so that we may identify with others, culturally, socially, professionally, or recreationally. Naturally, we are drawn to similarly minded individuals. Those we can connect or relate to, those with similar interests and backgrounds. But unconscious bias can be harmful in certain situations, such as in recruitment and selection committees.

Even though you may not be aware of it, your unconscious bias is going to draw you preferentially towards one candidate over another. Its also going to factor into your decisions on whether you believe a person is deserving of hire, advancement, or promotion. Such opportunities given to a person reflects their value. Thus, it is especially crucial for organizations to get this right.

A solution for organizations to overcome this bias is by diversifying recruitment and selection processes. The composition of the panel should be comprised of varying backgrounds of people that represent the demographics of the entire organization. This is the most reliable way to ensure a fair and equitable selection of those candidates from diverse backgrounds.

Acknowledging the existence of unconscious biases and building your recruitment strategies to mitigate potential disparities fosters a culture that welcomes diverse perspectives and prioritizes inclusivity.

What is VSA doing to improve long-term D&I goals?

1. Prioritizing the issue
2. Recently created and funded a resident component society which is meeting and discussing ways to expand outreach to involve more residents and be a more inclusive organization
3. Working with the ASA to collect more accurate demographic data of our members so that we may evaluate trends and monitor for gender and racial disparities.
4. Look to mirror state demographics of medical school enrollment (easiest to track for comparison purposes) in our membership and VSA leadership composition.

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Snapshots of the Women Presidents of the Virginia Society of Anesthesiologists

By Maxine Lee, MD, MBA, FASA

The VSA was incorporated in 1962 and each president serves a term of two years. In the ensuing 58 years, there have been five female presidents. They are Drs. Fabian, Hudson, Wilhite, Wells and Lee. Additionally, the VSA currently has a female President-elect, Dr. Marie Sankaran Raval, and Secretary, Dr. Casey Dowling.

What follows is a brief snapshot of each former president. I was not able to speak with Drs. Fabian and Hudson and obtained primarily publicly available data.

Drs. Wilhite, Wells and I are contemporaries and have spent a good bit of time together. Besides basic biographical data, I asked Drs. Wilhite and Wells several, more personal, questions and their answers are given below.

Judith Fabian, MD, FACA

Dr. Judith Fabian

Dr. Judith Fabian was VSA President in 1992. Her term was truncated when she took an academic position outside of Virginia. Dr. Fabian received her MD degree from Tulane University School of Medicine in 1970; there were only nine women in her medical school class.

After finishing her anesthesiology residency at Tulane, she spent her career in academic medicine. Dr. Fabian was Director of Cardiac Anesthesia at MCV (currently VCU School of Medicine) and was described as a "dynamo" by Dr. Anne Wilhite who was a resident while Dr. Fabian was on faculty.

Dr. Fabian subsequently became Chair of the Department of Anesthesiology at the University of New Mexico.

She recently funded an endowed chair within the Department of Anesthesiology at Tulane, her alma mater.

Joanne Hudson, MD

Dr. Joanne Hudson

Dr. Joanne Hudson was VSA President in 1997 and 1998. She received her MD degree from Tufts University School of Medicine in 1971. She completed her anesthesiology residency at the Massachusetts General Hospital. She became faculty at MCV where she was Director of OB Anesthesia.

Dr. Olga Suarez-Winowiski, Assistant Professor of Anesthesiology at VCU, was an advisee of Dr. Hudson and describes her as having a great sense of humor, being highly intelligent, detail-oriented and well-respected by all her colleagues.

She retired from VCU in 2016 after a long career in academic medicine and professional society leadership.

Anne Wilhite, MD

Dr. Anne Wilhite

Dr. Anne Wilhite was VSA President in 2007 and 2008. She graduated from the College of Arts and Sciences at the University of Virginia with a BS in Chemistry in 1980.

After her undergraduate degree, she worked in the Department of Pharmacology at UVA. She considered hospital administration as a career and toured the NICU during her interview for an administrative internship at Carilion Roanoke Memorial Hospital.

She was inspired to pursue a career in medicine when she saw physicians taking care of a neonate with gastroschisis. She received her MD degree from UVA.

Dr. Wilhite started her anesthesiology residency at the George Washington University Medical Center and completed her training at MCV in 1989. She remained on faculty at MCV for four years, before working in private practice for most of her career. She currently works at the McGuire Veterans Administration Hospital in Richmond.

Dr. Wilhite was drawn to anesthesiology in much the way we all were. She liked pharmacology, the "idea" of the specialty and the sense of gratification derived from patient care. Anesthesiology allows for flexibility in spending time with family. She was able to make practice choices which allowed her to minimize evenings and weekends away from home, such as taking a non-partnership track without overnight call.

Marital and family support allowed her to pursue serving in the ASA as a Delegate, and in VSA leadership. When asked about her approach to overcoming obstacles, Dr. Wilhite states that she takes an analytical approach. She breaks the problem into its component parts and considers each aspect in turn. She advises that this strategy prevents feelings of being overwhelmed.

When asked what she's most proud of, Dr. Wilhite states she is most proud of her two children who have grown into wonderful individuals. Her daughter, Annelise, graduated from the UVA Medical School in 2016 and recently completed her residency in Obstetrics and Gynecology. Her son, Andrew, is a musician who is an Artist in Residence with the Norwegian Opera in Oslo.

Dr. Wilhite's hobbies include shooting sporting clays, cycling, photography, and travel (before COVID).

Lynda Wells, MD, FCAI, FRCA

Dr. Lyn Wells

Dr. Lyn Wells was VSA president in 2012 and 2013. She was born in New Jersey then moved to England with her parents at age 8. Whenever Dr. Wells is in conversation, she's

Continued on page 7

invariably asked where she's from. I always smile when she responds, in an Oxford British accent, that she's from New Jersey.

She went to medical school at The Royal Free Hospital School of Medicine in London and subsequently completed a Family Medicine Residency. She did a one-year certificate in anesthesiology. During this initial training in anesthesiology, she realized this would be her future career path.

She completed her anesthesiology residency at the Royal Cornwall Hospital. She worked as an anesthesiologist for several years in England before returning to the USA. She was faculty at the University of Texas Health in Houston, and San Antonio before joining the faculty at UVA.

Dr. Wells attended her first VSA meeting in 2006 with Dr. George Rich who was the Chair of Anesthesiology at UVA. At that meeting the VSA leadership requested volunteers to serve as Alternate Delegates to the ASA House of Delegates. She volunteered and that started her on the path to becoming a member of the VSA Board of Directors.

Former VSA Presidents such as Drs. Brian McConnell, John Rowlingson, Byron Work, and Steven Long were very supportive and encouraging of her leadership efforts on behalf of the VSA.

Dr. Wells regards leadership as a means of engagement and self-determination. Like Woody Allen, she agrees 80% of success is showing up. To that, she adds, showing up is most effective when coupled with volunteerism. When asked what her personal philosophy is, Dr Wells counsels that one should take pleasure in even small things, should seek "silver linings" in adversity and should believe in oneself. She further advises that, especially in leadership roles, everyone needs a "battle buddy;" someone with whom an honest discussion of problems and solutions can be had.

She cautions that, in leadership, some tasks are impossible despite one's best efforts, nonetheless, even these situations provide an opportunity for growth.

Maxine Lee, MD, MBA, FASA

Dr. Maxine Lee

I was VSA president in 2014 and 2015. I was born in Jamaica and immigrated to Connecticut after high school at age 16. I graduated Fairfield University with a BS in Biology and was its first student to gain acceptance to Harvard Medical School. I completed my anesthesiology residency at Yale-New Haven Hospital in 1992.

I received the Howard Hughes Research Fellowship for Physicians and spent two years doing basic research. I was on faculty at Yale and the University of Arkansas for Medical Sciences, then, in 2000, accepted a position in private practice in Roanoke. I received an MBA from Radford University in 2005.

In addition to the honor of being VSA president, I have been privileged to serve as the Director from Virginia to the ASA Board of Directors, the Vice-president for Medical Affairs at Carilion Medical Center, the President of the Roanoke Valley Academy of Medicine, a member of the Virginia Board of Medicine, a member of the Board of Directors for Jefferson College of Health Sciences, the president of my private practice group, ACV, Inc. and a member of the Dean's Advisory Council for the Virginia Tech Carilion School of Medicine.

Service, at the level required to play active leadership roles, is very rewarding but also demanding.

In my experience, the drive to serve can only be fulfilled if mentors are available to give us guidance, our groups allow the time away from practice for non-clinical activities, and, for those of us who are parents, if childcare is secure. This creates a long list of folks to thank.

I have found the best way to maintain "balance" is through gratitude. Gratitude to God for the opportunities He brings and for the faith and strength to take advantage of those opportunities, gratitude to my family who sustain me, gratitude to wise mentors who guide me, especially Dr. Roger Litwiller, past president of the VSA and ASA, and gratitude to thoughtful and supportive partners who covered the clinical workload.

After all, no one does any of this work alone.

Eulalia

By Jessica Kaplan, RN, BSN
Central Virginia VA Health Care System

For years she crept around the sun
Until one day she came undone
Broken shattered and released to Space
Asteroids off at a destructive pace

She rained down upon the Earth
Taking the dinosaurs for all their worth
70% of life extinct
A fragile planet left on the brink

But, she carried with her a treasure
Phosphorus, vital to life's endeavors
Plants and mammals now could thrive
Life on Earth was soon revived

She found strength at a journey's end
One door shut but another opened
Tiny miracles captured in Time
Revolutions around a Sun...Sublime

Women Physicians Belong: What's the secret sauce?

By Alice Coombs, MD

"Out of struggle very often comes victory."

— Condoleezza Rice

Dr. Alice Coombs

A pivotal moment in the history of anesthesia, is highlighted by a patient being anesthetized in the classic picture "Under the Ether Dome" at Massachusetts General Hospital, on October 16, 1846.

While I am impressed with the historical significance of what happened under the Ether Dome, there exists another narrative. In a 19th century, male-dominated world, women understood the power of influence and bask in the appreciation of informal authority. While formal authority is expected in organizational structures, informal authority stems from relationships that are cultivated, which results in acquired influence. Informal authority or power is your brand and signature that ultimately impacts your organization and society.

Figure 1: Photo courtesy of Drexel University College of Medicine Legacy Center Archives

In Figure 1, women physicians are showcased in administering anesthesia in the operating amphitheater of the Woman's Medical College of Pennsylvania in 1903. While these women may be exhibiting formal authority, successful leadership development does evolve from informal authority. There are examples of positive and negative informal authority. As women physicians, we must understand the value of resourcefulness, empowerment, legitimacy, and affinity as relates to leadership development.

Dr. Elizabeth Blackwell was the first woman to receive a Medical Degree in 1849, and her role in mentoring and advocacy for the underserved was a constant theme in her life. She was a sponsor and mentor to her sisters and other women.

Dr. Blackwell demonstrated informal authority, but she had challenges that forced her to make career decisions based on an acquired physical disability (monocular blindness), infrastructure support, gender, and her finances. At one point she struggled to find work. She found strength in other women who encouraged her.

One of Dr. Blackwell's closest friends insisted that if she were cared for by a female physician, she would have received better care. Dr. Blackwell's empowerment allowed her to be decisive. Once she lost her vision, she could no longer be a surgeon but she considered her next best alternative - to become a generalist. Her legitimizing body was her patients and other women. She recognized the reciprocal appreciation in this sector.

Although she was forced to make decisions, in the midst of uncertainty, she was empowered because a key element in her decision-making was her "connectiveness". As women physicians we must determine who is our legitimizing body? In other words, who are my supporters, who shares a similar vision, and is there a reciprocal relationship?

Dr. Rebecca Lee Crumpler was the first African American female to graduate from a U.S. Medical School, the New England Female Medical College in 1864. Sometime after graduation, she traveled to Richmond, Virginia where she cared for the freed enslaved persons. In Richmond, she rendered care for a vast number of patients – her workload was similar to that rendered by any white male physician in Boston.

Despite this fact, she and other African Americans physicians in Richmond still experienced intense racism. She published a book, "Book on Medical Discourses." She was empowered because she recognized her legitimizing body was other African Americans and, having to relocate to practice medicine. Her informal authority and greatest influence were in the black community.

Women physicians sacrificed professional advancement because of their limited resources and lack of social capital. The struggle for women physicians was complex. Three years following Dr. Rebecca Lee Crumpler, Dr. Rebecca Cole, another African American female, graduated and received her medical degree from the Women's Medical College of Pennsylvania in 1967.

These early women physicians were resilient, focused, with dogged determination. But these qualities were only part of the solution. It is affinity that opens the door to success. Affinity is "connectiveness". As a woman physician, recognizing when we have affinity in an environment is essential to our success.

Several key questions are important. Affinity is influenced by personalities and tolerances. Can you increase affinity? Is there a secret sauce to making your colleagues be "connected" to you? For women, sometimes we recognize support when we first walk into a room. This is called the "Halo-effect". Other times, it may not be as obvious. We must be creative in gaining access into the minds of decision-makers. To do so, is an experience in understanding the value system of the environment. One way to gain affinity would be to engage in activities or work projects that increase your "Connectiveness" to others. Here are a few suggestions, which are by no means complete.

1) Find a mentor. The role of mentorship cannot be overstated. People who become your personal mentor are helpful for growth-propelling transparency.

Continued on page 9

Paternity Leave Then and Now

By Paul C. DeMarco, MD
Assistant Professor
Department of Anesthesiology
UVA Health System


Dr. Paul DeMarco

As an anesthesiologist and father of three young (almost four) biological children and one wonderful teenage stepson, I have a somewhat unique view of having had two children under a very antiquated parental leave system and now having had one child under a new system with one more on the way.

Prior to 2019, mothers could take six weeks of maternity leave after having had a child. Most found ways to expand this taking short term disability or PTO or other ways to expand the leave. Fathers had significantly fewer options, generally taking at most about a week of leave.

For my first two children, I took about a week of leave (in reality it worked out to about five full days), which included the two days spent in the hospital with my wife during labor, delivery, and recovery. I went back to work after only having been home for three days with my wife and newborn child. I came back to work exhausted, distracted, and clearly not performing anywhere near 100%.

Throughout my career, I have watched fellow residents, residents that I supervise, and now colleagues go through similar experiences. The women I have watched who have come back just six weeks postpartum are beyond tired and not even close to being recovered, let alone being well rested and alert. New mothers and fathers have very limited ability to pay attention to all of the details that we need to keep a close eye on as anesthesiologists (and healthcare providers, in general). The main reason for this is sleep deprivation.

The type of father I want to be is one who shares nighttime responsibilities with his wife. This means being up multiple times a night to help with feeding, changing diapers, or just getting my wife some water. I believe most fathers these days feel the same. Furthermore, that decreased capacity to pay attention is constantly divided with worry about our new child and spouse who are at home (whether or not family or friends are there to help). Worse, this is the case when everything has gone smoothly throughout the whole process of delivery and recovery. When you couple a quick return to work with the myriad of things that can go wrong peripartum and postpartum, things get even worse.

After the birth of my first child, my wife suffered from almost crippling postpartum anxiety/depression, almost bordering on psychosis. Because I returned to work quickly, I was not there to see my wife slowly spiraling out of control. I was not around to see the warning signs and to see how scary things were becoming.

After the birth of our second child, we knew better the signs and symptoms to look for and she was treated. The process of recovery was better, because we knew what to expect and had a better idea of how to mitigate the stressors. Even still, the process was not at all easy.

Fast forward to the birth of our third child under the new system, where I as the father qualify for eight weeks of paid paternity leave, and our experiences couldn't have been more different. I was able to set up ahead of time (albeit with some stress and headaches because this was brand new) several weeks of time off around the birth. To lessen the impact of my leave on our department, I took approximately two full weeks off (about 14 full days) immediately around/after the birth of my child. I then came back to work for a few weeks and then took several more weeks off after that.

The difference in the quality of life for my wife, my family, and me was amazing. My wife's postpartum anxiety symptoms were significantly lessened because I was there to see when she was tired, when she needed a nap, or simply needed a little time away. Her physical recovery was much smoother as well since I was home to do the heavy lifting and give her much needed rest periods.

My two youngest children adjusted incredibly well to their new baby brother. There were no jealousy issues, no one appeared to feel abandoned, and everyone stayed happy and healthy. All because I was able to focus on my family and my children. My relationship with my younger boys blossomed during this time. Ultimately I was able to return to work more rested than after previous births, less distracted, and able to fully focus on my job.

In our particular system you can break up your leave however you need to, which is a

Continued on page 10

Women Physicians, *from page 8*

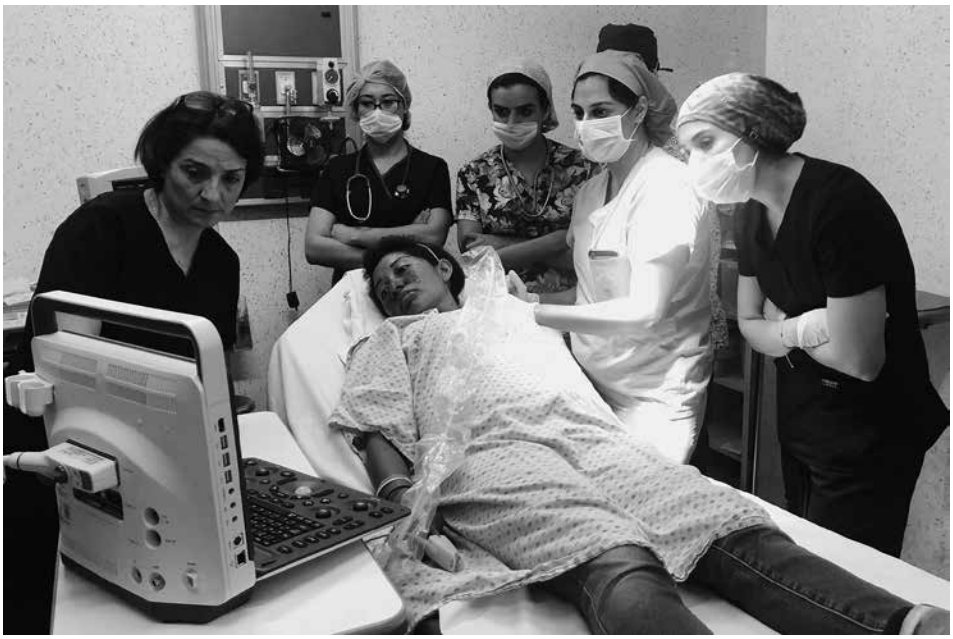
2) Identify and connect with hospital-based physicians who are active on the most visible and essential core committees.
3) Improve your "Halo-effect" by simply being a great physician.
4) Lastly, engage in professional society activities such as the Virginia Society of Anesthesiology, Medical Society of Virginia, and the AMA.

In some circumstances there will be obvious biases. I will caution physicians to hold steady and understand the perspectives of key players in your workplace prior to taking any stance or formulating conclusions. Once your homework is completed, next seek not just mentorship but "allyship". Allyship is an alliance. It means there is a person whose ideals resonate with yours, although they may not agree with you on all issues. There is amazing value in divergently thinking colleagues who are not paralyzed by "terminal group think".

September is the AMA, Women in Medicine Month. What are the lessons learned from these historic icons. At the turn of the century we had only a handful of women graduating from medical school. Today the AAMC data reveals that in 2019, 50.4% of the graduates from medical school are women. How do women physicians succeed in an evolving gender equalization world? A question which invites us to explore complex recipes for that "Secret Sauce"!

Women in Medicine: A Graduating Chief's Thoughts on Leadership and Global Health

By Juhee Sharma, MD
Virginia Commonwealth University Health System



Instruction of anesthesiology residents in performance of Supraclavicular nerve block

When I first started residency, the thought of being a leader in my field was hardly at the forefront of my mind. The overwhelming volume of information to be processed was physically, mentally, and emotionally taxing. It left little room for any contemplation of our roles as leaders.

But as we progress through residency and gain a better grasp of the clinical component, we find ourselves transitioning into positions of influence, whether as role models for junior residents or as contributors to logistics of the department as a whole. These roles can test your capabilities as not only an educator in your field, but also as a developing leader.

Becoming a compassionate, competent Anesthesiologist in four short years is a daunting task with many obstacles. This is especially true for women in medicine, who have to overcome additional barriers to establish themselves in the field. While significant strides have been made in recent years, there remains a considerable discrepancy between male and female clinicians in positions of leadership.

As a minority female, a former chief resident, and a current regional anesthesia fellow, I have had the opportunity to serve in a variety of different positions. In each of these roles, I was able to bring my own unique perspective while simultaneously learning from other experienced physicians.

One of the most valuable lessons that I have taken away from these experiences is that leadership takes active energy. While the hierarchy of residency training is well established, the investment of effort is necessary to build a foundation for effective leadership.

Continued on page 11

Paternity Leave, *from page 9*

great amount of flexibility. It gives me the flexibility to work around family visiting and work with my department to lessen the impact as much as possible.

I freely admit this is a burden on our department. It is a financial burden and a call/work burden to my colleagues. I was extremely nervous to take this newly offered leave because I was the first male physician in our department to take a leave like this. It was so significantly different from the "norm" of what physicians had done before me, and from even what I had already done myself.

Part of me felt a duty to take this opportunity to begin to change that "norm". I very much believe in the importance of family in our lives and in our careers. Our families keep us grounded in reality, keep us sane, and keep us human in a system that sometimes tries to strip us of our humanity.

In the end, my chairman and department were both very supportive in this endeavour. Being supported like this builds an immeasurable amount of dedication to the department. Building a family like this, really allows one to lay down some really deep roots (to use the cliche). In the end, eight weeks or more, is very little over the course of a 30 year career.

One benefit I did not realize until talking this over with a few colleagues was this helps to close some of the gender gap that still exists in medicine. Whether we want to admit it or not, I believe there is some inherent bias in hiring female physicians because of the "risk" that they will bear children at some point during their career and thus need to take maternity leave.

This should dispel some of that bias, because now men and women have an equal opportunity to take some very necessary and very deserved time off to be with their new/growing family.

An Update on Legislative Matters in an Eventful Year

By Lauren Schmitt
Commonwealth Strategy Group

2020 has been an eventful year in all aspects, including the legislative arena. While the regular 2020 General Assembly session adjourned in March, a lot has happened since then as a result of the COVID-19 pandemic. When the legislature returned for the Reconvened Session in April, they voted to freeze all new spending that had been included in the budget passed in March. Unfortunately, but not surprisingly, this included our Medicaid rate increase to bring anesthesiologists to 70% of Medicare.

On August 18, the General Assembly returned for a special legislative session focused on the budget, COVID-19 and criminal justice reform. It is unclear how long they will be in session, but it will likely be several weeks.

Delegate David Reid, who represents Loudoun County, submitted a budget amendment to "re-allot" our funding for the Medicaid increase. We will continue to advocate for this increase until it is permanent. With the ongoing fiscal crisis caused by COVID, we will likely have to focus our efforts on the 2021 legislative session.

We are also working with the Medical Society of Virginia to support funding of the Virginia Mental Health Access Program (VMAP). This is a statewide mental health access program specifically designed for children that provides them with mental health services by expanding the existing workforce.

It gives children's healthcare providers access to child psychiatrists, psychologists, social workers, and care coordination. Unfortunately, the funding originally allocated to expand VMAP statewide was "unallotted" in April. We are supporting a budget amendment proposed by Delegate Paul Krizek that would utilize federal CARES Act funding to help VMAP expand some services statewide and respond to the children's mental health crisis that has only gotten worse as a result of the pandemic.

Several healthcare related bills have been introduced during the special session. Read below for a brief recap of the top issues we're working on currently:

Telemedicine

VSA worked with the Medical Society of Virginia and other specialty physician groups to advocate for legislation that would make many of the telehealth policies allowed because of COVID permanent. Senator George Barker and Delegate Dawn Adams introduced bills that do the following:

- Prohibit health plans from requiring a provider to use proprietary technology or applications offered by the health plan in order to be reimbursed for telemedicine services
- Directs the Department of Medical Assistance Services to reimburse providers for Medicaid-covered services delivered via audio-only equipment and by telemedicine services, as described in guidance issued by DMAS on March 1, 2020 that is in effect until July 1, 2021.
- Reimburses for telemedicine services regardless of the originating site of care.

Nurse Practitioners

Governor Northam issued an Executive

Continued on page 12

Leadership and Global Health, *from page 10*

As I reflect on my residency journey, I feel proud of my accomplishments. As a young anesthesiology resident, I was fortunate to have many female mentors to whom I could relate from the beginning of my training, and who were able to help me shape my career into what it is today. I have learned that if you have interest in any form of leadership, you should take action. Do not wait for someone to offer you the chance to shine; instead, pave your own way. Join committees, take on extra work, continue reading and learning, and colleagues will quickly take notice. Strong residents and physicians are often created in their formative years of training, and there is no wrong time to step up. Oftentimes, if you see a solution to a problem, you have to be the one who follows through.

One example of this comes from my mentor, Dr. Olga Suarez-Winowiski. She single-handedly created the Virginia Commonwealth University (VCU) Global Health Initiative in 2018. This is a program linked to anesthesiology residency programs in Toluca, Mexico, which is Dr. Suarez's hometown just outside of Mexico City, Mexico. Residents from Toluca rotate at VCU, and senior residents at VCU travel to Toluca and participate in teaching ultrasound skills in transthoracic echocardiogram and regional anesthesia. I participated in this program in March 2020. We visited three anesthesia residency programs and provided basic ultrasound hands-on training to 45+ residents and 20+ attendings. I observed firsthand the effects just a few eager physicians can have on a community. As an acute pain and regional fellow at VCU, I find this to be an incredible opportunity to educate residents and anesthesiologists in my field of interest, while honing my skills as a teacher and future mentor.

Being a female in anesthesiology may come with its own nuances and challenges, but that should never deter someone from pursuing leadership roles and passions. Dr. Suarez-Winowiski and our Global Health Initiative is a prime example of "if you can dream it, you can do it." It reminds me that sometimes you have to create your own opportunities when the occasion arises. I hope women everywhere, whether finally embarking on, or in the middle of their own journeys in medicine, know that opportunities to shape your field are available in more ways than one. With passion, hard work, and dedication, women can continue to challenge the image of leaders in medicine.

The VCU Global Anesthesia Program is a 501c3 program supported through the MCV Foundation. If you would like to make a donation to help further the program's efforts, please email Dr. Olga Suarez-Winowiski at olga.suare-winowiski@vcuhealth.org

SleepGuardian by Anesthesia Connections

In-Office General Anesthesia by Physician Anesthesiologists

Anesthesia Connections, LLC was founded on the principal that surgeons and dental providers were looking for options to do surgical procedures in the comfort of their office. With advancements in technologies and the reimbursement landscape ever changing (favoring in-office) it makes sense for providers, insurance companies, and patients to look for alternatives outside of traditional healthcare settings.

Many procedures being performed in ASC's and hospital main operating rooms can comfortably be done in the office with proper anesthetic management, patient selection, and correct office setup. The cost overhead is much less expensive, anesthesia reimbursement remains consistent and patient's experience including outcomes and cost are clear winners. Who better to provide anesthetic management than a board-certified anesthesiologist?

With over 10 years of data including tens of thousands of cases over multiple states and a variety of surgical specialties it has clearly been proven an effective form of surgical treatment on multiple fronts.

SleepGuardian
In-Office General Anesthesia by Physician Anesthesiologists

Anesthesia Connections is an all-encompassing anesthesia provider. They help the surgeon's office order necessary medications, consumables, disposables, and equipment. They also set standards and protocols tailored to the specialty and cases being performed. Anesthesia Connections also has a division that will help offices become AAAHC or AAAASF accredited.

In an effort to brand and market board-certified anesthesiologists, to protect a very competitive landscape where physicians are losing contracts and direct contact with their patients, Anesthesia Connections decided to put a name to board-certified anesthesiologist so patients can better understand the choices they are making or not making about their healthcare.

SleepGuardian is the delivery of general anesthesia at the hands of board-certified physician anesthesiologists. Our medical doctors have high levels of training in anesthesia, airway, and emergency management. Our team is able to bring hospital-level standards of safety to the offices of numerous dental and elective medical practices to keep patients safe and comfortable during procedures.

SleepGuardian providers do much more than provide some IV sedation in the office setting for colonoscopies. In many spaces we are doing general anesthesia allowing surgeons to perform laparoscopy, nasal intubations for full mouth restorations, and full body cosmetic cases.

SleepGuardian providers do provide IV sedation/open airway cases in multiple settings but the value comes in the exploration of what can be done. The partnership between the surgeon, anesthesiologist, and the staff without the bureaucracy of the hospital creates innovation and economic processes.

Contact:
Thomas Dawson Lesperance II, M.S.
Co-Founder, Anesthesia Connections, LLC
anesthesiaconnections.com
mysleepguardian.com
Office: (888) 831-1942

Legislative Update, *from page 11*

Order in April that allowed nurse practitioners to practice without a practice agreement after only two years of clinical experience.

The physician community opposed this measure and expressed our disappointment to the Governor's office. It came as no surprise when legislation was introduced in the special session to make this permanent and allow nurse practitioners to practice independently after only two years. We advocated against this bill and were pleased that it died in the Senate Education and Health committee.

Unfortunately, there is still a proposed budget amendment that would extend the Executive Order until the end of the state of emergency. We will update you on the outcome once the budget is determined.

Personal Protective Equipment

VSA supported legislation introduce by the Attorney General around Personal Protective Equipment. This bill will allow the AG's office to investigate potential price gouging initiated by manufacturers and distributors. Physicians throughout Virginia have witnessed unconscionable price gouging for PPE as a result of COVID. We are thrilled that this legislation has passed committee and will continue to advocate for it.

Dentists and Influenza Vaccinations

A budget amendment has been proposed to allow dentists to administer influenza vaccinations. Currently, pharmacists, nurses and emergency medical technicians are permitted to do this under a special standing order from the Department of Health.

This amendment would add dentists to that list. VSA and the entire physician community oppose this amendment because it sets a precedent of allowing dentists to enter into the practice of medicine.

Surprise Billing

As a result of the surprise billing legislation we passed in March, the Virginia Health Initiative has convened a workgroup to develop commercially reasonable payments data sets for the arbitration process. VSA has three representatives on this workgroup and has been working closely with VHI staff to ensure the anesthesia rates are correct.

VHI has acknowledged that anesthesia billing is very complex and differs from other health care services. While there were several errors in the initial data set presented, we are pleased at how responsive VHI has been with working collaboratively with our representatives to ensure the numbers are truly reflective of a commercially reasonable rate. We will continue to monitor this closely and keep you updated.

Let's Talk About It: The Gender Gap in Anesthesiology and One Solution to Help Close It

By Kamilla Esfahani, MD and Allison J. Bechtel, MD

Dr. Kamilla Esfahani

Dr. Allison Bechtel

The data are staggering. By the mid-1990s, more than 40% of medical school graduates were women - a number that has been steadily rising. By 2006, over 30% of medical school faculty were women.[1] Yet, less women were in positions of leadership at medical schools, and were less likely to be promoted than their male counterparts (31% vs 37%)[1].

Anesthesiology saw its own wins and discrepancies. Since 2006, the number of women anesthesiology residents has increased from 31% to about 37%.[2] Each year, there has been an increase in the likelihood that a given faculty member will be a woman.

However, by 2015 only 7.4% of women were promoted to the rank of full professor, compared to 17.3% of men. There has been no change in the number of women as department chairs in anesthesiology from 2006-2017 – a worrying stagnation.[2]

Women in medicine are paid $0.90 on the dollar compared to men, even after adjusting for specialty, academic rank, and hours worked. Although, this is an improvement from the national data of the U.S. economy, where in general women are paid $0.82 on the dollar.[3] We also know that women are described differently to men in letters of recommendations and evaluations.[4]

Recommendations were more likely to describe women with generic terms and include adjectives like "hard-working," physical descriptions, doubt raisers, and remarks on work ethic. Overall, achievement words were geared towards men and caring words towards women.[4]

To make sense of these data and also provide the tools for change, the University of Virginia Women in Anesthesia and Women in Surgery groups joined forces to host the first annual Women Leadership Development Seminar on February 27, 2020.

Leadership development for women is a new area of interest. In the past, leadership development seminars designed for women were thought to be inferior due to the sole focus on gender differences rather than on building critical skills for emerging leaders. In addition, there has been a focus on studies that evaluate barriers for women developing into leaders, and this focus yields a narrow perspective depending on the institution and specific environment.

In the future, further studies are needed to assess the gendered culture in academic medicine and provide practical guidance for future women leaders.[5] Recently, there is renewed interest in leadership development designed for women due to gender differences in thought processes, gender stereotyping, and confidence levels.[6] By acknowledging these differences, leadership skill development for women in medicine, starting as early as possible in training, can empower women with necessary skills for successful career advancement and promotion into leadership roles.

The Leadership Seminar hosted by the University of Virginia Women in Anesthesia and the Women in Surgery was led by Dr. Kamilla Esfahani (Assistant Professor of Anesthesiology), Dr. Allison Bechtel (Associate Professor of Anesthesiology), and Dr. Anneke Schroen (Associate Professor of Surgery). Together, they developed and led the seminar with breakout sessions on The Likeability Trap[7] and Authentic Leadership, Surviving and Thriving in Residency and Beyond, and The Art of and Pitfalls in Communication.

This event was a tremendously successful leadership training event thanks to the participation and support of attending anesthesiologists and surgeons, including Drs. Dunn, Martin, Tracci, Lunardi, Kleiman, Hilton Buchholz, Forkin, Behar, Dengel, Kern, Jones, Shaffrey, Turza, Showalter, Rassmusen, Fedder, and Greene. The chairs and program directors for the Departments of Surgery and Anesthesiology, Drs. Adams, Friel, Huffmyer, and Rich, attended the event.

The UVA School of Medicine Vice Chair for faculty development, Dr. Sue Pollart attended the event and provided great insight as well. Over 20 anesthesia and surgery women residents and fellows participated in the seminar. The event would not have been such a big success without this amazing resident participation. The UVA Women

Continued on page 14

ASA Endorses Legislation to Preserve U.S. Workforce of International Physicians

The American Society of Anesthesiologists (ASA) applauds U.S. Senators David Perdue (R-GA), Dick Durbin (D-IL), Todd Young (R-IN), Christopher Coons (D-DE), John Cornyn (R-TX), and Patrick Leahy (D-VT) for introducing S. 3599, the Healthcare Workforce Resilience Act.

This bipartisan legislation would recapture 15,000 unused immigrant visas for physicians to strengthen the healthcare workforce and ensure patient access to care during the COVID-19 pandemic. ASA is pleased the bill aligns with recommendations made to the Administration earlier this year on addressing the national emergency.

ASA believes the strength of the physician workforce is vital to the overall healthcare infrastructure of our nation and urges Congress to advance this bill.

In March, ASA sent a communication to the White House formalizing key ASA recommendations to address top health concerns during the COVID-19 pandemic.

In the formal letter, ASA urged the Administration to expedite immigration processes to preserve the U.S. workforce of international physicians. The expiration of visas and loss of employment authorizations due to factors outside of the control of these physicians could result in the loss of valuable members of the U.S. healthcare workforce at this time of critical need. Many of these international physicians work in medically underserved areas and their potential loss would disproportionately affect care in areas with scarce physician resources.

ASA thanks the Senators for introducing the Healthcare Workforce Resilience Act. ASA will continue to advocate for legislation that addresses the physician workforce and work with Congress and the Administration to ensure patients have access to the care they need.

Gender Gap, *from page 13*

in Anesthesia group was founded by Drs. Dunn, Forkin, and Bechtel, and in addition to leadership development, this group hosts yearly journal clubs, lectures, and wellness events for the UVA anesthesia residents, fellows, and faculty.

UVA Women Residents in Anesthesia and Surgery Leadership Development Seminar Sessions

Session 1: The Likeability Trap and Authentic Leadership
- To be liked or successful, that is the question, or is it?
- Leadership backlash for women in the OR
- Social backlash for women in the OR
- Leading authentically: What does this mean and how do we do it?
- Widening the Margin for women leadership in the workplace

Session 2: Surviving and Thriving in Residency - The Ins and Outs, the Must-Dos, the To-Dos and Challenges
- How to set work boundaries
- Mentoring, sponsoring, networking: strategies and pitfalls
- Microaggression and how to respond to it
- Finances and negotiating salary

Session 3: "That's What She Said"
- Communication- things we say that he doesn't say
- Unconscious bias
- How we write: differences in research publications
- How do we deal with it and make it better

In the future, Drs. Bechtel and Esfahani hope to expand their leadership development seminar to include a regional conference for women residents and faculty to explore and develop leadership competencies, network with colleagues, and prepare for a career in academic medicine with enhanced leadership training.

If you are interested in hosting a Women Residents or Faculty Leadership Development Seminar and would like more information and to collaborate, please contact Dr. Bechtel at as4sk@virginia.edu and Dr. Esfahani at ke4h@virginia.edu.

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AAMC Statement on Gender Equity

Approved by the 2018-2019 Board of Directors

The Association of American Medical Colleges acknowledges that gender equity is a key factor in achieving excellence in academic medicine. It is well documented that diversity is a driver of excellence.

To achieve the benefits of identity and cognitive diversity, diversity must be inextricably linked to inclusion and equity. Environments are equity-minded when every person can attain their full potential and no one is disadvantaged from achieving this potential by their social position, group identity, or other socially determined circumstance.

Gender equity is an integral component of our efforts to achieve excellence through diversity, inclusion, and equity.

As society and industries outside medicine now redouble their efforts to be diverse and inclusive, so too must academic medicine.

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We all bear the responsibility and must work together as a community to effect this change.

AAMC-member institutions must be intentional in identifying exclusionary practices, critically deconstructing practices that sustain inequities within our institutions, and acting to elimi- nate these inequities. However, many inequities exist covertly outside institutional practices and policies.

To mitigate gender inequities, academic medicine must radically transform its culture of power and privilege into one of equity and inclusion.

Academic medicine has suffered as a result of systemic discrimination and can no longer ignore the large impact that gender inequities have created. Now is the time to act. Member institutions and societies must renew their efforts to end exclusionary and discriminatory practices that operate across infrastructure, governance, operations, policies and processes, and workforce development.

For the health of the academic medicine community, and for the patients who count on us, we can, we must, and we will achieve gender equity.

For more information about the AAMC is addressing the issue of gender equity, please visit aamc.org.

Dr. Fleisher Appointed to New Role at CMS

Lee Fleisher, MD, has been appointed to serve as the Centers for Medicare and Medicaid Services (CMS) Chief Medical Officer and Director of the Center for Clinical Standards & Quality (CCSQ). CCSQ serves as the focal point for all quality, clinical, medical science issues, survey and certification, and policies for CMS programs.

Dr. Fleisher leads ASA's Perioperative Brain Health Initiative, a campaign focused on providing patients information about the risks of delirium and cognitive dysfunction after surgery.

He is the Robert D. Dripps Professor and Chair of Anesthesiology and Critical Care and Professor of Medicine at the University of Pennsylvania School of Medicine. He has previous experience working with CMS, having advised on technical expert panels since 2003.

Dr. Fleisher will continue some professional and clinical activities, while working with CMS, including retaining faculty appointment with the University of Pennsylvania.

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